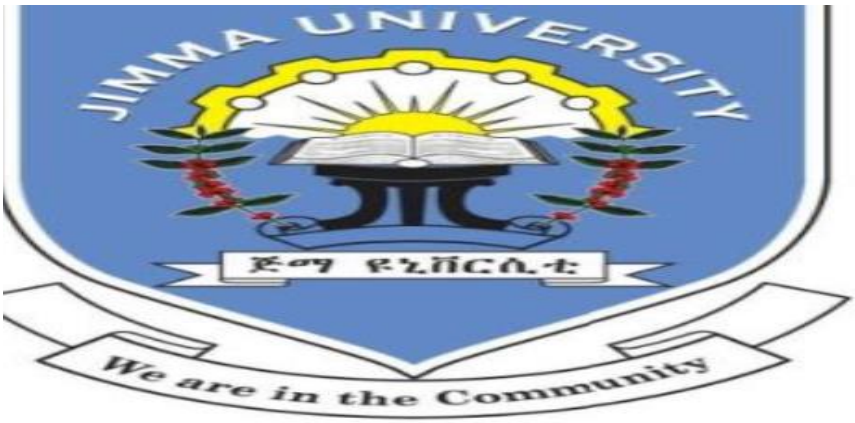

ASSESSMENT OF YOUTHS' COMMUNICATION ON REPRODUCTIVE HEALTH ISSUES AND RISKY SEXUAL BEHAVIOR AMONG HIGH SCHOOL STUDENTS WITH THEIR PARENTS, IN ALETA CHUKO WOREDA SIDAMA ZONE, SNNPR ETHIOPIA. CROSS SECTIONAL STUDY.

BY

NAHOM TESFAYE

A RESEARCH PROJECT SUBMITTED TO DEPARTMENT OF HEALTH EDUCATION AND BEHAVIORAL SCIENCE COLLEGE OF HEALTH SCIENCE, JIMMA UNIVERSITY; IN PARTIAL FULFILLMENT FOR THE REQUIREMENT FOR MASTERS OF PUBLIC HEALTH IN HEALTH EDUCATION AND PROMOTION.

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JIMMA,ETHIOPIA

College of health science

Department of health education and Behavioral Science

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BY

NAHOM TESFAYE

LIST OF ADVISORS

- YOHANNES KEBEDE **(BSC, MPH, ASS.**PROFESSOR**)**
- FIRA ABAMACHE (BSC, MPH)

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JIMMA, ETHIOPIA

Abstract

Back ground:-"Youth", "Adolescents " and "young people " are defined by WHO as the age group between 15-24 years ,10-19 years and 10-24 years respectively. Sexual and reproductive growth and development is one of the remarkable changes during this period. The health threats for adolescents today are predominantly behavioral rather than biomedical and more adolescents are involved in health behaviors with potential for serious consequences. In Ethiopia, Sexual and reproductive health problems of adolescents are increasing from time to time and this is related with most parents do not feel happy to discuss about sexual issues with their adolescents and early sexual commencement.

Objective: -The study was conducted to assess the youths' communication on Reproductive health issues and risky sexual behavior among high school students in Aleta Chuko Woreda, SNNPR, Ethiopia, February,2016.

Methodology:- A cross-sectional survey through self-administer questionnaires and FGD was conducted from March to April 2016 at Aleta Chuko preparatory and high schools to assess youths' communication on SRH issues and risky sexual behavior among school students and their parents.

Result:-A total of 760 adolescents participated in the study. Of these, 425(55.9%) were males and 335(44.1%) were females. Furthermore, about 35% of the respondents were sexually active. School was mentioned as the most common source of information for sexual and reproductive health. Six hundred eighty six (90%.3) of the respondents reported that it is important to discuss sexual and reproductive health with parents.407 (53%) of the students discussed with either of their parents in at least two topics of SRH. Nevertheless, most of the respondents preferred to discuss SRH issue with their peers than their parents. In addition, there were low communication between adolescents and their parents on SRH issues. Both males and females were more comfortable to discuss sexual and reproductive health issues with similar sex and siblings.

Conclusion:- Hence, based on the findings obtained it is recommended that sexuality education should be initiated for the students in school for effective communication on SRH.

Key words: school students, parent, communication, risky sexual behavior.

Acronyms and Abbreviations

AIDS= Acquired Human Deficiency Syndrome

FGD= Focus Group Discussion

FLE= Family Life Education

HI= Health Institution

HIV= Human Immunodeficiency Virus

LGV= Lympho Granuloma Venerium

MOH= Ministry Of Health

OCP= Oral Combined Contraceptive

RH= Reproductive Health

SNNPR =Southern Nations, Nationalities and People's Region

SPSS= Statistical Package For Social Science.

SRH= Sexual And Reproductive Health

STD= Sexual Transmitted Disease

STI= Sexual Transmitted Infection

UNAIDS =United Nations Programme on HIV/AIDS

UNDP =United Nations Development Programme

UNFPA =United Nations Population Fund.

USA = United States Of America

WHO= World Health Organization

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CHAPTER ONE

INTRODUCTION

1.1BACKGROUND

"Youth", "Adolescents " and "young people " are defined by WHO as the age group between 15-24 years ,10-19 years and 10-24 years respectively. The onsets of adolescence which more or less coincide with puberty are often influenced by manifestation of puberty. Adolescence is a period of rapid physical, psychological and emotional development and a period of adjustments with family and society. Generally this transition is smooth; though it can sometimes be stormy(1).Adolescents are at high risk for practicing risky sexual behaviors (2).

Across the life span, adolescence is the time of greatest risk taking (3).While sexual behavior in adolescence can be risky, it is also a natural part of human development (4). Even though, adolescent risk taking can derive them to development, it more results in experiencing risky behavior than disease (5).Risky sexual behavior is any behavior that increase the probability of negative consequence associated with sexual contact like sexually transmitted disease;HIV, unplanned pregnancy and abortion which can lead them to death and disability. It also includes behaviors like having multiple partners, early sexual initiation and failure to discuss risk topics with partner and inability to use protective methods like condom (6).

Globally above 1.8 billion young people between ages of 10-24 years and represent 27 % of the world population. Today some 1.4 billon, that make up above 90% of young people live in developing countries. In Ethiopia thirty four percent of population comprises young people age of 10–24 years old. (7, 8, 9).

Adolescents often lack basic RH information, knowledge, and access to affordable confidential health services for RH. Many do not feel comfortable in discussing RH with parents. Also parents, health care workers, and educators frequently are unwilling or unable to provide complete, accurate, age-appropriate RH information to adolescents. This is often due to their own discomfort about the subject or the false belief that providing the information will encourage sexual activity (10).furthermore, when young people feel unconnected to home, family, and school, they may become involved in activities that put their health at risk.

However, when parents assert the value of their children, adolescents more often develop positive, healthy attitudes about themselves.

Most adults want adolescents to know about abstinence, contraception, and how to prevent HIV and other sexually transmitted infections (STIs), parents often have difficulty communicating about sex. Nevertheless, positive communication between parents and children helps adolescents to establish individual values and make sexually healthy decisions (11).For youth to meet their sexual and reproductive health require special adjustments, like increased privacy , confidentiality, using neutral language (e.g. "youth friendly services"), trained providers who are comfortable for the service and reduced cost or cost free service (12).

1.2 Statement of the problem

Adolescent risky sexual behavior has global concern as a result of its negative consequences on physical, social and psychological health of adolescents. Adolescents who engage in sexual behavior at earlier ages have more lifetime sexual partners, a greater likelihood of acquiring HIV/AIDS and other sexually transmitted infections, and a greater likelihood of having an unintended pregnancy. (13) These will bring associated social costs like welfare dependence, medical expenses, and family psychological distress. (14) For instance in each year over one million teenagers become pregnant and over four million are diagnosed with a sexually transmitted disease (15).

In United States nearly 50% grades 9–12 high school youth are sexually active. Among them, 7.1% start sexual intercourse before 13 years of age, 14.9% have sexual intercourse with four or more partners, and over one third (38.5%) have not used a condom during their last sexual intercourse. These behaviors put youth at risk of negative consequences, such as unplanned pregnancy and sexually transmitted infections (STIs), including the human immunodeficiency virus (16).

Adolescents' risky sexual behaviors remain also a concern in most developing countries. Evidence from Demographic and Health Surveys of many countries shows high levels of multiple sexual partners and high-risk sex among female and male adolescents living in sub-Saharan Africa. A vast majority of who report not using a condom at their last high risk sex experience (17).

According to national adolescent and youth reproductive health strategy of Ethiopia, specifically directed to addressing their most persistent needs of reproductive health including early sexual debut, age at first marriage, early child bearing, unwanted pregnancy, abortion, knowledge and use of family planning methods, HIV/AIDS and STIs. Unfortunately, it is restricted at health

facility level and rural areas which have limited access to targeted reproductive health services. Sexual and reproductive health service has not been provided at school, at community and at family level broadly. The rapid spread of the HIV/AIDS epidemic in the country is posing very serious threats of overall socio-economic and human development prospects in the country. high rates of adolescent pregnancy that HIV infection will affect the next generation as well, putting babies at risk of vertical transmission and creating a generation of AIDS orphans (18, 19).

The world adolescents and youths suffered with sexual and reproductive problems, over 500,000 adolescents treaty gonorrhea each year, and 25% of AIDS cases involve young adults who probably become infected with HIV during adolescence, and now a day's half of all new HIV infections and 70% of STIs occur among 15-24 year olds(20). Every year 2.5-3 million teenagers acquire a STI of one or another kind. This shows us approximately one out of every ten adolescent even in developed countries becomes STD-infected each year(21).

Risky sexual behaviors of adolescents cause STIs and unwanted pregnancy and unsafe abortion, which may pose very serious threats of overall socio-economic and human development prospects. Furthermore, unwanted pregnancies lead to school dropout and a failure to complete their education. The situation gets worse for those who are not physically and mentally maturated, such as the youth. Most frequently, unwanted pregnancies also end up with unsafe abortion, which can lead to death and loss of life (22).

It is estimated that each year, worldwide, 16 million girls aged 15-19 years give birth and that about 11% of children are born to adolescent (23). In the developing world, 13 million adolescent girls and women younger than age 20 have unintended births each year, and significant unmet need for contraceptives exists among both unmarried and married adolescents (24). Forty-one percent of unsafe abortions in developing regions take place among young women aged 15–24; 15 percent are among those aged 15– 19 (25).Maternal mortality is 28% higher among 15-19 year olds than for women aged 20-24 year olds. (27).

70, 000 adolescents die annually of causes related to pregnancy and childbirth. A study on adolescent fertility in Sub-Saharan Africa revealed that 50-70% of first pregnancies in adolescents, in five out of eight countries surveyed, were unwanted and unplanned(24). In Ethiopia, 60% of adolescent pregnancies are unwanted pregnancies resulting from unprotected sexual intercourse. Pregnancy outside wed lock is however; usually major social stigma and therefore most of these pregnancies end up as cases of unsafe abortion (22).

Parent-child communication about sexual and reproductive health is an important proximal reproductive health consequence .where as in Africa sex-related discussion between parent and adolescent are taboo including in Ethiopia believed that telling adolescents about sex and instruction them how to keep themselves would make them sexually active and culturally shameful [28, 29].

Many parents don't discuss with their child until they discover their teen has already made difficult sexually related decision. By this time the teen has probably already engaged in sexual activity, Communication is ineffective. The child was not encouraged to discuss sexually related issues from an early age; the teen will feel uncomfortable with the subject matter at this point in time. As a result the teen might lie or tell the parents what they want to hear in order to avoid an awkward situation. The parents may also feel Uncomfortable discussing the subject matter with their child and will have difficult initiating such a conversation (30).

Sexuality communication about sexual matters, perhaps now more than any other time in the history the issue of sexual health is important for virtually every one. This is because adolescents are affected with the burden of unwanted pregnancy and its complication, HIV/AIDS/STI, and other sexual and reproductive ill-health. . Profound problems of sexually transmitted disease and out -of –wed lock pregnancy as well as the potentially significant negative emotional consequences of premature sexual activity point to the overwhelming need to provide sexuality education for young people (23).

Generally family Communication as well as parent child discussion about sexuality both seems factors in the study of family impact on sexuality. Since family can exert a strong influence on adolescents' sexual behavior, it is important to understand the role of family influence on sexual behavior. Thus, adolescent-parent communication regarding sexuality often is viewed as desirable and perceived by many to be effective means of encouraging adolescents to adopt responsible sexual behaviors (31).

Communication between parents and their children about sexual issue and impact of this communication on adolescents' sexual behavior has been one important research area; which will help in improving the prevention and education programmer that meet the needs and concerns of youth (32). Although this area has received considerable research attention, more Studies with representative samples are needed to assure that findings are reflective of populations of interest.

Therefore, the aim of this study is to assess the Youths' communication on reproductive health issues and risky sexual behavior among high school students in Aleta Chuko Woreda high school, SNNPR, Ethiopia.

CHAPTER TWO

2. Literature review

2.1.1 Back ground of information of the study

Adolescent sexual and reproductive health refers to the physical and emotional wellbeing of adolescents and includes their ability to remain free from unwanted pregnancy, unsafe abortion, STIs (including HIV/AIDS), and all forms of sexual violence and intimidation. Adolescence and youth is a period of many critical transitions: physical, psychological, economic and social (1).

2.1 .2 Communication on sexual issue and source of information on sexuality

A cross sectional study survey carried out in Ziway high school and parents on sexual matters indicates 54% of the students felt that it is culturally shameful to discuss about physical and psychological changes during adolescents [29].

A Study conducted in Butajira showed that only 5.6% and 2.6% of students reported talking about sexuality with friends and family members respectively [33].

A study in New York revealed 73.4% respondents had talked with their adolescent about condom (30). In line with this another study also showed that students were able to talk openly about sexuality firstly with friends (90.8%), and girl/boy-friend (80.5%) and least with teachers (18.7%), parents (17.8%) or priest (8.9%) [30].

Study done by Australian research center on high school students also revealed mothers were reported as more frequent communicators about sexuality than fathers. Young people rated parental communication about sexuality is unimportant [31].

Another study conducted among African-American adolescent ages 13-15 years showed that both male and female adolescents were likely to discuss sexual topics with their mothers than their fathers (32). Similarly in a study conducted in Mexico mothers had higher level of communication with their children about sex than did fathers [35].

In study conducted in students reported that they had got information on sexual maturation 48% from parents, 26% peer, 11% from health workers and mass media and seventy six percent of

them had mentioned that it is shame or culturally not acceptable to raise such questions for adult family members [36].

A study in Zimbabwe among young people, 80% of the respondents had discussion about reproductive health with friends (72%), siblings (49%), parents (44%), teachers (34%) or partners (28%) [37].

And a study in Philippines poor communication with parents about sex related issues were reported by 75% of the respondents [38].

A study conducted in Laos PDR on age 18-24 perception of youth on general communication with their mothers and fathers the results indicate that youth less frequently talked about sexual related topics with parents (39).Over all fathers were rated as poorer communicators about sexuality than were mothers [40].

A Study in Zambia on secondary school girls 30% felt it was easy to discuss sexual matters with their mothers and 77% felt it was difficult to discuss sexual matters with their fathers. The extent of premarital sexual activity (71% had boy-friends of which 67% had a steady or close relationship [41].

A study done among senior secondary school students in Ghana, Accra, and 73.6% had talked about HIV/AIDS with parents or other family members [42].

