ADOLESCENT-PARENT PARTNERSHIP GUIDELINES FOR IMPROVING COMMUNICATION ON SEXUAL AND REPRODUCTIVE HEALTH IN ADDIS ABABA, ETHIOPIA

by

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Adolescent-Parent Partnership Guidelines for Improving Communication about Sexual and Reproductive Health in Addis Ababa, Ethiopia

I declared that this thesis is my own work. All the sources used or cited have been recognised and acknowledged using comprehensive list of references.

This thesis has also been subjected to reliable software testing to check its originality.

I also confirm that this research thesis work has never been submitted to any other higher learning institution elsewhere before, including submission to Unisa for any degree purposes.

06 February 2024

Alemayehu Bogale Mesfin
(PhD Candidate)

Date

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DEDICATION

This work is dedicated to:

My late younger beloved brother Mulatu Bogale who did not live to see and celebrate my success. I always pray to my Almighty God to rest his soul in eternal peace. I am delighted that I have realized what my brother and family desired for me.

My loving spouse Mulu Tilahun and my lovely sons Biniyam and Mikiyas and daughter Hana with love

ABSTRACT

Background: Globally, adolescents face health risks, especially with respect to sexuality and reproduction. Each year, 7.4 million girls have unintended pregnancies that resulted to 3 million unsafe abortions. There is a paucity of evidence on the level of adolescent-parent communication on sexual and reproductive health issues and guiding framework for the essential sexual and reproductive health programs in Ethiopia.

Purpose: The purpose of the study was to assess adolescent-parent partnership and develop guidelines for improving communication on sexual and reproductive health in Addis Ababa, Ethiopia.

Methods: A cross-sectional study design was conducted among in-school adolescents paired with their parents. A total of 660 in-school adolescents and their parents and or guardians participated in the study.

A multi-stage sampling technique was applied to select the study participants. Data from in-school adolescents was collected using a facilitator guided self-administered questionnaire and face-to-face interviews with parents using structured quantitative survey questionnaire. Descriptive, binary and multiple logistic regressions were carried out to compute the proportions, and odds ratio at 95% confidence interval, respectively.

Results: More than one-fourth (28.3%) of in-school adolescents have ever had sexual intercourse. Nearly half (45%) of them had sex with multiple sexual partners and 54.4% did not use condoms. From sexually active in-school adolescent girls, one-in-ten (10.4%) of them had experienced an unwanted pregnancy. Of these, 70% had terminated their pregnancy. The comprehensive level of discussion regarding common sexual and reproductive health issues was found to be very low, 5.7%. In-school adolescents cited feeling ashamed, embarrassed, lack of knowledge, and cultural unacceptability as major barriers to discussing sexual and reproductive health issues with their parents.

School grade level of in-school adolescents', religion and knowledge were significantly associated with adolescent-parents' communication about their sexual and reproductive health issues. Adolescents' sex, age, religion, lived with and fathers' occupation were significantly associated with in-school adolescents' knowledge and in-school adolescents' sex, age and knowledge about sexual and reproductive health were significantly associated with in-school adolescents' behaviour. Parent's age and educational status

were significantly associated with parental communication and parents' sex, age and educational status were also significantly associated with parents' knowledge about their adolescents' sexual and reproductive health.

Conclusion: This study showed that in-school adolescents had early sexual initiation, experienced risky sexual behaviours that jeopardized with poor comprehensive sexual and reproductive health communication between in-school adolescents and their parents. Therefore, designing effective parent-adolescent communication intervention is critical in improving knowledge and communication of both parents and adolescents about common sexual and reproductive health issues. Adolescents' engagement and participation in different clubs, awareness raising sessions and other platforms plays a pivotal role to prevent and avoid those risky adolescent sexual behaviours.

Key terms: In-school adolescents, Parents, sexual and reproductive health issues, Parent-adolescent communication; knowledge; risky sexual behaviour, factors affecting communication, guideline, Ethiopia

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immunodeficiency syndrome
AOR	Adjusted Odds Ratio
AU	African Union
CI	Confidence Interval
COR	Crude Odds Ratio
CSA	Central Statistics Agency
EDHS	Ethiopian Demographic and Health Survey
EPHI	Ethiopian Public Health Institute
ETB	Ethiopian Birr
FDRE	Federal Democratic Republic of Ethiopia
FIGO	International Federation of Gynaecology and Obstetrics
FMoH	Federal Ministry of Health
HBM	Health Belief Model
HIV	Human Immunodeficiency virus
IMB	Information-motivation behavioural skills
LMICs	Low and Low Middle-Income Countries
MSI	Marie Stopes International
PCC	Parent-Child/Adolescent Communication
RH	Reproductive Health
SDGs	Sustainable Development Goals
STI	Sexually transmitted Infections
STROBE	Strengthening the Reporting of Observational studies in Epidemiology
SRH	Sexual and Reproductive Health
SRHRs	Sexual and Reproductive Health and Rights
SPSS	Statistical Package for Social Sciences
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNAIDS	United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

CHAPTER 1 - ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Adolescence is the period of the most rapid and formative phases of human development. The fast-changing physical, cognitive, social, emotional and sexual development that takes place during adolescence demands special attention. It is that period of formative and dynamic transitions, when young people take on new roles, responsibilities, and identities. In the world today, 1.3 billion adolescents account for 16% of the global population (UNICEF, 2022). Globally, adolescents, both females and males, face health risks, particularly associated with sexuality and reproduction. Adolescent pregnancy is a global public health concerns with clearly known causes and impacts on health, social and economic consequences (WHO, 2023). Several sexual and reproductive health (SRH) behaviours and awareness issues are shaped during adolescence that mark cultural transitions including female genital mutilation, early marriage, and childbirth (Ayalew & Nigatu, 2018).

Each year, late adolescent girls between the age range of 15-19 years, in low- and middle-income countries (LMICs) have an estimated 21 million pregnancies. Among these, almost half, 10 million are unintended that result to an estimated 12 million births. More than a quarter of these adolescent pregnancies, 5.7 million, end in abortion with the majority being carried out in unsafe conditions(UNFPA, 2022a). Around one in three women in LMICs begin childbearing during adolescence, 19 years and younger. Close to half of first births to adolescent child mothers are to those aged 17 years and younger and 6% are to child mothers aged 14 years and younger. A girl who has her first birth at 14 years or younger has, on average, 2.2 births before she reaches 20 years of age. A girl with a first birth between the ages of 15-17 years has, on average, 1.5 births before she is 20. Once an adolescent girl becomes a mother, she has a one-in-five chance of experiencing another adolescent birth within two years. Such short birth intervals come with considerable health risks. More than half of all repeat births in adolescence occur within 23 months of a previous birth (UNFPA, 2022b).

Approximately 12 million late adolescent girls and at least 777 000 girls under 15 years of age give birth each year in developing regions. Pregnancy related complications are

among the leading causes of death for girls aged 15–19 years globally. Adolescents birth rate accounts 42 births per 1000 for girls of this age globally (Unicef, 2023; WHO, 2021). Further, an estimated 1.7 million adolescents are living with HIV, 90% of whom are in the African Region. Adolescents still account for about 10% of new HIV infections, with three-quarters of them being adolescent girls. The prevalence of adolescent pregnancy remains a concern in LMICs. Adolescent pregnancy is a global public health concern with medical, emotional, social, spiritual and cultural consequences. Reportedly, 61% of all unintended pregnancies and 29% of all pregnancies end in induced abortion. Approximately 73 million induced abortions take place each year, and nearly 45% of these are carried out under unsafe conditions (Sebola, 2023).

Survival chances for adolescents and young adults vary greatly across the world. Over, 1.5 million adolescents and young adults aged 10–24 years died in 2021, about 4,500 every day. The probability of dying amongst those aged 10–24 years was highest in sub-Saharan Africa and lowest in Europe and Northern America. The average global probability of a 10-year-old dying before reaching age 24 was about 6 times higher in sub-Saharan Africa(WHO, 2021).

Based on 2019 WHO available data, 55% of unwanted pregnancies ends in abortion among adolescent girls aged 15–19, which are often unsafe in LMICs. Adolescent mothers face higher risks of complicated pregnancies than women who are aged 20–24. The babies of adolescent mothers also face greater risks of low birth weight, preterm birth and severe neonatal conditions. Preventing unintended pregnancy among adolescents, and minimizing pregnancy-related mortality and morbidity are major foundations to achieve positive health outcomes across life's course and imperative for achieving the global Sustainable Development Goals (SDGs) related to maternal and newborn health (WHO, 2023).

Addressing adolescent health, growth, and development is a critical public health priority. Investments in adolescent SRH programs that target vulnerable adolescents will help girls stay in school, delay early sexual initiation, prevent child marriage and adolescent girl childbearing, and contribute to them earning a better income. Investments in adolescents' SRH can delay first pregnancies, reduce maternal mortality, and improve all other reproductive health outcomes for women and their children that substantially contribute to the SDGs, particularly SDG Target 3 (Women's Refugee Commission, Save the Children, UNHCR, 2012).

Many LMICs are increasingly recognizing the importance of addressing the wellbeing and development issues of their adolescent to achieve the SDG 3 (Finlay, Assefa, Mwanyika-Sando, et al., 2020; UN, 2017). A healthy and successful development from adolescent stage into adulthood is the right of every individual. A right that can only be fulfilled if societies make targeted investments and provide opportunities to ensure that their adolescents progressively develop the knowledge, skills, social and economic assets, and resilience needed for a healthy, productive, and fulfilling life. Moreover, as adolescence is that critical transition period during a human being's life course it needs an emphasis on empowerment and preventative approaches that enable adolescents to survive, thrive, and transform their societies (UN, 2017).

Adolescent disclosure appears to be enhanced when parents and adolescents more openly and flexibly express different positive and negative emotions. The predominant reason adolescents refrain from disclosing what is happening in their lives is their concern about potential negative reactions from parents (Branje 2018). Adolescents, individually and/ or collectively, form and express their views and influence matters that concern themselves directly and indirectly. Opportunities to be heard need to start in early adolescence to lay the foundation for expression and active participation in decision-making and to support adolescent growth and development into healthy, resilient and active citizens.

According to the UNICEF report, adolescents who can openly communicate with their parents or caregivers on a regular basis and feel like they are being heard are highly protected from various risky sexual behaviours (UNICEF, 2020). Optimal adolescent-parent communication about SRH issues aid in favourable attitudes towards many reproductive health issues that affect adolescents. Parents tend to avoid sexuality related issues in discussion, such as pleasure, love, and healthy relationships, but they are in favour of warnings (Haile et al 2020). Adolescent-parent conversations about SRH issues lack positive topics about sexuality, pregnancy, STIs, and gender equality. Parents feel unprepared and unable to address their adolescent's sensitive matters around sexuality and reproduction. Parental guidance that consists of evidence-informed accurate and complete information about SRH issues to respond to their adolescents is required.

1.2 BACKGROUND INFORMATION

1.2.1 The source of the research problem

About 1.65 million adolescents between the ages of 10-19 years live with HIV worldwide. About 1.40 million or 85% of those, live in sub-Saharan Africa. Adolescents account for about 4% of all people living with HIV and about 10% of new adult HIV infections. Adolescent girls account for four-fifth of all new HIV infections among adolescents (Unicef, 2023). The 2022 UNAIDS statistics showed that adolescent girls and young women from sub-Saharan Africa (SSA), aged 15-24 years remain at substantial risk of acquiring HIV. Every week, an estimated 4,900 incident infections occur among women in this age group globally. In SSA, approximately six out of seven new infections occur among adolescents aged 15-19 years and young women 15-24 years are twice likely to be living with HIV than their male counterparts. Adolescent girls and young women accounted for 63% of all new HIV infections in 2021 (UNAIDS, 2022)

As of 2019, adolescents aged 15–19 years in LMICs had an estimated 21 million pregnancies each year, of which, approximately 50% were unintended resulting in an estimated 12 million births. Of the unintended pregnancies among adolescent girls aged 15–19 years, 55% ended in abortions, which are often performed under unsafe conditions in LMICs (WHO, 2023).

In Ethiopia, adolescents cover over 26.2% of the country's population, with about 15.6% being between the ages of 10-14 years (WHO 2016). Adolescents often experience unfavourable reproductive health outcomes because of inadequate SRH information and risky sexual practices (Haile et al 2020). In addition, adolescence carries the highest disease burden, particularly in the arena of SRH (UNICEF, 2020). In Ethiopia, adolescents suffer from negative SRH outcomes that includes unwanted pregnancies; unsafe abortion; maternal mortality; STIs including HIV/AIDS; sexual violence against young women and girls; and there are an increasing number of adolescents with prenatally acquired HIV; and poor nutrition (CSA 2016; Kassa, Arowojolu & Odukogbe 2019). Young adults in Ethiopia are vulnerable to unintended pregnancies, because they initiate sex at a relatively early age, are not knowledgeable about their sexuality, are less likely to use contraception, have little access to family planning method choices, informed consent

and adolescent targeted services, and often have little control over their reproductive health. Most of all births to women below the age of 15 years, and more than one-in-three births to young women are unintended (Haile et al 2020). Studies conducted from different parts of Ethiopia indicate that the prevalence of unintended pregnancies ranges from 13.7% to 41.5% (Tsegaye, Mengistu & Shimeka 2018).

Based on the sentinel surveillance on STIs conducted by the Ethiopian Public Health Institute in 2015, a total of 1,421 STI cases were reported from 20 sentinel surveillance sites. More than half of these cases were reported from Addis Ababa's four facilities. About 66.6% of the patients had an educational status of 8th Grade or less, around 51.3% of the respondents were married and 15.4% of them were daily labourers (EPHI, 2015).

1.2.2 Background to the research problem

Parent-Child/Adolescent Communication (PCC) plays a crucial role in preventing adolescents from engaging in risky sexual behaviours, and promoting access to contraceptive, maternal health and other sexuality related services. Parents who are not communicating clearly with their adolescents about sexuality and reproduction (Sebola & Thupayagale-Tshweneagae 2019). This lack of communication has led to many adolescents falling pregnant whilst still at school, contracting STIs and experiencing other factors that can have negative consequences for their growth and development into adulthood. Consequentially this has led to them dropping out from school and more seriously, death through illegal abortions (Nigatu, Thupayagale-Tshweneagae & Akpor 2019). A study undertaken in Arsi Zone of Ethiopia indicates that more than eight- in- ten adolescents between 15-19 have undergone unsafe abortions (Legesse, Solomon & Teresa, 2017). According to the 2016 Ethiopian Demographic and Health Survey (EDHS) report, Ethiopia has a maternal mortality ratio of 412 deaths per 100,000 live births. Thus, the lifetime risk of pregnancy-related mortality (a death related to pregnancy or childbirth) is 21 in 1,000 women in Ethiopia (EDHS, 2017).

Existing evidence shows that adolescents have inadequate knowledge and fail to seek health care about SRH issues that compromise their ability to prevent unintended pregnancy and STIs including HIV (Sebola 2018; Phuthi 2018). Social beliefs concerning sexuality among adolescents, increasing social costs and stigma are associated with

health seeking behaviours and access to services. Further, many adolescents are married as children, a fundamental violation of their rights (UNFPA 2019).

In Ethiopia, like other continental states, communication with one's child about SRH issues including sex, abstinence and changes brought about by puberty are regarded as taboo (Dessie, Berhane & Worku, 2015). It is within this context that the study aims to develop guidelines for adolescent-parent partnerships for improving discussions about SRH issues in Ethiopia.

1.3 RESEARCH PROBLEM

Adolescents account for a significant proportion of the population, around 16%, yet their SRH needs and rights remain mostly unmet. Adolescents are one of those groups for whom existing health services are inadequate as they usually encounter discrimination and bottlenecks to accessing existing information and services. Some of these barrier's stem from age restrictions on access to such services, while others are generated by social norms and stigma that hinder the adolescent's ability to seek information about their sexuality and their SRH. These barriers can deter adolescents from seeking health care assistance or information at that point in their lives just when they begin to become sexually active and thus require such information for their own protection. In low economic countries, 12 million girls between 15-19 years and 2.5 million girls below 16 years gave birth yearly. Moreover, 3.9 million girls aged 15-19 underwent unsafe abortions. Complications during pregnancy and childbirth are a major causes of death for 15-19-year-old girls globally (United Nations Human Rights 2020).

In LMICs, female adolescent mortality due to unwanted pregnancy has a serious impact on the overall maternal mortality rate (Neal et al 2016). Similarly, in 46 other LMICs, children born to mothers younger than 19 years have high early neonatal deaths, stillbirth, and neonatal mortality when compared with mothers who gave birth between the age range of 23-25 years (Noori et al 2022).

A study conducted in Ecuador has shown that an estimate abortion ratio among adolescents was 73 per 1000 live births. From all adolescents that gave birth, 57.4% of those were aged 17 and over and 43% of them were between 14-16 years old. The

maternal mortality rate among adolescents was 7.7 per 100,000 (García et al 2022). Although maternal mortality in adolescence has similar causes to those of older women, hypertension during pregnancy and malaria are more common causes of adolescent maternal mortality than in older women (Neal et al 2016). Adolescent pregnancy is associated with life threating child survival conditions that need to be mitigated by health-seeking behaviour, likely reflecting a combination of biological and social factors (Noori et al 2022).

Adolescents are exposed to multiple SRH risky behaviours, early sexual initiation, and unsafe, or risky sexual activity. The major factors that predict to this exposure are lack of affordable, manageable, and suitable contraception information and services and lack of sexuality related article-findings that assist in designing evidence-based intervention strategies to prevent risky sexual practices worldwide (WHO 2012). Various cofounding factors like politics, economic situation, and sociocultural conditions restrict the delivery of information and services; healthcare workers often lack adequate knowledge and skills to equip adolescents with age-specific and demand-driven information and services. International players like International Federation of Gynaecology and Obstetrics (FIGO) playing a critical role with other partners and member associations to avert some of these bottle necks by enabling obstetricians and gynaecologists to brought change in their countries and advocate the SRH agenda on a global scale (Morris & Rushwan 2015).

Adolescents that experience sexual initiation at an early age in life have a greater likelihood to continue with risky behaviour in early adulthood, including having multiple partners and practising inappropriate and inconsistent condom usage. Thess exposes adolescents to greater risk of the undesired outcomes of sexual activity, including unwanted pregnancy and/ or STIs, including HIV (Brown et al 2010). In Ethiopia, adolescents participate in unprotected sexual behaviour that, in many instances, results in the increased chance of unintended pregnancy and associated unsafe abortion, and a high risk of transmission of STIs including HIV/AIDS. Shortage of timely appropriate information regarding sexual and reproductive health, limited access to health services including contraception, and vulnerability to sexual violence put adolescents at high risk (CSA, 2016). Nearly half (45%) of the total births are attributed to adolescent girls and young women (Pav 2002).

Adolescent childbearing is associated with having sexual intercourse before their 18th birthday, or being married during adolescence (Kassa et al 2019). Regular and effective

parent-adolescent discussions about SRH issues is a major milestone that can affect the adolescents to prevent risky sexual practices and therefore prevent teenage pregnancies and STIs. Parents should be aware that it is their responsibility to provide their children with the correct SRH information from an early age and to create an environment where children are free to talk and ask questions. Adolescents and parents both benefit when PCCs about SRH are open and honest. Adolescents need to be empowered with adequate knowledge for them to make informed choices and decisions to avail themselves of SRH services. For that, parental or guardian discussions with their adolescents about major SRH issues are imperative (UNFPA, 2022a).

Positive PCC protects adolescents from developing mental health problems and ensures emotional and instrumental support. Such support from parents and family members is associated with decreased internal and external problems that can face adolescents. A high level of PCC strengthens parental connectedness, trust, and family cohesion. Conversely, poor PCC includes such as criticism and rejection, and can cause stress or depression among adolescents. Studies indicate that many adolescents who experience depressive symptoms in high school have negative communication with their parents. Adolescents who feel insecure within their families often develop symptoms of depression because they feel their parents do not trust them (Zhang et al 2021).

There are very limited studies that have been conducted around PCC on SRH issues for both adolescents and parents in Ethiopia. The researcher established that no studies have been carried out in the country which paired adolescent and parent communication patterns with SRH among in-school adolescents and their parents. The need for producing evidence-based information on SRH knowledge, practice and communication of in-school adolescents with their parents is found to be pivotal. Hence, it is crucial to have adequate information on adolescents-parents comprehensive knowledge, behaviour and communication on sexual and reproductive health issues to have a clear understanding of the existing scenario and design contextualized implementation guidelines to prevent adolescents from risk taking sexual behaviours in Addis Ababa Ethiopia.

1.4 AIM/PURPOSE OF THE STUDY

1.4.1 Research purpose

The main purpose of this study was to assess the current pattern of adolescent-parents communication about SRH issues and develop guideline for adolescent-parent partnerships to improve communication on SRH issues in Addis Ababa, Ethiopia

1.4.2 Research objectives

The objectives of the study were:

- To assess the communication patterns between adolescents and parents about sexual and reproductive health issues.
- To identify factors that facilitate/ promote parent-adolescent communication about sexual and reproductive health issues.
- To determine the attitudes of adolescents and parents about sexual and reproductive issues and parental monitoring.
- To develop a guideline and propose refinements to improve parent-adolescent partnerships communication about sexual and reproductive health issues in Ethiopia.

1.4.3 Research questions/hypotheses

This study was designed to address the below research question:

- What is the extent of adolescent-parents communication about sexual and reproductive health issues?
- What are the factors that promote parent-adolescent communication about sexual and reproductive health issues?
- What are the attitudes of parents and adolescents about sexual and reproductive health issues and parental monitoring?

- How will the proposed and refined guidelines improve parent-adolescent partnerships communication about sexual and reproductive health issues in Ethiopia?

1.5 SIGNIFICANCE OF THE STUDY

Adolescent SRH issues are a serious public health challenge in Ethiopia. Assessing knowledge, behaviour and communication about SRH is of crucial importance to those stakeholders who have already begun work with this and have to invest in adolescent SRH issues. The findings of the study will be used to inform policymakers and program implementers about the current pattern of adolescent-parent SRH communication. In addition, this study's findings will be used to develop guidelines that propose interventions and strategies that can address SRH issues in Addis Ababa City and beyond. Further to the policy and program importance, the study findings will serve as a baseline for further scientific studies about SRH communication related issues in Ethiopia.

1.6 DEFINITION OF KEY TERMS

Adolescence: A transitional stage of rapid physical and psychological development that generally occurs from the period of puberty to adulthood (Ajdukovic 1998). WHO in 2010 defines adolescence as being the chronological age between 10-19 years, and as a period of life marked by special attributes. For this research purpose, an adolescent refers the ages between 13-19 years is defined to be 'in-school adolescent' (WHO, 2010).

Sexual and Reproductive Health (SRH): Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of diseases, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (WHO, 2010). This study covered adolescent knowledge, communication and practice of issues related to sexuality; contraception; STI/HIV; unintended pregnancy; abortion; condom use; abstinence; and puberty.

Sexual and Reproductive Health (SRH) knowledge: Adolescent knowledge about SRH issues was assessed using six questions about contraception; STI/HIV; abstinence; puberty/menstrual cycle; unwanted pregnancy; and condom usage. From these questions, if the adolescent responded with at least one 'yes' they were considered as having knowledge regarding SRH matters.

Sexual and Reproductive Health (SRH) behaviour: Adolescent SRH behaviour was assessed using six item questions that included if they had ever experienced: sexual intercourse; contraceptive use; condom use; an STI/HIV; an abortion; an unwanted pregnancy; or emergency contraception. Of these, if the adolescent mentioned 'yes' for one SRH issue, this was considered as having experience about SRH issues.

SRH communication: Adolescent-parent communication about SRH issues was assessed using seven items that included discussions about contraception; STI/HIV; sexuality; unwanted pregnancy; abstinence; condom use; and puberty. If the adolescent responded 'yes' to one of these issues, this was considered as having had discussion with their parents about SRH issues.

Parents: For this study, parents refer to biological parents and any legal guardian reported by the in-school adolescents included in the study.

1.7 THEORETICAL FOUNDATIONS

1.7.1 Research paradigm

The research paradigm is an approach or farmwork used to guide in conducting research. This thesis is relied on quantitative research method from paired study participants (adolescent-parental survey), that means. a research paradigm is a way of describing a worldview informed by philosophical assumptions or underpinning (Chilisa and Kawulich, 2012). The guiding philosophical underpinnings of the research plays critical role to properly structure the rationale, research questions and design to capture relevant information to provide conclusive response to the research inquiry through depth understanding of the context (Makombe (2017). A positivist theoretical perspective was adopted to determine the extent of SRH discussions among parents and adolescents

quantitatively. This paradigm emphasizes that adolescent-parent SRH communication can be measured using reliable measurement to generate valid research findings. To identify the extent of communication, the study used a study design that described adolescent's characteristics about their sexual and reproductive health issues discussion with parents through self-administered structured questionnaire and parental survey. In response to this, school-based cross-sectional study technique was used to measure the extent of adolescent-parent communication about their SRH issues. Random sampling was applied to select the schools and in-school adolescents followed by sampling and interviewing of their parents. A different questionnaire to that for the adolescents was developed for the parents to assess the characteristics; these were analysed using SPSS Version 28. The extent of adolescent-parent communication regarding SRH issues was identified. Based on the major research findings recommendations, parent-adolescent partnership guidelines have been developed to improve SRH communication.