A study in Uganda the main communication problem faced by adolescent daughters to talk about sexuality to their mothers were 42% reported that they feared their mothers, followed by mothers did not want to talk to them about sexuality 24%, mothers were too busy with their work 24%, other reason given were, the daughter was feeling shy to ask her mother 8%, mothers was not educated 4%. The main communication problem faced by mothers was shyness to talk to the daughter 68.4%, daughters were stubborn and would not listen to them 34.2% and mother was very busy 10.5% [43].

Youth survey in Kenya most reported that source of information about sex was from their peers, followed by books, magazines, and movies. Parents were mentioned the least number [44].

2.1.2 Adolescents' knowledge on reproductive and sexual health

The study conducted in Ziway show that Seventy four point nine percent of the high school students correctly knew the age at menarche and 71% of the total knew some forms of contraception pill (OCP), calendar method, and intrauterine device. Moreover, 27.7%of the

respondents were able to correctly name three commonly STI (syphilis, gonorrhea and chancroid) [29].

2.1.3 Parents' knowledge and attitude

On survey conducted on parents in Ziway nearly 94% of the 246 subjects admitted that there are some physical and psychological changes that take place during puberty. However, only 148(60%) of them reported the correct age range for puberty in females, and only 105 (42.7%) knew the corresponding age for males. It is only 65 (26.4%) respondents who correctly told the unsafe period in the menstrual cycle. Ninety three percent of the parents had a negative attitude towards premarital sex, though later on, 151 (61.4%) of them approved use of contraception in cases of unprecedented sexual acts in adolescents. Only 66 (26.8%) of the parents said that teenage pregnancy is associated with difficulties in childbirth. Two hundred and six (83.7%) mentioned two commonest types of STIs (gonorrhea, and syphilis), and only 70 (28.5%) believed that STIs predispose a person to HIV/AIDS (29).

2.1.4 Content and preference of adolescents for discussing on sexual and reproductive health issues.

A study in Kenya showed that males were most uncomfortable talking to their mothers, aunts, fathers, sisters, uncles and members of the clergy. They were comfortable talking to their brothers, friends and health care workers. Females were most uncomfortable with fathers, uncles, brothers and members of the clergy. They were most comfortable talking to sisters, friends, with boyfriends their same sex siblings and health workers [45, 46]. In one study both female and male reported that they were most comfortable discussing sexuality topics with their friends. Males adolescent were more likely than female adolescents to discuss sex based topics with their father [20]. If discussion is happened youth preferred to talk about the sexual matters with parents of the same sex [25].

And similarly in Kenya mothers were more likely to discuss reproductive health issues with their children than fathers [46].

The study done in USA among rural parents, 65% of them reported being comfortable talking with their teens about sexual issues [47]. And in study done in Harrar showed sex was a topic of discussion with friends in 57.6% of males and 28.1% of females [48]. In study conducted in Nigeria, adolescents reported that mothers talked to them on a wide range of sexual issues ranging from avoiding men and pregnancy 72.8%, avoiding STDs and HIV/AIDS 60%, about menstruation hygiene 63.2%[43].

In another study, about three-quarters of young men reported ever having spoken with their parents about AIDS and other STDs, birth control. However, for each topic only about half of the teenage males reported ever having discussed with either of the parents [49].

2.1.5 Sex education, sexual attitude and behaviors.

Study conducted in southern part of Ethiopia when asked about who should participate in educating the youth about sex and family life 54.7% school, 64.3% health professionals,9% peer educators, 8.8% community [51].A similar study conducted in Ethiopia 92.6% of students, 98.7% of parents and 96.1% of teachers approved the incorporation of health education in regular curriculum. The idea of sex education in school was approved by 80.1%of the students, 90.9% of the parents and 96.1% of the teachers should be commencing even in junior secondary school (grade 7-8) [52]. However, in another study most parents 80% believed that majority sexuality education should be provided by family and supplemented by outside organization preferably school [47].

The mean age of sexual initiation conducted among different studies in adolescents was (15.5 ±1.5, 16.1± 2.1, 15.3±1.5, 16.9±2.3 [55, 56, 57, 58]. The highest proportion of adolescents 22% had their first sexual intercourse at the age of 16 years. (54)

The Study conducted in Butagira showed, the majority of the students disapproved premarital sex (69.0%), adolescent pregnancy (76.5%) and abortion (67.8%). On the other hand, majority 90.7% approved introduction of sex education in school [33]. In addition in another study 77.7% of young females and 53.2% of males disapproved a premarital sex and approximately 26% of males and 15.9% of females approved of premarital sex if the two plan to marry [48].

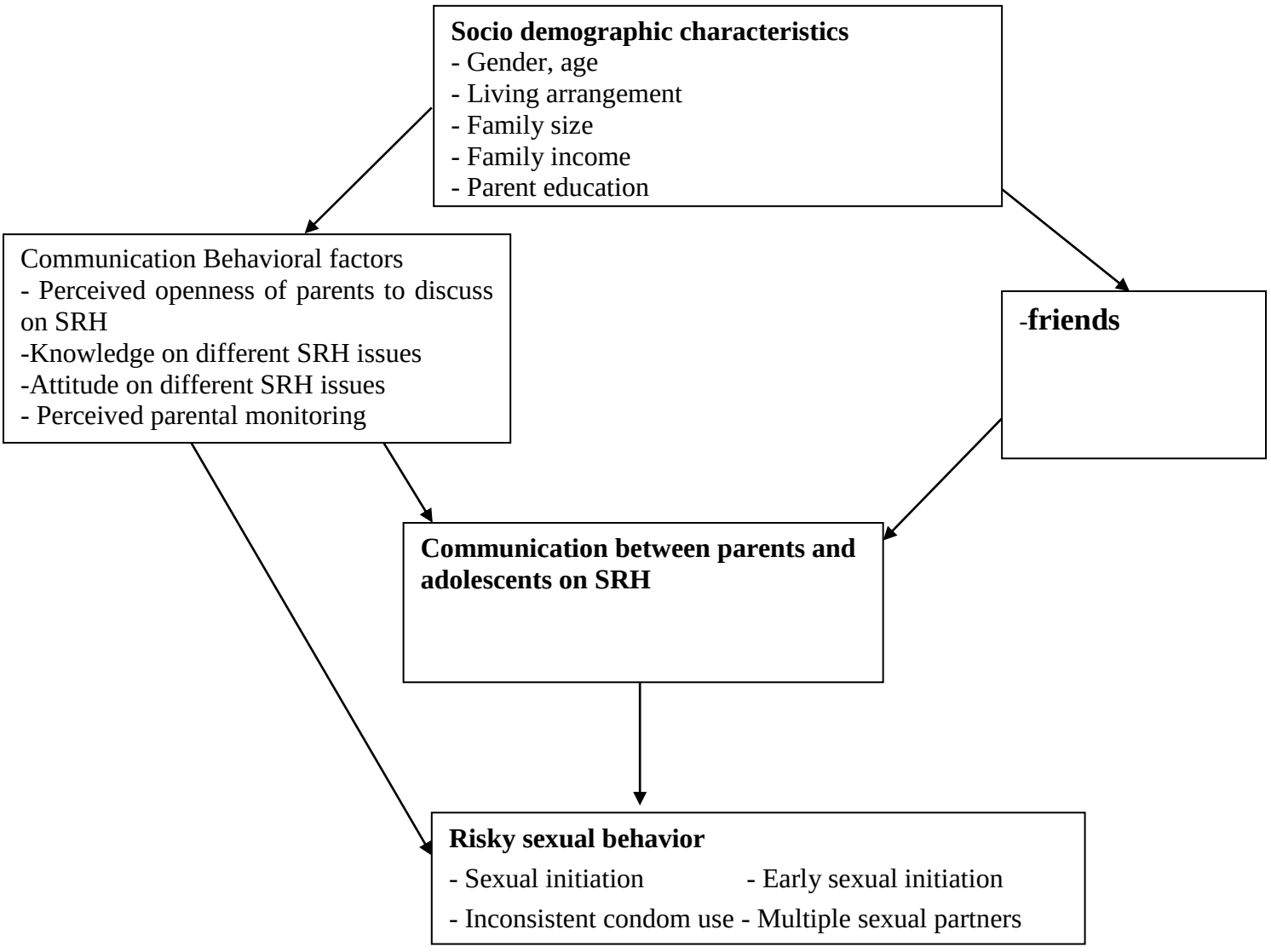
The study done in Debremarkos revealed, 88.2% of the parents had a negative attitude towards premarital sex (61).Similarly a study in Philippines most respondents held non-accepting attitudes towards both premarital sex and recreational sex 88%, 49% respectively [38].

Significance of Study

This study will have a contribution to both *knowledge* and *practice* with regards to adolescent pregnancy, and sexually transmitted diseases including HIV/AIDS prevention. The study examines factors associated with risky sexual behavior one of the key pre-requisite information required in designing relevant, effective and comprehensive adolescent health programs; considerable strategic significance to national efforts to prevent adolescent pregnancy, and sexually transmitted diseases including HIV/AIDS. This will have an impact in the design and development of sexual &reproductive health communication materials. It will also give insights to future research in the effect of adolescent-parent communication on different adolescent sexual reproductive health issues in this segment of the population. In fighting the early marriage, adolescent pregnancy, and sexually transmitted diseases including HIV/AIDS, conducting research that investigates the youths' communication on SRH and risky sexual behavior their parents is important which will help those who are working on ASRH programs.

Conceptual framework of the study

Conceptual framework in this study was developed after reviewing the relevant literatures (58, 59, 61.62, 65, 66) as shown in the figure socio demographic factors, communication behavioral factors and peers linked with parental communication on SRH issues. It was also illustrated that communication behavioral factors and parental communication on SRH issues directly linked to risky sexual behavior.



Chapter Three

3. Objective of the Study

3.1 General Objective

The general objective of this study is to assess the youths' communication on Reproductive health issues and risky sexual behavior among high school students in Aleta Chuko Woreda, SNNPR, Ethiopia, February, 2016.

3.2 Specific objectives

- To describe parental communication on reproductive health issue
- To identify factors associated with risky sexual behavior.

CHAPTER FOUR

Methods and Materials

4.1 Study Area and period

The study will be conducted in Aleta chuko woreda which is located in SNNPR regional state; Sidama zone, across the International road 330 km apart from Addis and 52km from regional and zonal capital city Hawassa. The reason why this area is selected is that the investigator is familiar with area; so that can easily get the necessary information and cooperation. Moreover, the relevant characteristics of the district are similar to the rest of the population of the zone. It covers 322.48 karee KM land area which bordered with Aleta Wondo woreda at East, Dara woreda and Oromia region at south, Dale and Loka Abaya woreda at North and West respectively. It located at 1400m-2300m above sea level with annual temperature of 15^{o}c -20^{o}c and annual rain fall of 1100mm-2300m. According to 2015 CSA annual projection; the total population of the woreda is 207,108, of whom 103,134(49.8%) male and 103968(50.2%) is female, the estimated total house hold or 2008 Ethiopian fiscal year is 42263. To see age structure of the population; 41,090 non pregnant women, 7166 estimated pregnant women, 32330 under 5 year population and 99971 15-59 age group constitute the total population. Regarding health infrastructures availability; there are 8 health centers, twenty six health posts, 6 private drug stores and 4 medium clinics. Youth friendly service has been provided at one only urban health center. The woreda has 26 rural and 5 urban Kebeles administrative structures. According to the report of woreda education office there were 43 primary schools, one secondary and preparatory school, and three junior secondary schools.

The study was conducted from March10-16, 2016.

4.2Study Design

Institution based cross sectional study was carried out among high school adolescent in Aleta Chuko Woreda, Sidama zone, SNNPR supplemented by qualitative data

4. 3 Population and sample

4.3.1 Source population: All students who attended class in high schools in Aleta Chuko Woreda and their parents.

4.3.2 Study population and unit: All sampled students enrolled in grade 9- 12 in Aleta Chuko Woreda for the academic year 2016. And Parents of those selected adolescents participated in focused group discussion.

Inclusion criteria: Those who attended school during the day at the time of data collection.

Exclusion criteria: Those who were married and severely ill.

4.4 Sample size

The sample size was determined by using single population proportion formula considering the following parameters; the level of confidence of 95%, which gives the percentile of the normal distribution, (Zα/2=1.96); the margin of error assumed to be 5%, using Proportion of parent-adolescent communication on sexual and reproductive health issues among adolescents from previous study is 57.6% in 2014 (65) for objective one which is intermediate variable of this study , Estimated non-response rate = 10%, Design effect of 2

Accordingly, the following formula given by Hollander and Wolfe (1999) was used to determine the sample size:

$$n = \frac{\left(Z_{\left(\frac{\alpha}{2}\right)}\right)^2 P\,(1-P)}{d^2} X Deff$$

Where: n = the required minimum sample size.

$$n = \frac{(1.96)^2 0.576\,(1-0.576)}{(0.05)^2}$$

$$n = 375$$

Since the source populations was less than 10,000 the calculation preceded with the correction formula as follows

$n_f = n_{i*N} / N+n-1$ Where n_f =final sample size ,n_i= initial sample size, N=source population

n_f =375*5009/5009+375-1=350

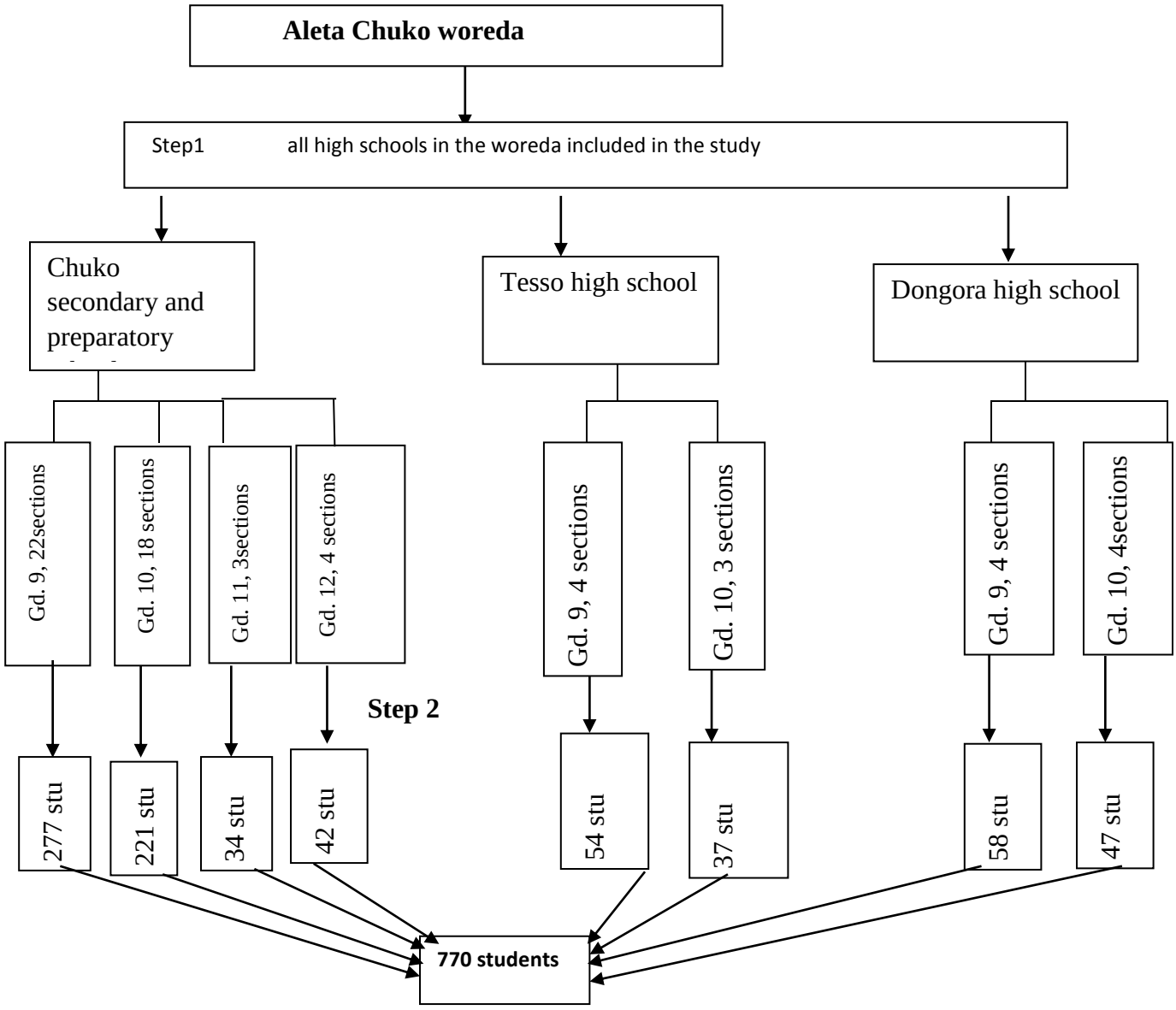
Final sample size by considering non-response rate = 10%, design effect of 2 for multistage sampling. Therefore the total sample size became 770 students.