1.7.2 Conceptual framework

Information-motivation behavioural skills (IMB) model theory-based research is necessary to identify the determinants of SRH communication which can be targeted for intervention. This study utilized the IMB model as a framework to guide the SRH communication assessment (Fisher et al 2002). This model incorporates elements from other theories such as the Health Belief Model (HBM), which is described as a simple construct to explain complex health behaviours (Samkange-zeeb, 2013). According to the IMB model as is shown in Figure 1.1, information (knowledge), motivation and behavioural skills are the fundamental determinants of sexual initiation and maintenance of healthy behaviours (Fisher et al 2002). This model hypothesizes that if someone is well informed about a behaviour, is motivated to perform that behaviour and has the necessary skills and confidence in their ability to do so across various situations, then this person is more likely to engage in that healthy behaviour. In the context of this study, if parents have the knowledge and skill to communicate SRH issues with their adolescents then

they will be able to do so, and their adolescent children will obtain knowledge to avoid risky behaviours.

The information and motivation model are potentially independent constructs which means that well-informed individuals are not necessarily motivated to engage in health-promotion behaviours or well-motivated individuals are not necessarily well informed about health-promotion practices. The behavioural skills represent a final common pathway for predicting complex acceptable behaviours (Fisher, Fisher & Harman 2009). This study, therefore, assessed PCC on SRH using the IMB model as a framework. The identification of communication prevalence and the exploration of a relationship of IMB constructs to communication practice will provide pertinent information for planning appropriate intervention guidelines for parents to prevent and reduce risky sexual behaviours among their adolescents.

Conceptual framwork

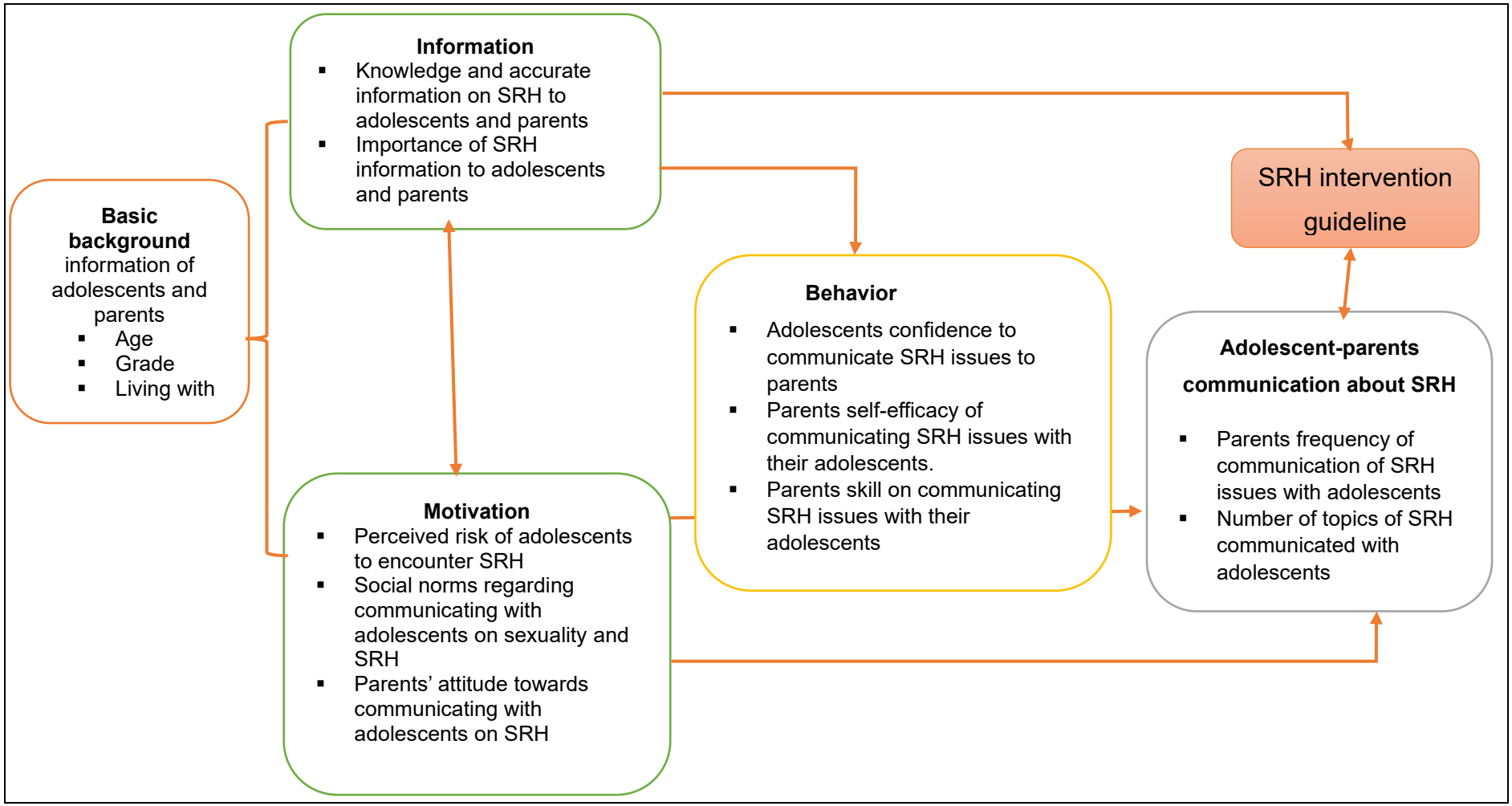

Figure 1.1: The Information-Motivation-Behavioural Skills (IMB) Model (Source: Fisher, Fisher and Harman 2009)

1.8 RESEARCH METHODOLOGY

This study used a quantitative study design that involved in-school adolescents with their parents and/or guardians to capture relevant data on the outcome and exposure variables related to adolescent-parents discussion on SRH matters at a point in time. The detailed methodology parts are described in chapter 3 of the study.

1.9 SCOPE OF THE STUDY

This study was conducted at secondary schools in Addis Ababa which is the capital city of the country [Ethiopia] and the political capital of the African Union. The study involved in-school adolescents and their parents to order to assess adolescent-parent communication on SRH issues. Four major key areas were covered in this study, such as adolescent-parent knowledge about SRH issues; adolescent behaviour related to SRH issues; adolescent-parent communication about SRH issues and their determinants. Eventually, a guideline was drafted to propose a pathway to design the necessary interventions to address the communication gaps around SRH issues.

1.10 STRUCTURE OF THE THESIS

This research work comprises of seven main chapters presented in the below figure 1.2 and is structured based on the following chapters (the details described in each chapter):

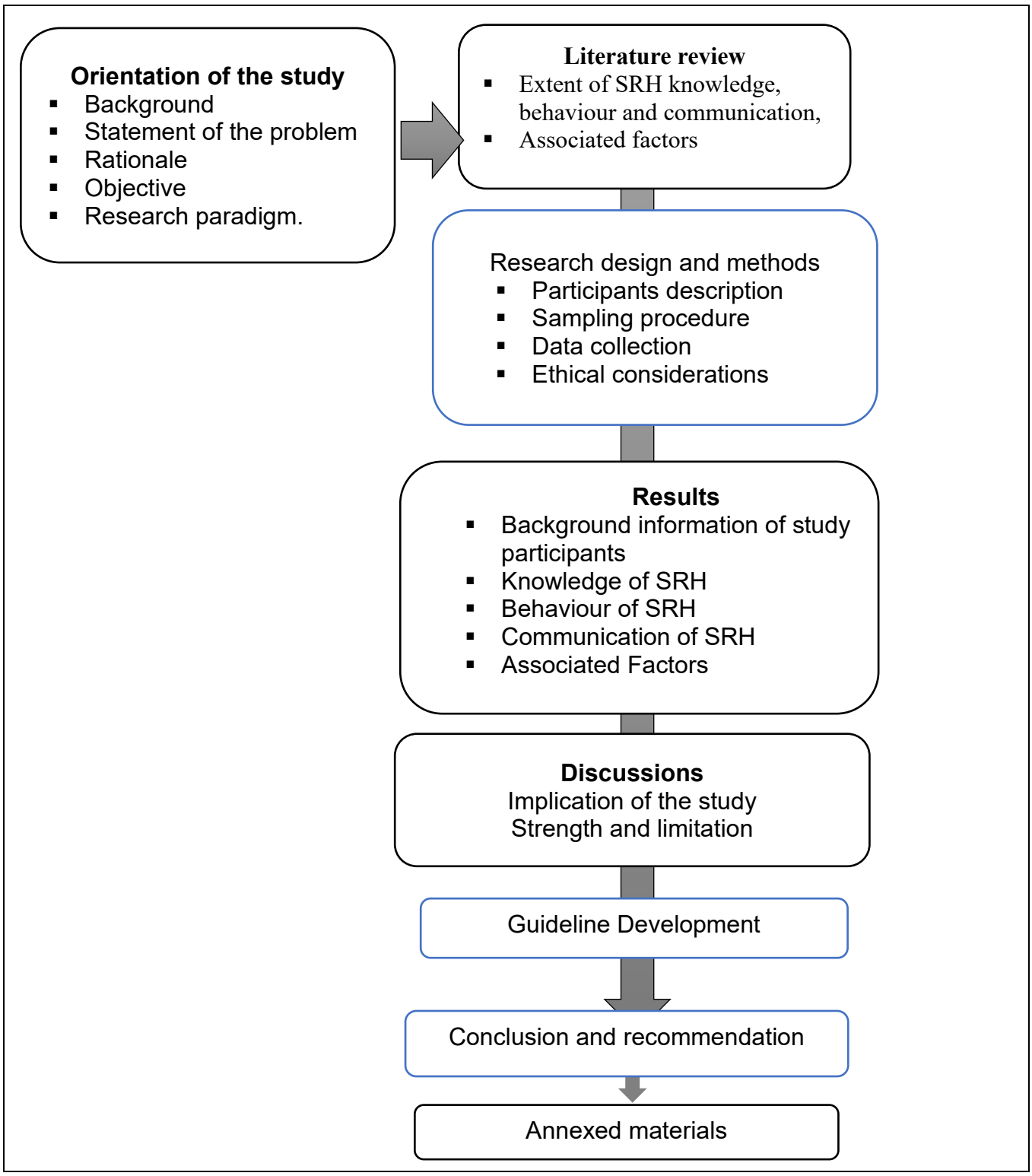

Figure 1.2: Strcuture of the thesis work

CHAPTER 2 - LITERATURE REVIEW

This chapter consists of a review of literatures related to SRH knowledge of adolescents, sexual practices, and SRH communication assessed from many sources. Literature that was found to be useful for the study topic was selected, interpreted, analysed, and presented using the different themes or sub-topics in this part. Based on the various studies review, SRH knowledge, behaviour and communication with adolescents is discussed in this chapter.

2.1 LITERATURE REVIEW METHODLOGY

The literature reviews were through comprehensive search of published and unpublished (grey literature). Both published and unpublished literatures were searcher from major electronic databases using search terms derived from the research question. Search terms were constructed accordingly considering the databases interface and recommended search strategies. PubMed/Medline, Global Health, Cochrane literature, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and direct google scholar search were carried out to retrieve available relevant literature on adolescent sexual and reproductive health issues. The retrieved literature was imported to Mendeley Desktop reference citation manager for further review and data abstraction. Then the literatures were synthesized and presented on logical flow of adolescent-parent sexual and reproductive health knowledge, risk taking behaviour and communication.

2.2 INTRODUCTION

Adolescence is the life transition between childhood and adulthood, from ages 10-19 years. It is a peculiar stage of rapid human development and a critical time for laying the basis of good health for healthy adulthood. Adolescents experience rapid physical growth, cognitive and psychosocial development. This positions how they feel, perceive, make decisions, and interact with the various external factors around them (Schichor, 2012).

Despite being majorly considered as a healthy stage of life, adolescents can be injured, diseased, and even exposed to untimely death during the adolescent years, much of which is fully preventable or treatable. During this phase, adolescents developed positive and life threating behaviours – for instance, diet, physical activity, substance use, and sexual practices – that can protect their health and the health of others around them or exposes their health at a higher risk now and in the future. Adolescents need information, including age-appropriate comprehensive sexual education; opportunities to develop life skills; seeking health services that are affordable, acceptable, equitable, appropriate; and effective, safe and supportive environments to grow and develop in good health. They also need opportunities to meaningfully engage and participate in the design and delivery of adolescent targeted interventions to improve and maintain their health. Expanding such opportunities is key to responding to the specific needs and rights of adolescents (Schichor, 2012).

2.3 ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH ISSUES

The adolescents sexual and reproductive health issues in this study includes the knowledge of adolescents about SRH, their risk-taking sexual behaviours or practices, and the communication of SRH issues with their parents and/or guardians. The literatures were searched using these key terms and their logical sequences.

2.3.1 Knowledge about sexual and reproductive health issues

Most adolescents in India have adequate knowledge about their SRH issues. Of these, 92% of boys know that use of condoms is a safe sexual practice but only 43% of girls have the same awareness. Overall, girls were found to have less knowledge in comparison to boys and the higher the class the student was in, the greater the level of knowledge, i.e., 10th Grade students had more knowledge than 9th and 8th Grade students. Parents need to have adequate communication with their adolescents concerning sex-related topics as they were found to be among the least common source

of information, while teachers were the most common source of information on this topic (Deshmukh & Chaniana, 2020a).

Adolescents in Malaysia generally lack knowledge about sexuality, STIs, and pregnancy related issues but the reported level of knowledge is higher in males than females. This finding can guide the research community to focus future projects on gender differences especially when working on sexuality knowledge within populations linked to religious and cultural norms of such conservative countries as Malaysia, where Islam is predominant (Mustapaa et al., 2015). Similarly, although general knowledge about SRH was moderate, knowledge gaps were found, such as prevailing myths and inadequate knowledge regarding transmission of HIV and methods choices of contraception (Bergström et al., 2018).

Research undertaken in Italy reveals that 48% of students have sufficient SRH knowledge. Factors associated with higher knowledge levels were being female, age, first SRH information at age 11–13, Italy as the country of origin, and attendance at a technical school (Brunelli et al., 2022).

A study from Nepal reveals that one-third of parents have adequate knowledge about safe abortion, menstrual hygiene and management, modern contraceptives, prevention of STIs, night dreams among male adolescents, abstinence from sexual intercourse during the reproductive period, and the possibility of a male adolescent's ability to impregnate a girl. Moreover, only 40.9% of parents were found to have communicated with their adolescent about SRH issues (Singh et al., 2023).

In sub-Saharan Africa, among adolescents' knowledge regarding HIV is high (89.7%). However, many (37.3%) lack knowledge of menstruation and even more than half of the adolescents do not knew menstruation and STIs other than HIV (55.9%) (Finlay, Assefa, Mwanyika-sando, et al., 2020). Study conducted in Gambia indicates that 60.0% of adolescents have heard of SRH. One-third, 67.3% knew about STIs; 56.5% about HIV/AIDS; 40.5% Gonorrhoea and 2.5% Syphilis. Social media was the most commonly reported source of information for SRH issues at 31.0%, followed by television at 22.0%, school 14.0% and parents at 9.0% (Sagnia et al., 2020).

Good SRH is a state of complete physical, mental, and social well-being in all matters relating to the reproductive system and its functions. It implies that people can have a

satisfying and safe sex life, the opportunity to reproduce and the freedom to decide if, when, and how often to do so. To maintain one's SRH needs, a person need access to accurate information and the safe, effective, affordable, and acceptable contraception method of their choice. Adolescents must be capacitated and empowered to protect themselves from STIs. When they decide to have children, women must have access to skilled birth care attendant services and services that can help them have a safer pregnancy, safe births, and a healthy baby. Every individual has the right to make their own choices about their SRH. The United Nations Population Fund (UNFPA) together with a wide range of partners, works toward the goal of universal access to SRH and rights, including family planning (UNFPA, 2022a).

The term 'sexual and reproductive health' can be elaborated as a person's right to a healthy body and the autonomy, education, and healthcare to freely decide who to have sex with and how to avoid STIs or prevent an unintended pregnancy. Sexuality and reproduction health is an integral part of overall health and well-being, ensuring everyone can have pleasurable and safe sexual experiences, free of coercion, discrimination, or health risks. Access to SRH information and services enable people to exercise this right. It can take the form of medical care related to the reproductive system, for example, treatment of a sexually transmitted infection, or the facilitation of reproductive autonomy with the provision of contraception and abortion care (MSI, 2022).

SRH matters because it is an essential component of an individual's overall health and wellbeing. Autonomy in decision-making regarding SRH matters is also a fundamental human right that is grounded in the right to health, free from sexual violence, and to determine whether or not to become pregnant. If SRH needs and rights are not fulfilled, individuals are denied the right to make choices about their own bodies and futures, which can have a knock-on impact on their families' welfare and future generations. Because it is often women who face the health and financial implications of not having access to services such as contraception and abortion care, SRH and rights cannot be separated from gender equality (MSI, 2022)

The SRH issues of young people varies from those of adults (WHO, 2010). In adolescent stage, the body undergoes rapid developmental changes, most notably during the time of puberty, the changes in sexual maturation, and the formation of sexual identity (NIH, 2007). Achieving SRH needs requires not only preventing unwanted pregnancy and STIs, it also includes developing the ability to form and maintain meaningful relationships with

others and with one's own body. Psychological, social, educational, environmental, and economic factors, among others, all play a role (Schwarz 2010).

According to WHO (2011a), adolescents have limited knowledge about SRH and know little about the natural developmental changes at the time of puberty. This lack of adequate knowledge about reproduction can have grave consequences. There is little doubt that younger female and male adolescents are highly vulnerable to violations of their rights to bodily integrity. Among the many reasons for this are the attractiveness of their developing sexual bodies, their willingness to trust others, their sexual curiosity, and their sometimes-limited capacity to critically analyse potentially harmful situations, foresee consequences, and take a course of protective action (WHO 2011a).

A study conducted in Nigeria shows that while 89.0% of adolescents were aware of SRH only 19.1% had good knowledge of it. Most of them, 93.2%, demonstrated a positive attitude towards SRH (Isara & Nwaogwugwu, 2022). A study conducted in Ghana reveals that the mean age of menarche among females was 13 years, while the age at which puberty was attained amongst boys was 14 years. School teachers (63.7%) were the major source of information on SRH matters for the students followed by parents at 12.2%. The majority (67.1%) of participants had good knowledge of SRH (Obasi et al 2019). Another study conducted in Northern Ghana found that knowledge on reproductive health choices was low among respondents with the majority of them relying on their peers for information on SRH (Kyilleh et al., 2018).

A study conducted in Cameroon established that more than half (54.0%) of in-school adolescents had a good overall knowledge of SRH. However, 63.1% and 55.3% of adolescents had poor knowledge on reproductive system functions and STIs, respectively. In addition, 56.0% had good overall contraceptive knowledge, with 51.6% having poor knowledge on condom usage (Fubam et al., 2022).

The study conducted in the southwest Ethiopia has indicated that nearly three-fourth (73.8%) of adolescents involved in the study knew about the risks of sexual behaviours. Slightly more than one-third (34.93%) of adolescents were informed about sexual matters by their parents, and 76.86% had good knowledge about risky sexual behaviour (Sidamo et al., 2023). Another Ethiopian study shows that one-fourth (26.1%) had the ability to exercise their sexual and reproductive health rights (SRHRs) while 45.3% were knowledgeable about them (Wakjira et al., 2022).

2.3.2 Adolescent sexual and reproductive health behaviour

The research finding in Bangkok, Thailand shows 69.5% of adolescents had risky sexual behaviour (Thepthien & Celyn, 2022). In Ghana, half (50.4%) of adolescents had sex before marriage, and many engaged in risky sexual behaviour: 48.8% had multiple sexual partners; 21.4% had sex while drunk; and 60.7% of those who reported having sex while drunk did not use a condom. Only 22.9% of sexually active adolescents ever used contraceptives (A. Adam et al., 2021).

Findings in Nigeria revealed that 6.2% were sexually active with 76.9% having their sexual debut before the age of 15, 35.9% had more than one sexual partner while only 39.4% consistently used condoms during sexual intercourse. From these 43.6% had experienced vaginal/penile discharge, 15.4% had been tested for STIs, 64.1% had received treatment for STIs with home treatment (64.0%) being the predominant choice (Isara & Nwaogwugwu, 2022). Another study from Nigeria revealed that the majority of the youth (58.2%) were sexually active, with sexual intercourse starting between 15-19 years. Contraceptive knowledge was very high (78.8%), while 34.6% did not use any type of contraception, even among the educated youth notwithstanding their level of education (Ugwu et al., 2022).

A study finding in South Africa indicated that one-fifth (18.3%) had had sex and less than 1% had accessed SRH services in the last year. Of the 157 females who had sex, 50.9% used contraception. Of those who had sex in the last three months, 59.0% reported using a contraceptive method. Condom use was inconsistent: almost all females said they had not used or could not remember if a condom was used during their last sexual encounter (Pleaner et al., 2023).

A study in Northern Ghana indicated that having a sexual partner and engaging in premarital sex was common and viewed as normal. Adolescents mainly engaged in unprotected sexual practices as a way of testing their fertility, bait for marriage, assurance of love and for their livelihood. Adolescents used various local traditions and harmful practices like herbs insertion into the vagina, drinking concoctions and boiled pawpaw leaves to induce abortion. The available reproductive health services to the community poorly utilized because of the perceived negative attitude of health workers, confidentiality and social norms (Kyilleh et al., 2018).

A survey from Northern Ethiopia indicated that the prevalence of risky sexual behaviour was 17.2% (Srahbzu & Tirfeneh, 2020). Another study in central Ethiopia reported that 13.2% of adolescents had had sexual intercourse. Of these, the overall level of risky sexual behaviour was 11.4% (Berhanu Teshome Woldeamanue, 2020). In addition, research finding from southwestern Ethiopia indicated that 32.75% of adolescents had had at least one sexual encounter prior to the study. Among them, 27.07% had sex 3 months prior to the study, from which only 43.55% used a condom and 58.06% had sex with multiple partners; 6.11% and 15.72% practiced homosexuality and masturbation, respectively (Ena et al., 2016).

A study in Southwest Ethiopia revealed that only 8.4% of in-school adolescents able to utilize the existing SRH information and education services. Nearly half (49%) of adolescents knew family planning as SRH services followed by (21.4%) voluntary counselling and testing for HIV. Only 17.2% of in-school adolescents with disabilities visited nearby health facilities for voluntary counselling and testing (VCT) services (Diribsa et al., 2022).

2.3.3 Adolescent-parent communication about sexual and reproductive health issues

A study from Oman shows that parents rarely communicated with their adolescents about SRH concerns, including HIV. Barriers to open parent-adolescent SRH communication include the fear that such discussions might encourage early sexual debut; feelings of shyness, discomfort, and shame; associated socio-cultural taboos; gender mismatch; and lack of SRH knowledge (Zaabi et al., 2022).

A Gambian study indicates that half of the adolescents discussed sexual related matters with their parents - preferably with their mothers. Parental and cultural unacceptability, feeling ashamed, fear, and feeling not listened were the main reported reasons why adolescents did not communicate specific SRH issues with their parents (Sagnia et al., 2020). Another study from Nigeria revealed that discussion regarding SRH issues practiced in many households, but informally. Mothers discuss common SRH issues with their adolescents better than fathers. While female adolescents communicate to their

parents only on limited topics, the consequences of sexual behaviours are the least communicated (Aliyu & Aransiola, 2023).

Abridged evidence from literature reviews and meta-analysis has shown that the level of PCC on SRH topics in Ethiopia was 45.18% (Mekie et al., 2020). A study in Ethiopia reported that 48.5% of adolescents discussed SRH issues with their parents (N. D. Adam et al., 2020). Another study from Ethiopia indicated that only two-in-ten of the parents (21.3%) had communicated with their adolescents on SRH issues (Bekele et al., 2022). Moreover, a research study in North-western Ethiopia showed that the level of parent-adolescent discussion was 32.8% (Ewnetu et al., 2021). Another findings from North-east Ethiopia revealed that 30.4% had communicated two or more SRH topics with their parents (Fetene & Mekonnen, 2018), whereas one from Southwest Ethiopia indicated that more than half of the adolescents (56.6%) reported SRH problems in parent-adolescent communication (Toru et al., 2022). A study conducted in Ethiopia revealed that the extent of in-school adolescents who had SRH communication with their parents was 37.6% (Bikila et al., 2021). In yet another study from Ethiopia the proportion of adolescents who had communicated with their parents was 35.0% (Kusheta et al., 2019). This percentage is very low and shows that studies around parental-adolescent communication is needed.

There are variations in how much communication takes place among parents with their adolescents on SRH matters. A study from Ethiopia indicated that 30.6% of the students had communication with parents on at least 60% of SRH topics (Wudineh et al., 2021). This was expatiated from earlier studies which did not report whether the percentages covered all SRH topics or just some of them.

A systematic review and meta-analysis in Ethiopia revealed that adolescent-parent communications on SRH issues were reported within the range of 25.3% to 36.9% and more preferred to discuss such issues with their friends. The overall pooled level of PCC was 40.7% (Eshete & Shewasinad, 2020). Another study finding showed that the pooled prevalence of PCC on SRH issues in Ethiopia was 42.96% (Yalew et al., 2020).