4.5 Sampling procedure and Frame

A multi-stage sampling technique was employed in order to select the study units and then Probability proportionate stratified random sampling to select the number of participants from grade (grades 9-12) ,all sections of the grade were taken as stratum and final simple random sampling method were used to select the participants. The rosters of the students for each grades level and sections were made available from each of the school. Finally, the total sample size was proportionally allocated to each school, grades and sections.

Qualitative data was collected from parents of students who were not selected on quantitative data collection. Homogenous purposive sampling was used.

Schematically Presentation of the sampling procedure



4.6 Measurement and Variables.

The study have used, semi structured and translated self-administered questionnaire adopted from different literatures (58, 59, 61, 62, 65, 66). Questionnaire that was prepared in English and was translated to Amharic language then back was translated into English. The questionnaire comprises 14 items from socio demographic characteristics, 9 items on sexual and reproductive health knowledge, 7 items on sexual behaviors,13 items on sexual attitude, 7 items on parental monitoring and 49 items on communication about sexuality.

Dependent variable

- Risky Sexual behavior of adolescents.(multiple sexual partners, inconsistent condom use, early sexual initiation)

Independent variables

- Socio demographic variables
- Family income
- Educational status of students
- Knowledge on reproductive health
- Family size
- Living arrangements of the students.
- Parental communication on SRH matters

4.7 Data collection procedures.

Six data collectors who completed 10^{th}grade were recruited. Three supervisors were selected and they were responsible to lead the whole situation of data collecting process, to check the data was collected for consistence, completeness, editing, and suspicious of irregularity. The process was assisted by six teachers from the high school. Data collectors distributed the questionnaire to the students, remain in the class room during administration and transport the complete questionnaire from the school. The data collection instrument was anonymous structured closed ended self-administered question was filled by the students.

For qualitative data Tape recorder was used in order to capture their opinion fully after they were told about the objective of the study and upon recipient of written consent. A semi structured questions guide was used to lead the discussion.

4.8 Operational definitions

Communication on SRH: adolescent who discussed about SRH in at least two SRH topics with their parents (about condom, STI ,HIV/AIDS, sexual intercourse, unwanted pregnancy, contraception, avoiding premarital sex, puberty in the last 12 months (65).

Risky Sexual behavior- is early age sex or inconsistent condom use or multiple sexual partners.

Parental monitoring: - students whose parents really know where they spend their time outside home or school and with whom they spend their time outside home or school.

Parent: - biological parents or step parents or foster parents but it does not include elder siblings.

High School: - schools from grade 9^{th} to 12^{th}.

Inconsistent condom use: -sexual intercourse with inconstant condom use.

Multiple sexual partners: - more than one sexual partner.

Early age sex-is defined as experience of sexual intercourse before the age of 18 years

4.9 Data Processing and Analysis

To ensure the quality of the data, all questionnaires were checked for completeness and consistency. Data was entered using Epi data 3.5 and exported to SPSS version 20. Data was cleaned, coded, missing values were checked and analyzed using SPSS version 20. Univariate and multivariate analyses were carried out to assess the relationship between the outcome variables and selected determinant factors. Univariate analyses were carried out to describe socio-demographic characteristics, parental communication about SRH and risky sexual behavior. Model fitness was checked using HosmerLem show test at P value > 0.05. Odds ratios (OR) with 95% confidence intervals were calculated. Statistical significance was accepted at the 5% level ($p<0.05$). Chi-square was used as appropriate. Then out puts were presented using tables, charts and graphs. All focus group discussions were taped and transcribed. Analyses of the qualitative data were accomplished based on the predetermined themes and adding the context of additional information provided by the respondents.

4.10. Data quality management

The instruments were originally developed in English and then translated Amharic then back to English by another person to check consistency. The quality of the data were assured through pretest5% of participants on questionnaire, and discussion guide among students and parents those have adolescent learning in Sentereya high school in Aleta Chuko Woreda that helped for the

consistency and flow of the questionnaire. Double entry of the data, training for data collectors and supervisors, supervision, cross checking questionnaires on daily basis among data collectors and supervisors. Training was given for both data collectors and the supervisors for two days before the pretest and a day after the pretest by the investigator. Trustworthiness of qualitative study was enhanced by Credibility and Conformability achieved by using systematic data collection.

4.11Ethical consideration

Ethical rules approval and clearance was obtained from institutional Review board (ERC) of Jimma University College of Health Sciences. Permission to conduct the study was obtained from Aleta Chuko woreda Education Bureau. An official letter of co-operation was written to respective schools. Official cooperation letter was obtained from Aleta Chuko woreda education bureau.

Respective educational bureau and school officials also expressed their willingness after they were informed about the whole purpose of the research project. Consent was obtained from each participant. Information on the study was given to each participant, to encourage provision of accurate and honest responses. The instrument and procedures used in this study did not cause any harm to the study subjects, the community and the data collectors.

CHAPTER FIVE

Results

5.1 Socio demographic characteristics of the respondents

A total of 770 school students completed the questionnaire, of which 10 responses were excluded for gross incompleteness and inconsistency. Therefore, analysis was made based on 760 questionnaires. Thus, the response rate was 98.7%. Out of the total 760 respondents, 425(55.9%) were males and 335(44.1%) were females. The mean age of the respondents was 17.0 ± 1.12SD Majority, 378(49.7%), of the respondents were from grade 9 followed by grade 10, 11 and 12 accounting 305(40.1%), 35(4.6%) and 42(5.6%) respectively. Two hundred thirty four (30.8%) of the respondents were aged 13- 16, while the rest were aged 17 to 19 years old. they were within the range of 13-19 years. All the respondents were single. The majority of the respondents were ethnically Sidama 663(87.2%), followed by 43(11.9%) Guraghe.

Most of the respondents 535(70.4%) were Protestant by religion. six hundred forty eight respondents (65.9%) were living with both parents, followed by were living with single parent only, relatives and alone accounting 49 (6.5%), 12(2.5%) &42(5.7%) respectively. The majority of the respondents' parents 693(91.2%) were married, the mean family size and median of the estimated income of the participants were 6 ± 1.4Sd, 1600 respectively.

The majority 323(42.5%) of the participants had literate mothers. two hundred sixty six (35%) of participants' fathers were literate. The majority of the students' mothers 491(64.6%) were housewife. Two hundred fifty six (33.7%) of the participants' fathers were farmers by occupation. About 542(71.3%) of the students received pocket money

Table: 1 **Socio-demographic characteristics of school students in Aleta ChukoWoreda 2016**

Variables		Number(763)	Percent (**%**)
Sex	Male	**425**	**55.9**
	Female	**335**	**44.1**
Age	13-16	**234**	**30.7**
	17-19	**526**	**69.3**
Grade	Grade 9	**378**	**49.7**

	Grade 10	**305**	**40.1**
	Grade 11	**35**	**4.6**
	Grade12	**42**	**5.6**
Religion	Protestant	**535**	**70.4**
	Orthodox Christian	**131**	**17.2**
	Muslim	**92**	**12.1**
	Others	**2**	**.3**
Ethnicity	Sidama	**633**	**83.3**
	Guraghe	**43**	**5.7**
	Amhara	**36**	**4.7**
	Wolita	**28**	**3.7**
	Oromo	**18**	**2.4**
	Others	**2**	**.3**
Living arrangement of the students	Fathers and mothers	**651**	**85.3**
	Alone	**42**	**5.5**
	Mothers only	**37**	**4.8**
	Relatives	**19**	**2.5**
	Fathers only	**12**	**1.6**
	Others	**2**	**.3**
Pocket money	Yes	**542**	**71.3**
	No	**214**	**28.2**

	Missing value	**4**	**0.5**

Table: 2 **Socio-demographic characteristics of the parents of Students, April, 2016**

Variable	Number(n=760)	Percent (%)
Marital status of parents	692	91.1
Married		
Widowed	40	5.3
Separated	28	3.7
Mothers educational status		
Literate	323	42.5
Illiterate	139	18.3
Secondary school	124	16.3
Diploma	66	8.7
Degree and above	20	2.6
Father's educational status		
Literate	266	35
Secondary school	185	24.3
Diploma	114	15
Primary school	74	9.7
Degree and above	58	7.6
Illiterate	38	5
Mother's occupation		
House wife	149	19.6
Merchant	123	16.18
Gov't Employee	77	10.13
Farmer	39	5.13

Private Employee	14	1.84
No mothers	14	1.8
Father's occupation		
Farmer	256	33.7
Merchant	238	31.3
Gov't Employee	133	17.5
Private Employee	103	13.6
No fathers	30	3.95
Estimated family income		
<1000	45	6.2
1000-2000	384	52.8
>2000	298	41

5.2. Attitude and behavior of adolescents on parental monitoring.

Six hundred two (79%) respondents agreed parental monitoring on adolescents behavior. two hundred seventeen (50.9%) of females reported that they were forbidden to play with opposite sex despite the fact that the rest were allowed. Furthermore, 299 (56.6%) of males reported they were forbidden to play with opposite sex. Three hundred fifty seven (47%) of the students reported that their parents knew with whom their son or daughter are when out of home while 468(61.6%) of the respondents reported that parents did not know where their son or daughter are when out of home.

5.3. Communications on sexual and reproductive health issues

The majority of the students 686(90.3%) accepted the importance of education on issues related to sexual and reproductive health to adolescents. 641(84.5%) preferred school to be site for sex education more males than females agree on the importance of educating students on sexuality. And six hundred sixty (86.8%) respondents reported that it is important to discuss sexual and reproductive health with parents. However, only three hundred ninety seven 407(53%) of the students had discussed with either of the parents on at least two topics of sexual and reproductive issues. Three sixty five 335 (44%) of the students discussed with either of their parents in at least three topics of SRH.

5.3.1Communications on contraceptive methods

One hundred sixty four (21.6%) of the respondents reported that they had discussed on contraceptive methods. Out of 595 who had not discussed, majority 162(23.3%) reported their reason as it is lack of knowledge to discuss such issues with parents. Out of those who discussed on contraceptive majority 501(67.1%) discussed with their friends followed by 83(50.3%) with mothers.

5.3.1.1Communication on condom

Two hundred forty four (59.2%) of the participants had discussed. Out of those who had not discussed 73(46.5%) reason out as it is shameful to discuss about condom with parents and 55(35%) parents lack knowledge. On the other hand, out of those who had discussed about condom, majority 666(87.6%) discussed with their friends, 336(44.2%) brothers and 159(21%) with sisters.

5.3.2 Communication on STI

Three hundred eight (40.5%) of the students reported that they had discussed on STIs. The remaining had not discussed because 140 (31%) said their parents have lack of knowledge and another 108(24%) mentioned parents lack of communication skill. However, majority of the students 614(81%) had discussed this issue with their friends, followed by 212(28%) with brothers.

5.3.2.1Communication on HIV/AIDS

Three hundred seventy five (49.3%) of the students reported that they had discussed on **HIV/AIDS**. The remaining had not discussed because 117(30.4%) said their parents are not good listeners and another 92(24%) mentioned parents have lack of knowledge. However, majority of the students 655(86.2%) had discussed this issue with their friends, followed by 258(34%) with brothers.

5.3.3Communication on sexual intercourse

Two hundred forty two (31.8%) of the students had discussions related to sexual intercourse. six hundred forty six respondents held discussions with their friends (85%), 148(19.4%) with sisters and 98(12.8%) with brothers.

5.3.4Communication on unwanted pregnancy

One hundred thirty nine (20.3%) reported to have had discussion about unwanted pregnancy. four hundred fifty five (57.5%) of the respondents had discussed with their friends and 259 (34.1%) with their brothers and 79(10.4%) with sisters.

5.3.5Communication on avoiding premarital

Two hundred thirteen respondents (28%) had discussed on avoiding premarital sex**.** The most commonly mentioned reason for which they didn’t discuss with their parents about avoiding premarital sex were 137(25%) shameful to discuss followed by 133(24.3%) culturally unacceptable

and 53(29.6%). However, from those respondents who had discussion on avoiding premarital sex majority of them 445(87.2%) had discussed with their friends and 94(41.6%) with their brothers.

5.3.6 Communication on puberty

Three hundred twenty six (42.9%) of the respondents had discussed on physiological and psychological changes seen in youth (puberty). Out of those who had not discussed the most frequently mentioned reason were 101(23.3%) parents lack knowledge, 96(21%) are not good listeners to discuss in puberty. However, out of those who had discussed 617(81.2%) discussed with their friends followed by 337(44.3%) with brothers.

5.3.7 Preference of school students for discussing on sexual and reproductive health issues

Regarding the preference group for discussion about sexual and reproductive health issues majority 636(83.7%) of the participants chose their friends followed by 291(38.3%) brothers, 229(30.1%) sisters, 314(76.4%) mothers, and 85(20.7%) fathers.

Perceived parental Openness to discuss and rates of parental communication skill on sexual and reproductive health issues.

Two hundred forty respondents (31.7%) reported that fathers were open to discuss on sexual and reproductive health related issues. In line with this, three hundred fifty eight respondents (53.3%) students reported that mothers were open to discuss on sexual and reproductive health related issues. And four hundred fifty four respondents (59.7%) reported that parents communication skill was low, followed by 244(32.1%) medium and 62(8.2%) high.