A study conducted in southern Ethiopia revealed that 25.7% of adolescents had reported discussion about at least two components of SRH issues in the last 6 months prior to the study (Malango et al., 2022). In yet another from another part of Ethiopia it was established that the percentage of adolescents who had ever discussed SRH issues with

their parents was 31.2% (Feyissa et al., 2020). Another study conducted in Ethiopia revealed that 55.9% and 53.2% of adolescents discussed contraceptive methods and STI/HIV/AIDS, respectively. In addition, 50.9% of the study participants reported they prefer to discuss such issues with their friends, while 20.4% and 14.8% of the adolescents' choices were their sisters and mother, respectively (Neme & Dereje, 2020). A study in Southwest Ethiopia revealed that 61.3% of adolescents discussed SRH issues with their parents (Habte et al., 2019).

Another study conducted in Ethiopia revealed that PCC on sexual and reproductive levels was reported to be seen as important by both adolescents and parents. Parental initiation is rare. The initial sexual activity by the adolescent triggers' initiation by parents. The communications are gender dependent, not planned and not continuous and inhibited by intergenerational cultural taboo. A gap exists in parental knowledge on such communications. Parents deny responsibilities to communicate with adolescents as they fear it will perpetuate early sex practices, adolescents are too young, it is an embarrassment, and often being too busy sourcing household income retards their will to communicate (Yibrehu & Mbwele, 2020). Another study in Ethiopia showed that 61.9% of parents had poor SRH communication with their female adolescents (Taye et al., 2023b).

2.4 PREDICTORS ASSOCIATED WITH SEXUAL AND REPRODUCTIVE HEALTH ISSUES

2.4.1 Factors affecting adolescents sexual and reproductive health knowledge

Girls in India were found to have less knowledge in comparison to boys and the higher the standard the student was in, the higher the level of knowledge; standard 10 students had more knowledge compared to those in standards 8 and 9 (Deshmukh & Chaniana, 2020b). Late adolescence and being in-school are positively correlates with STI knowledge (Finlay, Assefa, Mwanyika-sando, et al., 2020).

A study conducted in Nepal revealed that parents who have knowledge about puberty, belong to Bharamin/Chhetri ethnic group, were self-employed, had two or more adolescent children, and those whose adolescent children were staying in school hostels

were more likely to have had SRH parental communication with their adolescent children (Singh et al., 2023).

A study finding conducted in eight sites across sub-Saharan Africa indicates that elders, being in-school and being rich are statistical positive correlates of STI knowledge. Elder adolescent, being female and in school are significant positive correlates of knowledge of menstruation. Being knowledgeable in HIV is high and relatively consistent across adolescent age, sex, wealth and school and occupation attendance (Finlay, Assefa, Mwanyika-sando, et al., 2020).

A study from Ghana revealed that age, religion, sources of information and guardians were significantly associated with SRH knowledge level (Obasi et al., 2019). A study conducted in Cameroon showed that being male and using the internet to search for sexuality related information was associated with good knowledge. Being in lower secondary school was an independent predictor of poor knowledge (Fubam et al., 2022).

2.4.2 Factors associated with adolescent sexual and reproductive health behaviour

A research finding in Thailand presented that adolescents who smoke cigarettes, use cannabis, gamble, have sex without contraceptives, and have a history of child sexual abuse were correlated with risky adolescent sexual behaviour (Thepthien & Celyn, 2022). Another finding from Thailand also reports that adolescent reproductive behaviours were associated with education level, age and the perception of peer norms. Getting social support from media information can also be strongly correlated with those behaviours (Butdabut & Homchampa, 2021).

In Ghana, adolescent use of contraceptives was significantly associated with being aged 17-19 years, knowing where to obtain contraceptives, not having drunk sex, and not feeling pressured to have unprotected sex. Public health education and self-efficacy interventions are needed to address risky sexual behaviours and improve contraceptive use (A. Adam et al., 2021). Risky sexual behaviour in adolescents was clearly associated with poor social support, living without family, experiencing parental neglect, and drinking alcohol (Srahbzu & Tirfeneh, 2020). Similarly, being male, drinking alcohol, chewing Khat, watching pornographic movies, using Shisha/hashish were significant factors associated

with higher risk-taking sexual practice. Nevertheless, SRH discussions with their parents reduced their risk-taking behaviours by 67% (Berhanu Teshome Woldeamanue, 2020). Adolescents who did not seek healthcare, and adolescents aged below 15 years were closely associated with risky sexual behaviour (Fetene & Mekonnen, 2018). Likewise, another from Addis Ababa, Ethiopia showed that risky sexual behaviour of adolescents was at 43.1% (Fetene & Mekonnen, 2018).

A study conducted in Zambia indicates that sexually experienced youth and not being tested for HIV nor having utilized family planning services in the previous year were associated with higher comprehensive sexuality education knowledge, attitude, and values index scores. Salient barriers to SRH service uptake include limited perceived benefits, unsupportive household and community environments, and negative interactions with health providers (Namukonda et al., 2021).

A finding in Southwest part of Ethiopia revealed being male, having a favourable attitude, and ever had sexual intercourse were statistically associated with SRH service utilization (Diribsa et al., 2022). An alternate Ethiopian study revealed that 17-19 year old adolescents from Grades 11-12 and having knowledge were significantly associated with exercise of their SRHRs (Wakjira et al., 2022).

2.4.3 Factors affecting adolescent-parent communication about sexual and reproductive health issues

A study conducted in four Global Early Adolescent Study sites shows that communication with a parent about SRH matters among female respondents was significantly associated with increased pregnancy knowledge. Adolescent girls in Shanghai and New Orleans and boys in Kinshasa who communicated with a parent at some point about SRH matters were significantly more likely to know where to obtain condoms. Moreover, across all four study sites it was established that girls who communicated with a parent about any SRH matters were more likely to know where to source other forms of contraception (Sievwright et al., 2023). Evidence from meta-analysis shows that adolescent knowledge of sexual reproductive health matters, belief in the benefits of discussion on SRH matters, history of sexual practice, parents' connectedness to discuss SRH issues, and being

female were associated positively with parent-adolescent SRH communication (Mekie et al., 2020).

Another study from Ethiopia indicates that being knowledgeable and having a positive attitude towards SRH issues was linked with communication (Wakjira et al., 2022). A study undertaken in Harar town of Ethiopia revealed that adolescents who have poor behaviour or belief in communication, perceive their parents to have poor SRH knowledge, and co-viewing of television were unlikely to communicate SRH related matters with their parents (Dessie et al., 2015). Being male, having a family with a monthly income of more than 1000 Ethiopian Birr (ETB), adequate knowledge of SRH issues and a favourable perception related to SRH matters were the factors linked with adolescent-parent SRH communication (N. D. Adam et al., 2020).

A study conducted in North-western Ethiopia reported that adolescents who live in the rural residence of their mother, have a family size of 6 and above, mothers educational status is uneducated, mothers occupational status is housewife, low wealth status, poor knowledge about SRH, cultural taboo, fear and lack of knowledge, and negative maternal attitude towards SRH communication has significant impact on parent-adolescent communication (Ewnetu et al., 2021). Another study in North-east Ethiopia revealed that mothers who were able to read and write and have diploma certificates were high likely to communicate SRH matters with their adolescents. Adolescents who agreed on the importance of discussion on SRH issues, received SRH information and those who had had sexual intercourse were more likely to discuss different SRH issues with their parents (Fetene & Mekonnen, 2018). A study from Southwest Ethiopia indicated that students who thought it was important to talk about SRH issues, female students, and parents with a high school diploma or higher were all significantly associated with parent-adolescent communication on SRH (Toru et al., 2022).

A research conducted in Ethiopia revealed being female, educated at private school, has a father with secondary education, a diploma and above educational status, considered sex education necessary, obtained information about SRH issues from school and media and had a mother open to communicate about SRH issues were significantly associated with parent-adolescent communication on SRH issues (Bikila et al., 2021). A study conducted in Southern part of Ethiopia indicated that being a female in-school adolescent; being in the 10th Grade; having a mother who was educated, who had completed secondary and above secondary education; knowledge on SRH issues; and perceived

the importance of discussing SRH issues was significantly associated with the communication between parents and adolescents on RH issues (Fanta et al., 2016).

Another study from Ethiopia revealed that participants' knowledge about the availability of adolescent and youth friendly SRH services at health facilities, utilization of adolescent and youth friendly SRH services and respondents' educational status: being Grades 9 and 11; were statistically associated factors that affect adolescents resulting in them not communicating SRH matters with their parents (Kusheta et al., 2019). A study conducted in Ethiopia indicated that being Grade 9 and Grade 10 students, students who were knowledgeable on SRH issues and students who accepted the benefit of communicating SRH issues with parents were more likely to communicate on SRH issues (Wudineh et al., 2021).

A systematic review and meta-analysis in Ethiopia revealed that adolescents who lived in urban areas, have good knowledge of SRH issues, agreed on the importance of discussion and who ever had sexual intercourse were more likely to discuss SRH issues with their parents (Eshete & Shewasinad, 2020).

A study from southern Ethiopia revealed that attending primary and secondary school, obtaining a diploma and above, having a monthly income of above 2000 ETB, good knowledge and a positive attitude regarding SRH issues were statically associated with enhanced parent–adolescent discussion about SRH (Malango et al., 2022). A study from another part of Ethiopia revealed that mothers and fathers who have educational level of diploma, students' perceived importance of SRH discussions, knowledge about SRH issues and attitude towards SRH issues were identified as independent predictors of parent-adolescent SRH communication (Feyissa et al., 2020).

A literatures review and meta-analysis conducted in Ethiopia revealed that positive perception of young people towards PCC and female sex were significantly associated with PCC on SRH issues (Yalew et al., 2020).

A study from Southwest Ethiopia revealed that mothers who have educational status of primary and secondary education, the father having primary and secondary education, having a family size of <5 and having boy- /girl-friend were significantly associated with PCC (Abdissa & Sileshi, 2023). A research study conducted in Ethiopia revealed that having communication challenges regarding sexual and reproductive health matters, poor knowledge of SRH issues, a preference attitude towards parent-female adolescent SRH

communication, parents not having any previous experience of SRH problems, parents whose female adolescent did not ask about SRH conditions were the identified statically associated factors with limited parent-female adolescent communication regarding SRH issues (Taye et al., 2023b).

2.5 SUMMARY

In conclusion, significant number of studies have disclosed the extent of adolescents' knowledge about SRH issues. In addition, adolescents had committed various type of risky sexual behaviours. Nevertheless, parents of these adolescents are not aware of their adolescents physical, and behavioural transition. These might be lack of communication between adolescents and parents on SRH issues. Hence further study has to be conducted to produce up to date evidence to inform the development of guideline that can guide interventions to transform adolescent and parents' knowledge, behaviour and communication on SRH matters in Addis Ababa, Ethiopia

CHAPTER 3 - RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter discusses the research design and methods that were used to answer the research hypothesis and achieve the purpose of the present study. The chapter consists of the research design, methods including the study setting, participants, eligibility criteria, sampling procedure, sample size determination, data collection tool and techniques, data processing and analysis, the ethical considerations undertaken in this study and the actions taken to ensure the rigorousness of the study to generate quality evidence.

3.2 RESEARCH DESIGN

A school-based cross-sectional study was conducted using a quantitative study approach that involved in-school adolescents with their parents and/ or guardians. This approach is associated with the research paradigm that involves collecting outcome and exposure variables at a specific time, and processing data into information to form an answer to the research questions through the application of statistical methods, and interpretation of the findings (Creswell & Creswell 2017). The study used non-experimental cross-sectional techniques that describe the distribution of the key profile or characteristics of the study participants that applied institution-based study techniques for in-school adolescents followed by involving their parents and/ or guardians at their residence (Arassi & Ross 2019:34). This study design guides the implementation of a cross-sectional study that helps to collect information on the associated conditions and the extent of PCC on SRH issues at a time. A cross sectional study is also useful for priority setting, resource allocation, provision of useful information for planning programs, and to show relative distribution of in-school adolescents and parents' communication about SRH issues. Comprehensive literature review was conducted to select appropriate study design for gathering information about schools and in-school adolescents with their parents as is shown in Figure 3.1.

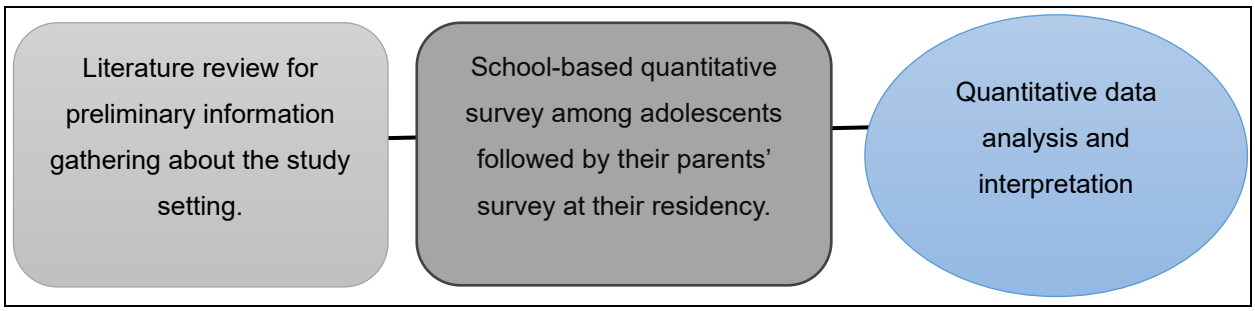

Figure 3.1: Schematic presentation of approaches applied in this study

3.3 RESEARCH METHODS

The research methods of this study were written in accordance with the standard recommendation of Strengthening the Reporting of Observational studies in Epidemiology (STROBE) guidelines (Cuschieri 2019). The study relied on quantitative research methods that gathered numerical data to measure or categorise the status of PPC about SRH issues through rigorous analysis and interpretation of the findings. It assists in uncovering the patterns of PPC about SRH issues, its relationship, and making generalisations. This type of research is useful to establish the magnitude of the problem, frequency of event occurrence, and extent of parent-adolescent interaction about SRH issues discussion. The methods consisted of the details of the study settings, study participants selection process, data collection, analysis and ethical considerations undertaken during data collection and handling of data.

3.3.1 Study setting

Based on systematic review and meta-analysis conducted in Ethiopia the pooled prevalence of teenage pregnancy and repeated induced abortion were found to be 23.59% and 30.89%, respectively (Mamo et al., 2021; Seyoum & Mengistu, 2023). The study was conducted in Addis Ababa city which has been the capital city of the Federal Democratic Republic of Ethiopia (FDRE) for more than a century and has been the political capital of the African Union (AU) since 1963. According to the 2022 National [Ethiopia] Central Statistics Agency (CSA) population projection, Addis Ababa city has an

estimated population of 3.85 million. Addis Ababa is a metropolitan city that is comprised of 11 sub-cities. According to the Addis Ababa City Education Bureau 2022 report, there were 67 Senior secondary schools with a total of 97,285 (42,749 male and 54,536 female) in-school adolescents. The city has heterogeneous inhabitants who originate from different parts of the country whereby the findings of this study can be used as a proxy indicator for the other parts of the country to inform program and policy related to SRH issues.

3.3.2 Sampling procedure

3.3.2.1 Population

The study population was teenager secondary school adolescents (Grades 9-12) whose age ranged from 13-19 years, followed by interviewing of their parents (biological mother, father, and/ or guardians). The study population was enrolled considering grades at secondary school and consisted of in-school adolescents whose parents lived in the town in 2022.

3.3.2.2 Eligibility criteria

Inclusion criteria: In-school adolescents and their parents who satisfied the following eligibility criteria were considered:-

i. In-school adolescents attending Grades 9-12;
ii. Whose age ranged from 13-19 years;
iii. Regular [Daytime] in-school adolescents (the majority of night shift students are above the age range and it is difficult to collect data from them due to ethical perspectives);
iv. Attending public schools, because obtaining permission to conduct a study from private schools is challenging;
v. Parents and/ or guardians of the selected in-school adolescents at their residence: and

vi. Willing to involve in the study and gave their assent or full consent.

Exclusion criteria:

i. In-school adolescents who were not be able to give independent responses on the study assessment instruments due to confidentiality;
ii. Unable to give consent and/ or assent due to severe physical and/ or mental illness during the data collection period;
iii. Unable to give consent or communicate due to known medical and/ or mental health conditions during the data collection period.

3.3.2.3 Study participant selection process

Multi-stage probability sampling methods were applied to sample in-school adolescents at secondary schools and their parents at their residences in a stepwise manner. Four secondary schools were sampled by lottery method out of 67 schools bearing in mind the number of in-school adolescents, resource constraints and time available to collect the data. Then adolescents from the selected schools were counted based on their Grades (9-12). The calculated sample size proportionally allocated to each selected school as is shown in Figure 3.2. In-school adolescents from selected secondary schools were identified from the school roster to determine the total number of study participants and to construct the sampling frame. Simple random sampling was deployed to select the actual in-school adolescents by lottery method as study participants from the selected schools. Hereafter, parents were included into the study based on adolescent recruitment in which included adolescents were paired with their parents and/ or guardians. Furthermore, quantitative survey was employed among selected in-school adolescents' parents at their residence after prior communication through their adolescents to book an appropriate time for the survey. All the parents of the selected in-school adolescents were purposively sampled in connection with their adolescent's inclusion to the study and were requested to participate.

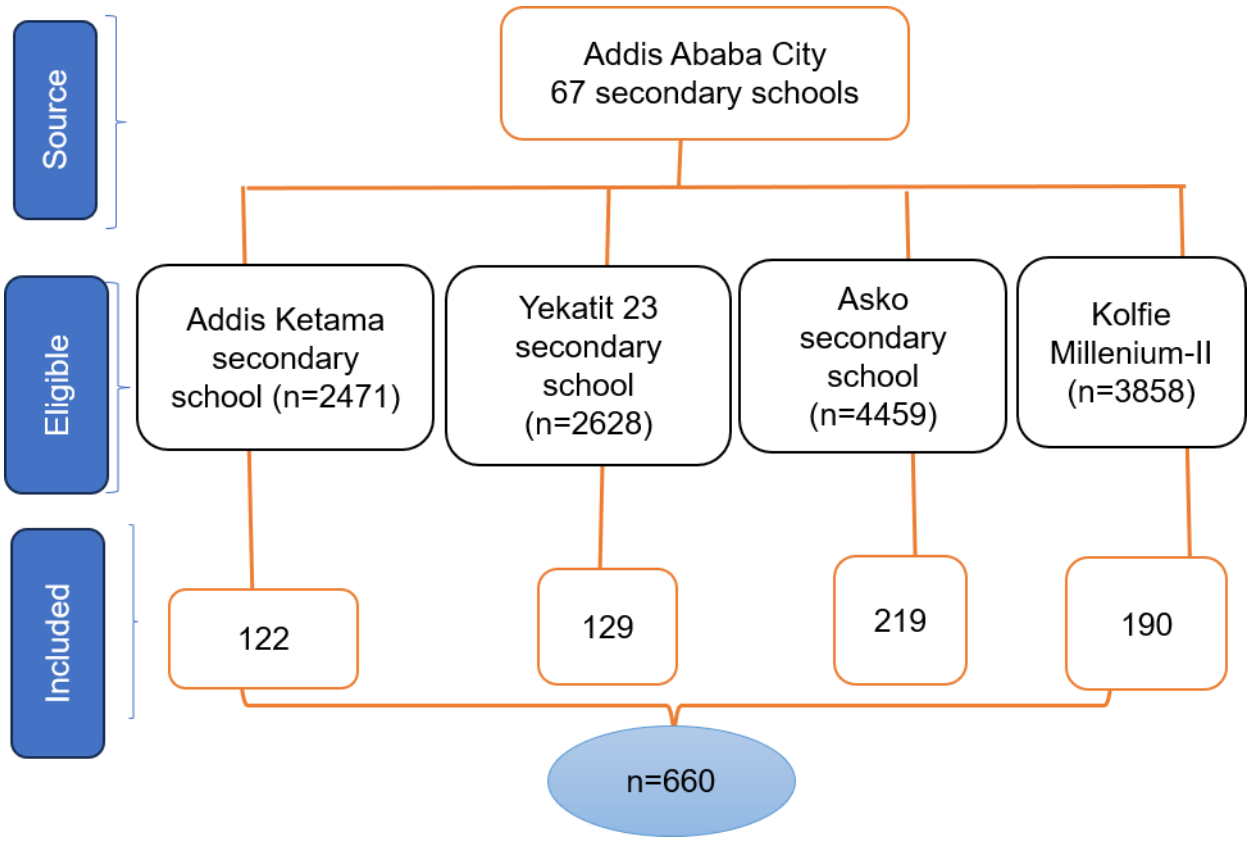

Figure 3.2: Schematic presentation of the participant selection process of in-school adolescents (n=636)

3.3.2.4 Sample size determination

The sample size for in-school adolescents was calculated using adolescent-parent communication about SRH issues as a main dependent variable. A single population proportion formula was applied to determine the number of study participants for this cross-sectional study by considering the major parameters, including 95% significance level (α= 0.05), margin of error (4%), and the prevalence of parent-adolescent communication on SRH matters (51.82%) (Dessie, Berhane & Worku 2014:4).

$$n1 = \frac{\left(\frac{Za}{2}\right)^2 \cdot p(1-p)}{d^2}$$

$$n1 = \frac{(1.96)^2 \cdot 0.52(0.48)}{(0.04)^2}$$

$$n1 = 600$$

Ten percent of the calculated sample size was added for any potential non-responses, yielding a total sample size of 660. Finally, the calculated sample size figure was proportionally determined to the targeted secondary schools based on the total number of in-school adolescents actively registered as regular students.

Furthermore, the sample size for parents was guided by the recruited in-school adolescents at the four selected secondary schools. All the parents (biological mothers, fathers and/ or guardians) of the selected 660 in-school adolescents were contacted using information obtained from the students' files. The contact addresses were obtained from the schools after receiving full permission and consent from the school principals or directors. Then 660 parents and/or guardians were contacted via phone calls by the data collectors to obtain consent and schedule for the quantitative structured questionnaire-based survey.

3.3.3 Data Collection

3.3.3.1 Data collection instrument

Data were collected using a structured and pre-tested questionnaire that was adapted from existing relevant literature (Ayalew et al 2014; CSA 2016; Fanta et al 2016; Mekie et al 2020). The adapted questionnaire consisted of the socio-demographic variables of in-school adolescents and parents, risk-taking sexual practices, knowledge about SRH issues, adolescent-parent communication about SRH, and SRH service utilization questions with structured and predefined response options. Initially, the questionnaire was designed in English and translated to the local language 'Amharic' by proficient language experts.

3.3.3.2 Training and pretesting of data collection instruments

Training was provided to data collectors and supervisors by the researcher for two days including a pre-test demonstration of the questionnaire in non-targeted secondary

schools, that included the data collection procedure, sampling technique and obtaining consent from participants. Then the assessment instrument was pre-tested using 5% (n=33) of the sample size to check the flow of questions, sensitive or inappropriate words in the tool, sampling procedure, adhering to the ethical principles, estimated time allocation for data collection, and data collectors' interview skills. Necessary amendments were made to the questionnaire based on the feedback received from data collectors and pre-test study participant, such as sequence of questions and terms compatibility with local dialects.

3.3.3.3 Data collection approaches and methods

Data was collected from selected in-school adolescents using the local dialect, 'Amharic', version of the questionnaire. A self-administered questionnaire method was deployed to gather data from in-school adolescents that was facilitated or coordinated by twelve trained data collectors and four supervisors.

Parent-adolescent communication about SRH matters related information from the parents or guardians was collected by trained data collectors using face-to-face interviews in their residences. The data collectors were trained healthcare professionals and teachers who were working at nearby health facilities and secondary schools. The overall data collection process was supervised by four trained field supervisors, twelve data collectors and overseen by the principal investigator. Regular meetings and discussions were conducted by the principal investigator with the data collectors and supervisors to brief and debrief them about challenges faced during data collection and any necessary measures were taken timeously to ensure the ethical principles and quality of the data collection process. The data collection was carried out from February 22- June 14, 2022.

3.3.4 Ethical considerations

Ethical review: The study protocol was reviewed and ethical clearance was obtained from the Department of Health Studies, College of Human Sciences at the University of South Africa (ERC Reference #: HSHDC/973/2020).

Permission from officials: Permission letter request together with the ethical clearance letter was presented to the City Administration Education Office and letter of cooperation was presented to the secondary schools and their parents selected for the study.

Consent: Informed verbal consent was secured from study participants after a brief explanation by the research team on the purpose, benefits, risks and the data collection process. The participants were adequately advised about the study to enable them to make informed choices without being forced to participate in the study. Informed consent was obtained from adolescents aged 18 and above and from their parents, and well-informed assent was secured from adolescents less than 18 years after a brief explanation about the purpose of the study. The study participants were informed of their right to withdraw from the study during data collection that they could stop without any fear of reprisals/penalties. The study groups were informed that this research did not have any direct personal incentive or risk except emotional discomfort because of the use of sensitive questions and the inconvenience of taking up their time. Their beneficence and human dignity were maintained in all stages.

Confidentiality: The responses provided by the participants were kept confidential and anonymous. The participants were also asked not to write their names and/ or any other identifiers in the questionnaire. Accurate and honest information was provided to the researcher during data collection through the questionnaire which helped to develop guidelines to improve existing parent-adolescent communication about SRH issues. All the collected information from adolescents and their parents or guardians was kept anonymous and confidential. De-identified data used for analysis and completed questionnaires were kept in a locked metal-cabinet.

3.3.5 Data analysis method

The collected data was checked for its completeness at field level during the data collection period. The data was then entered into the SPSS software version 28 for analysis. Data cleaning was carried out through running frequency to identify anomalies, such as outliers, errors, and to prevent any other erroneous findings. Data reduction method was applied for the three outcome variables such as adolescent-parents knowledge, risk-taking behaviour, and communication about SRH issues. The composite measures for adolescent-parent communication on SRH issues were computed using a 7-item questionnaire. Descriptive statistical method was applied to compute frequency, proportion, mean with standard deviation of the outcome and independent variables accordingly. Bivariate and multivariate logistic regression interpretation was used to determine the relationship between dependent and independent variables. The Hosmer-Lemeshow goodness of fit test was used to fit the final model. Variables having a p value of less than 0.25 in binary logistic regression were eligible for the multiple logistic regression analysis. An adjusted odds ratio at 95% confidence interval (CI) with p value less than 0.05 wase used to declare significance association between independent variables and adolescent-parent communication on SRH issues. The findings from statistical analysis out puts were reported using tables, figures, and text statements as per the sub-sections of SRH knowledge, behaviour and communication between adolescents and their parents.

3.4 ENSURING RIGOUR OF THE STUDY

Comprehensive efforts were employed to ensure the quality of the study, minimize erroneous findings, and adhere to the ethical standards of safeguarding the study participants. Intensive literatures were reviewed to conduct evidence-based research to understand the existing knowledge and produce quality research findings that could guide the development of guidelines. Substantial consideration was given not only to the results of the study but also to the rigour of the research to enhance the quality of the study. In this quantitative descriptive research, rigour was ensured through measurement of validity and reliability. During this research design due consideration was given to

accurately measuring the concept and the instrument tool to ensure the validity and reliability of the research finding. Appropriate research tools were used to meet the stated objectives of the study. Maximum precision efforts were applied in the study during planning, data collection, analysis, and reporting. The reliability, replication, and validity of the research work was ensured. The information which was collected from the study participants was used for addressing the research purpose intended to strengthen existing parent-adolescent discussion on SRH issues through development of guidelines.

3.4.1 Validity of the data collection tool

Validity implies to the level to which the assessment tool adequately reflects that which it is intended to measure. Comprehensive literature review was carried out to adapt the questionnaire and it content that was designed in English. The questionnaire was given to senior public health researchers and statisticians to review for the intellectual contents that comprehensively assess the SRH characteristics, knowledge, risk taking behaviours and communication between in-school adolescents' and parents. Feedback from public health researchers and statisticians were collected and incorporated for the enrichment and content validity of the questionnaire. Then, the tool was pretested among 5% (33) of in-school adolescents at school and their parents at their residence. The principal investigator and supervisors had done through review to make sure that the validity of the assessment tools was ensured prior to actual data collection.

3.4.2 Reliability of the questionnaire

The data collection tool internal consistency or reliability was ensured through intensive review by experts prior to initiating the main data collection. Reliability was assessed through pretesting of the tool among in-school adolescents and their parents. The local language version of the data collection tool was used to enhance similar understanding about the tool by study participants to obtain a reliable response across selected in-school adolescents and parents. The reliability of the data collection instruments was checked using Cronbach's alpha, but most of the variables in the questionnaire had binary outcomes which were not best fit to estimate the internal consistency of the tool. A

reliability estimate using Cronbach's alpha is highly recommend for Likert scale response. In addition, training was provided to data collectors and supervisors to facilitate a data collection process that could yield quality findings. Then any reflection obtained from the research team was addressed to ensure the reliability of the questionnaire.

3.5 SUMMARY

This chapter addressed the research design and methods applied in the study. It provides a detailed description on the study design, study setting, study population, sampling procedures, sample size calculation, data collection tools and procedures, validity and reliability of the questionnaire, ethical consideration, data collection, entry and analysis methods. Mechanisms in placed by the researcher to maintain ethical principles in conducting the study and procedures followed in developing the guidelines to improve parent-adolescent communication about SRH matters were also covered. The next describes the analysis, presentation and description of the research findings.

CHAPTER 4 - ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter presents the method used for statistical analysis and data management, and findings produced from this study with related to the research objectives. The chapter consists of a brief introduction to the applied data management process, basic characteristics of in-school adolescents and their parents or guardians. Descriptive statistical findings of the outcome variable adolescent-parent communication with respect to SRH issues, and predictors associated with PCC regarding SRH conditions between in-school adolescents with parents who live in Addis Ababa City are also discussed. The findings are presented using text statements, tables, and graphs.

4.2 DATA MANAGEMENT AND ANALYSIS

Initially, gathered information was processed for comprehensiveness, and consistency during data collection. Then the completed and consistent data was entered into the software (SPSS v.28) for cleaning and analysis. Data cleaning was carried out through running frequency to identify anomalies, such as outliers, errors, and to prevent any other erroneous findings. Then a data reduction method was carried out for both explanatory, and outcome variables accordingly recording it into different variables to prepare for analysis. The age of the adolescents was coded as early adolescent (≤14) years; middle adolescent (15-17) years; and late adolescents (≥18) years. Other were treated as nominal categorical variables that were written into the questionnaire. In-school adolescent risk-taking behaviour that consisted of cigarette smoking, alcohol consumption and Khat chewing were assessed using ‘never used’ and ‘ever used’ responses.

The main outcome variable ‘adolescent-parent communication about SRH issues’ was assessed as a composite measure using a seven-item questionnaire. The seven selected SRH issues for adolescent-parent discussion were contraception use, STIs including HIV,

sexuality, condom use, unwanted pregnancy, abstinence, and puberty related issues. Eventually, descriptive statistical analysis was applied to compute frequency, proportion, mean with standard deviation of the outcome and independent variables accordingly. Bivariate and multivariate logistic regression method was applied to determine the relationship between dependent and independent variables.

4.3 RESEARCH RESULTS

4.3.1 Sociodemographic characteristics of the in-school adolescent participant

From a total of 660 in-school adolescents who received the questionnaire, 636 of them gave complete responses yielding a response rate of 96.4%. From amongst the study participants, 40.4% (n=257) were males and 59.6% (n=379) were females. The majority (55.7%, n=354) were late adolescents from the age group 18-19 years, followed by 42.5% (n=270) middle adolescents. The mean age of the study participants was 17.43 (± 1.26) years. Nearly one-third (31%, n=197) of these in-school adolescents were Grade 12 students. More than half of the respondents (56.9%, n=362) were Orthodox Christian followed by 30.7% (n=195) being Muslim. More than half of the study participants (54.7%, n=348) attend religious services daily, and 37.7% (n=240) attend once a week. Most of the in-school adolescents belong to the Amhara ethnic group (40.6%, n=258) followed by Gurage (29.7%, n=189). Nearly two-thirds (63.8%, n=406) of participants lived with both their parents, whereas 16.0% (n=102) lived with their mothers only. Most respondents (83.3%, n=530) considered that their parents were in the medium income bracket. More than half (51.6%, n=328) of these in-school adolescents did not receive pocket money, although 133 (16.2%) were engaged in income generating activities. Of these, 31.1% (n=32) earned less than 500, and 28.2% (n=29) earned 500-1,000 ETB per month as depicted in Table 4.1.

Table 4.1: Socio-demographic characteristics of in-school adolescents (n=636)

Variables	Categories	Frequency	Percent
Age	≤14	12	1.9
	15-17	270	42.5
	≥18	354	55.7
Sex	Male	257	40.4
	Female	379	59.6
Grade	9th	112	17.6
	10th	160	25.2
	11th	167	26.3
	12th	197	31.0
Religion	Orthodox Christianity	362	56.9
	Muslim	195	30.7
	Protestant	72	11.3
	Others	7	1.1
Attend religious services	Daily	348	54.7
	Once a week	240	37.7
	Once in a month	24	3.8
	Once in a year	12	1.9
	Never attended	12	1.9
Ethnicity	Amhara	258	40.6
	Oromo	110	17.3
	Tigre	34	5.3
	Gurage	189	29.7
	Wolayta	21	3.3
	Others	24	3.8
Adolescents lives with	Both Parents	406	63.8
	Mother only	102	16.0
	Father only	13	2.0
	Grand parents	45	7.1
	Relatives	57	9.0
	Alone	13	2.0
Having pocket money	Yes	308	48.4
	No	328	51.6
Engagement in income generating activities	Yes	102	16.1
	No	534	83.9
Income level	<500	32	31.1
	500-1,000	29	28.2
	>1,000	42	40.8

With respect to the educational status of their parents, more than one-third (38.2%, n=243) of the mothers of these in-school adolescents had no formal education, 29.1% (n=185) had a primary education. One-fourth (24.8%, n=158) of the fathers had no formal education, and 26.1% (n=166) only had a primary education. Nearly half, (48.6%, n=309) of the mothers were housewives by occupation. In addition, nearly half (45.0%, n=286) of the fathers worked in private business, and 25.9% (n=165) were merchants as indicated in Table 4.2.

Table 4.2: Socio-demographic characteristics of family of in-school adolescent participants (n=636)

Variables	Categories	Frequency	Percent
Family size	Less than 3	66	10.4
	Greater than 3	570	89.6
Perceived family economic status	Poor	59	9.3
	Medium	530	83.3
	Rich	47	7.4
Educational status of adolescent's mother	No formal education	243	38.2
	Primary education	185	29.1
	Secondary education	144	22.6
	Diploma and above	64	10.1
Educational status of adolescent's father	No formal education	158	24.8
	Primary education	166	26.1
	Secondary education	207	32.5
	Diploma and above	105	16.5
Occupation of adolescent's mother	Housewife	309	48.6
	Private business	135	21.2
	Government employee	192	30.2
Occupation of adolescent's father	Private business	286	45.0
	Government Employee	113	17.8
	merchant	165	25.9
	Others	72	11.3

Regarding risk taking behaviours of adolescents, almost one-in-twenty of these in-school adolescents, (5.3%, n=34) have smoked cigarettes, and 6.6% (n=42) of them have chewed Khat. Nearly one-fourth (23%, n=146) has drunk alcohol as is shown in Figure 4.1.

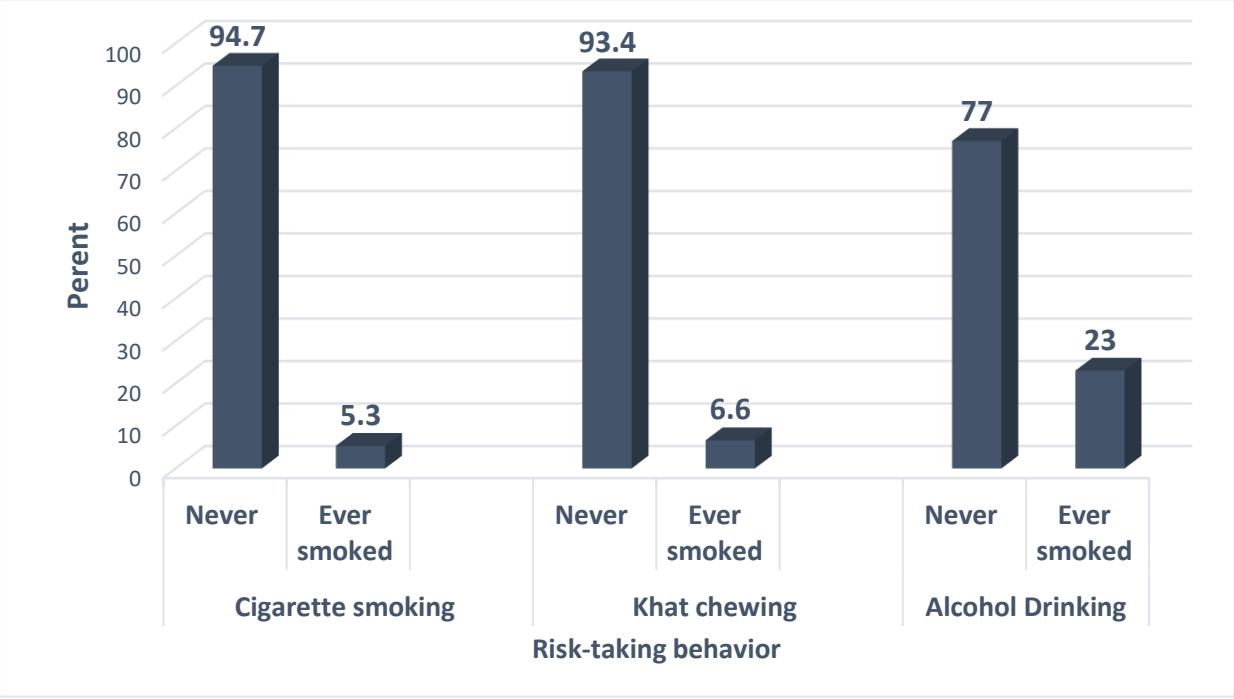

Figure 4.1: Risk-taking behaviours of in-school adolescent participants (n=636)

4.3.2 Adolescent knowledge on sexual and reproductive health issues

The majority (83.4%, n=316) of the in-school female adolescents knew when menstruation starts. The median age of first menses was 14 years within the age range of 9-17 years. More than one-third of those, (37.5%, n=142), experienced fear when they started menses. The majority, (85.2%, n=542) of in-school adolescents knew about STI/HIV, with 20.3% (n=111) knowing about Chancroid; 30.5% (n=167) about Syphilis; 27.6% (n=151) Gonorrhoea; 82.7% (n=453) HIV/AIDS; and 23.5% (n=129) about herpes simplex. Most (85.8%, n=545) of the study participants knew about contraceptives; within this category, 60% (n=330), knew about contraceptive tablets; 44.7% (n=246) about Depo Provera; 58.7% (n=323) implants; 42.2% (n=232) intrauterine device; condoms 56.9% (n=313), abstinence 47.8% (n=263) and 26% (n=143) about the calendar method. Only 27.2%, (n=173) of in-school adolescents knew about emergency contraception. More than half (58.8%, n=374) knew about the likelihood of becoming pregnant between menstruations as is shown in Table 4.3.

Table 4.3: In-school adolescent's knowledge of sexually transmitted infections and contraceptives (n=636)

Variables	Categories	Frequency	Percent
Knowledge about STIs including HIV	Chancroid	111	20.3
	Syphilis	167	30.5
	Gonorrhoea	151	27.6
	HIV/AIDS	453	82.7
	Herpes simplex	129	23.5
Knowledge of contraceptive methods	Pills	330	60.2
	Depo Provera	246	44.9
	Implant	323	58.9
	IUCD	232	42.3
	Condom	313	57.1
	Abstinence	263	48
	Calendar method	143	26.1

4.3.3 Sexual behaviour of in-school adolescents

The majority (80%, n=509) of the in-school adolescents thought that it was neither acceptable nor normal to have sexual desires during the adolescence period. More than one-fourth (28.3%, n=180) of them had had sexual intercourse. The mean age when in-school adolescents initiated sexual intercourse was 16.59 (±1.002) years. The majority

88.9%, n=160) of in-school adolescents had already had sexual intercourse with their boy- or girlfriends. Of these sexually active adolescents, nearly half (45%, n=81) had a history of multiple (two or more) sexual partners. More than half (54.4%, n=98) of sexually active in-school adolescents didn't make use of condoms while experiencing sexual intercourse. Amongst those who used condoms during sexual intercourse, nearly three-in-ten (28.4%, n=25) of them used them consistently.

From amongst the sexually active in-school adolescent girls, one-in-ten (10.4%, n=10) of them had experienced an unwanted pregnancy. Seventy percent (n=7) of them had terminated (aborted) a pregnancy and 30% (n=3) of them had given birth. The majority (83.3%, n=530) of the in-school adolescents did not believe in or support premarital sexual intercourse. Nearly three-fourths (73%, n=464) admitted that sex education is necessary with the majority (82.4%, n=389) preferring sex education to be given at school. Most (83.0%, n=528) mentioned that they obtained sexuality information from different mainstream medias as indicated in Table 4.4.

Table 4.4: Sexual behaviour of in-school adolescents (n=636)

Variables	**Categories**	**Frequency**	**Percent**
Ever had sexual intercourse	Yes	180	28.3
	No	456	71.7
Age of first sexual intercourse	<15 years	18	10
	15-18 years	161	89.4
	>18 years	1	0.6
With whom did they first have sex	Boy-/girlfriends	160	88.9
	Relatives	4	2.2
	Unknown partner	16	8.9
Number of sexual partners	One	99	55.0
	Two	47	26.1
	Three and above	34	18.9
Condom use	Yes	82	45.6
	No	98	54.4
Consistency of condom use	Always	25	28.4
	Often	46	52.3
	Sometimes	17	19.3
Experienced unwanted pregnancy	Yes	10	10.4
	No	86	89.6
Necessity of sexual education	Yes	464	73
	No	125	19.7
	Do not know	47	7.4
Preference of place of sexuality education	School	389	82.4
	Home	131	27.8
	By friends	123	26.1
	Religious places	122	25.8
	Others	5	0.9

Source of information on sexuality matters	School	241	37.9
	Media	528	83.0
	Home	111	17.5
	Peers	142	22.3

4.3.4 Adolescents perception of parental monitoring of sexual reproductive health issues

The majority (86.2%, n=548) of in-school adolescents believed that parental monitoring of adolescents is necessary. Male in-school adolescents (11.5%, n=29) stated that during the ages of 10-17 years, parents forbade them to play with female adolescents. Similarly, one-fourth (24.5%, n=94) of the female in-school adolescents declared that between the ages of 7-17 years, parents forbade them to play with male adolescents. The majority (82.4%, n=524) of in-school adolescents reported that parents should know where and when their in-school adolescents were when not at home or at school. Approximately three-fourths (70.6%, n=449) of in-school adolescents felt that their parents must know when and with whom their adolescent children were with outside home or school.

4.3.5 In-school adolescents' communication on sexual reproductive health

The majority (84.6%, n=538) of the adolescents had communicated with their mothers, fathers or guardians on at least one of the major identified SRH issues. Of those, two thirds (64.5%, n= 347) had discussed three or more SRH issues. However, comprehensive communication about common SRH matters with their parents was found to be very poor, (5.7%) as is shown in Figure 4.2.

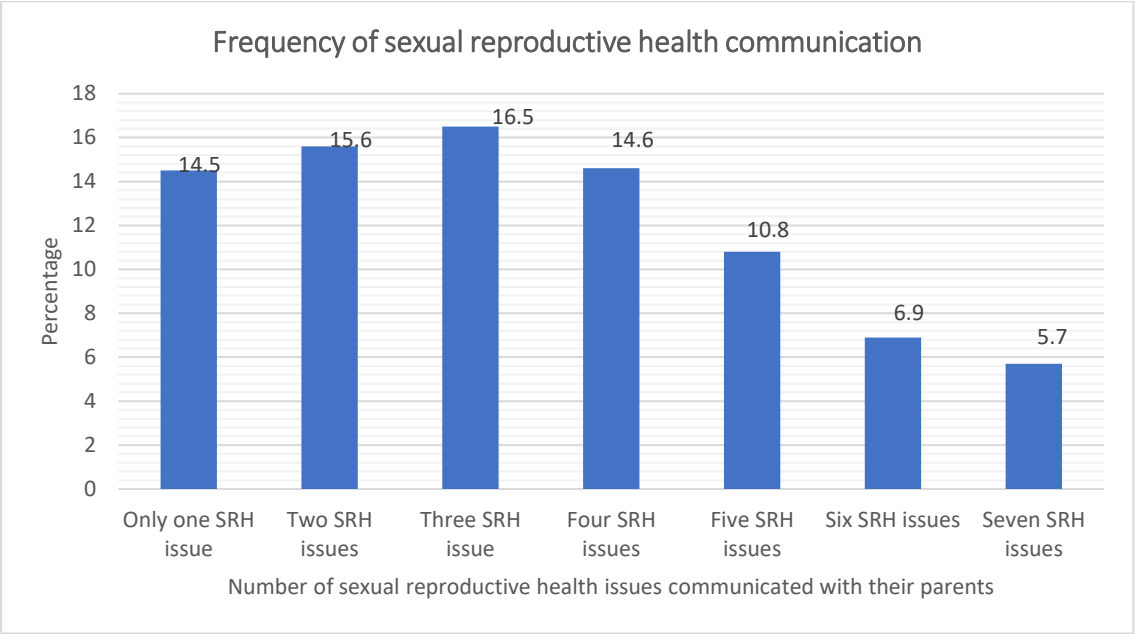

Figure 4.2: In-school adolescent-parent communication on sexual reproductive health (n=636)

The majority (89%, n=566) of study participants noted the availability of different sources of information on SRH issues. One-fifth, (20.4%, n=116) of in-school adolescents received information from their parents, 157 (27.6%) from peers, 242 (42.5%) from health institutions, 194 (34.2%) from school, 88 (15.5%) from religious places, 93 (16.3%) from newspapers and other magazines, and 318 (55.9%) from TV or radio as indicated in Figure 4.3.

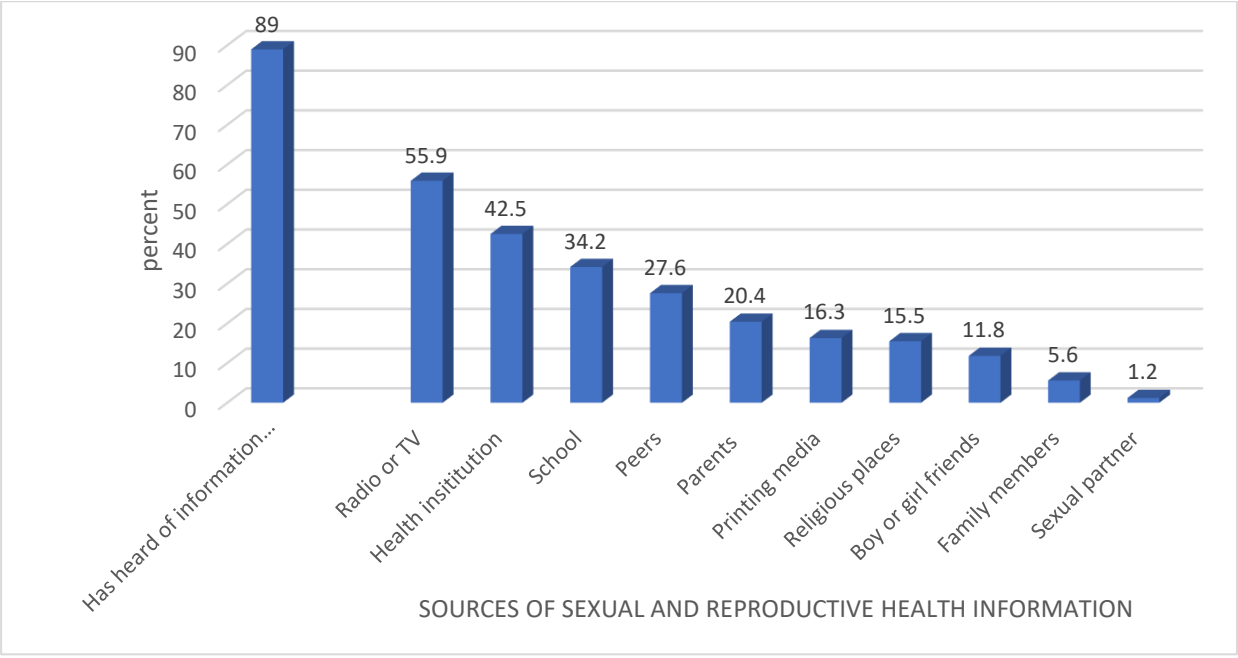

Figure 4.3: Sources of sexual reproductive health information among in-school adolescents (n=636)

More than two-fifths (42.9%, n=273) of in-school adolescents indicated that it was not easy to communicate SRH matters with their father. The majority (86.5%, n=539) of in-school adolescents stated that they had never discussed SRH issues with their fathers. More than three-fourths (75.8%, n=482) responded that it was easy to discuss SRH issues with their mothers. More than two-thirds (70.3%, n=447) disclosed that they never discussed SRH related matters with their mother, whereas 41.7% (n=265) had discussed SRH related issues with friends or relatives. Nearly one-third (31.6%, n=201) of in-school adolescents stated that it was not necessary to discuss or communicate SRH related issues with parents. The majority (80.5%, n=512) of in-school adolescents stated that they preferred to talk SRH issues with their mother than their father.

Approximately one-third (30.2%, n=192) of in-school adolescents discussed contraception with their parents. Nearly half (53.0%, n=337) had discussed STI/HIV issues with their parents. Only one-third (34.9%, n=222) discussed sexuality with their parents. Nearly one-fourth (28.0%, n=178) discussed condom use with their parents. Almost four-in-ten (41.8%m n=266) of them discussed the issue of unwanted pregnancy with their parents. Almost half (49.7%, n=316) had discussed abstinence with their parents. Nearly half of the study participants (49.8%, n=317) discussed physical and psychological changes related to puberty with their parents as is shown in Figure 4.4.