Table:4 Showing school students, with whom they had discussed in different topics in Aleta Chuko Woreda,May, 2016

Topics of discussion	N (%) Discussed Yes	With whom they had discussed				
		Mothers	Fathers	peers	Brothers	Sister
Contraceptive	272(35.8 %)	147(19.3%)	125(16.5%)	635(83.6%)	74(9.7%)	185(24.3 %)
STIs	303(39.9 %)	132(17.4%)	171(22.5%)	614(80.8%)	81(10.7%)	186(24.5 %)
HIV/AIDS	375(49.5 %)	113(14.9%)	263(34.6%)	655(86.2%)	148(19.5 %)	134(17.6 %)
Sexual intercourse	242(31.8 %)	145(19%)	97(13.8%)	646(85%)	98(12.9%)	148(19.5 %)

Unwanted pregnancy	**246(32.4)**	**133(17.5%)**	**113(14.9%)**	**600(78.9%)**	**79(10.4%)**	**244(32.1%)**
Avoiding premarital sex	**211(27.8%)**	**109(14.4%)**	**102(13.4%)**	**653(86%)**	**103(13.6%)**	**212(27.9%)**
Condom	**210(28.6%)**	**67(8.8%)**	**143(18.8%)**	**666(87.6%)**	**141(18.6%)**	**126(16.6%)**
Pubertal stage	**328(43.2%)**	**165(21.7%)**	**163(21.5%)**	**617(81.2%)**	**121(15.9%)**	**188(24.7%)**

Table: 5 The major reasons for not discussing with their parent in school students, in Aleta Chuko Woreda, May 2016.

Topic of discussion	**N (%) not Discussed Yes**	**Reasons for not discussing**					
		Culturally Unacceptable	**Shameful**	**Parents have Less Comm. Skill**	**Parents lack knowledge**	**Parents are not good listener**	**Difficulty& embarassing**
Contraceptive	498 (65.5%)	58(11.6%)	37(7.4%)	114(23%)	123(24.7%)	59 (119%)	50(10%)
STIs	452 (59.5%)	103(22.8%)	48(10.6%)	108(14.2%)	140(31%)	30 (6.6%)	23(5%)
HIV/AIDS	384 (50.5%)	43(11.2%)	39(10.2%)	59(15.4%)	92(24%)	117 (30.5%)	34(8.9%)
Sexual intercourse	518 (68.2%	153(29.5%)	74(14.3%)	33(6.4%)	65(12.6%)	106 (20.5%)	86 (16.6%)
Unwanted pregnancy	515(67.8)	92(17.9%)	68(13.2%)	37(8%)	52(12.2%)	127 (24.7%)	123 (24%)
Avoiding premarital sex	547(72%)	133(24.3%)	72(13.2%)	37(6.8%)	52(9.5%)	137 (25%)	115 (21%)
Condom	445 (28.3%)	52(9.2%)	92(19.1%)	68(87.6%)	126(43.4%)	124 (21%)	82(18%)
Pubertal stage	434 (57.1%)	78(18%)	71(16.4%)	42(9.7%)	101(23.3%)	92 (21.2%)	50 (11.5%)

5.4 Sexual behavior of the adolescent.

5.4.1 Knowledge and attitude on selected sexual and reproductive health issues

Seven hundred eleven (93.3%) respondents knew about STI. HIV/AIDS was the most commonly known STI 625 (82%), followed by Gonorrhea 410 (53.8%).

Most of the respondents 623(81.7%) knew when first menstrual period started (menarche), and the reported mean age of menarche was 13.3± 1.8 SD. Feeling towards first menarche among female respondents include fear, tension, felt sick, felt ashamed , felt pleasure, don't have menarche yet which accounted 113(34.5%),81(24.7%),60(18.3%),36(11%),30(9%),8(2.4%)respectively.six hundred sixty three (87.2%) of the students knew contraceptives methods. Injectable contraceptive and condom were mentioned by 485(63.8%) and 440(57.9%) the respondents respectively.

Table:7 School students' response to knowledge of STI in Aleta Chuko Woreda,2016

Variable	Number	Percent (%)
HIV/AIDS	625	82.2
Gonorrhea	407	53.6
Syhpilis	341	44.9
Chancroid	317	41.7
LGV	270	35.5
Others	180	23.7

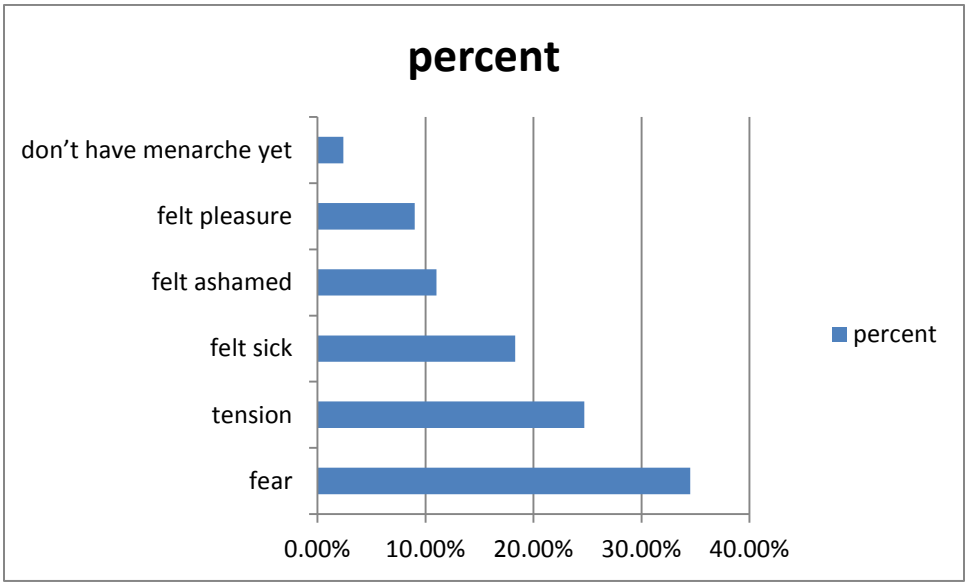


Fig.1 Female school students' feeling towards Menarche in Aleta Chuko Woreda, 2016

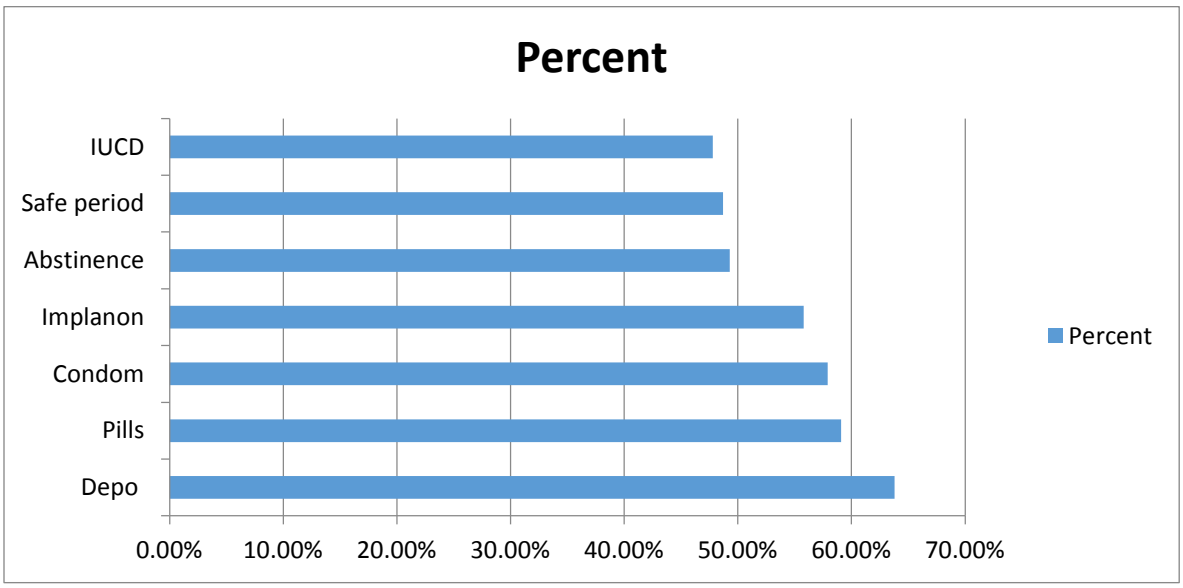


Fig.2. Knowledge of school students on contraceptive methods in Aleta Chuko, south, Ethiopia, April, 2016.

5.4.2 Source of information on sexual and reproductive health (SRH)

Majority of the students 686(90.3%) accepted the importance of education on issues related to sexual and reproductive health to adolescents while the remaining 74(9.7%) had negative attitude towards its importance. The most frequently mentioned source of information for SRH were school 641(84.3%) followed by mass media 623(82%), by friends143 (18.8%). Concerning the preference of the respondents as to where the education given majority of the participants mentioned school 506 (66.6%), followed by friends 96 (12.6%), home 49 (6.4%), and Church 55(7.2%).

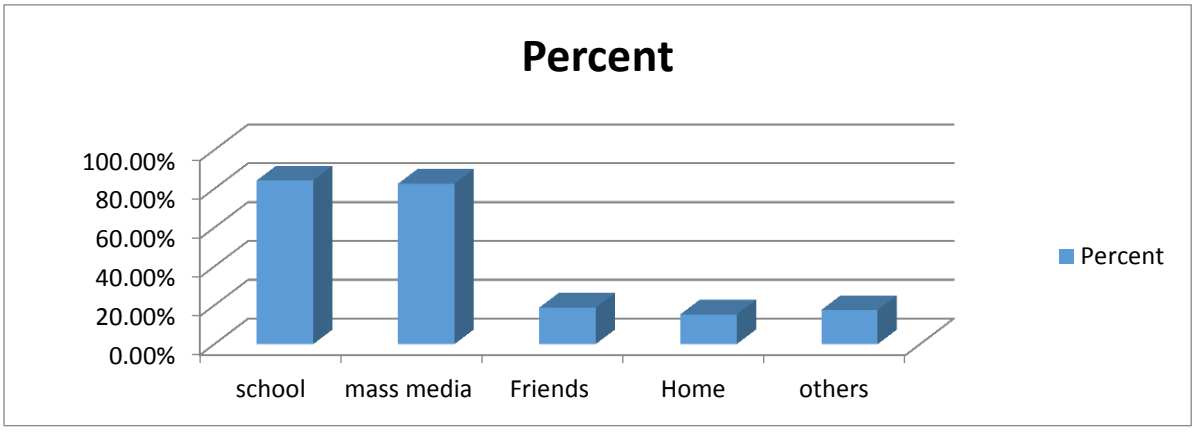


Fig.3 Source of information on SRH issue

5.5 Sexual attitude and behavior of students

Five hundred twenty five (69.1%) students believed that it is normal and acceptable to have sexual feeling during adolescence. Majority of the respondents 455 (60%) disapprove premarital sex. Most students, 686(90.3%), agree about the importance of educating students on sexuality, 507(71.8%) preferred school to be site for sex education. Out of 760 respondents, 266 (35%) were sexually active. Among students, 82(11%) were practicing risky sexual behavior. Engaging in sexual activity was reported to be higher (40.5%) among males compared to females (38.2%). The mean age of sexual commencement was 17± 1.12 SD and the median was 17 years old. From those who are sexually active students 85(30.2%) their sexual debut was fifteen and below fifteen years and 260 (98.2%) was below eighteen during their first sexual commencement.

One hundred ninety three (72.5%) of sexually active students reported that their first sexual partner was a boy/girlfriend, 15 (5.6%) an unknown person, 58 (21.9%) a relatives. One hundred seven (40.3%) students reported to have had two or more sexual partners in their life time. Out of the sexually active female students 26(19.1%) experienced unwanted pregnancy, out of which 24(92.3%) ended with abortion while 2(7.7%) ended with delivery.

Amongst 266(35%) students who had experienced sexual intercourse, 209 (78.7%) did ever use condom, out of which 116 (43.6%) were using consistently. Consistent condom use was reported by 74(64.1%) of males and 42(35.9%) of females.

5.5.1 Factors associated with risky Sexual behavior

After doing bivariate analysis on socio demographic characteristics, youths' communication and sexual attitudes of students verses risky sexual behavior.

From knowledge part, knowledge on contraceptive, on Gonorrhea and on LGV were significant

From Attitude part, only attitude on (sexual feeling during adolescence is normal, approval of risk of multiple sexual partner and approval to use condom for only occasional partner) were significant and on Communication part those who communicate on (HIV, sexual intercourse, STI and Condom) were significant on bivariate analysis on p value <0.25 in95%CI

Table: 8 Bivariate analysis output tables

Bivariate analysis STIs and contraceptive methods knowledge on risky sexual behavior

Variables	Risky sexual behavior		COR in 95%CI	PValue
	Yes	NO		
DO YOU knew Gonorrhea Yes No	 23 8	 172 178	 1. 2.97(1.30,6.83)	 0.01
DO YOU knew LGV Yes No	 16 15	 110 240	 1. 2.32(1.11,4.88)	 0.025
DO YOU knew Pills Yes No	 24 7	 182 168	 1. 3.12(1.33,7.54)	 0.009
DO you knew Depoprovera Yes No	 25 6	 195 155	 1. 3.31(1.33,8.27)	 0.010
DO you knew Implanon Yes No	 23 8	 165 185	 1. 3.22(1.04,7.40)	 0.006
DO you knew Implanon Yes No	 21 10	 136 214	 1. 3.30(1.51,7.23)	 0.003
DO you knew Condom Yes No	 25 6	 174 176	 1. 4.21(1.69,10.23)	 0.002
DO you knew Abstinence Yes No	 21 10	 142 208	 1. 3.07()1.41,6.73)	 0.005
DO you knew Safe period Yes No	 21 10	 140 210	 1 2.12(1.44,6.89)	 0.002
DO you knew emergency contraceptive Yes No	 30 4	 185 164	 1. 26.59(3.6,97)	 0.01

Attitude on selected RH matters				
Sexual feeling Normal and acceptable during adolescent Yes No	 29 2	 269 81	 1.0 4.36(1.02,18.69)	 1.0 0.047
Approval of risky of multiple sexual partners Disagree Agree	 5 26	 120 230	 1. 0.37(0.14,0.98)	 0.046
Approved use condom only for occasional partners Disagree Agree	 24 7	 154 196	 1.0 4.36(1.83,10.39)	 0.001

Communication on risky sexual behavior

Have you ever Communicated on HIVAIDS Yes No	 16 15	 160 189	 1. 3.70()1.61,8.50)	 0.002
Have you ever had Communicated on Sexual intercourse Yes No	 19 12	 102 248	 1. 3.85(1.80,8.22)	 <0.001
Have you ever had Communicated on STIs Yes No	 23 8	 119 231	 1. 5.58(2.42,12.85)	 <0.001
Have you ever had Communicated on Condom Yes No	 17 14	 96 254	 1. 3.21(1.52,6.77)	 0.002

Multivariate analysis

By entering all candidate variables into multivariate analysis only knowledge on contraceptive and communication on STI and RH issue were significantly associated with Risky sexual Behavior. Those students who had knowledge on Contraceptive use were less likely to get risky sexual behavior than those students who had not AOR 0.25, CI 95 %(0.08, 0.786).Those students who had ever communicated with their parents, were less likely to get risky sexual behavior than those who had not. AOR=0.17, CI95 %(0.03, 0.84)

Multivariate logistic regression analysis with risky sexual behavior.

Variables	Risky sexual behavior Yes Not at all		COR	AOR
Those Communicated on STIs Yes No	 113 200	 21 6	 0.16(0.63-0.41) 1.	 0.17(0.03-0.84) 1.
Knowledge on Contraceptive Method Yes No	 165 147	 23 4	 0.19(0.07-0.58) 1.	 0.25(0.08-0.76) 1.