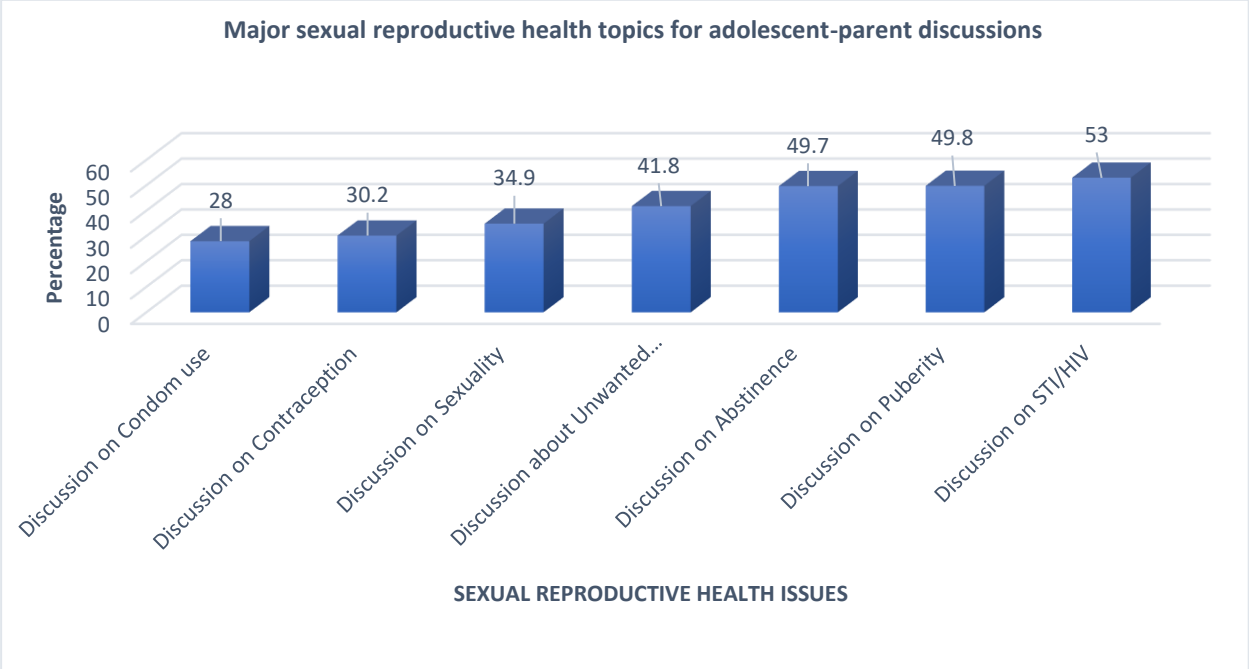

Figure 4.4: In-school adolescent communication practices on sexual and reproductive health issues with their parents (n=636)

From those who discussed sexuality with their parents, about three-fourths (70.2%, n=132) of the discussions were with their mothers. With respect to frequency of discussion, the majority (81.3%, n=152) of them sometimes had discussions. In addition to discussions with their parents, three-fourths (77.7%, n=171) discussed issues of sexuality with their peers or friends.

4.3.5.1 Barriers to adolescent-parent communication on sexual reproductive health issues

In-school adolescents cited feeling ashamed as a major barrier to discussing SRH issues. The major reason for not discussing contraception was feelings of embarrassment and difficulty (20.5%, n=91). Nearly half (47.0%, n=299) did not discuss STI/HIV issues with their parents. Cultural unacceptability was the other common reason for not having discussions on sexuality (32.9%, n=136), and condom use (39.7%, n=182). Similarly, lack of knowledge was a frequently cited reason for lack of discussions about unwanted pregnancies (35.1%, n=130), abstinence (38.4%, n=123), STIs including HIV (46.2%, n=138), sexuality (22.7%, n=94) contraceptives (28.4%, n=126), and puberty (33.5%, n=107). The detail of adolescents' reasons for not having discussions with their parents are described in Table 4.5.

More than four-fifth (82.3%, n=144) of in-school adolescents preferred to discuss contraceptive usage matters with their mothers. Among the adolescents who had discussions, the majority (84.2%, n=149) discussed sometimes. More than two-thirds (69.6%, n=206) of in-school adolescents discussed STI/HIV with their mothers. The majority (70.2%, n=132) discussed sexuality with their mothers. The majority (79.3%, n=188) discussed unwanted pregnancy, and nearly three-fourths (73.3%, n=206) discussed abstinence with their mothers. The majority (70.9%, n=100) of in-school adolescents discussed condom use with their mothers. Around three-fourths (73.7%, n=221) discussed puberty with their mothers as indicated in Table 4.6.

In-school adolescents described that they started discussions around SRH issues with their parents between 10-19 years with median age of 14 (±1.83) years. The in-school adolescents indicated that SRH issues discussion should be started from the age of 7 years accordingly. More than one-third (38.7%, n=246) were having discussions on

sexual and reproductive health matters with their parents at the time of the study. Regarding parents' communication on SRH issues with their in-school adolescents, adolescents rated that only 9.6% (n=61) had frequent discussions with their parents, and 60% (n=381) rated their parents communication skills on sexual related matters were poor.

Table 4.5: In-school adolescents' reasons for not communicating sexual reproductive health issues with their parents (n=636)

Reasons for not communicating sexual reproductive health issues	Common sexual reproductive health issues						
	Contraception	STI/HI	Sexuality	Unwanted pregnancy	Abstinence	Condom use	Puberty
Culture	66 (14.9%)	39 (13.0%)	136 (32.9%)	50 (13.5%)	44 (13.8%)	182 (39.7%)	48 (15.0%)
Ashamed	107 (24.1%)	63 (21.1%)	190 (45.9%	104 (28.1%)	91 (28.4%)	185 (40.4%)	121 (37.9%)
Lack of knowledge	126 (28.4%)	138 (46.2%)	94 (22.7%)	130 (35.1%)	123 (38.4%)	124 (27.1%)	107 (33.5%)
Lack of Communication skill	62 (14.0%)	54 (18.1%)	54 (13.0%)	61 (16.5%)	59 (18.4%)	43 (9.4%)	60 (18.8%)
Parents are not good listeners	41 (9.2%)	37 (12.4%)	43 (10.4%)	49 (13.2%)	43 (13.4 %	24 (5.2%)	41 (12.9%)
Embarrassing	91 (20.5%)	46 (15.4%	114 (27.5%)	100 (27.0%)	46 (14.4%)	65 (14.2%)	46 (14.4%)
Don't know	78 (17.6%)	48 (16.1%)	40 (9.7%)	52 (14.1%)	44 (13.8%)	66 (14.4%)	44 (13.8%)
Others	15 (3.38%)	8 (2.7%)	16 (3.9%)	9 (2.4%)	3 (0.94%)	0 (0.0%)	1 (0.3)

*Table 4.6: In-school adolescent's communication about sexual and reproductive health issues (n=636), *multiple responses were possible*

With whom discussed	Frequency	Common sexual reproductive health issues						
		Contraception	STI/HIV	Sexuality	Unwanted pregnancy	Abstinence	Condom use	Puberty
Parents	Very often	9 (5.1)	16 (5.4)	14 (7.5)	14 (5.9)	21 (7.5)	7 (4.9)	19 (6.3)
	Often	19 (10.7)	37 (12.5)	21 (11.2)	36 (15.1)	59 (21.0)	25 (17.5)	64 (21.3)
	Sometimes	149 (84.2)	243 (82.1)	152 (81.3)	188 (79.0)	201 (71.5)	111 (77.6)	217 (72.3)
Peers and/ or friends	Very often	9 (4.8)	14 (4.4)	18 (8.2)	16 (6.2)	20 (6.6)	13 (7.4)	28 (9.1)
	Often	17 (9.0)	45 (14.0)	32 (14.5)	39 (15.1)	55 (18.1)	22 (12.6)	69 (22.5)
	Sometimes	162 (86.2)	262 (81.6)	170 (77.3)	203 (78.7)	229 (75.3)	140 (80.0)	210 (68.4)

4.3.6 Factors associated with adolescent-parent sexual reproductive health issues

The key determinant factors associated with adolescent-parents on sexual reproductive health issues were analysed with respect to communication, knowledge and behaviour as presented below in subtopics.

4.3.6.1 Predictors of adolescent's communication on sexual reproductive health issues

The association between independent variables and outcome variables was examined using the logistic regression statistical analysis method. Each independent variables' (n=10) association was initially tested using bivariate logistic regression method. The variables tested using a binary logistic regression were the adolescent's sex, age, school grade, religion, lived with, mother and father's education level, mother and fathers' occupation and adolescent's knowledge. Of these variables, in-school adolescents' school grade, religion, lived with, mother's education, mother's occupation and adolescent knowledge were eligible to be tested in the final model fit (multiple logistic regression) using P value less than 0.25 as a criterion.

Finally, the in-school adolescent's grade, religion, and knowledge about SRH issues were significantly associated with their communication about SRH issues with their parents. The level of communication on SRH matters with their parents increased as their Grade level increased. Those who were in Grade 12 were 3.6 times high likely to communicate some SRH issues with their parents as compared to Grade 9 adolescents (AOR = 3.62, 95% CI:1.79,7.32). In-school adolescents who belong to protestant Christianity were 10 times communicate SRH issues with their parents in comparison to other common religions followed in Addis Ababa (AOR = 10.41 95% CI:1.42,76.53). Those adolescents who have knowledge of at least one of the common SRH matters were 4.36 times likely to discuss their issues with their parents when compared to adolescents who don't have knowledge at least one of the SRH issues (AOR = 4.36, 95% CI: 2.53, 7.49) as is shown in Table 4.7.

Table 4.7: Factors associated with in-school adolescent's communication on sexual reproductive health issues (n=636)

Variables	Category	Adolescent communication		COR 95% CI	AOR 95% CI
		Yes	No		
Sex	Male	215 (83.7)	42 (16.3)	1.00	
	Female	323 (85.7	54 (14.3)	1.13 (0.73,1.74)	
Age	Adolescent (≤14)	8 (66.7)	4 (33.3)	1.00	
	Adolescent (15-17)	223 (82.9)	46 (17.1)	2.37 (0.69,8.20)	
	Adolescent (≥18)	307 (87.0)	46 (13.0)	3.27 (0.95,11.27)	
Grade	9th Grade	82 (73.2)	30 (26.8)	1.00	1.00
	10th Grade	134 (84.3)	25 (15.7)	1.89 (1.04,3.41)	2.30 (1.18,4.48)
	11th Grade	143 (85.6)	24 (14.4)	2.18 (0.20,3.98)	2.02 (1.03,3.96)
	12th Grade	179 (91.3)	17 (8.7)	3.64 (1.92,6.90)	3.62 (1.79,7.32)
Religion	Orthodox	313 (86.7)	48 (13.3)	4.79 (1.04,22.06)	2.83 (0.51,15.86)
	Muslim	153 (78.9)	41 (21.1)	2.73 (0.59,12.69)	2.18 (0.38,12.42)
	Protestant	68 (94.4)	4 (5.6)	12.75 (2.10,77.51)	10.41 (1.42,76.53)
	Others	4 (57.1)	3 (42.9)	1.00	1.00
Lived with	Both parents	331 (81.5	75 (18.5)	1.96 (0.59,6.54)	1.19 (0.29,4.86)
	Either mother or father	109 (94.8)	6 (8.9)	8.07 (1.92,33.95)	3.66 (0.73,18.46)
	Grand parents	41 (91.1)	8.9)	4.56 (0.96,21.73)	3.19 (0.55,18.40)
	Relatives	48 (84.2)	9 (15.8)	2.37 (0.60,9.39)	1.41 (0.29,6.77)
	Alone	9 (69.2)	4 (30.8)	1.00	1.00
Mother's education	No formal education	201 (83.1)	41 (16.9)	0.41 (0.15,1.07)	0.45 (0.13,1.37)
	Attended 1 education	149 (81.0)	35 (19.0)	0.35 (0.13,0.94)	0.38 (0.12,1.15)
	Attended 2 education	129 (89.6)	15 (10.4)	0.73 (0.25,2.10)	0.86 (0.26,2.83)
	Tertiary Education	59 (92.2)	5 (7.8%)	1.00	1.00
Father's education	No formal education	135 (85.4)	23 (14.6)	1.00	
	Attended 1 education	133 (80.6)	32 (19.4)	0.69 (0.38,1.23)	
	Attended 2 education	179 (86.9)	27 (13.1)	1.09 (0.60,1.98)	
	Tertiary Education	91 (86.7)	14 (13.3)	1.11 (0.54,2.27)	
Mother's occupation	Housewife	249 (80.8)	59 (19.2)	1.00	1.00
	Private business	122 (90.4)	13 (9.6)	2.26 (1.20,4.28)	1.41 (0.69,2.87)
	Government employee	167 (87.4)	24 (12.6)	1.61 (0.97,2.67)	1.20 (0.68,2.12)
Father's occupation	Private business	240 (84.5)	44 (15.5)	1.00	
	Government employee	93 (82.3)	20 (17.7)	0.89 (0.50,1.59)	

	Merchant	139 (84.2)	26 (15.8)	1.03 (0.61,1.73)	
	Others	65 (91.5)	6 (8.5)	2.11 (0.86,5.15)	
Adolescent Knowledge	No	55 (60.4)	36 (39.6)	1.00	1.00
	Yes	483 (88.6)	62 (11.4)	0.19 (0.12,0.32)	4.36 2.53,7.49)

4.3.6.2 Predictors of adolescent knowledge on sexual reproductive health

The relation between independent and dependent variables (in-school adolescents' knowledge about SRH issues) were examined using logistic regression statistical analysis method. Each independent variables (n=12) association was initially tested using bivariate logistic regression method. The independent variables tested using a binary logistic regression were adolescent sex, age, grade, religion, lived with, mothers and fathers' education, mother and fathers' occupation, interviewed parents' age, sex and educational status. Of these, study participants (in-school adolescents) age, sex, Grade, religion, lived with, and fathers' occupation were eligible to be analysed in the final model fit (multiple logistic regression) using P value less than 0.25 as a criterion.

In-school adolescents' sex, age, religion, lived with and fathers' occupation were significantly associated with in-school adolescents' knowledge regarding SRH issues with their parents. Female in-school adolescents were 5.42 times likely to be knowledgeable about SRH matters in comparison to male in-school adolescents (AOR = 5.42, 95% CI: 3.19,9.21). In-school adolescents lived with their single parents were 2.61 times high likely to be knowledgeable about SRH scenarios compared to in-school adolescents lived with their both parents (AOR = 2.61, 95% CI: 1.04, 6.54). The probability of having knowledge about SRH issues were 81% less among early age in-school adolescents compared to late age in-school adolescents (AOR = 0.19 95% CI: 0.04,0.84). The probability of in-school adolescents' having knowledge about SRH issues were 51% less among Muslim in-school adolescents when compared to Orthodox Christianity in-school adolescents (AOR = 0.49, 95% CI: 0.28, 0.84). Similarly, the odds of in-school adolescents' knowledge about SRH issues were 75% less among having fathers' occupation in private business when compared to others occupation (AOR = 0.25, 95% CI: 0.07,0.90). Moreover, the odds of in-school adolescents' knowledge about SRH issues were 84% less among in-school adolescents who had fathers who were merchants compared to other occupations (AOR = 0.16, 95% CI: 0.04,0.62) as is shown in Table 4.8.

Table 4.8: Factors associated with adolescent knowledge on sexual reproductive health issues (n=636)

Variable	Category	Adolescent knowledge		COR 95% CI	AOR 95% CI
		Yes	No		
Sex	Male	191 (74.3)	66 (25.7)	1.00	1.00
	Female	354 (93.4)	25 (6.6)	4.98 (2.99,8.01)	5.42 (3.19,9.21)
Age	Adolescent (≤14)	6 (50.0)	6 (50.0)	0.13 (0.04, 0.41)	0.19 (0.04, 0.84)
	Adolescent (15-17)	225 (83.3)	45 (16.7)	0.64 (0.40, 1.01)	0.78 (0.39,1.54)
	Adolescent (≥18)	314 (88.7)	40 (11.3)	1.00	1.00
Grade	9th Grade	88 (78.6)	24 (21.4)	0.46 (0.25,0.87)	0.67 (0.27, 1.68)
	10th Grade	130 (81.3)	30 (18.8)	0.55 (0.30,0.99)	0.60 (0.27, 1.36)
	11th Grade	152 (91.0)	15 (9.0)	1.27 (0.64, 2.54)	1.45 (0.68, 3.09)
	12th Grade	175 (88.8)	22 (11.2)	1.00	1.00
Religion	Orthodox	234 (89.5)	38 (10.5)	1.00	1.00
	Muslim	154 (79.0)	41 (21.0)	0.44 (0.27,0.71)	0.49 (0.28, 0.84)
	Protestant	62 (86.1)	10 (13.9)	0.73 (0.34,1.54	1.02 (0.45, 2.32)
	Others	5 (71.4)	2 (28.6)	0.29 (0.55,1.56)	0.71 (0.08,6.17)
Lived with	Both parents	338 (83.3)	68 (16.7)	1.00	1.00
	single parent	109 (94.8)	6 (5.2)	3.66 (1.54,8.66)	2.61 (1.04,6.54)
	Grand parents	37 (82.2)	8 (17.8)	0.93 (0.42,2.09)	0.70 (0.28,1.72)
	Relatives	51 (89.5)	6 (10.5)	1.71 (0.71,4.14)	0.85 (0.31,2.31)
	Alone	10 (76.9%)	3 (23.1)	0.67 (0.18,2.50)	0.96 (0.19,4.77)
Mother's education	No formal education	207 (85.2)	36 (14.8)	1.00	
	Attended 1 education	156 (84.3)	29 (15.7)	0.94 (0.55,1.59)	
	Attended 2 education	127 (88.2)	17 (11.8)	1.23 (0.70,2.41)	
	Tertiary Education	55 (85.9)	9 (14.1)	1.06 (0.48,2.34)	
Father's education	No formal education	138 (87.3)	20 (12.7)	0.73 (0.33,1.62	
	Attended 1° education	137 (82.5)	29 (17.5)	0.50 (0.23,1.07)	
	Attended 2° education	175 (84.5)	32 (15.5)	0.58 (0.27,1.22)	
	Tertiary Education	95 (90.5)	10 (9.5)	1.00	
Mother's occupation	Housewife	256 (82.8)	53 (17.2)	0.62 (0.37,1.07)	
	Private business	119 (88.1)	16 (11.9)	0.96 (0.49,1.91)	
	Government employee	170 (88.5)	22 (11.5)	1.00	
Father's occupation	Private business	243 (85.0)	43 (15.0)	0.25 (0.08,0.83)	0.25 (0.07,0.90)
	Government employee	102 (90.3)	11 (9.7)	0.41 (0.11,1.52)	0.37 (0.09,1.51)

	Merchant	131 (79.4)	34 (20.6)	0.17 (0.05,0.57)	0.16 (0.04,0.62)
	Others*	68 (95.8)	3 (4.2)	1.00	1.00
Parental age	<40	120 (83.3)	24 (16.7)	1.00	
	40-44	88 (89.8)	10 (10.2)	1.76 (0.80,3.87)	
	45-49	135 (85.4)	23 (14.6)	1.17 (0.63,2.19)	
	50-54	115 (87.1)	17 (12.9)	1.35 (0.69,2.65)	
	≥55	34 (77.3)	10 (22.7)	0.68 (0.30,1.56)	
Parental sex	Male	206 (84.8)	37 (15.2)	1.09 (0.69,1.74)	
	Female	286 (85.9)	47 (14.1)	1.00	
Parent education	No Formal education	86 (84.3	16 (15.7)	1.00	
	1 education	87 (85.3)	15 (14.7)	1.08 (0.50,2.32)	
	2 education	190 (87.6)	27 (12.4)	1.31 (0.67,1.56)	
	Tertiary education	129 (83.2)	26 (16.8)	0.92 (0.47,1.82)	

4.3.6.3 Predictors of in-school adolescents sexual reproductive health behaviour

Logistic regression statistical method was applied to examine the correlation between independent and response variables (in-school adolescents' behaviour about SRH issues). The independent variables (n=13) association was initially tested using bivariate logistic regression method. The variables tested using a binary logistic regression were in-school adolescents' sex, age, grade, religion, lived with, parental education, parental occupation, interviewed parental's knowledge and communication about SRH issues were included in the bivariate logistic regression model. Of these, in-school adolescents' sex, age, grade, religion, adolescents' knowledge, and communication about SRH were eligible ($p<0.25$) for the multivariate logistic regression (final model fit).

In-school adolescents' sex, age, and knowledge about SRH issues were significantly associated with in-school adolescents' behaviour about SRH issues. The odds of in-school adolescents having a risk-taking behaviour were 67% less among female in-school adolescents compared to the male in-school adolescent (AOR = 0.33, 95% CI: 0.19,0.56). Late adolescents were 4.3 times likely to have risk-taking practices as compared to early adolescents (AOR = 4.31, 95% CI: 1.06,17.41). In-school adolescents who had knowledge about risk-taking behaviours were 2.8 times to have experienced risky sexual behaviours as compared to those in-school adolescents who had no knowledge about common SRH issues (AOR = 2.79, 95% CI: 1.47,5.27) as is presented in Table 4.9.

Table 4.9: Factors associated with in-school adolescents' behaviour on sexual reproductive health issues (n=636)

Variables	Category	Adolescent communication		Crude odds ratio 95% CI	Adjusted OR 95% CI
		Yes	No		
Sex	Male	227 (88.3)	30 (11.7)	1.00	1.00
	Female	297 (78.4)	82 (21.6)	0.48 (0.30,0.75)	0.33 (0.19,0.56)
Age	Adolescent (≤14)	5 (41.7)	7 (58.3)	1.00	1.00
	Adolescent (15-17)	213 (78.9)	57 (21.1)	5.23 (1.60,17.17)	3.07 (0.84,11.27
	Adolescent (≥18)	306 (86.4)	48 (13.6)	8.93 (2.72,29.26)	4.31 (1.06,17.41)
Grade	9th Grade	80 (71.4)	32 (28.6)	1.00	1.00
	10th Grade	132 (82.5)	28 (17.5)	1.89 (1.06,3.36)	1.80 (0.94,3.42)
	11th Grade	144 (86.2)	23 (13.8)	2.50 (1.37,4.57)	1.86 (0.90,3.83)
	12th Grade	168 (85.3)	29 (14.7)	2.32 (1.31,4.09)	1.56 (0.69,3.51)
Religion	Orthodox	305 (84.3)	57 (15.7)	2.14 (0.41,11.30)	1.65 (0.25,10.79)
	Muslim	148 (75.9)	47 (24.1)	1.26 (0.24,6.71)	0.97 (0.15,6.42)
	Protestant	66 (91.7)	6 (8.3)	4.40 (0.70,27.72)	2.85 (0.37,21.94)
	Others	5 (71.4)	2 (28.6)	1.00	1.00
Lived with	Both parents	330 (81.3)	76 (18.7)	1.00	
	Either mother or father	92 (80.0)	23 (20.0)	0.92 (0.55,1.55)	
	Grand parents	41 (91.1)	4 (8.9)	2.36 (0.82,6.79)	
	Relatives	49 (86.0)	8 (14.0)	1.41 (0.64,3.10)	
	Alone	12 (92.3)	1 (7.7)	2.76 (0.35,21.58)	
Mother education	No formal education	201 (82.7)	42 (17.3)	1.00	
	Attended 1 education	147 (79.5)	38 (20.5)	0.81 (0.50,1.32)	
	Attended 2 education	118 (81.9)	26 (18.1)	0.95 (0.55,1.63	
	Tertiary Education	58 (90.6)	6 (9.4)	2.02 (0.82,4.50)	
Father education	No formal education	128 (81.0)	30 (19.0)	1.00	
	Attended 1 education	138 (83.1)	28 (16.9)	1.16 (0.65,2.04)	
	Attended 2 education	169 (81.6)	38 (18.4)	1.04 (0.61,1.77)	
	Tertiary Education	89 (84.8)	16 (15.2)	1.30 (0.67,2.53)	
Mother occupation	Housewife	248 (80.3)	61 (19.7)	1.00	
	Private business	116 (85.9)	19 (14.1)	1.50 (0.86,2.63)	

	Government employee	160 (83.3)	32 (16.7)	1.23 (0.77,1.97)	
Father occupation	Private business	234 (81.8)	52 (18.2)	1.00	
	Government employee	94 (83.2)	19 (16.8)	1.10 (0.62,1.96	
	Merchant	134 (81.2)	31 (18.8)	0.96 (0.59,1.57)	
	Others	61 (85.9)	10 (14.1)	1.38 (0.66,2.87)	
Adolescent knowledge	Yes	462 (84.8)	83 (15.2)	2.60 (1.58,4.29)	2.79 (1.47,5.27)
	No	62 (68.1)	29 (31.9)	1.00	1.00

4.3.7 Results from interviewed parents about their adolescent's sexual reproductive health issues

The collected data through face-to-face interviews with parents using structured quantitative survey questionnaire was analysed using descriptive, bivariate and multivariate logistic regression analysis.

4.3.7.1 Socio-demographic characteristics of parents

From among the 636 in-school adolescents who gave complete responses and whose parents agreed to be interviewed about their adolescent's SRH issues, 576 of the parents gave a complete response with a response rate of 87.27%. Nearly six-in-ten (57.8%, n=333) of these were mothers. The average age of the parents were 45 (+ 6.09) years. More than half (55.0%, n=317) were followers of orthodox Christianity. Nearly half (48.4%, n=279) of the parents are Amhara followed by Oromo (22.4%, n=129) ethnicities. More than two-thirds (69.3%, n=399) of the parents live with their partners. With respect to educational status, nearly one-fifth (17.7%, n=102) of the parents had no formal education, (17.7%, n=102) had a primary education, (37.7%, n=217) had attended secondary school and (26.9%, n=155) had a diploma or above educational status. With respect to the parents' occupation, one-fourth (25%, n=144) of the mothers were housewives, and nearly half (47.4%, n=273) of the parents were employees of government. Regarding parental risky behaviours, (6.8%, n=39) had smoked cigarettes, more than one-fifth (21.4%, n=123) had chewed Khat and nearly half (45.7%, n=263) had drunk alcohol as depicted in Table 4.10.