CHAPTER SIX

Discussion

This study has attempted to assess youths' communication on reproductive health issues and risky sexual behavior among high school students and their parents in Aleta Chuko woreda, Sidama zone, SNNPR, Ethiopia.

The knowledge on contraceptive and Communication on STI and RH issue were significantly associated with risky sexual behavior of students.

Those students who had knowledge on contraceptive were less likely to practice risky sexual behavior. AOR 0.25(0.08-0.76) in 95% CI. This may be due to, the knowledge on contraceptives such as Condom and abstinence may help individuals to protect themselves from unsafe sexual practice. Thus; they may be refrained from risky sexual behavior. This finding is inconsistent with the study finding conducted in A.A Ethiopia which says "the knowledge of contraceptives encourages having sex with many people" (52).

When we see the youth's communication on RH and risky sexual behavior, those students who communicated with their parents on STI and reproductive health were less likely to engage in risky sexual behavior. this may be due to sexuality communication promotes healthy behavior and it is the major means to transfer knowledge, values and practice on sexuality issues .this finding is also consistence with the study finding conducted in Jimma High school students.(53).

Three hundred ninety one (35%) of the participating students reported to have had sexual experience, accounting 38.2% for the girls and 61.8 % the boys. This figure is considerably high when compared with the result of study done in Yirgalem high school students which was 22 %(55).This could be the fact that the difference in rural and urban nature of the study area.

The mean age of sexual initiation and the median of respondents of the present study was 16.5± 1.3SD and 17 respectively which revealed similar finding with study done among senior secondary school students in Ghana, Accra age of sexual initiation and the respondents was 16.0 and 17.4 years respectively and the finding also similar with the study done in Yirgalem, Bullen Woreda and Dire Dawa (42, 55, 56, 57).

In this study majority 455(60%) of the respondents disapproved sex before marriage; which is a consistent result with the study done at DebreMarkos high school students where 88.2% of the

students disprove premarital sex. The finding is also similar with other study done in Philippines, and local studies in Harrar, Butajira (61, 38, 29,48).

The majority 686 (91.3%) of the respondents in this study approved introduction of sex education in school which is comparable result with a study done in Butagira high school in which the majority 90.7% of students approved introduction of sex education in school.(16). In studies conducted among parents at Queensland Brisbane, Nigeria, and in local studies at Butagira, Hawassa and Yirgalem Southern Ethiopia results showed that parents were very supportive of school sexuality education program which is in agreement with the present study conducted on parents (29, 54, 55). This is an encouraging finding the fact that approving introduction of sex education in school by both respondents could possibly create a conducive environment for effective communication between parents and adolescents on sexuality issues. Similarly, approving introduction of sex in school and disproving premarital sex, which could have positive impact towards the prevention of sexual and reproductive health problems. In a study done in Nigeria, the focus group discussion of parents, showed that parents would accept sex and related reproductive education program in school is important to prevent unwanted pregnancy, HIV/AIDS (46). This finding reflects similar situation with the present study, which is also an encouraging finding, which could have a positive impact on the sexual behavior of adolescents.

The present study finding showed that majority of parents said sexuality education should be given in school and supplemented at home, which is in contrary finding from study conducted among rural parents in USA in which case most parents believed that the majority of sexuality education should be provided by family and supplemented by outside organization preferably school (34). This may be because of the fact that economical, educational status, and family life educations between these countries vary. Those variations could have an effect in accessing to different technology like Television, Radio, and internet service and etc in which they can help to teach their children at home level than school.

The result of the present FGD showed that parents were more discussing on schooling, future career which is comparable finding with the study done in Kenya (32).

Six hundred twenty one (81.7%) of the students in the present study correctly knew the age of menarche the result of this finding is consistent finding with the study done in Ziway high school students, which was 74.9% (29). More than 93.6% of the study population knew major sexually transmitted diseases indicating there is high knowledge and HIV/AIDS is the most commonly known

STIs. This may be related to the information that is widely disseminated through different Medias and the adverse effect of the problem that HIV is affecting still more and more young people in the area and the country at large.

Communication regarding sexuality often is viewed as desirable and perceived by many to be effective means of encouraging adolescents to adopt responsible sexual behaviors (20). Moreover, this study illustrates that most parents realize the importance of discussing with their children about sexuality but as many of them find they unable to address the subject comfortably. Some believe they don't know enough, feel embarrassed.

A study at Adelphi university Garden city in New York shows parents who were unwilling or unable to discuss this important and sensitive part of life with their children considered it as a negative and a taboo rather than as a natural part of being human (40).

This finding is consistent with the present study of focus group discussion of the parents.

This may indicate that there is a need to put an effort to improve discussion between parents and their adolescent through increasing their knowledge and communication skill.

Moreover, a study in Atlanta Georgia in USA indicates that the content of parent adolescents' conversation seemed to focus more on the negative outcomes of sexual intercourse and sexuality and low on what adolescents should know to more completely understand how they are growing and developing (20). This finding is also consistent with the FGD conducted in this study, which may indicate that there is a gap in discussing the positive aspect of adolescent sexuality related issues.

Thus, if young children discussed only a negative out come about sexuality with their parents, they will be highly unlikely to turn to their parents to discuss sexual matters as they get older.

On the other hand, positive communication about sexual information, feelings, attitudes, values and behavior when children are young often leads to ongoing discussions as they mature. Establishing a conducive environment to open and comfortable communication is thus, extremely important.

Additionally, a study in Ziway showed the impact of cultural taboo, shamefulness, and low communication skill of adolescents in many developing countries makes adolescents to discuss rarely on sexual matters explicitly with their parents (29). This is also a consistent finding with the present study.

In this present study adolescents were more comfortable discussing SRH issues with mothers than fathers. Moreover, both female and male adolescents prefer similar sex. A study done in Emory University, Atlanta Georgia USA, and Mexico showed that both male and female adolescents were

more likely to discuss sexual topics with their mothers than their fathers. Male adolescents were more likely than female adolescents to discuss sex-based topics with their fathers (20, 32). This shows similar picture with present finding.

Similarly, a study in Kenya showed that both male and female adolescents would be most comfortable discussing sexual matters with their friends of same sex and siblings.

Similarly a study done in Vientiane Lao PDR youth preferred to talk about sexual matters with parents of the same sex (25, 31).This is consistent finding with the present study.

This may suggest that there is sex preference in discussing sexual related issue which may indicate that discussing sexual issue with similar sex is comfortable. This may be possibly also due to the sensitive issues where youth preferred to have someone that they could discuss these issues and not feel shy when discussing sexual matters.

Moreover, in this study adolescents reported discussing a number of sex- based topics with friends and this supports the importance of peers, which is similar finding with study done in Atlanta Georgia USA (20). Discussing a number of sex-based topics with friends rather than parent may have a negative impact on adolescents' sexuality and sexual behavior if their peer is not equipped with appropriate information on sexuality.

On the other hand, in this study there was gender difference in discussing SRH issues.

For instance, discussing on HIV/AIDS, unwanted pregnancy and condom were high in males than females (51.1%vs47.2%), (34.3%vs29.6%), and (31.3%vs 23.3%) respectively. This may suggest possibly females are shyer than males to express their feeling. Still the reason is not satisfactory thus; to have full understanding difference further study should be conducted. However, topics like menses discussed more by females than males (86.7%vs 48.9%); which is in agreement with the natural phenomena the fact that, this is the females concern more than the males.

Majority of the female respondents feeling towards first menstrual cycle /menarche in the present study reported that fear, followed by felt tension, felt sick, and felt shame. This may suggest that most of the female adolescents did not discuss with their parents prior to their menarche, which is also comparable to FGD of the present study in which the majority of parents did not discuss on menstrual issues with their female adolescents.

Thus, not discussing on menarche may have negative psychological impact on female adolescents when they had for the first time.

Three hundred seventy five (49.3%) of the school adolescents had discussed on HIV/AIDS and 86.2.1% discussed with their peer of same sex about HIV/AIDS which is low as comparable to the study done in Dessie preparatory and high school students in that 85.8% of the students had discussed on sexuality and HIV/AIDS and 61.9% with their peers of same sex (58). This could possibly be explained by difference in the rural and urban nature of the study area, which could have an effect in accessing information from different Medias.

Regarding the influence of culture in this study 16.5% of the students reported that it is culturally shameful to discuss about physical and psychological changes in adolescents with parents. But the result is low as compared to study done in Ziway where 54% of the students felt that it is culturally shameful to discuss about it (15). In line with this, in this study 81.2% of the students preferred to discuss about body changes that occur during adolescents with peers of same sex; which is consistent finding with study done in Ziway that 75 % of the students prefer to discuss about it with peers of the same sex (29).

Most of the respondents in this study agreed parental monitoring. However, female adolescents reported a higher level of parental control in their activities like social mobility and social mixing with opposite sex than did male (51.6%vs 43.3%) and study done in Nicaragua showed a similar picture that there were higher level of parental control in female adolescents than male (44). This could be possibly explained by parents perception about female is different as compared to male adolescents in being affected by sexual and reproductive ill health problems.

Strength and Limitation of the study

Strength of the study

The sampling technique employed the achievement of high response rate, the use of appropriate methods to minimize bias; self-administered questionnaire and combining quantitative and qualitative data to diversify data could be also mentioned as the strength of the study.

Limitation of the study

Communication on SRH, sexual behaviors and attitude outcomes are based on self-reported information, which is subjected to reporting errors, missed values and recall bias. Since the study touches sensitive and intimate issues the possibility of underestimation cannot be ruled out. Some sort of desirability bias may not be eliminated even the survey was anonymous.

CHAPTER SEVEN

CONCLUSION AND RECOMMENDATION

7.1 conclusions

There was positive attitude towards avoiding premarital sex both in the students' response and focus group discussion of the parents. Furthermore, there is also positive attitude towards introduction of SRH program in school by both the respondents. There were also good attitude toward the importance of communication on SRH in both the students' response and focus group discussion of the parents. However, communications on sexual and reproductive health issues were more with their friends of similar sex than parents. When they are equipped with appropriate information on SRH related they can pass on easily and influence each other positively. The focus group discussion revealed that the content of parent-adolescents conversation focus more on the negative outcomes of sexual intercourse and sexuality and poor on what adolescents should know and understand how they are growing and developing this will make adolescent unlikely to turn to their parents to discuss with them comfortably.

Finally, the study also concluded that students and parents have low communication on sexual and RH related issues still continues to be cultural taboo and shame by both students and their parents.

This study also identified that the Knowledge on contraceptive and communication on SRH issue with their parents were significantly associated with risky sexual behavior. Thus; strengthening knowledge on contraceptive methods and communication with parents is indirectly addressing risky sexual behavior.

7.2 Recommendation

Based on the findings, therefore, the following recommendations are suggested.

- There is a need to equip peer of same sex with appropriate sexuality information and IEC materials, which can pass on to their friends.
- Effective sex education should be introduced to them at an early age.
- There is a need to equip parents with appropriate IEC material and communication skill on sexuality and RH related issues.
- Sensitize the community to encourage open and informative communication among family members in general and between parents and children in particular.

Reference

1. Lewis M VF. Clinical aspects of child and adolescent's development, third edition 1990:211.
2. Chick C.F and Reyna V.F: A fuzzy trace theory of adolescent risk taking: Beyond self-control and sensation seeking. The Adolescent Brain, American Psychological Association 2012:379-428.
3. Guttmacher institute. Facts on American teens' sexual and reproductive health.2013 <http://www.guttmacher.org/pubs/FBATSRH.html> (AccessedDec8, 2015).
4. Institute of Medicine & National Research Council. The science of adolescent risk-taking. DC Washington: The National Academies Press.2011.
5. Cooper ML: Alcohol use and risky sexual behavior among college students and youth evaluating the evidence. Journal of studies on alcohol 2002.
6. Askew I BM. The contribution of sexual and reproductive health services to the fight against HIV/AIDS. A review Reproductive health matters2003; 11(22):51-73.
7. WHO. Progress in reproductive health research. <http://www.WHO.int/reproductive>. Health/hrp /progress/58/news. (AccessedDec8, 2015).
8. UNFPA.The state of world population 2014.
9. Agency CS AA.Ethiopia Mini Demographic and Health Survey. 2014.
10. USAID. Youth in Development: Realizing the Demographic Opportunity WD, USA.2012.
11. UNDPA. Adolescent Sexuality, Gender and the HIV Epidemic.1999.
12. MOH. Five-year plan of action for adolescent reproductive health in Ethiopia. Family health department; 9
13. Simons LG BC, Peterson FR. The effect of religion on risky sexual behavior among college students. Deviant Behavior.2009 May 29; 30 (5):467-85.
14. CDC. The global HIV/AIDS pandemic.2006<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5531a1.htm>. (AccessedDec8, 2015).
15. Kauffman L OM, Johnson AL, Cooke-Jackson A Memorable familial messages about sex .A qualitative content analysis of college student narratives. Electronic Journal of Human Sexuality.2013 Jan 1:16:1-21.
16. Guy S AR, Christine M. Family Connectedness and Sexual Risk-Taking among Urban Youth Attending Alternative High Schools. Journal of Perspectives on Sexual and Reproductive Health2003; 35(4):174-9.
17. Doyle AM MS, Plummer ML, Ross DA. . The sexual behavior of adolescents in sub-Saharan Africa: patterns and trends from national surveys. Tropical Medicine &International Health2012.
18. Shah, I. and E. Ahman. "Unsafe abortion in 2008: Global and regional levels and trends," Reproductive Health Matters. 2010; 18 (36):90- 101.
19. UNFPA. Motherhood in Childhood: Facing the challenge of adolescent pregnancy. 2013.
20. WHO.Adolescentpregnancy.http://www.who.int/maternal_child_adolescent/topics/maternal/adolescentpregnancy .(AccessedDec8, 2015).
21. Presler-Marshall EaNJ. "Charting the future: Empowering girls to prevent early pregnancy." Overseas Development Institute and Save the Children2012.
22. Bayley O. Improvement of sexual and reproductive health requires focusing on adolescents. The Lancet. 2003 Sep 6; 362(9386):830-1.