Table 4.10: Sociodemographic characteristics of parents of the selected in-school adolescents (n=576)

Variable	Categories	Frequency	Percentage
Sex	Male	243	42.2
	Female	333	57.8
Age	<40	144	25.0
	40-44	98	17
	45-49	158	27.4
	50-54	132	22.9
	≥55	44	7.6
Parent's religion	Orthodox	317	55.0
	Muslim	168	29.2
	Protestant	67	11.6
	Others	24	4.2
Parent's ethnicity	Amhara	279	48.4
	Oromo	129	22.4
	Tigre	38	6.6
	Gurage	93	16.1
	Others	37	6.4
Living with their husband/wife	Yes	399	69.3
	No	177	30.7
Parent's educational status	No formal education	102	17.7
	Attended 1 education	102	17.7
	Attended 2 education	217	37.7
	Attended tertiary education	155	26.9
Parent's occupation	Housewife	144	25.0
	Employee	273	47.4
	Merchant	156	27.1
	Others	3	0.5
Parent's cigarette smoking habits	Never smoked	537	93.2
	Has smoked	39	6.8
Parent's Khat chewing habit	Never chewed Khat	453	78.6
	Has chewed Khat	123	21.4
Parent's alcohol drinking habit	Never drunk alcohol	313	54.3
	Has drunk alcohol	263	45.7

4.3.7.2 Parental knowledge of common sexual and reproductive health matters

Half (51.7%) of the parents who had adolescent girls knew when their adolescent girl had started their menses. Parents reported that the mean age of menses of their female adolescents was 14 (±1.47) years. The majority (86.3%, n=497) of the parents knew about STI/HIV related issues. Of these parents 20.7%, (n=103) knew of Chancroid, Syphilis (34.8%, n=173), Gonorrhoea (19.5%, n=97), HIV/AIDS (85.5%, n=425) and herpes simplex (14.3%, n=71). Regarding contraceptive knowledge, the majority (84.7%, n=488) of parents had heard about contraceptives. Of these, 65.8% of the parents knew

about pills (n=321), injectables (69.7%, n=340), implants (35.0%, n=171), intrauterine device (19.1%, n=93), condoms (27.0%, n=132) and calendar methods 13.1%, n=64). Nearly one-third (30.2%, n=174) of the parents knew when pregnancy can occur.

4.3.7.3 Sexual behaviour of parents

More than half (51.4%, n=296) of the parents believed that sexual practice is unacceptable during the time of adolescence. Nevertheless, nearly half (49.3%, n=284) of the parents had engaged in sexual intercourse with about two people during their adolescent period and almost one-in-ten (8.7%, n=50) of parents had sexual intercourse with more than two people. Nearly half (45.1%, n=260) of the parents believed that in-school adolescents may not use condoms while having sex. More than two-thirds (70.3%, n=222) of the parents believed that adolescents should use condoms consistently. From the participating mothers, approximately one-in-five (17.4%, n=58) of them had experienced an unwanted pregnancy. Of these, 25.9% (n= 15) of parents had a history of abortion for their unwanted pregnancies. The majority (83.2%, n=479) of the parents did not accept premarital sex. More than two-fifths (43.3%, n=250) of the parents refused sex education for their adolescents. Of those who believed sex education for their adolescent was necessary, two-thirds (64.1%, n=209) preferred this to happen in school, in home (29.1%, n=95), via friends/peers (22.7%, n=74), in religious places (24.5%, n=80) and through the media (0.92%, n=3).

4.3.7.4 Parental perception on monitoring their adolescents

More than two-thirds (67.2%, n=386) of the parents considered that adolescent monitoring is necessary. One-in-ten (9.9%, n=23) of the fathers stated that they forbade their male adolescents to play with female adolescents. Nearly one-fifth (16.5%, n=55) of the mothers of female adolescents forbade their daughters to play with male adolescents, and at a median age of 13 (± 2.13) years. Almost half (46.9%, n=270) of the parents knew where and when their adolescent went outside from home or school. However, 55.6% (n=320) of the parents didn’t know with whom their adolescent spent time with outside of the home or school.

4.3.7.5 Parental sexual and reproductive health issues communication practices

More than four fifths (81.9%, n=472) of the parents had various sources of information about SRH issues. Of these, 57.4%, (n=271) was from health institutions, from TV and radio (52.1%, n=246), from friends (28.4%, n=134), from spouses (19.7%, n=93), and from magazine or posters (16.3%, n=77) as is shown in Figure 4.5

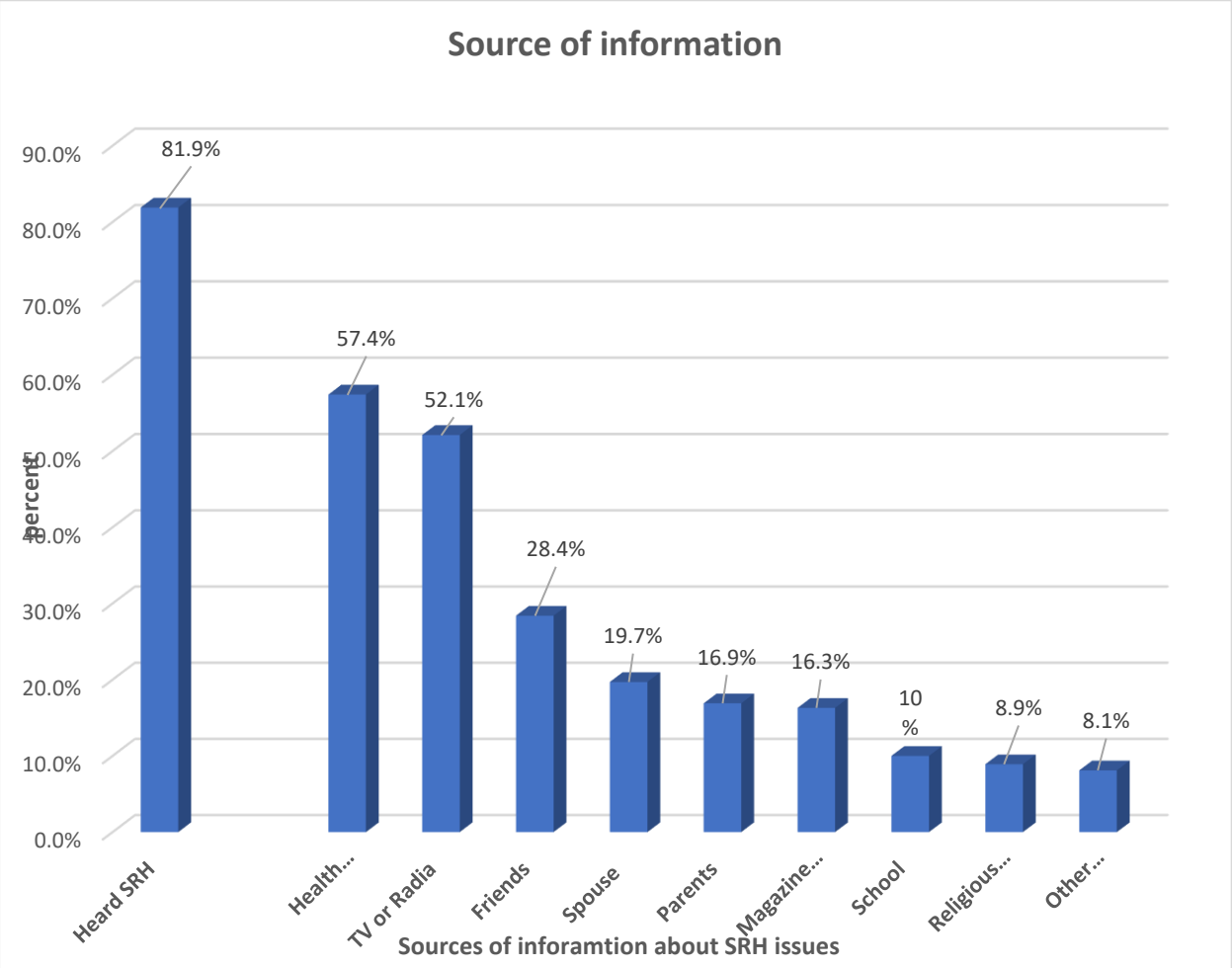

Figure 4.5: Parental sources of sexual reproductive health information (n=576), *Multiple responses were possible)

More than two-fifths (40.5%, n=233) of the parents reported having difficulties in communicating SRH matters with their adolescent sons that were useful to them. Half (50.0%, n=288) of the parents never discussed sexuality related issues with their adolescent sons. One-third (36.8%, n=212) of the parents had difficulty communicating with their adolescent daughters about SRH issues important to her. More than half

(53.3%, n=307) had never discussed sexuality related issues with their adolescent daughter. Nearly half (47.2%, n=272) of the parents believed that discussions regarding SRH issues are not important to their adolescents. Nearly two-thirds (61.5%, n=354) of the parents opted to communicate SRH issues with their daughters.

Among the parents who discussed SRH issues with their adolescents, approximately one-third (30.4%, n=175) of the parents discussed family planning with their adolescents. Slightly more than one-fourth (26.4%, n=152) of them discussed sexuality with their adolescents, and only 15.1% (n=87) of them discussed condom usage as is shown in Figure 4.6.

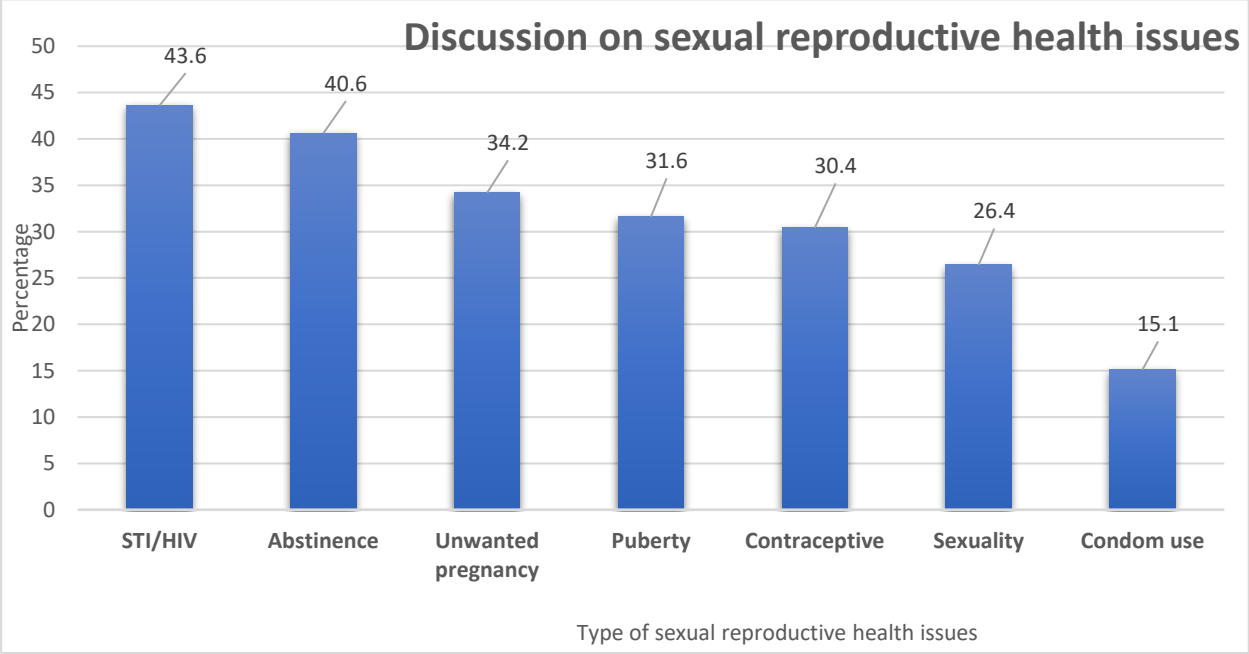

Figure 4.6: Parental major sexual and reproductive health matters communication practices with their adolescents (n=576)

More than two-thirds (69.6%, n=401) of the parents did not discuss family planning with their adolescents. The major reasons for not discussing contraception were a lack of knowledge (28.2%, n=113) and adolescents were not good listeners (25.4%, n=102). More than half (56.4%, n=325) of the parents didn't discuss STI/HIV related issues with their adolescents. The major reasons for not discussing these issues were, adolescents were not good listeners (39.7%, n=129) and a lack of knowledge (35.1%, n=114). Approximately three-fourths (73.6%, n=424) never discuss on sexuality with their

adolescents. The major reasons for not discussing sexuality were feeling embarrassed (38.0%, n=161) and cultural barriers (36.6%, n=155). Furthermore, two-thirds (65.8%, n=379) of parents never discuss pregnancy related matters with their adolescents. The major reasons for not discussing unwanted pregnancy were a lack of knowledge (30.9%) and lack of communication skills (30.9%). More than half (59.4%, n=342) of parents didn't discuss abstinence with their adolescents because of a lack of communication skills (37.4%, n=128) and that adolescents were not good listeners (36.8%, n=126). The majority (84.9%, n=489) of parents were not discussing on condom usage with their adolescents due to cultural unacceptability (49.9%, n=244) and feeling ashamed (28.8%, n=137). In addition, slightly more than two-thirds (68.4%, n=394) of parents did not discuss puberty with their adolescents as they felt that adolescents were not good listeners (32.7%, n=129) and a lack of knowledge (32.2%, n=127). More detailed explanations for reasons for not having discussions is illustrated in Table 4.11.

Eight- in- ten (78.3%, n=137) of the parents preferred to discuss family planning issues with their daughter. The majority (68.6%, n=120) of the parents discussed family planning with their in-school adolescents on occasions. Parents stated that 38.5% (n=60) had discussions with their friends other than with their adolescents. The majority (66.0%, n=103) occasionally discussed family planning issues with others rather than their adolescents as is shown in Table 4.12.

Table 4.11: Reasons parents gave for not discussing sexual reproductive health issues with their in-school adolescents (n=576)

Reasons for not discussing sexual reproductive health issues	**Major sexual reproductive health issues**						
	Contraceptive	**STI/HIV**	**Sexuality**	**Unwanted pregnancy**	**Abstinence**	**Condom use**	**Puberty**
Culture	84 (20.9)	36 (11.1)	155 (36.6)	41 (10.8)	34 (9.9)	244 (49.9)	46 (11.7)
Ashamed	97 (24.2%)	60 (18.5%)	112 (26.4%)	47 (12.4%)	50 (14.6%)	137 (28.0%)	70 (17.8%)
Lack of knowledge	113 (28.2%)	114 (35.1%)	44 10.4%)	117 (30.9%)	104 (30.4%)	119 (24.3%)	127 (32.2%)
Lack of communication skill	96 (23.9%)	82 (25.2%)	74 (17.5%)	115 (30.9%)	128 (37.4%)	85 (17.4%)	108 (27.4%)
Adolescents are not good listeners	102 (25.4%)	129 (39.7%)	81 (19.1%)	107 (28.2%)	126 (36.8%)	47 (9.6%)	129 (32.7%)
Embarrassment	58 (14.5%)	58 (17.8%)	161 (38.0%)	57 (15.0%)	56 (16.4%)	88 (18.0%)	87 (22.1%)
Don’t know	2 (0.5%)	5 (1.5%)	3 (0.7%)	9 (2.4%)	2 (0.6%)	7 (1.4%)	5 (1.3%)

Table 4.12:Parental communication about sexual reproductive health issues with their peers/relatives (n=576)

With whom	**Frequency**	**Key sexual reproductive health issues**						
		Contraceptive	**STI/HIV**	**Sexuality**	**Unwanted pregnancy**	**Abstinence**	**Condom use**	**Puberty**
Adolescents	Very often	21 (12.0%)	26 (10.4%)	13 (8.8%)	18 (9.2%)	26 (11.1%)	13 (15.1%)	12 (6.7%)
	Often	34 (19.4%)	42 (16.8%)	45 (30.6%)	48 (24.5%)	53 (22.6%)	21 (24.4%)	40 (22.2%)
	Sometimes	120 (68.6)	182 (72.8%)	89 (60.5%)	130 (66.3%)	155 (66.2%)	52 (60.5%)	128 (71.1%)
Peers/ friends	Very often	28 (17.9%)	33 (15.2%)	17 (11.8%)	22 (12.9%)	30 (16.4%)	15 (18.3%)	18 (11.3%)
	Often	25 (16.0%)	35 (16.1%)	32 (22.2%)	52 (30.4%)	37 (20.2%)	14 (17.1%)	29 (18.1%)
	Sometimes	103 (66.0%)	149 (68.7%)	95 (66.0%)	97 (56.7%)	116 (63.4%)	53 (64.6%)	113 0.6%)

4.3.7.6 Factors associated with parental communication about sexual reproductive health issues

The association between independent variables and outcome variable was examined using the logistic regression statistical analysis method. Each independent variable (n=7) association was initially tested using a binary logistic regression method. The independent variables test using a binary logistic regression were parent's sex, age, educational status, religion, lived with, occupation and their adolescent's SRH knowledge. Of these variables, the parent's sex, age, educational status, religion, lived with and occupation were eligible to be incorporated in the final model fit (multiple logistic regression) using P value less than 0.25 as a criterion.

Finally, parent's age and educational status were significantly associated with parental communication on SRH issues with their in-school adolescents. Parental communication about SRH issues with their adolescents increased as their age increased, parents whose ages ranged from 50-54 years were 3.08 times likely to discuss some SRH issues with their adolescents when compared to parents who were aged less than 40 (AOR = 3.08, 95% CI:1.41,6.73).

The likelihood of parents having discussions about SRH issues were 77% less among primary education level parents compared to those parents with no formal education (AOR = 0.23, 95% CI: 0.09,0.59). Similarly, the odds of parental discussions about SRH issues were 72% less among those with secondary education when compared to those with no formal education (AOR = 0.28, 95% CI: 0.11,0.79) as is shown in Table 4.13.

Table 4.13: Factors associated with parental sexual reproductive health issues communication with their in-school adolescents (n=576)

Variable	Category	Parent communication		Crude OR 95% CI	Adjusted OR 95% CI
		Yes	No		
Sex	Male	196 (80.7	47 (19.3)	0.70 (0.45,1.09)	0.70 (0.43,1.15)
	Female	285 (85.6)	48 (14.4)	1.00	1.00
Age	<40	115 (79.9)	29 (20.1)	1.00	0.43
	40-44	81 (82.7)	17 (17.3)	1.20 (0.62,2.33)	1.29 (0.64,2.57)
	45-49	124 (78.5)	34 (21.5)	0.92 (0.53,1.61)	1.02 (0.58,1.82)
	50-54	122 (92.4)	10 (7.6)	3.08 (1.44,6.60)	3.08 (1.41,6.73)
	≥55	39 (88.6)	5 (11.4)	1.97 (0.71,5.43)	1.82 (0.63,5.22)
Parent's educational status	No formal education	96 (94.1)	6 (5.9)	1.00	0.002
	1 education (1-8)	78 (76.5)	24 (23.5)	0.20 (0.08,0.52)	0.23 (0.09,0.59)
	2 education (9-12)	169 (77.9)	48 (22.1)	0.22 (0.09,0.53)	0.28 (0.11,0.79)
	Tertiary education	138 (89.0)	17 (11.0)	0.51 (0.19,1.33)	0.64 (0.23,1.74)
Religion	Orthodox	266 (83.9)	51 (16.1)	1.97 (0.75,5.18)	0.86 (0.27,2.70)
	Muslim	141 (83.9)	27 (16.1)	0.40 (0.20,0.79)	0.94 (0.29,3.06)
	Protestant	54 (80.6)	13 (19.4)	0.43 (0.24,0.79	0.69 (0.194,2.47)
	Others	20 (83.3)	4 (16.7)	1.00	0.886
Live with their spouse	Yes	327 (82.0)	72 (18.0)	0.68 (0.41,1.13)	0.74 (0.43,1.26)
	No	154 (87.0)	23 (13.0)	1.00	0.264
Parent's occupation	Housewife	125 (86.8)	19 (13.2)	1.00	0.429
	Employee	234 (85.7)	39 (14.3)	0.91 (0.51,1.64)	0.84 (0.44,1.62)
	Merchant	122 (76.7)	37 (23.3)	0.50 (0.27,0.92)	0.65 (0.33,1.28)
Adolescent's knowledge of sexual reproductive health	Poor knowledge	73 (86.9)	11 (13.1)	1.00	
	Good knowledge	408 (82.9)	84 (17.1)	0.73 0.37,1.44)	

4.3.7.7 Predictors associated with parental knowledge of sexual reproductive health issues

The association between independent and outcome variable were examined using logistic regression statistical analysis method. Each independent variable (n=9) association was initially tested using a binary logistic regression method. The independent variables test using a binary logistic regression were parent's sex, age, grade, religion, lived with, educational status, occupation, adolescent's age, adolescent's sex, and adolescent's grade. Of these variables, parent's sex, age, religion, lived with, educational status, occupation and adolescent's grade were eligible to be included in the final model fit (multiple logistic regression) using P value less than 0.25 as a criterion.

Finally, parent's sex, age and educational status about SRH issues were significantly associated with parents' knowledge about their adolescent's SRH issues. Parental knowledge about SRH issues with their adolescents was significantly associated with their gender. Mothers were 2.86 times likely to be knowledgeable with regard to some issues of their adolescent's SRH when compared with their male parents (AOR = 2,86, 95% CI:1.9,4.20). The odds of a parent aged between 45-49 years having knowledge about SRH issues were 40% less when compared to those parents whose age was less than 40 years (AOR = 0.40, 95% CI: 0.37,0.98). The odds of a parent's knowledge about SRH issues were 54% less among those who had a primary education when compared to those with no formal education at all (AOR = 0.46, 95% CI: 0.24,0.87). Similarly, the odds of a parent's knowledge about SRH issues were 53% less among those having a secondary education when compared to those with no formal education (AOR = 0.47, 95% CI: 0.27,0.83) as is presented in Table 4.14.

Table 4.14: Predictors associated with parental knowledge about their in-school adolescents sexual reproductive health issues (n=576)

Variable	Category	Parent knowledge		COR 95% CI	AOR 95% CI
		Yes	No		
Sex	Male	11446.9	129 (53.1)	1.00	1.00
	Female	240 (72.1)	93 (27.9)	2.92 (2.06,4.13)	2.86 (1.97,4.20)
Age	<40	95 (66.0)	49 (34.0)	1.00	1.00
	40-44	56 (57.1)	42 (42.9)	0.69 (0.41,1.17)	0.72 (0.41,1.26)
	45-49	86 (54.4)	72 (45.6)	0.62 (0.39,0.98)	0.60 (0.37,0.98)
	50-54	86 (65.2	46 (34.8)	0.96 (0.59,1.59)	0.93 (0.55,1.56)
	≥55	31 (70.5)	13 (29.5)	1.23 (0.59,2.56)	1.24 (0.57,2.70)
Religion	Orthodox	198 (62.5)	119 (37.5)	1.00	
	Muslim	104 (61.9)	64 (38.1)	0.98 (0.66,1.44)	
	Protestant	36 (53.7)	31 (46.3)	0.70 (0.41,1.19)	
	Other	16 (66.7)	8 (33.3)	1.20 (0.50,2.89)	0.888
Lived with	Yes	239 (59.9)	160 (40.1)	0.81 (0.56,1.16)	0.97 (0.65,1.45)
	No	145 (65.0)	62 (35.0)	1.00	
Parent's educational status	No formal education	78 (76.5)	24 (23.5)	1.00	1.00
	1 education (1-8)	62 (60.8)	40 (39.2)	0.48 (0.26,0.87)	0.46 (0.24,0.87)
	2 education (9-12)	124 (57.1)	93 (42.9)	0.41 (0.24,0.70)	0.47 (0.27,0.83)
	Tertiary education	90 (58.1)	65 (41.9)	0.43 (0.24,0.74)	0.58 (0.32,1.05)
Parent's occupation	Housewife	104 (72.2)	40 (27.8)	1.00	1.00
	Employee	159 (58.2)	114 (41.8)	0.54 (0.35,0.83)	0.72 (0.44,1.17)
	Merchant	91 (57.2))	68 (42.8)	0.52 (0.32,0.83)	0.85 (.50,1.44)
Adolescent's age	Adolescent (≤14)	8 (66.7)	4 (33.3)	1.00	
	Adolescent (15-17)	140 (61.9)	86 (38.1)	0.81 (0.24,2.78)	
	Adolescent (≥18)	206 (60.9)	132 (39.1)	0.78 (0.23,2.64)	
Adolescent's sex	Male	147 (62.3)	89 (37.7)	1.00	
	Female	207 (60.9)	133 (39.1)	0.94 (0.67,1.33)	

Adolescent grade	Grade 9	59 (62.8)	35 (37.2)	1.00	0.877
	Grade 10	85 (64.4)	47 (35.6)	1.07 (0.62,1.86)	0.99 (0.55,1.78)
	Grade 11	90 (57.7)	66 (42.3)	0.81 (0.48,1.37)	0.83 (0.48,1.44)
	Grade 12	120 (61.9)	74 (38.1)	0.96 (0.58,1.60)	0.95 0.56,1.63)

4.4 OVERVIEW OF RESEARCH FINDINGS

This research founds that almost one-in-twenty in-school adolescents have smoked cigarettes, 6.6%, have chewed Khat and nearly one-fourth of in-school adolescents have drunk alcohol. More than one-fourths of in-school adolescents have had sexual intercourse with the mean age of in-school adolescents who initiated sexual practice being 16.59 (±1.002) years. Among sexually active in-school adolescents, nearly half of them had experienced sexual practices with multiple sexual partners. More than half of sexually active in-school adolescents didn't use condom during sexual intercourse. Of these, nearly three-in-ten of them consistently used condoms. From the sexually active in-school adolescent girls, one-in-ten of them had experienced an unwanted pregnancy. Among those, 70% had terminated their pregnancy (aborted) and 30% of them gave birth. Two-thirds of the adolescents had discussed three or more SRH issues with their parents, however, comprehensive communication about common SRH issues was found to be very low at 5.7%.

Regarding discussions around major SRH issues between in-school adolescents and their parents; one-third discussed contraceptives, nearly half discussed STI/HIV, only one-third discussed sexuality, nearly one-fourth discussed condom use, four-in-ten discussed unwanted pregnancy, almost half had discussed abstinence and nearly half discussed the physical and psychological changes related to puberty. In-school adolescents cited feeling ashamed, lack of knowledge, feeling embarrassed and cultural unacceptability as major barriers to discussions on SRH issues.

In-school adolescent's grade, religion, and knowledge of SRH issues were statistically associated with in-school adolescent communication about SRH issues with their parents; in-school adolescent's sex, age, religion, lived with and father's occupation were significantly associated with in-school adolescents' knowledge about SRH matters with their parents and

in-school adolescents' sex, age, and knowledge regarding SRH matters were found to be determinants of in-school adolescents' behaviour about SRH issues.

Approximately one-third of the parents discussed family planning with their adolescents, slightly more than one-fourth of them discussed sexuality with their adolescents, and only 15.1% of them discussed condom usage. Parental age and educational status about SRH matters were the determinant factors of parental communication about SRH with their in-school adolescents. Parental sex, age and educational status about SRH issues were also found to be predictors of their knowledge about their adolescents SRH issues.

4.5 SUMMARY

This chapter presented the findings that were conducted sequentially of communication regarding SRH issues between in-school adolescents and their parents. It consisted of a brief introduction, data management and analysis process, basic characteristics of in-school adolescents and their parents or guardians, descriptive statistical findings of the outcome variable adolescent-parent communication about SRH issues, and predictors linked with in-school adolescent-parent discussion about SRH matters among in-school adolescents and their parents living in Addis Ababa City. The findings are presented using text statements, tables, and graphs. The next chapter will present the discussion part.

CHAPTER 5 - DISCUSSION

5.1 INTRODUCTION

This chapter discusses the key findings generated from this study in line with research objectives. The chapter consists of the summary of key findings, discussion about in-school adolescents' knowledge, behaviour and communication on SRH issues, and factors associated with in-school adolescent-parent communication, knowledge, and behaviour. In addition, the chapter discusses the impact of the study on program, and policy, and its contribution to knowledge.

5.2 RESEARCH OBJECTIVE AND KEY FINDINGS

The specific objectives of the study were formulated to assess the communication, knowledge and behavioural patterns between parents and in-school adolescents around SRH issues and to identify those factors that facilitate or promote PCC on SRH issues. The majority (84.6%) of in-school adolescents communicated about at least one SRH issue with their parents. However, comprehensive communication about common SRH issues (5.7%) with their parents was found to be very low. Nearly nine-in-ten (89%) of in-school adolescents stated that they have different sources of information for SRH issues. Only one-fifth, (20.4%) of in-school adolescents received SRH information from their parents with the majority (86.5%) stating that they never discussed SRH issues with their father.

The majority (83.4%) of in-school female adolescents knew when menstruation starts; there was a median age of first menses of 14 years between the age range of 9-17 years. More than one-third, (37.5%), experienced fear when they started menses. The majority (85.2%) of in-school adolescents knew about STI/HIV. Most (85.8%) of the study participants knew about contraception but only (27.2%) had knowledge of emergency contraceptives. More than half (58.8%) of the in-school adolescents knew about the likelihood of pregnancy between menstruations with nearly one-third (30.2%) of the parents knowing when pregnancy can occur. Only half (51.7%) of the parents with in-school adolescent girls knew when their adolescent girls started their menses. The majority (86.3%) of the parents were

knowledgeable about STI/HIV related issues. The majority (84.7%) of parents had heard about contraceptives.

Almost one-in-twenty in-school adolescents, (5.3%) had smoked cigarettes, and 6.6% had chewed Khat. Nearly one-fourth (23%) of in-school adolescents have drunk alcohol. Similarly, parents also practiced risk-taking behaviours, 6.8% smoked cigarettes, more than one fifth (21.4%) of the parents had chewed Khat and nearly half (45.7%) had drunk alcohol. More than one fourth (28.3%) of in-school adolescents had had sexual intercourse with the majority (88.9%) having sexual intercourse with their boy- or girlfriends. Of the sexually active in-school adolescents, nearly half (45%) had sexual debut with multiple sexual partners. More than half (54.4%) of sexually active in-school adolescents didn't use condom during sexual intercourse. From among the pregnant in-school adolescents 70% had terminated their pregnancy (aborted) and (30%) of them gave birth.

More than half (51.4%) of the parents believed that sexual practice is unacceptable during adolescence, the majority (83.2%) of the parents did not accept premarital sex. Nevertheless, nearly half (49.3%) of the parents engaged in sexual intercourse with about two people during their adolescence and almost one-in-ten (8.7%) had sexual intercourse with more than two people. Nearly half (45.1%) of the parents thought that in-school adolescents may not use condoms while having sex. More than two-thirds (70.3%) of the parents believed that the adolescents should use condoms consistently. From among the mothers of the adolescents who participated, approximately one-in-five (17.4%) of them had experienced an unwanted pregnancy. Of these, 25.9% had a history of abortion for their unwanted pregnancies. More than two-fifths (43.3%) of the parents refused sex education for their adolescents. Of the parents who believed sex education for their adolescents is necessary, two-thirds (64.1%) preferred this to happen in school, 29.1% at home, 22.7% through friends/peers and 24.5% by religious institutions.

The major barriers affecting effective communications between in-school adolescents and their parents on SRH issues were cultural unacceptability, feeling ashamed, finding it difficult or too embarrassing to talk about SRH issues, comprehensive knowledge and communication skill gap. grade level of in-school adolescents, religion, and knowledge on SRH issues. The in-school adolescent's sex, age, religion, lived with and father's occupation were significantly associated with in-school adolescents' knowledge about SRH issues with their parents. The in-school adolescent's sex, age, and knowledge about SRH issues were significantly associated with in-school adolescents' behaviour about SRH issues. The

parent's age and educational status about SRH issues were significantly associated with parental communication about SRH issues with their in-school adolescents. Parental communication about SRH issues with their adolescents increased as their age level increases. Parents' sex, age and educational status were significantly associated with their knowledge about their adolescent's SRH issues.

5.3 KNOWLEDGE ABOUT SEXUAL AND REPRODUCTIVE HEALTH ISSUES

The majority (83.4%) of in-school female adolescents knew when menstruation starts. This finding is consistent with a study finding undertaken in Ethiopia (Woreta) where 72.8% of the adolescents knew when their first menses initiated (Wudineh et al 2021). More than one-third, (37.5%), experienced fear when they started menses. The majority (85.2%) of in-school adolescents knew about STI/HIV. This study finding result is lower than a study conducted in Ethiopia (Arekit) where 96.9 % of participants knew about STI/HIV (Toru et al 2022). Most (85.8%) of the study participants knew about contraceptives; this was broken down to pills (60%), Depo Provera (44.7%), implants (58.7%), intrauterine device (42.2%), condoms (56.9%) whereas a study conducted in Indonesia revealed that 89.66% know condoms as contraception (Putri et al 2022), abstinence (47.8%) and calendar methods (26%). Only (27.2%) of in-school adolescents knew about emergency contraceptives. More than half (58.8%) of in-school adolescents knew about the likelihood of pregnancy occurring between menstruations. Only half 51.7% of the parents of adolescent girls knew when their adolescent girl started their menses.

The majority (86.3%) of the parents knew about STI/HIV related issues. This finding is higher than the study findings conducted in Indonesia and Gambia where 51.68% and 67.3% of adolescents know only HIV/AIDS from the multiple sexually transmitted infections, respectively (Putri et al 2022; Sagnia et al 2020).

With respect to contraceptive knowledge, the majority (84.7%) of parents heard about contraception. This study is lower than a study conducted in Indonesia and Ethiopia where 98.71% and 93.7% of parents, had heard about contraception, respectively (Putri et al 2022; Bekele et al 2022). Of these, 65.8% of parents knew about pills, injectables (69.7%), implants (35.0%), intrauterine device (19.1%), condoms (27.0%) and calendar methods (13.1%). This

research result is lower than the finding conducted in Ethiopia (Sawla) where almost all (98.2%) knew about at least one contraceptive method. When asked individually, the majority knew about injectables (96%), condoms (95.4%), pills (91%) and the natural safe period using standard days method (70.9%) (Malango et al 2022). Nearly one-third (30.2%) of the parents knew when pregnancy can occur.

The majority (89%) of in-school adolescents stated that they have access to different sources of information regarding SRH issues. One-fifth, (20.4%) received information from their parents. This finding is higher as compared to a finding conducted in Ethiopia where 68.5% of in-school adolescents received SRH information with 52% mentioning their peers as their major source of information (Abdurahman et al 2022).

5.4 SEXUAL AND REPRODUCTIVE HEALTH ISSUES BEHAVIOUR

Almost one-in-twenty in-school adolescents, (5.3%) smoked cigarettes and 6.6% of them have chewed Khat. Nearly one-fourth (23%) have drunk alcohol in their lifetime. The finding of this study is lower than a study conducted in Thailand where 20.8% smoke cigarettes and 40.9% had drunk an alcoholic beverage in the last 30 days (Thepthien & Celyn, 2022). This could be attributed to differing cultural and living habits of the study participants. Similarly, parents also practicing risky behaviours, 6.8% smoked cigarettes, more than one-fifth (21.4%) of the parents chewed Khat and nearly half (45.7%) drank alcohol.

More than one-fourth (28.3%) of in-school adolescents have had sexual intercourse. This result is consistent with a study conducted in (Adam et al., 2020; Wakasa et al., 2021) where 30.4% and 29.8% of in-school adolescents had sexual intercourse, respectively (Adam et al 2020; Wakasa et al 2021). The majority (88.9%) of in-school adolescents had sexual intercourse with their boy- or girlfriends. Of these sexually active in-school adolescents, nearly half (45%) had sexual intercourse with multiple sexual partners. More than half (54.4%) of sexually active in-school adolescents did not use condoms during sexual practices. From among the in-school adolescent girls who became pregnant, 70% terminated their pregnancies (aborted) and 30% of them gave birth. This study finding is consistent with a finding conducted in Ethiopia (Dabat) where 51% of sexually active adolescents used condoms during their first sexual experience and 10% of the female participants reported that they had become pregnant (Adam et al., 2020).

5.5 COMMUNICATION ABOUT SEXUAL AND REPRODUCTIVE HEALTH ISSUES

The majority (84.6%) of the adolescents communicated at least one SRH issue with their parents or guardians. This result is relatively consistent with a finding conducted in Ethiopia (Haiyk & Agaro) where 83% and 61.3% of the adolescents discussed SRH issues with their parents, respectively (Abdissa & Sileshi, 2023; Chane & Cherie, 2018). This finding is higher when compared to the findings of another study from Ethiopia (Jimma) that established that the proportion of adolescents who communicated with their parents about SRH issues was 43.7% (Abraham et al., 2022). However, comprehensive communication about common SRH matters with parents in the present study was found to be very low at 5.7%.

The majority (86.5%) of in-school adolescents stated that they never discussed SRH issues with their fathers. This finding is consistent with a study conducted in Ethiopia (Jimma) that found that 90.4% had never had discussions with their mother, and 93.4% with their father (Abraham et al., 2022).

Nearly half (53.0%) of in-school adolescents discussed STI/HIV issues with their parents. This study finding is slightly higher when compared with a study finding conducted in Assela town, Ethiopia that reported that 21.3% had communicated with their adolescents on SRH issues(Bekele et al., 2022). The probable reasons for this variation might be attributed to the fact that the present study was conducted in the national capital city where the parents and their adolescents are expected to have better information on SRH issues and that this contributed to this relatively good communication finding. This result is also lower than a study finding in Southwestern Ethiopia that found that 61.9% of the parents had poor communication on SRH matters with their female adolescents (Taye et al., 2023a). The need for discussing SRH issues with their parents are found to be critical in equipping in-school adolescents with adequate knowledge on SRH issues in preventing them from risky sexual behaviours and enhance communication with parents.

5.6 FACTORS ASSOCIATED WITH PARENT-ADOLESCENT KNOWLEDGE, BEHAVIOUR AND COMMUNICATION ABOUT SEXUAL AND REPRODUCTIVE HEALTH ISSUES

The present study has shown that barriers to effective communication between in-school adolescents and parents on SRH issues were cultural unacceptability, feeling ashamed, it being difficult or embarrassing to talk about SRH issues, comprehensive knowledge and a communication skill gap. This study finding is consistent with a study conducted in Oman revealed that major bottlenecks to parent adolescent SRH communication are fear, discomfort and shame, feelings of shyness; socio-cultural taboos; gender mismatch; and lack of SRH knowledge (Zaabi et al 2022). Similarly, this finding result is consistent with a Zambian study that established that parenting style, adolescents' perception of parental attitudes and parental communication styles are associated with whether or not parents and adolescents communicate about sexual matters (Isaksen et al 2020:1). This study finding is also comparable with one from South Africa where embarrassment when discussing sexual topics; and cultural and religious beliefs were found to be barriers to communication (Motsomi et al 2016). In addition, the barriers are similar with another literature reviews result conducted in Ethiopia indicated that the communications are gender dependent, inhibited by intergenerational cultural taboo, parental knowledge on such communications, fear, and embarrassment to communicate (Yibrehu & Mbwele 2020). Furthermore, parental attitude towards SRH issues have significant impact on PCC and intergenerational cultural unacceptability to talk about sexual issues (Bekele et al 2022; Taye et al 2023).

Grade 12 in-school adolescents were 3.6 times likely to communicate on some SRH matters with their parents in comparison to Grade 9 adolescents. This finding is consistent with a study conducted in Sri Lanka where having adolescents with an educational status above Grade 11 was positively associated with SRH knowledge (Mataraarachchi et al 2023). Nevertheless, another study in Ethiopia has shown that in-school adolescents who were in Grade 10 were statistically associated with adolescent-parent communication on SRH issues (Fanta et al 2016).

In-school adolescents who belong to protestant Christianity were 10 times more likely communicate SRH issues with their parents when compared to other common religions practised in Addis Ababa. This research result is consistent with a study finding in Nigeria that noted that religion played influential role in PCC about SRH issues (Aliyu & Aransiola 2021).

In-school adolescents who have knowledge of at least one of the SRH issues were 4.36 times more likely to communicate their SRH issues with their parents in comparison to those who have no knowledge of even one of the SRH issues. This study finding is consistent with a study conducted in Ethiopia (Asella, Fiche & Dabat) that being knowledgeable regarding sexual reproductive health matters was significantly associated with communication (Adam et al 2020; Bekele et al 2022; Feyissa et al 2020). Furthermore, this study finding is consistent with a study conducted in Ethiopia (Jimma) that established that complete lack of information on SRH issues, particularly on sexually transmitted infections and not knowing the period in which there is a possibility for a girl to become pregnant were found to be independent factors that negatively affected adolescent-parental communication (Abraham et al 2022). In addition, this study is consistent with a finding from a systematic review and meta-analysis in Ethiopia that adolescents who have good knowledge of SRH issues were more likely to discuss those issues with their parents (Eshete & Shewasinad 2020). This study finding is also consistent with a study conducted in Ethiopia (Jimma) that revealed that in-school adolescents who never received information on SRH issues were found to be low in discussing SRH issues (Abraham et al 2022).

Female in-school adolescent were 5.42 times likely to be knowledgeable regarding SRH issues in comparison to male counterparts. This study varies from an Indian study which revealed that girls were found to have less SRH knowledge than boys (Deshmukh & Chaniana 2020). This can possibly be attributed to cultural differences between Ethiopia and India. In addition, this finding is consistent with a study finding in Ethiopia that shows that female in-school adolescents were more likely to participate in adolescent-parent communication on SRH issues (Fanta et al 2016).

In-school adolescents who lived with single parents were 2.61 times likely to be knowledgeable about SRH issues compared to those who lived with both parents. Nevertheless, parents whose adolescent staying in school hostels were more likely to have parental communication with their adolescent children about SRH (Singh et al 2023).

The probability of having knowledge of SRH issues were 81% less among early age in-school adolescents when compared to late age in-school adolescents. This finding is consistent with a study done in Philippines that determined that age was associated with knowledge, attitudes, and practices concerning reproductive health (Pasay-an et al 2020). Furthermore, this finding is similar with a study conducted in India that revealed that the higher the standard the student was in, the greater the level of knowledge (Deshmukh & Chaniana 2020).

The odds of in-school adolescents having knowledge about SRH issues were 51% less among Muslim in-school adolescents than those that belonged to Orthodox Christianity. This study is consistent with another study where religious and cultural beliefs were found to be barriers to contraceptive use and access to SRH services and information (Alomair et al 2020).

Similarly, the odds of in-school adolescents' knowledge about SRH issues were 75% less among those whose fathers were in private business rather than any other occupation. This study varies from a study conducted in Nepal where self-employed parents were more likely to have parental communication about SRH with their adolescent children (Singh et al 2023).

Moreover, the odds of in-school adolescents' knowledge about SRH issues were 84% less among in-school adolescents with merchant fathers compared to other occupations. This research finding is consistent with a study conducted in Ethiopia where the maternal occupational status of a housewife had a significant negative association with PCC (Ewnetu et al 2021)

The odds of in-school adolescents having a risk-taking behaviour were 67% less among female in-school adolescents compared to the male in-school adolescent. This study finding is consistent with a study undertaken in Ghana that reports that adolescents who had no risk-taking behaviour were high likely to use SRH services (contraceptive) (Adam et al 2021). Late adolescents were 4.3 times more likely to have risk-taking behaviours in comparison to early adolescents. This study is consistent with a study conducted in Ethiopia (Harari) where adolescents aged 15–18 years old were independently associated with risky sexual behaviour (Eyeberu et al 2023).

The odds of parents having discussions about SRH issues were 77% less among parents with a level of primary education compared to parents with no formal education. This study is consistent with another study from Ethiopia (Boditi) which indicates that parents who can read and write were less likely to communicate SRH issues with their in-school adolescents (Fanta et al 2016). Similarly, the odds of parental discussions about SRH issues were 72% less among parents having secondary education as compared with those who are illiterate. This finding is comparable with a study undertaken in Ethiopia (Boditi) which reveals that parents who completed secondary school were less likely to communicate SRH issues with their in-school adolescents (Fanta et al 2016).

Parental knowledge about SRH issues with their adolescents were statistically associated with gender. Mothers were 2.86 times more likely to be knowledgeable about some SRH issues concerning their adolescents in comparison to fathers. This finding is consistent with a study conducted in Nepal which determined that parents who have knowledge about puberty were more likely to have parental communication about SRH with their adolescent children (Singh et al 2023). In addition, this study result is consistent with the findings conducted Ethiopia that being knowledgeable is positively associated with PCC on SRH issues (Bekele et al 2022; Taye et al 2023).

5.7 SUMMARY

This chapter presented and discussed the major findings of the study conducted among in-school adolescents and their parents. The chapter consisted of a brief introduction, research objective and key findings, communication about SRH issues, knowledge about SRH issues, behaviour about SRH issues, determinants associated with parent- adolescent knowledge behaviour and communication about SRH issues, and the contribution of the study.

Mechanisms need to be in place to make adolescents aware of SRH matters to reduce risky behaviours, and to enhance knowledge on risky behaviours to ensure preventive measures and enhance contraceptive and condom use services. Parent, adolescents, school community, health professionals and involvement of the community are critical for the successful implementation of any intervention guideline that may be proposed. The next chapter presents the guideline for improving parent-adolescent communication on sexual and reproductive health issues.

CHAPTER 6 - GUIDELINES FOR IMPROVING PARENT-ADOLESCENT COMMUNICATION ON SEXUAL AND REPRODUCTIVE HEALTH ISSUES

6.1 INTRODUCTION

This chapter provides guidelines for improving parent-adolescent communication on SRH issues. The guideline was designed by this research findings, relevant aspects of the literature reviewed, the theoretical framework of the study, and investigator findings. These guided interventions were formulated to improve PCC on SRH issues and enhance regular discussions between in-school adolescents and their parents on common SRH issues to advise in-school adolescents about risky sexual behaviours.

6.2 BACKGROUND AND MOTIVATION FOR GUIDELINE DEVELOPMENT

Guidelines are recommendations intended to assist recipients and providers of health care and other stakeholders to make informed decisions to achieve the best health outcomes possible, individually, or collectively. Recommendations made related with clinical interventions, public health activities and government policies (WHO 2014).

A guideline is designed to integrate knowledge into policies and practices to blend a set of evidence for a particular situation, disease, mechanisms, or treatment and propose specific recommendations that assists to make decisions for healthcare planning, programming, monitoring, and improvement (Kim et al 2020). Strengthening the use of well-developed, research-based implementation guidelines is a crucial objective for healthcare services and individual professionals (Busse et al 2019). Thus, developing guidelines for parents and adolescents to improve parent-adolescent partnership for communicating SRH issues that meet the needs and expectations of parents and their adolescents. Guidelines which address in-school adolescents' preferences are more likely to be used because the recommendations reflect adolescent priorities and are aligned with the cultural values and age-specific communication skills that can address major barriers hindering PCCs. The guideline helps to engage adolescents in communicating SRH issues with their parents which then advises

them against risky sexual behaviours, thus leading to higher rates of guideline adherence by both parents and their adolescents. Unlike many other guidelines, this guideline addresses and considers the experience of parents and their adolescent's partnership on communicating SRH issues.

6.3 SCOPE OF THE GUIDELINE

The guideline is primarily intended for parents and their in-school adolescents to improve communication on SRH issues, as well as schoolteachers and health professionals to enhance communication skills and knowledge of adolescents and parents regarding SRH matters. Further, it contributes to the strategic planning and decision-making of health management and policymakers to integrate comprehensive sexuality education in the school curricula to advise in-school adolescents against risky sexual behaviours.

6.4 PURPOSE OF THE GUIDELINE

The objective of the communication guideline is to guide and support parents in enhancing closer communication and discussion with their adolescents on SRH issues. It helps as a tool guide for parents, schoolteachers and health professionals on how to communicate with adolescents to enhance their knowledge in making informed decisions, serves as a source of information, and highlights gaps from the parent's perspective. As the development of guidelines for improving PCC was a decisive endpoint for this study, the guidelines focus on the concerns and needs of parents and their adolescents as derived from the study results.

6.5 OBJECTIVES OF THE GUIDELINE

The objectives of the guidelines are to:

i. Capacitate the parents with sexual reproductive health knowledge and communication in order to improve parent-adolescent discussion on sexual and reproductive health.

ii. Enhance schoolteachers and health professionals' ability to promote sexuality and reproductive health information and services.
iii. Increase comprehensive knowledge of adolescents on sexual and reproductive health matters.
iv. Minimize risky sexual behaviours for STI/HIV and other sexual and reproductive health problems among in-school adolescents.
v. Generate evidence-based and adolescent friendly sexual and reproductive health information and services.
vi. Serve as a tool for monitoring and evaluating PCC levels.

6.6 THE PROCESS OF DEVELOPING THE GUIDELINES

The guideline development process adhered to the following key steps recommended by WHO Guideline Development Handbook - 2nd edition (WHO 2014).

6.6.1 Planning

The researcher first identified the scope and purpose of the guideline development to decided what would or would not be included by considering the following issues:

i. The objectives of the guideline.
ii. Focused target beneficiaries.
iii. Availability of other similar guidelines.
iv. The stakeholders to be engaged in the guideline development and use.

The stated issues were considered and applied during the guideline development.

6.6.2 Development

The strategy guideline development is informed by comprehensive literatures review followed by a quantitative survey, aims to guide efforts to strengthen evidence-based guidance for parenting of adolescents. The major focus areas for the guideline development

are in-school adolescent substance use; risky sexual behaviours; PCC on SRH issues; barriers for PCC; parent-adolescent knowledge on common SRH issues and predictors of PCC on SRH issues. All major focus areas are considered in the development of the guideline, and the developed guidelines reflect the preferences of study participants in the process of improving communication. Moreover, the UNICEF programming guidance for parenting of adolescents was applied to provide a structure to the guidelines (UNICEF 2021). The final guidelines are divided into six main themes: caring with love, warmth, and affection; increasing knowledge about adolescent development; respectful communication; employing positive discipline techniques; creating safe environments and providing for basic needs for improving PCC on SRH issues.

6.6.3 Validation

The adolescent and youth reproductive health team under the ministry of health, experts on the field of SRH and researchers reviewed the draft guideline document to reach an agreement on the content and determine its feasibility in the Ethiopian context. The supervisor also reviewed the draft guidelines document.

6.6.4 Implementation

The researcher consulted and incorporated feedback from experts to complete the guideline development. The final guideline will be implemented as an integrated approach to improve PCC on SRH issues.