23. UNFPA. Motherhood in Childhood: Facing the challenge of adolescent pregnancy.2013.
24. Blanc A WW, Ross J. New findings for maternal mortality age patterns: aggregated results for 38 countries. PLoSOne2013.
25. W Evans KD, C Umanzor, K Patel and M Khan. "Evaluation of Sexual Communication Message Strategies." Reproductive health. 2011; 8(15).
26. Hallman K: Socio-economic Disadvantage and Unsafe sexual behaviours among young men and women in South Africa. Population Council: The Population Council, Population Research Division 2004.
27. MOH. Communicating about sex: adolescents and parents in Kenya. 1996.
28. Deborah Holtzman and Richard Rubinson. Parent and peer communication effects on AIDS related behavior among U.S high school students. Family planning perspective Nov/Dec1995; 27(6).
29. Taffa N HR, Desalegn S, Tesfaye A, Mohamed K. Do parents and young people communicate on sexual matters? The situation of family life education (FLE) in rural town in Ethiopia. Ethiop J Health Dev, Dec 1999; 13(3):207.
30. RomerodecastillaGillrj L, Canefer Estrada R. Adolescents and source of sex information: preferences and perceived usefulness, Hospital alto guadal quivivr, Cordoba, Atenprimaria. Jan, 2001 279(1):12-7.
31. Rosenthal DA SF. The importance of importance: Adolescents' perception of parental communication about sexuality.adolesc.1999Dec; 22(6):835-51.
32. DilorioC KM, Hocken berry Eatonm. Communication about sexual issues: mothers, fathers, and friends. Adolesc health, 1999 March; 24(30):181-9.
33. Maartje Versnel YB, Yohannes. F, wend F. Sexuality and contraception among never married high school students in Butagira. Ethiop Med J2002; 40(1):46.
34. Kims.miller aDJw, Atlanta, Georgia. . Predictors of mother adolescents' discussion about condom: implication for providers who serve youth. Pediatr NeonatolAug 2001; 108(2):28.
35. Picks PP. Impact of family on sex lives of adolescents. Adolescents fall. 1995; 30(119): 667-75.
36. Seifu A, Fantahun M, Worku A. Reproductive health needs of out-of-school adolescents. Ethiopian Journal of Health Development2006; 20(1):10-7.
37. Young Mikim, Adriene Kols, Ronika, Nyakauru, Caroline Morangwanda, and Peter Clibatamota. Promoting sexual responsibility among young people in Zimbabwe. Family international perspective 2001; 27(1): 15.
38. Romel saulone Theocharis T, Robert S, Franciscos .Sy, Murray L and etal. Correlates of sexual abstinence among urbane university students in the Philippines. . International family planning perspective1997; 23(4):169.
39. Sychareum.V.Parent- youth communication and youth's attitudes and Behaviour in Vientiane municipality in Lao PDR. Journal of community medicine and Primary health care June 2005; l16 (1):8.
40. Rosentha D, Senserrick T, Feld man S.A typology of approach to describe parents as Communicators about sexuality. Arch sex Behav. 2001 Oct; 30(5):463-82.
41. Pillaivk YD. Teenages sexual activity in Zambia: the need for a sex education. Policy J Biosoc sci. 1993 Jul; 25(3):411-4.
42. Adu-Mireku S. Family communication about HIV/AIDS and sexual behavior among senior secondary school students in Accra, Ghana. Afri health sci, 2003 April; 3(1):7-14.

43. Damalie N. Communication between mothers and their adolescent daughters on the subject of sexuality and HIV/AIDS in Uganda. <http://www.ossrea.net/publications/girr/abstract no14.htm > (AccessedDec8, 2015).
44. Maina G. Youth peer survey in Kenya. Plan parent chall.1993 (1):24-5.
45. Karungari Kirangu Ea, Dan odallo and caral Van Hulzen.Communicating about sex: adolescents and parents in Kenya. Population report.1995.
46. Kiragu o, Odallo.D van hulzen. Communicating about sex: adolescents and parents in Kenya, AIDS/STD health promt Exch. 1996(3):11-3.
47. TR p, Fitzgerald s.Rural parent's communication with their teen ages about sexual issue J school health Oct 2000; 70(8):338-44.
48. Haile M. Knowledge attitude and practice on sexuality and reproductive health among Harrar adolescents 1997.
49. Laura Duberstein Lindberg, Leighton Ku and Freya sonenstien. Adolescents reports of reproductive health education. Family planning perspective Sep/Oct2000:32(5).
50. Girma.T. Report on reproductive health survey among female teenagers in Awassa and Yirgalem high school.1999.
51. Taffa N. Sexually active of out-of-school youth, and their knowledge and attitude about STD and HIV/AIDS in southern Eth. April 1998.
52. Gizaw A JD, Ketema K Risky Sexual Practice and Associated Factors among High School Adolescent in Addis Ababa, Ethiopia. 2014.
53. Abebe Mamo Gebretsadik NFB. Family Environment and Sexual Behaviors in Jimma Zone, South West Ethiopia. 2014.
54. Fikre. M. Assessment of Parent-Adolescent Communication on Sexual and Reproductive Health Matters in Hawassa Town. 2009.
55. Tsegaye B, Yohannes Z. Barriers of Parent-Adolescent Communication on Sexual and Reproductive Health Issues among Secondary and Preparatory School Students in Yirgalem, Town, South Ethiopia. FAM Med Sci Res 2015; 4(4).
56. Gebreysus D, Fantahun M. Assessing communication on sexual and reproductive health issues among high school students with their parents, Bullen Woreda, Benishangul Gumuz Region, North West Ethiopia. 2010.
57. Ayalew M Mengistie B, Semahegn A .Adolescent-parent communication on sexual and reproductive health issues among high school students in Dire Dawa, Eastern Ethiopia. 2014.
58. Eyob T, Abate G, Genet M.A survey of adolescent reproductive health in the city of Addis Ababa. Ethiopian Journal of Health Development1996; 10(1):35-9.
59. Fantahun M.Sexual behavior, Knowledge and attitude toward HIV/AIDS among out of school in Bahrdar town, Ethiopian Journal of Health Development,1996,34 (4)
60. Zemenu Y. Yonas G, Shimels H, Bazezew F. Factors Associated with Parent-Adolescent Communication on Sexual and Reproductive Health Issues Among Secondary and Preparatory School Students in Mekelle City, North Ethiopia.2015; 3(6).
61. Shiferaw K ,Getahun F, Asres G. Assessment of adolescents' communication on sexual and reproductive health matters with parents and associated factors among secondary and preparatory schools' students in Debremarkos town, North West Ethiopia. 2014.

Annexes

Questionnaire

Information sheet

The questionnaire prepared to study youths' communication and risky sexual behavior among high school students in Aleta chukoWoreda, Sidama zone, SNNPR, Ethiopia February, 2016.

I am ……..working as data collector in this study that assess Youths' communication on reproductive health and risky sexual behavior among high school students in Aleta chukoWoreda, Sidama zone,SNNPR. Dear respondents here are lists of questions with different sections, which are designed for research work to be conducted in partial fulfillment of master of public health in health education and promotion by Nahom Tesfaye from Jimma University departments of health education and behavioral sciences. I am going to give you the questionnaire to be filled by you only and your responses are completely confidential. In order to protect confidentiality, your names or school IDs will not be written on the questionnaires. Identification of an informant will be only possible through numerical codes.

Participation in the study will not impose any risk on you, and you may end to participate in the study any time you want. However, your honest response to these questions will help us to better understand the youth communication on reproductive and risky sexual behavior among high school students. We would greatly appreciate your help in responding to these questions. It will take about 30 to 40 minutes and there is no benefit or payment that you get for your participation in this study. However, your honest &genuine response to each question will play a major role in the attainment of the objective of the study .The results of the study will hopefully serve as an important input to intervention programs that aim at improving health and wellbeing of high school youths in general at different levels. Therefore, we thank you in advance and greatly appreciate your helping.

Consent Form

I the selected participant heard the information in the study information sheet & understood the purpose, benefit and what is required from me if I take part in the study. I understood that all information regarding me and all answers given by me are secret and confidential. I also understand that I can decide whether or not to take part in the study or even withdraw from the study at any time.

So I am willing to participate in the study.

Yes ☐

Proceed

No ☐

Terminate

Thank you !

Section I. socio-demographic characteristics of adolescents.

S.N	Question	Response	Code
101	Age	-----in years	
102	Grade	--------	
103	Sex	1.male 2.Female	
104	Religion	1.Orthodox Christian 2. Muslim 3. Protestant 7. Catholic 8. Others(specify)	
105	Ethnic group	1. Sidama 2. Amhara 3. Oromo 4. Wolaita 5. Guraghe 6. Others(specify)	
106	With whom are you living	1. Lives with mother and father 2. With mother only 3. With father only 4. Others(specify)	
107	Marital status of the mother	1. Together 2. Separated 3. Divorced 4. Widowed	
108	Marital status of the father	1. Together 2. Separated 3. Divorced 4. Widowed	
109	Family size	--------	
110	Parent's income/month	--------	
110	Mother's educational status	1. cannot read and write 2. Read and write only 3. Primary school 4. Secondary school 5.Certificate/TTI 6. Diploma 7. Degree and above 8. No mother	
111	Father's educational status	1. cannot read and write 2. Read and write only	

		3. Primary school 4. Secondary school 5. Diploma 6. Degree and above 7. No mother	
112	Occupation of the mother	1. House wife 2. Employed (private) 3. Employed (gov't) 4 merchant 5. Farmers 6. No mother 7. Others(specify)	
113	Occupation of the father	1. Employed (private) 2. Employed (gov't) 4. merchant 5. Farmers 6. No mother 7. Others(specify)	
114	*Do you have pocket money?*	*1. Yes* *2.No*	*(----)*
***Section* II. Knowledge on major selected Reproductive health**			
201	Do you know when menstrual cycle starts?	1.yes 2.no	
202	If yes at what age it starts	-------in years	
203	What was your feeling when the first menses comes (for girls only)	1. Tension 2. Fear 3. Pleasure 4. Feeling diseased 5. Shame 6. Do not see	
204	Do you know STI ? **If your answer is no skip to Q206**	1. yes 2. no	
205	If yes to Q#204 which one do you know (circle all answer you think)	1. Chancroid 2. Syphilis 3. Gonorrhea 4. LGV 5. HIV/AIDS 6. Herpes simplex 7. Others(specify)	
Section II. Sources of Information on Sexual and Reproductive Health			
207	Do you know contraceptive methods? If your answer is 'No'skip to question no208	1. Yes 2. No	
207	If yes which one do you know? (Circle all answer you think)	1. Pill 2. Depoprovera 3. Norplant	

		4. IUD 5. Condom 6. Abstinence 7. Using safe period	
208	Do you know what emergency contraceptive means?	1. Yes 2. No	
209	Do you know the likely date of pregnancy between menstruations?	1. Yes 2. No	
Section III. Sexual attitude and behavior of adolescents			
301	Is it normal and acceptable to have sexual feeling during adolescent?	1. Yes 2. No	
302	Student should abstain from sex until marriage.	1.Disagree 2. Neutral 3. Agree	
303	Multiple sexual partners risky for life.	1.Disagree 2. Neutral 3. Agree	
304	One should not start sex before 18 years old.	1.Disagree 2. Neutral 3. Agree	
305	Pregnancy is not possible at first intercourse.	1.Disagree 2.Don't know 3. Agree	
306	If you really love your girlfriend/boyfriend you should have sex with her/him.	1.Disagree 2.Don't know 3. Agree	
307	It is possible to have safe sexual behavior.	1.Disagree 2.Don't know 3. Agree	
308	Condoms make sex less enjoyable.	1.Disagree 2.Don't know 3. Agree	
309	Condoms are useful for occasional partners only.	1.Disagree 2.Don't know 3. Agree	
310	Have you ever started sexual intercourse? If your answer is 'No'skip to question# 310	1. Yes 2. No	

311	If yes at what age was your sexual act?	---------years	
312	With who have you made your first sex?	1. Boy/girl friend 2. Relative 3. Unknown person	
313	With how many partner have you made sex?	1. One 2. Two 3. Three and above	
314	Have you ever used condom during sex? If your answer is 'No' skip to question #308	1.Yes 2. No	
315	If yes do you use consistently?	1. Yes 2. No	
316	Have you ever-experienced unwanted pregnancy?(for girls only) If your answer is 'No' skip to question no 310	1. Yes 2. No	
317	If yes how did you managed it?	1. Deliver 2. Abortion	
318	Do you accept premarital sex?	1. Yes 2. No 3. Do not know	
319	Do you think sex education is necessary? If your answer is 'No' skip to question no 313	1. Yes 2. No	
320	Where do you prefer sex education to be given? (Circle all answers you think)	1. School 2. Home 3. By Friends 4. Church 5. Other (specify) ……	
321	Where did you get information about sexual matters? (Circle all answer you think)	1. School 2. Media 3. Home 4. Peers 5. Other specify……...	
Section IV. Adolescents perception of parental monitoring			
401	What is your view to parental monitoring on adolescents?	1. Agree 2. Disagree	
402	For male only. Did parents ever forbid you to play with female?	1. Yes 2. No	
404	For female only. Did parents ever forbid you not to play with male?	1. Yes 2. No	

406	Do parents know where, when you are outside home/school?	1.Yes 2. No	
407	Do parents know with whom are you, when outside home/school?	1. Yes 2. No	
Section V. Communication of adolescents and parents sexual and reproductive health			
501	Is it important to discuss (communicate) sexual issues with parents?	1. Yes 2. No	
502	Which parent do you prefer to discuss on sexual and RH issues.	1. Mother 2. Father	
503	Have you ever discussed on contraception? If your answer is 'Yes' skip to question Q#505	1. Yes 2. No	
504	If you do not discuss on contraception with parents. What do think the reasons are?	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. Do not know 8. Others	
505	If yes to question # 503 with whom do you prefer to discuss it with?(circle all answers you think)	1. Father 2. Mother	
506	How frequent you have discussed about contraception?	1.Never 2.Rarely 3. Sometimes 4. Often 5.Very often	
507	With whom have you discussed other than parents	1. Peer 2. Sisters 3. Brothers 4. Others specify	
509	Have you ever discussed on STD/HIV? If yes skip to Q #511	1. Yes 2. No	
510	If you do not discuss on HIV/STD with parents. What are the reasons?	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Lack of communication skill 5. Parents are not good listener 6. Difficult and embarrassing	

		7. Do not know 8. Others	
511	If yes for question # 509 with whom does you discuss?	1. Mother 2. Father	
513	With whom have you discussed other than parents	1. Peer 2. Sisters 3. Brothers 4. Others (specify)	
514	How frequent have you discussed about HIV/STD?	1.Never 2.Rarely 3. Sometimes 4. Often 5.Very often	
515	Have you ever discussed on sexual intercourse? If yes skip to #513	1. Yes 2. No	
516	If you do not discuss on sexual intercourse with parents. What are the reasons?	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Lack of communication skill 5. Parents are not a good listener 6. Difficult and embarrassing 7. Do not know 8. Others	
517	If yes for question # 515 with whom	1. Father 2. Mother	
519	With whom discussed other than parents	1. Peer 2. Sisters 3. Brothers 4. Others specify	
520	How frequent you have discussed about sexual intercourse?	1.Never 2.Rarely 3. Sometimes 4. Often 5.Very often	
521	Have you ever discussed about unwanted pregnancy? If yes skip to # 523	1. Yes 2. No	
522	If you do not discuss on un wanted pregnancy with your parents. What are the reasons?	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Lack of communication skill 5. Parents are not a good listener 6. Difficult and embarrassing 7. Don’t know	

		8. Others(specify)	
523	If yes for question # 521 with whom do you discuss?	1. Father 2. Mother	
524	With whom discussed other than parents	1. Peer 2. Sisters 3. Brothers 99. Others (specify)	
525	How frequent you have discussed about un Wanted pregnancy?	1.Never 2.Rarely 3. Sometimes 4. Often 5.Very often	
526	Have you ever discussed on not having sex until marriage? If your answer is yes skip to Q#529	1. Yes 2. No	
527	If you don't discuss on not having sex until marriage with parents. What are the reasons? (Circle all answer you think)	1. Culturally un acceptable 2. Shame 3. Lack of knowledge 4. Lack of communication skill 5. Parents are not a good listener 6. Difficult and embarrassing 7. Don't know 8. Others	
528	If yes for question # 527 with whom do you discuss?	1. Father 2. Mother	
529	With whom discussed other than parents	1. Peer 2. Sisters 3. Brothers 4. Others specify	
530	How frequent you have discussed about on not having sex until marriage?	1. Very often 2. Often 3. Sometimes	
531	Have you ever discussed on condom? If your answer is no skip to Q#535	1. Yes 2. No	
532	If you don't discuss on condom With parents, what are the reasons?(circle all answer you think)	1. Culturally un acceptable 2. Shame 3. Lack of Knowledge 4. Lack of communication skill 5. Parents are not a good listener 6. Difficult and embarrassing	

		7. Don't Know 8. Others	
533	If yes for question # 533 with whom do you discuss?	1. Father 2. Mother	
534	With whom discussed other than parents	1. Peer 2. Sisters 3. Brothers 4. Others specify	
535	How frequent you have discussed on condom?	1.Never 2.Rarely 3. Sometimes 4. Often 5.Very often	
536	Have you ever discussed on physical and psychological changes on puberty? If your answer is yes skip to Q#541	1. Yes 2. No	
547	If you don't discuss on physical and psychological changes on puberty With parents. What are the reasons?	1. Culturally un acceptable 2. Shame 3. Lack of Knowledge 4. Lack of communication skill 5. Parents are not a good listener 6. Difficult and embarrassing 7. Don't Know 8. Others	
548	If Yes for question # 539 with whom do you discuss?	1. Father 2. Mother	
549	With whom discussed other than parents (circle all answer you think)	1. Peer 2. Sisters 3. Brothers 4. Others specify	
550	How frequent you have discussed on physical and psychological changes on puberty?	1.Never 2.Rarely 3. Sometimes 4.Often 5.Very often	
553	Do you currently discussing on the above issues?	1. Yes 2. No	
554	Is your mother open to discuss?	1. Yes 2. No	
555	How do you rate parent communication skill about sexual matters	1. Low 2. Medium 3. High	

Section VI. Regarding your responses, what do you feel?

Underestimate ☐

Overestimate ☐

Annex

A. Focus group discussion

Discussion to parents on level of communication (discussion) parents with their adolescent on sexual matters and factors affecting communication.

Guide to Focus Group Discussion

The guideline will be as follow:

1. Greeting
2. Ask the willingness of the parents for participating in the discussion.
3. Explain the objective of the study and focus group discussion.
4. Telling the participant that confidentiality will be maintained and telling them we will use tape recorder.
5. Topics to be discussed

- What do you think the knowledge of parents on reproductive health? (Contraception, STD/HIV/AIDS, and Puberty)

-What is the feeling of parents on premarital sex and unwanted pregnancy in adolescents?
-What is your suggestion for sex education first do they agree? (Why and why not) where to be given?
-Is it important for parents to discuss about sexual matters with their adolescents? (Why, why not?)
-If you suggest discussion on sexual and reproductive health matters is important at what age the discussion should be started?
-What are the topics (contents) discussed with their adolescents
- Do you think parents and adolescents communicate on different SRH issues?
-parents' view about SRH service provision at school and reasons (health information about sexuality, condom, Emergency contraceptives, VCT…..)

Thank you very much!

ጅማ ዩኒቨርሲቲ የጤና አጠባበቅና የስነ-ባህሪ ሳይንስ ት/ክፍል

ሰላም እንደምን አሉ!

ስሜ_____ይባላል፡፡የጅማ ዩኒቨርሲቲ የጤና ሳይንስ ኮሌጅ የጤና አጠባበቅና የስነ-ባህር ሳይንስ ት/ክፍል የሁለተኛ ዲግሪ ተማር ለሆነው ለናሆም ተስፋዬ መመረቂያ ፅሁፍ የወላጆችና ጎረምሳ ልጆች በግብረስጋ ግንኙነት ጉዳይ እና በስነተዋልዶ ጤና ላይ የሚያደርጉትን ውይይት በማጥናት ላይ መረጃ ሰብሳቢ ነኝ ፡፡ጥናቱም የሚካሄደው በአለታ ጩኮ ወረዳ ነው፡፡

ይህ ጥናት በወላጆችና ጎረምሳ ልጆች በግብረስጋ ግንኙነት ጉዳይ እና በስነተዋልዶ ጤና ላይ የሚያደርጉትን ውይይት በማጥናት ላይ በአለታ ጩኮ ወርዳ መረጃዎችን መሰብሰብ ዓላማ ሲኖረው ዋና ጥቅሙ ግን የሁለተኛ ዲግሪ ለዲህረ መመረቂያ ማሟያ ፅሁፍ ነው፡፡ በተጨማሪም የዚህ የጥናት ፅሁፍ ግኝቶች ለተለያዩ ፖሊሲ አውጪዎች ጠቃሚ መረጃን በመስጠት ያገለግላል፡፡ያለምንም ቅድመ ሁኔታ ወይም መስፈርት የተመረጡ ሲሆን እንዲሳተፉ እጋብዝዎታለሁ፡፡

ለመሳተፍ ፈቃደኛ ከሆኑ የመረጃ መሰብሰቢያ ቃለ መጠይቅ በራስህ/ሽ ይሞላል፡፡ በጥናቱ ለሚጠየቁት ጥያቄዎች የሚሰጡት ማንኛውም መረጃ ምሰጢራዊነቱ የተጠበቀ መሆኑን ላረጋግጥልዎ እወዳለሁ፡፡ በጥናቱ ላይ ያለዎት መልካም ፈቃድ በሚያገኙት አገልግሎት ላይ ምንም አይነት አሉታዊ ተፅዕኖ አይኖረውም፡፡ በጥናቱ በመሳተፍዎ በቅድሚያ አመሰግናለሁ።

በጥናቱ ለመሳተፍ ፈቃደኛ ነዎት ? አዎ----------, አይደለሁም----------

ቀን _____

የተሳታፊው ኮድ _____

ወላጆችና ጎረምሳ ልጆች በግብረ ስጋ ግንኙነት ጉዳይ እና በስነተዋልዶ ጤና ላይ የሚያደርጉትን ውይይት ለማጥናት የተዘጋጀ መጠይቅ፡፡

I. መሰረታዊና ማህበራዊ ጉዳይን በተመለከተ

ተራቁ	ጥያቄ	መልስ	ኮድ
101	እድሜ	……በአመት	
102	ክፍል	.....	
103	ጾታ	ነ. ወንድ 2. ሴት	
104	ቦታ	ነ. አለታ ጩኮ ከተማ 2. ቴሶ 3. ዶንጎራ ካዋዶ 4. ሠንቴርያ	
105	ሀይማኖት	1. ኦርቶዶክስ 2. ሙስሊም 3. ፕሮቴስታንት 4. ሌላ ካለ ይገለፅ	
106	ብሄር	1. ሲዳማ 2. አማራ 3. ኦሮሞ 4. ወላይታ 5. ጉራጌ 6. ሌላ ካለ ይገለፅ_____	
107	አሁን የምትኖረው/ሪው ከማን ጋር ነው?	1. ከእናት ና አባትህ/ሽ ጋር 2. ከእናት ጋር ብቻ 3. ከአባት ጋር ብቻ 4. ከዘመድ ጋር 5. ለብቻ 6. ሌላ ካለ ይገለጽ_____	
108	የወላጆች የጋብቻ ሁኔታ	ነ. በአንድ ላይ የምኖሩ	

		2. ተለያይቶ የምኖሩ 3. የተፋቱ 4. ልጅ መውለድ የማይችሉ	
109	የቤተሰብ ብዛት	--------በቁጥር	
110	የወላጆች የገቢ መጠን በወር	----------	
111	የእናት የትምህርት ደረጃ	1. ማንበብና መጻፍ አትችልም 2. ማንበብና መጻፍ ትችላለች 3. አንደኛ ደረጃ 4. ሁለተኛ ደረጃ 5. ዲፕሎማ 6. ዲግሪ እና ከዚያ በላይ 7. እናት በህይወት የለችም	
112	የአባት የትምህርት ደረጃ	1. ማንበብና መጻፍ አይችልም 2. ማንበብና መጻፍ ይችላል 3. አንደኛ ደረጃ 4. ሁለተኛ ደረጃ 5. ዲፕሎማ 6. ዲግሪ እና ከዚያ በላይ 7. አባት በህይወት የለም	
113	የእናት የስራ ሁኔታ	1. የቤት እመቤት 2. በግል ተቀጣሪ 3. በመንግስት ተቀጣሪ 4. ነጋዴ 5. ገበሬ 6. እናት በህይወት የለችም 7. ሌላ ካለ ይገለፅ_____	
114	የአባት የስራ ሁኔታ	1. በግል ተቀጣሪ 2. በመንግስት ተቀጣሪ 3. ነጋዴ 4. ገበሬ 5. አባት በህይወት የለም 6. ሌላ ካለ ይገለፅ_____	
115	ከቤተሰብህ/ሽ የሻይ ገንዘብ ታገኛለህ/ሽ?	1. አዎ 2. የለም	
II. በተመረጡ የስነ ተዋልዶ ጤና ላይ የእውቀት ጥያቄዎች			
201	የወር አበባ የሚጀምርበትን እድሜ ታውቃለህ/ሽ? አላውቅም ከሆነ መልስህ ወደ ጥያቄ ቁጥር 204 እለፍ/እለፊ	1. አዎ 2. አይ	
202	አዎ ካልክ/ሽ በስንት አመት የመጀመሪያ የወር አበባ በስንት አመት ይጀምራል?	----------በአመት ይገለፅ	
203	ለመጀመሪያ ጊዜ የወር አበባ ስታይ ምን ተሰማሽ ? (ለሴቶች ብቻ) (የምታውቂያቸውን መልሶች አክብቢ)	1. ጭንቀት 2. ፍርሀት 3. ደስታ 4. በበሽታ የተያዝኩ መሰለኝ 5. እፍረት 6. እስካሁን አላየሁም	

204	በግብረ ስጋ ግንኙነት ስለሚመጡ በሽታዎች ታውቃለህ/ሽ? አዎ ካልሆነ መልስህ/ሽ ወደ ጥያቄ ቁጥር 207 እለፍ/እለፊ	1. አዎ 2. አይ	
205	አዎ ካልክ/ሽ የትኛውን ታውቃለህ/ሽ? የምታውቂያቸውን መልሶች አክብብ/ቢ	1. ቻንክሮይድ 2. ጨብጥ 3. ቂጥኝ 4. ባምቡሌ 5. ኤች. አይ. ቪኤድስ 6. ኸርፐስ ሲምፕሌክስ 7. ሌላ ካለ ይገለፅ_____	
206	በግብረ ስጋ ግንኙነት ስለሚመጡ በሽታዎች መረጃዎች ከየት ታገኛለህ/ሽ?	1. ት/ቤት 2. ቤት 3. በጓደኞቻቸው 4. ቤተ እምነት 5. መገናኛ ብዙሀን 6. ሌላ ካለ ይገለፅ_____	
207	የወሊድ መቆጣጠሪያዎችን ታውቃለህ/ሽ? አዎ ካል ሆነ መልስህ ወደ ጥያቄ ቁጥር 209 እለፍ/እለፊ	ı. አዎ 2. አይ	
208	አዎ ካልክ/ሽ የትኞቹን ታውቃለህ/ሽ? (የምታውቂያቸውን መልሶች አክብብ/ቢ)	1. የወሊድ መቆጣጠሪያ ኪኒን 2. የወሊድ መቆጣጠሪያ መርፌ 3. ክንድ ውስጥ የሚቀበር 4. መህፀን ውስጥ የሚቀመጥ 5. ኮንዶም 6. መታቀብ 7. ካላንደር በመጠቀም 8. ሌላ ካለ ይገለፅ_____	
209	ድንገተኛ የወሊድ መቆጣጠሪያ ታውቃለህ/ሽ?	1. አዎ 2. አይ	
210	በወር አበባዎች መካከል እርግዝና ሊከሰት የሚችልበት ጊዜ ታውቃለህ/ሽ?	1 አዎ 2 አይ	
III. ጎረምሶች በስነተዋልዶ ጤና እና በግብረ ስጋ ግንኙነት ላይ ያላቸው አመለካከት ና ባህር			
301	በጉርምስና ጊዜ የግብረ ስጋ ግንኙነት ለማድረግ መፈለግ ጤናማና ተቀባይነት አለው?	1. አዎ 2. አይ	
302	ብዙ የወሰብ ጓዴኛ ለጤንነትሽ/ህ ጠንቅ አለዉ::	1. በጣም አልስማማበትም 2. አልስማማበትም 3. አላዉቅም 4. እስማማበታለሁ 5. በጣም እስማማበታለሁ	
303	ከጋብቻ በፊት ከአሰራ ስምንት አመት በታች ግብረ ስጋ ግንኙነት ማድረግ አለብህ/ሽ ::	1. በጣም አልስማማበትም 2. አልስማማበትም 3. አላዉቅም 4. እስማማበታለሁ 5. በጣም እስማማበታለሁ	
304	እርግዝና በመጀመርያ ግብረ ስጋ ግንኙነት ልከሰት ይችላል ::	1. በጣም አልስማማበትም	

		2. አልስማማበትም 3. አላዉቅም 4. እስማማበታለሁ 5. በጣም እስማማበታለሁ	
305	ከፍቅር ጓዴኛህ/ሽ ጋር ግብረ ስጋ ግንኙነት መፈጸም አለበት ፡፡	1. በጣም አልስማማበትም 2. አልስማማበትም 3. አላዉቅም 4. እስማማበታለሁ 5. በጣም እስማማበታለሁ	
306	ጤንነትን በማይጎዳ ሁኔታ ግብረ ስጋ ግንኙነት መፈጸም ትችላለህ/ሽ ፡፡	1. በጣም አልስማማበትም 2. አልስማማበትም 3. አላዉቅም 4. እስማማበታለሁ 5. በጣም እስማማበታለሁ	
308	ኮንዶም መጠቀም የምያስፈልገው ለጊዜያዊ ጓዴኛ ብቻ ነው፡፡	1. በጣም አልስማማበትም 2. አልስማማበትም 3. አላዉቅም 4. እስማማበታለሁ 5. በጣም እስማማበታለሁ	
309	የግብረ ስጋ ግንኙነት መፈፀም ጀምረሃል/ሽ? አዎ ካልሆነ መልስሽ/ህ ወደ ጥያቄ ቁጥር 317 እለፍ/እለፊ	1. አዎ 2. አይ	
310	አዎ ካልሽ በስንት አመት እድሜ ፈፀምሽ/ክ?	----------በአመትይገለፅ	
311	ለመጀመሪያ ጊዜ ከማን ጋር ፈፀምሽ/ክ?	1. ከወንድ/ከሴት ጓደኛ 2. ዘመድ 3. ከማይታወቅ ሰው ጋር 4. ሌላ ካለ ይገለፅ_____	
312	የግብረ ስጋ ግንኙነት ከስንት ሰው ጋር ፈፅመሽ/ህ ታውቂያለሽ/ህ?	1. ከአንድ ሰው ጋር 2. ከሁለት ሰው ጋር 3. ከሶስትና ከዚያ በላይ	
313	በግብረ ስጋ ግንኙነት ወቅት ኮንዶም ትጠቀማለህ/ሽ?	1. አዎ 2. አይ	
314	አዎ ከሆነ መልስሽ/ህ ለጥያቄ ቁጥር 313 ከተጠቀምክ/ሽ ሁልጊዜ እና በአግባቡ ትጠቀማለህ/ሽ?	1. አዎ 2. አይ	
315	ያልተፈለገ እርግዝና ገጥሞሽ ያውቃል? ለሴት ብቻ) አዎ ካልሆነ መልስህ/ሽ ወደ ጥያቄ ቁጥር 317 እለፍ/እለፊ	1. አዎ 2. አይ	
316	ያልተፈለገ እርግዝና አጋጥሞሽ ከነበረ እንዴት አደረግሽ?	1. ወለድሽ 2. አስወረድሽ	
317	ከጋብቻ በፊት ግብረ ስጋ ግንኙነትን ትቀበለዋለህ/ሽ?	1. አዎ 2. አይ	
318	ተማሪዎችን ስለግብረ ስጋ ግንኙነት ማስተማር አስፈላጊ ይመስልሀል/ሽ? አዎ ካልሆነ መልስህ ወደ ጥያቄ ቁጥር 320 እለፍ/እለፊ	1. አዎ 2. አይ	
319	ልጆች የት ብማሩ ይሻላል ብለህ ታስባለህ/ሽ?	1. ት/ቤት 2. ቤት 3. ከጓደኞቻቸው	

		4. ከቤተእምነት 5. ሌላ ካለ ይገለፅ_____	
320	ስለግብረ ስጋ ግንኙነት የምታገኛቸውን መረጃዎች ከየት ታገኛለህ/ሽ?	1. ት/ቤት 2. መገናኛ ብዙሀን 3. ቤት 4. ከጓደኞች 5. ሌላ ካለ ይገለፅ_____	
IV. የቤተሰብን ቁጥጥር በተመለከተ እንደ ልጆች አስተሳሰብ			
401	ወላጆች በጎረምሳ ልጆች ላይ የሚያደርጉት ቁጥጥር ላይ ምን አስተያየት አለህ/ሽ?	1. እስማማበታለሁ 2. አልስማማበትም	
402	ለወንዶች ብቻ ወላጆችህ ከሴት ልጅ ጋር እንዳትጫወት ከልከለውህ ያውቃሉ?	1. አዎ 2. አይ	
403	ለሴቶች ብቻ ወላጆችሽ ከወንድ ልጅ ጋር እንድትጫወቺ አይፈቅዱልሽም?	1. አዎ 2. አይ	
404	ወላጆችህ/ሽ ከቤት ውጭ የምትሄድበትን ቦታ ያውቃሉ?	1. አዎ 2. አይ	
405	ወላጆችህ/ሽ ከቤት ውጭ በምትሆንበት/ኝበት ጊዜ ከማን ጋር እንደምትውል/ይ ያውቃሉ?	1. አዎ 2. አይ	
V. በወላጆ ና በልጆች መካከል በስነተዋልዶ ጤና እና በግብረ ስጋ ግንኙነት ላይ የሚደረጉ ውይይቶች			
501	በወላጆችና በልጆች መካከል በግብረስጋ ግንኙነት ላይ ያሉ ሁኔታዎች ላይ መወያየት አስፈላጊ ይመስልሀል/ሻል?	1 አዎ 2 አይ	
502	ከየትኛው ወላጅ ጋር መወያየቱ ይሻላል ብለህ/ሽ ታስባለህ/ሽ?	1. ከእናት ጋር 2. ከአባት ጋር	
503	አንተ/አንቺ ከወላጆችህ/ሽ ጋር በስነተዋልዶ ጤና በግብረ ስጋ ግንኙነት ዙሪያ ትወያያለህ/ሽ?	1. አዎ 2. አይ	
504	ስለወሊድ መቆጣጠሪያ ቤተሰቦችህ/ሽ አወያይተውህ/ሽ ያውቃሉ? መልስህ/ሽ አዎ ከሆነ ወደ ጥያቄ ቁጥር 506 እለፍ/እለፊ	1. አዎ 2. አይ	
505	የማትወያዩ ከሆነ ምክንያቱ ምንድነው ብለህ/ሽ ታስቢያለሽ/ህ?	1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6. ርዕሶቹ ከባድና የሚያበሳጩ ናቸው 7. ሌላ ካለ ይገለፅ____	
506	አዎ ካልክ/ሽ ውይይቱን በአብዛኛው ጊዜ ከማን ጋር ታደርጋለህ/ሽ	1. ከአባት ጋር 2. ከእናት ጋር	
507	ምን ያህል ጊዜ ስለወሊድ መቆጣጣሪያ ከወላጆችህ/ሽ ጋር ተወያይተሻል/ሀል?	ነ. በፍጹም የለም 2. በድንገት አንዳንዴ 3. አንዳንዴ 4. በብዛት 5. በጣም በብዛት	
508	ከወላጆች ውጪ ከማን ጋር ትወያያለህ/ለሽ	1. ከጓደኞች ጋር 2. ከእህት ጋር 3. ከወንድም ጋር	

		4. ሌላ ካለ ይገለፅ	
509	ስለኤችአይ.ቪ..ኤድስ ከወላጆችህ/ሽ ጋር ተወያይተህ/ሽ ታውቃለህ/ሽ? መልስህ/ሽ አዎ ከሆነ ወደ ጥያቄ ቁጥር 511 እለፍ/እለፊ	1. አዎ 2. አይ	
510	የማትወያዩ ከሆነ ምክንያቱ ምንድነው ብለህ/ሽ ታስቢያለሽ/ህ?	ነ. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6. ርዕሶቹ ከባድና የሚያበሳጩ ናቸው 7. ሌላ ካለ ይገለፅ.....	
511	አዎ ካልክ/ሽ ውይይቱን በአብዛኛው ጊዜ ከማን ጋር ታደርጋለህ/ሽ	1. ከአባት ጋር 2. ከእናት ጋር	
512	ምን ያህል ጊዜ ስለኤች.አይ.ቪ.ኤድስ ከወላጆችህ/ሽ ጋር ተወያይተሻል/ሀል?	1. በፍጹም የለም 2. በድንገት አንዳንዴ 3. አንዳንዴ 4. ብዛት 5. በጣም በብዛት	
513	ከወላጆች ውጪ ከማን ጋር ትወያያለህ/ለሽ	1. ከጓደኞች ጋር 2. ከእህት ጋር 3. ከወንድም ጋር 4. ሌላ ካለ ይገለፅ	
514	ስለግብረ ስጋ ግንኙነት ከወላጆችህ/ሽ ጋር ተወያይተህ/ሽ ታውቃለህ/ሽ? መልስህ/ሽ አዎ ከሆነ ወደ ጥያቄ ቁጥር 516 እለፍ/እለፊ	1. አዎ 2. አይ	
515	የማትወያዩ ከሆነ ምክንያቱ ምንድነው ብለህ/ሽ ታስቢያለሽ/ህ?	1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6. ርዕሶቹ ከባድና የሚያበሳጩ ናቸው 7. ሌላ ካለ ይገለፅ.....	
516	አዎ ካልክ/ሽ ውይይቱን በአብዛኛው ጊዜ ከማን ጋር ታደርጋለህ/ሽ	1. ከአባት ጋር 2. ከእናት ጋር	
517	ምን ያህል ጊዜ ስለግብረ ስጋ ግንኙነት ከወላጆችህ/ሽ ጋር ተወያይተሻል/ሀል?	ነ. በፍጹም የለም 2. በድንገት አንዳንዴ 3. አንዳንዴ 4. በብዛት 5. በጣም በብዛት	
518	ከወላጆች ውጪ ከማን ጋር ትወያያለህ/ለሽ	ነ. ከጓደኞች ጋር 2. ከእህት ጋር 3. ከወንድም ጋር 4. ሌላ ካለ ይገለፅ	
519	ስለአልተፈለግ እርግዝና ከወላጆችህ/ሽ ጋር ተወያይተህ/ሽ ታውቃለህ/ሽ? መልስህ/ሽ አዎ ከሆነ ወደ ጥያቄ ቁጥር 521 እለፍ/እለፊ	1. አዎ 2. አይ	
520	የማትወያዩ ከሆነ ምክንያቱ ምንድ ነው ብለህ/ሽ ታስቢያለሽ/ህ?	1. በባህል ተቀባይነት የለውም	

		2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6. ርዕሶቹ ከባድና የሚያበሳጩ ናቸው 7. ሌላ ካለ ይገለፅ	
521	አዎ ካልክ/ሽ ውይይቱን በአብዛኛው ጊዜ ከማን ጋር ታደርጋለህ/ሽ	1. ከአባት ጋር 2. ከእናት ጋር	
522	ምን ያህል ጊዜ ስለአልተፈለግ እርግዝና ከወላጆችህ/ሽ ጋር ተወያይተሻል/ሀል?	ነ. በፍጹም የለም 2. በድንገት አንዳንዴ 3. አንዳንዴ 4. በብዛት 5. በጣም በብዛት	
523	ከወላጆች ውጪ ከማን ጋር ትወያያለህ/ለሽ	1. ከጓደኞች ጋር 2. ከእህት ጋር 3. ከወንድም ጋር 4. ሌላ ካለ ይገለፅ	
524	ስለግብረ ስጋ ግንኙነት ስለሚመጡ በሽታዎች ከወላጆችህ/ሽ ጋር ተወያይተህ/ሽ ታውቃለህ/ሽ?መልስህ/ሽ አዎ ከሆነ ወደ ጥያቄ ቁጥር526 እለፍ/እለፊ	1. አዎ 2. አይ	
525	የማትወያዩ ከሆነ ምክንያቱ ምንድ ነው ብለህ/ሽ ታስቢያለሽ/ህ?	1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6. ርዕሶቹ ከባድና የሚያበሳጩ ናቸው 7. ሌላ ካለ ይገለፅ	
526	አዎ ካልክ/ሽ ውይይቱን በአብዛኛው ጊዜ ከማን ጋር ታደርጋለህ/ሽ	1. ከአባት ጋር 2. ከእናት ጋር	
527	ምን ያህል ጊዜ በግብረ ስጋ ግንኙነት ስለሚመጡ በሽታዎች ከወላጆችህ/ሽ ጋር ተወያይተሻል/ሀል?	ነ. በፍጹም የለም 2. በድንገት አንዳንዴ 3. አንዳንዴ 4. በብዛት 5. በጣም በብዛት	
528	ከወላጆች ውጪ ከማን ጋር ትወያያለህ/ለሽ	1. ከጓደኞች ጋር 2. ከእህት ጋር 3. ከወንድም ጋር 4. ሌላ ካለ ይገለፅ	
529	ከጋብቻ በፊት የግብረ ስጋ ግንኙነት ስለአለማድረግ ከወላጆችህ/ሽ ጋር ተወያይተህሽ ታውቃለህ/ሽ? መልስህ/ሽ አዎ ከሆነ ወደ ጥያቄ ቁጥር 531 እለፍ/እለፊ	1. አዎ 2. አይ	
530	የማትወያዩ ከሆነ ምክንያቱ ምንድ ነው ብለህ/ሽ ታስቢያለሽ/ህ?	1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች	

		አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6. ርዕሶቹ ከባድና የሚያበሳጩ ናቸው 7. ሌላ ካለ ይገለፅ.....	
531	አዎ ካልክ/ሽ ውይይቱን በአብዛኛው ጊዜ ከማን ጋር ታደርጋለህ/ሽ	1. ከአባትጋር 2. ከእናትጋር	
532	ምን ያህል ጊዜ ከጋብቻ በፊት የግብረስጋ ግንኙነት ስለአለማድረግ ከወላጆችህ/ሽ ጋር ተወያይተሻል/ህል?	ነ. በፍጹም የለም 2. በድንገት አንዳንዴ 3. አንዳንዴ 4. በብዛት 5. በጣም በብዛት	
533	ከወላጆች ውጪ ከማን ጋር ትወያያለህ/ለሽ	1. ከጓደኞች ጋር 2. ከእህት ጋር 3. ከወንድም ጋር 4. ሌላ ካለ ይገለፅ	
534	ስለኮንዶም ከወላጆችህ/ሽ ጋር ተወያይተህ/ሽ ታውቃለህ/ሽ? መልስህ/ሽ አዎ ከሆነ ወደ ጥያቄ ቁጥር 536 እለፍ/እለፊ	1. አዎ 2. አይ	
535	የማትወያዩ ከሆነ ምክንያቱ ምንድ ነው ብለህ/ሽ ታስቢያለሽ/ህ?	1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6. ርዕሶቹ ከባድና የሚያበሳጩ ናቸው 7. ሌላ ካለ ይገለፅ.....	
536	አዎ ካልክ/ሽ ውይይቱን በአብዛኛው ጊዜ ከማን ጋር ታደርጋለህ/ሽ	1. ከአባትጋር 2. ከእናትጋር	
537	ምን ያህል ጊዜ ስለኮንዶም ከወላጆችህ/ሽ ጋር ተወያይተሻል/ህል?	ነ. በፍጹም የለም 2. በድንገት አንዳንዴ 3. አንዳንዴ 4. በብዛት 5. በጣም በብዛት	
538	ከወላጆች ውጪ ከማን ጋር ትወያያለህ/ለሽ	1. ከጓደኞች ጋር 2. ከእህት ጋር 3. ከወንድም ጋር 4. ሌላ ካለ ይገለፅ	
539	ጉርምስና በሚጀምርበት ወቅት ስለሚከሰቱ የሰውነትና የስነ-ልቦና ለውጦች ከወላጆችህ/ሽ ጋር ተወያይተህ/ሽ ታውቃለህ/ሽ? መልስህ/ሽ አዎ ከሆነ ወደ ጥያቄ ቁጥር 541 እለፍ/እለፊ	1. አዎ 2. አይ	
540	የማትወያዩ ከሆነ ምክንያቱ ምንድነው ብለህ/ሽ ታስቢያለሽ/ህ?	ነ. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀትማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም	

		5. ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6. ርዕሶቹ ከባድ ና የሚያበሳጩ ናቸው 7. ሌላ ካለ ይገለፅ	
541	አዎ ካልክ/ሽ ውይይቱን በአብዛኛው ጊዜ ከማን ጋር ታደርጋለህ/ሽ	1. ከአባትጋር 2. ከእናትጋር	
542	ምን ያህል ጊዜ ጉርምስና በሚጀምርበት ወቅት ስለሚከሰቱ የሰውነትና የስነልቦና ለውጦች ከወላጆችህ/ሽ ጋር ተወያይተሻል/ህል?	ነ. በፍጹም የለም 2. በድንገት አንዳንዴ 3. አንዳንዴ 4. በብዛት 5. በጣም በብዛት	
543	ከወላጆች ውጪ ከማን ጋር ትወያያለህ/ለሽ	ነ. ከጓደኞች ጋር 2. ከእህት ጋር 3. ከወንድም ጋር 4. ሌላ ካለ ይገለፅ	
544	እናትህ/ሽ በስነተዋልዶ ጤና እና በግብረ ስጋ ግንኙነት ላይ ውይይት ለማድረግ ግልፅ ነች?	1. አዎ 2. አይ	
545	የወላጆችህን/ሽን በስነተዋልዶ ጤና እና በግብረ ስጋ ግንኙነት ጉዳዮች ላይ ለመወያየት ያላቸውን ችሎታ ምን ያህል ነው ብለህ/ሽ ታስቢያለሽህ	1. ዝቅተኛ 2. መካከለኛ 3. ከፍተኛ	

VI. የመለስካቸውን/ሻቸውን መልሶች በተመለከተ ምን አይነት ስሜት አለህ/ሽ?

ከእውነታው ያነሰ ነው ☐

ከእውነታው የተጋነነ ነው ☐