6.7 APPLYING HOLISTIC PRINCIPLES TO THE DEVELOPMENT OF THE GUIDELINE

Based on the UNICEF Parenting of Adolescent's Programme Guidance, parents should play an essential role in capacitating adolescents how they interact with the complex, interlinked situations that shape their development. Not only having positive parental relationships enhances developmental outcomes for adolescents, but effective parenting can solve the

impact of negative external factors. In addition, the influence of parenting practices can extend across generations. Building on parents' existing knowledge, strengths and equipping them to provide support to their adolescent through a parenting programming has the potential to have a crucial positive influence on adolescent development.

Parenting programmes of adolescents should consider:

i. Use a strengths-based approach that acknowledges parents' existing skills and experience, and which in turn supports them to adopt the strengths of their adolescents.
ii. Enhance gender-equitable norms and minimize exposure to gender-specific risks.
iii. Promote meaningful participation of adolescents within their families and communities, according to their evolving capacities.
iv. Be inclusive of all parents and guardians, including the most marginalised, to meet the needs of their adolescent.
v. Rely on the sizeable existing knowledge based on parenting of adolescents.

6.8 FORMULATION OF GUIDELINES FOR IMPROVING PARENT-ADOLESCENT PARTNERSHIP ON SEXUAL AND REPRODUCTIVE HEALTH ISSUES

The developed guidelines comprise six major focus areas. These include:

i. Promote loving, warm and affectionate relationships between parents and their adolescent, using age-appropriate strategies, to promote adolescent well-being.
ii. Improve parents' knowledge of adolescent physiological, cognitive, social, and emotional development, to enable them to meet their adolescent's needs more effectively.
iii. Develop parental skills to communicate respectfully with adolescents in a manner that respects their evolving capacities.
iv. Support parents to employ positive, non-violent discipline techniques that rely on communicating expectations and setting parameters around adolescents' behaviour.
v. Empower parents to create safe environments, by reducing exposure to risks, and to assisting their adolescent children to access support services.

vi. Support parents to provide adolescents' basic needs, such as through the inclusion of parenting programmes in social protection schemes supporting families living in poverty, whilst taking account of adolescents' growing decision-making roles in the household

Table 6.1: Summary of interventions for improving parent-adolescent communication on sexual and reproductive health issues in Addis Ababa city, Ethiopia.

Guidelines	**Interventions**
Programmes that promote parental warmth to strengthen their relationships with their adolescent	i. Encourage demonstration of love and affection with adolescents ii. Create multiple points of entry for interventions targeting parents' knowledge, skills, and confidence, which are vital to helping adolescent achieve healthy sexual development and may help to break the intergenerational cycle of shame. iii. Advocate for interventions that engages parents, especially fathers, to help them develop their confidence, knowledge and skills to discuss SRH information with their adolescents in order to destigmatize parent- adolescent communication on SRH issues. iv. Provide adolescents with regular praise to feel being heard v. Show interest in adolescents' ideas and activities vi. Set aside time to spend with adolescents vii. Consider how to meet their emotional needs and provide support, including stressors resulting from risky sexual behaviour. viii. Programmes should address differences for younger and older adolescents, as well as adolescents with disabilities.
Increasing knowledge about adolescent development	i. Integrate content on usual adolescent development into interventions ii. Build parental awareness of how to help adolescents access sexual and reproductive health information and services and support for their needs, iii. Provide counselling to adolescents on risky taking behaviours to prevent them from substance use iv. Empower parents to discuss with their adolescents about mitigating misuse of substances, engaging in protected sex, communicating regarding sexuality and reproductive health issues to keep them healthy. v. Build parents' knowledge, skills and confidence in their ability to discuss sensitive issues such as sexual and reproductive health issues with their adolescents vi. Enhance parental knowledge of risk reduction strategies. Parents are better equipped to support

	their adolescent if their own knowledge about protective behaviours, such as condom use and contraception, is accurate vii. Improve access to sexual and reproductive health education, discussion and skills building for adolescents viii. Enhance parents on increasing their adolescents awareness to risky sexual behaviours and prevention mechanisms ix. Increase parental participation (male and female) in adolescent care activities.
Respectful communication	i. Promote mutual respect within and between generations through modelling of respectful communication in sessions ii. Ensure parent–adolescent connectedness and promote regular discussion on common sexual reproductive health matters appropriate to the adolescents age and development. iii. Develop parents' skills to engage with adolescents around sensitive issues, and decisions that need to be made for the well-being of the adolescent and their family iv. Improve parental awareness of adolescents' needs for information and safe platforms for discussing sensitive topics, such as sexual and reproductive health, mental health and substance use, as well as empowering them to have the confidence to communicate with their adolescent on these issues v. Improve parent-adolescent engagement around sexual and reproductive health issues (such as puberty, unwanted pregnancy, sexuality, STI/HIV prevention, abstinence, condom and contraceptive use) vi. Parents need to provide adolescents with opportunities for their views to be heard and considered, particularly in contexts where adolescents are not encouraged to express themselves openly vii. Parents should listen their adolescents and allow them to feel being heard, prevent being ashamed and embarrassed and create conducive environment for cultural appropriateness.
Employing positive discipline techniques	i. Develop parental skills to engage with their adolescent around behaviour change and discipline which are developmentally appropriate according to their adolescent's age. ii. Support parents to jointly plan with their adolescents how to avoid poor behaviour and risky situations, including sexual risk-taking iii. Show parents how to role model positive behaviours and non-violent approaches to conflict resolution

	iv. Provide opportunities to adolescents to initiate and give input regarding behavioural expectations and consequences v. Engage adolescents in school health and anti-HIV/AIDS clubs.
Creating safe environments	i. Capacitate parents on the nature of the risks that adolescents face, including risk-taking behaviour, unwanted pregnancy, unprotected sexual practice and sexual abuse ii. Show parents how to seek services, or support adolescents to access services as they become more independent iii. Promote parent-adolescent communication, joint decision-making on setting limits and family routines iv. Build networks and connections with schools, peers and custodians of other social environments where adolescents spend time to promote safe and supportive environments v. Parents of adolescents at risk of self-harm should be supported to restrict access to alcohol, tobacco, Khat, drugs and others vi. Maintaining a close relationship is critical for parents to be able to recognise when their adolescent is in at-risk situation, such as experiencing unprotected sex, sexual abuse or violence, or engaging in risky behaviours including substance use vii. Develop family media plans (appropriate rules around internet use, limits for social media use etc) viii. Promote monitoring (not control) of internet use (e.g. keeping device in shared space) and jointly setting rules about internet use ix. Model appropriate behaviour of healthy internet use, e.g. restricting their own phone usage and having a respectful online presence x. Co-using media with adolescents xi. Encouraging internet use that supports social interaction xii. Develop adolescents' skills to engage online responsibly and maintain privacy xiii. Raise parental awareness of adolescent sexual behaviour, substance use and peer pressure xiv. Improve age-appropriate positive discipline techniques xv. Shift social norms that are harmful to adolescents.
Providing for basic needs	i. Include socio-economic strengthening components, such as cash transfers, material support, membership of savings clubs, and financial education ii. Support parents to gradually engage with adolescents about decision-making for the family, according to their evolving capacities

	iii. Empower parents to communicate with adolescents about the economic impact of risky sexual behaviours on their family and mitigating that impact iv. Improve adolescent communication and negotiation skills v. Increase opportunity for adolescents to express their views and participate in decision-making in families vi. Shift of social norms that prevent adolescents from participating in their communities vii. Encourage adolescents to engage in religious activities.

6.9 CONCLUSION

This chapter discussed the developed guidelines for improving PCC on SRH issues. The guidelines are designed to guide PCC; encourage in-school adolescents and parents' connectedness to openly discuss common SRH issues and feel comfortable enough to seek support and information promptly by encouraging communication. Policymakers, health care administrators, and professionals can use this set of guidelines as a resource in their initiatives to enhance PCC on SRH issues. The last chapter will present the key research findings conclusion and recommendations part of the study.

CHAPTER 7 - CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

The previous chapter presented the guidelines designed to enhance PCC on SRH issues. In this part, the conclusions emanated from the main study findings and the recommendations made by the researcher are described. Moreover, the contribution of this study to the existing knowledge and the limitations of the study are also presented. The chapter ends by summarizing the overall conclusions of the study.

7.2 RESEARCH DESIGN AND METHOD

A school and residence – based cross-sectional study was applied using a quantitative study approach that involved in-school adolescents paired with their parents and/ or guardians. The study used non-experimental cross-sectional techniques that describe the distribution of the key profile or characteristics of the study participants that applied institution-based study techniques for in-school adolescents followed by involving their parents and/ or guardians at their residences. This study design helped to collect information on the associated predictors and the extent of PCC on SRH issues at a time. The research methods of this study were written in accordance with STROBE guidelines. This study relied on quantitative research methods that gathered numerical data to measure or categorize the extent of adolescent-parent discussion about SRH matters through rigorous analysis and interpretation of the findings. It assists to identify the patterns of PCC about SRH issues, its relationship, and making generalizations.

7.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

7.3.1 Knowledge about sexual and reproductive health matters

More than eight out of ten (83.4%) of in-school female adolescents knew when menstruation starts. This result is consistent with a study finding undertaken in other part of Ethiopia (Woreta) where 72.8% of the adolescents knew when their first menses started (Wudineh et al 2021). More than one-third, (37.5%), experienced fear when they started menses. The majority (85.2%) of in-school adolescents knew about STI/HIV. This study finding is lower than one from a study conducted in Ethiopia (Arekit) where 96.9 % of participants knew about STI/HIV (Toru et al 2022). Most (85.8%) of the study participants knew about contraceptives. This research finding is higher than a finding conducted in Indonesia and Gambia where 51.68% and 67.3% of adolescents only know that HIV/AIDS is a sexually transmitted disease, respectively (Putri et al 2022; Sagnia et al 2020). The majority (84.7%) of parents had heard about contraceptives. This study is lower than a study conducted in Indonesia and Ethiopia where 98.71% and 93.7% of parents have heard about contraception, respectively (Bekele et al 2022; Putri et al 2022; Wakjira et al 2022). The majority (89%) of in-school adolescents stated that they have different sources of information regarding SRH issues. One-fifth, (20.4%) of in-school adolescents received information from parents. This finding is also a bit higher than a study finding conducted in Ethiopia where 68.5% of adolescents received SRH information and 52% mentioned the main source of information are their peers or friends (Abdurahman et al 2022).

7.3.2 Behaviour about sexual and reproductive health issues

Almost one-in-twenty in-school adolescents, (5.3%) smoked cigarettes, and 6.6% of them have chewed Khat. Nearly one-fourth (23%) of in-school adolescents have drunk alcohol. This study finding is lower than a study conducted in Thailand where 20.8% smoke cigarettes and 40.9% have drunk alcoholic beverages in the last 30 days before the study (Thepthien & Celyn 2022). This variation might be as a result of cultural and living habits of the adolescents. Similarly, parents also practiced risky behaviours, 6.8% smoked cigarettes, more than one-fifth (21.4%) of the parents chewed Khat and nearly half (45.7%) drank

alcohol. More than one-fourth (28.3%) of in-school adolescents have had sexual intercourse. This finding is similar with a study undertaken in Ethiopia (Dabat and Guduru) where 30.4% and 29.8% of in-school adolescents had sexual intercourse (Adam et al 2020; Wakasa et al 2021). Among sexually active in-school adolescents, nearly half (45%) had sexual practices with multiple sexual partners. More than half (54.4%) of the sexually active in-school adolescents did not use condom during sexual intercourse. From among the pregnant in-school adolescents, 70% had terminated their pregnancy (aborted) and 30% of them gave birth. This result is also consistent with the research finding conducted in Ethiopia (Dabat) where more than half of the sexually active adolescents ever used condoms during their first sexual commencement (Adam et al 2020).

7.3.3 Communication about sexual and reproductive health issues

Majority of in-school adolescents communicated at least one SRH issue with their parents. This finding is relatively consistent with a study conducted in Ethiopia (Haiyk & Agaro) areas where the adolescents communicated SRH issues with their parents (Abdissa & Sileshi 2023; Chane & Cherie 2018). This finding is relatively higher than a study finding conducted in Ethiopia (Jimma) that established that the proportion of adolescents who communicated with their parents on SRH issues was low (Abraham et al 2022). However, comprehensive communication about common SRH matters with their parents in the present study finding was very low at 5.7%. The majority (86.5%) of in-school adolescents stated that they never discussed SRH issues with their fathers. This finding is consistent with a study conducted in Ethiopia (Jimma) that found that 90.4% had never discussed issues with their mothers, and 93.4% never discussed issues with their fathers (Abraham et al 2022).

7.3.4 Factors associated with parent- adolescent communication, knowledge and behaviour about sexual and reproductive health issues

The present study has showed that barriers to effective communication between in-school adolescents and parents on SRH issues were cultural unacceptability, feeling ashamed, it being difficult or too embarrassing to talk about SRH issues, comprehensive knowledge and communication skills gap. This study finding is consistent with a study finding in Oman revealed that the common barriers to parent adolescent SRH communication were feelings

of shyness, fear, discomfort and shame; socio-cultural norms; gender mismatch; and lack of adequate SRH knowledge (Zaabi et al 2022). Similarly, this study finding is consistent with a study conducted in Zambia that found that parenting style, children's perception of parental attitudes and parental communication styles are associated with whether or not parents and adolescents communicate about sexual issues (Isaksen et al 2020). This study is also similar with a finding conducted in South Africa where embarrassment when discussing sexual topics; and cultural and religious beliefs were found to be communication barriers (Motsomi et al 2016). In addition, the major barriers found in this study are similar with a study undertaken in Ethiopia which indicated that communications are gender dependent, inhibited by intergenerational cultural taboo, parental knowledge on such communications, fear, and embarrassment to communicate (Yibrehu & Mbwele 2020). Furthermore, parental attitude towards SRH issues has significant impact on PCC and intergenerational cultural unacceptability to talk about sexual issues (Bekele et al 2022; Taye et al 2023). The grade level of in-school adolescents, religion, and have the knowledge on SRH issues were found to be the determinant factors associated with adolescent-parent communication. In-school adolescents' sex, age, religion, lived with and fathers' occupation were statistically associated with their knowledge about SRH issues with their parents. In-school adolescents' sex, age, and knowledge about SRH issues were significantly associated with their behaviour about SRH issues. Parental age and educational status about SRH issues was significantly associated with parents' communication about SRH issues with their in-school adolescents. Parental communication about SRH issues with their adolescents increases as their age level increased. Parent's sex, age and educational status were significantly associated with parental knowledge about SRH issues with their adolescents.

7.4 CONCLUSIONS

The major findings in this study indicated the enormous challenges and factors leading in-school adolescents to engage in substance use, early sexual initiation, risky sexual behaviours and its negative impacts. While the extent of knowledge of adolescents about different SRH issues comprising, risky sexual behaviours, unwanted pregnancy, contraceptive use and STI/HIV was high, there are still knowledge gaps on the risks linked with risky sexual behaviours among adolescents. Comprehensive discussion among in-school adolescents and their parents on selected SRH issues were found to be low in Addis

Ababa, Ethiopia, something that needs to be improved to assist in-school adolescents in avoiding risky sexual behaviours. The major reasons indicated by adolescents for not communicating SRH issues with their parents were feeling ashamed, lack of knowledge, feeling embarrassed and cultural unacceptability. Effective PCC on SRH issues is a factor that can influence adolescents towards adopting safer sexual behaviour to prevent teenage pregnancies, sexually transmitted infections, and other risky sexual behaviours. Parent-adolescent joint actions can accelerate a more comprehensive approaches to ensure adolescent health.

It is suggested that efforts should be reinforced to make adolescents aware about SRH, mechanisms to reduce risky sexual behaviours, and to enhance awareness on preventive measures and uptake of contraceptive and condom use services. The SRH knowledge, behaviour and communication of adolescents could also be enhanced through them participating in different health clubs in-school and out-of-school. Interventions are needed to improve communication between parents and their adolescents through equipping and educating both on common SRH issues. This resulted to the development of evidence-oriented intervention guidelines to improve PCC on SRH issues. Parents, adolescents, school community, health professionals and community participation are key players for the success of the proposed guideline implementation.

7.5 RECOMMENDATIONS

Based on the major study findings the researcher outlined the following recommendations:

7.5.1 Recommendations to the parents and adolescents

i. Promote regular communication among adolescents and parents on sexual and reproductive health issues and its consequences.
ii. Create a positive environment, and effective communication between parents and their adolescents through capacitating adolescents to enhance the overall sexual and reproductive health conditions.

iii. Enhance parental connectedness and monitoring, parents are the primary source of information to their adolescents.
iv. Communicating with adolescents regularly; promote abstinence and faithfulness to prevent adolescents from early sexual initiation and exposure to risky sexual behaviours
v. Promote useful cultural beliefs that do not encourage risky sexual practices among adolescents.

7.5.2 Recommendations to secondary schools and health systems

i. Secondary schools and health institutions should promote parental knowledge concerning the importance of communicating sexual and reproductive health matters with their adolescents and its implication on reducing the negative outcomes related to risky sexual practices by educating the parents about adolescent sexual and reproductive health. This can be achieved during school parent days, mass campaign, school family committees, official gatherings, open days and religious institutions.
ii. Establish and strengthen health clubs and adolescent friendly service centres, mini-medias within school compounds which should be managed, organized and strengthened by the student, school and parent committee representatives.
iii. School-based sexual and reproductive health information and awareness interventions should be inculcated as part of the study curricula starting from primary schools and incorporate age targeted advanced messages about sexual and reproductive health for higher grades.
iv. Provision of regular school health information and promotion programmes by health professionals focused on sexual and reproductive health.
v. Incorporate demonstrations to enhance appropriate use of condoms in the health education programmes provided to adolescents.
vi. Provide evidence-driven facts related to pregnancy and its negative outcomes and enhance use of family planning including emergency contraceptives and condom
vii. Health institutions should give priority on providing adolescent-friendly sexual and reproductive health services to prevent risky sexual behaviours and ensure early screening, treatment of sexually transmitted infections and ensure comprehensive abortion care services.

viii. Use peer-to-peer educators and schoolteachers to make adolescents aware of the benefits of sexual and reproductive health information and services.

7.5.3 Recommendations to the Government and Non-governmental organizations

i. A significant number of adolescents experienced early sexual initiation before completing secondary school. Hence, comprehensive sexuality and reproduction Education should be provided to in-school adolescents with the necessary advice, information and tools for reducing risky behaviours.
ii. The Government should incorporate sexual and reproductive health information and trainings in primary and secondary schools curricula, support deployment and retention of adequate numbers of trained experts and allocate appropriate time for implementation of the interventions.
iii. According to the existing utilization rate analysis, ensure availability of condoms at and around the schools in accessible and confidential sites.

7.5.4 Recommendations to the medias

i. Enhance information and sensitization campaigns on risky sexual behaviours and its impacts through local and national broadcasting medias like radio and television mainstreaming's including printed media plat forms.
ii. Make readily available comprehensive and reliable information in a simple and easily understandable language focusing parents and adolescents.

7.6 CONTRIBUTION OF THE STUDY

The finding showed that a significant number of adolescents at secondary schools are sexually active and experience unsafe sexual practices. In-school adolescents communication on comprehensive SRH issues with their parents was found to be low. The major reasons identified were feeling embarrassed, cultural unacceptability, feeling ashamed

and a lack of communication skills. This study was useful because it carried out within the specific study context. Therefore, based on the major findings, and recommendations, intervention guidelines that will address the identified challenges were stipulated. This study can further serve as a basis for other similar studies among adolescents in different settings in Ethiopia.

7.7 STRENGTHS OF THE STUDY

The secondary schools' staff (especially teachers) were very cooperative during the entire process which has added to the credibility of the study, and most of the adolescents in this study were in the age range of 15-19 years, keen on participating in the study, and were easily accessible during study period. The response rate was 96.4% for the in-school adolescents and 87.3% among their parents.

The study has assessed knowledge, behaviour, and communications of adolescents and parents on common SRH issues, risky sexual behaviours, and identified major barriers to communications which the study participants encountered. The involvement of adolescents from all grades based on their proportion and applying a random technique to achieving a representative sample size are a major strength of this study. In addition, the findings, conclusions and recommendations can be generated within the limits of accuracy and reliability on a targeted population segment of similar phenomena. The study utilised in-school adolescents paired with their parents. Similarly, the pre-tested structured instrument that was used to collect quantitative data from both in-school adolescents and their parents has enabled an insight into the complex pattern of sexual practices in this segment of most vulnerable population. The developed guidelines on improving PCC on SRH issues and for reducing risky sexual behaviours among adolescents and parents have been designed based on the quantitative findings, which are focused and readily implementable.

7.8 LIMITATION OF THE STUDY

The major limitation of this research was the cross-sectional nature of the study design which did not show the temporal relationship between the dependent variables and some of the

explanatory variables. The study topic covered very sensitive and personal issues related to sexuality and reproduction which might have caused social desirability bias to the study participants. The study was undertaken in Addis Ababa, Ethiopia and only among in-school adolescents paired with their parents from four selected secondary schools. Hence, the findings are valid for in-school adolescents attending secondary schools in Addis Ababa and may not be generalized to the national and out-of-schools adolescents. However, the findings of this study could be used as a valuable indicator for other areas where Addis Ababa city residents are heterogeneous populations originating from all parts of the country. Thus, the key findings of this research result should be interpreted with these limitations.

7.9 SUMMARY

This concluding chapter presented the key conclusions and recommendations drawn from the completion of the study and discusses the contribution, strengths and main limitations of the study. This study revealed that adolescents engaged in risk-taking behaviours such as substance use and exposure to risky sexual behaviours. Although the extent of knowledge on STIs/HIV/AIDS and contraceptive information among the studied participants is found to be good, still there are knowledge gap on the associated risky sexual practices among adolescents. This study has also indicated a poor level of comprehensive PCC on SRH issues among the studied population. The developed guideline for improving PCC on SRH issues can result in a meaningful contribution to catalysing the existing investments in reducing risky sexual behaviours among adolescents. In summary, the need for further studies to understand the contribution of each factor on the outcome and to strengthen the ongoing efforts to reduce risky sexual practices in the targeted population groups.

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APPENDIX A1: - QUESTIONNAIRE FOR THE IN-SCHOOL ADOLESCENTS

English Version questionnaire

Adolescent parent partnership guidelines for improving communication on sexual and reproductive health in Ethiopia.

Questionnaire No: _____

Introduction

My name is (Data collector) _____. I am working for ----------

Confidentiality and consent: I am going to give you this questionnaire to be filled by yourself. Your answers are completely confidential, your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer and you may end completeing the questionnaire at any time you want to. However, your honest and accurate answers to these questions will help us better understand about the level of parent- adolescent communication and factors affecting it on sexual and reproductive health matters and design guidelines to improve communication. If you need additional information or clarification you can contact the principal investigator Mr Alemayehu Bogale through his mobile: +251910309303. We would greatly appreciate your helping. Are you willing to participate?

If Yes, _____ (1) Continue If No, _____ (2) Stop.

Checked by supervisor:

Name: _____Signature: _____Date:_____

Questionnaire to assess parent - adolescent communication on sexual and reproductive health to be filled by the adolescent

I. Socio demographic characteristics of adolescents

S/n	Question	Response	Code
101	What is your age	_____in years	
102	What is your grade?	1. 9^{th} 2. 10^{th} 3. 11^{th} 4. 12^{th} 5.	
103	What is your sex	1. Male 2. Female	
104	What is your religion	1. Orthodox Christian 2. Muslim 3. Protestant 4. Catholic 99. Others, specify	
105	How often do you attend religious services ?	1. Every day 2. At least once in a week 3. At least once in a month 4. At least once in a year 5. Never at all 99. Others, specify ----------	
106	What is your ethnic group	1. Amhara 2. Oromo 3. Tigray 4. Gurage 5. Wolaiyta 99. Others, specify----------	

107	With whom do you usually live?	1. With my father & mother 2. With my mother only 3. With my father only 4. With grand parents 5. With relatives 6. With friends 7. Alone 99. Others, specify ----------	
108	What is your family size?	_____	
109	How do you perceive the economic status of your family?	1. Poor 2. Medium 3. Rich	
110	What is the level of your mother's educational status?	1. Illiterate 2. Read and write only 3. Primary school (1-8) 4. Secondary school (9-12) 5. Diploma 6. Degree 7. Masters and above	
111	What is the level of your father's educational status?	1. Illiterate 2. Read and write only 3. Primary school (1-8) 4. Secondary school (9-12) 5. Diploma 6. Degree 7. Masters and above	
112	Occupation of the mother	1. House wife 2. Employed (private) 3. Employed (gov't) 4. Small scale merchant 5. Farmers 99. Others, specify_____	

113	Occupation of the father	1. Employed (private) 2. Employed (gov't) 3. Small scale merchant 4. Farmers 99. Others, specify_____	
114	Do you smoke cigarettes?	1. I have never smoked 2. I have tried once or twice 3. I smoke from time to time 4. I smoke daily 99. Other, specify ----------	
115	Do you chew khat?	1. I have never chewed 2. I have tried once or twice 3. I chew from time to time 4. I chew daily 99. Others, specify ----------	
116	Do you drink alcoholic beverages?	1. I have never drank 2. I have tried once or twice 3. I drink from time to time 4. I drink daily 99. Others, Specify ----------	
117	Do you have pocket money?	1. Yes 2. No	
118	Do you work for pay and have income of your own?	1. Yes 2. No	
119	If you have income /paid, what is your average monthly income?	_____birr/month	

II. Knowledge on Major selected Reproductive health

201	Do you know when the menstrual cycle starts?	1. Yes 2. No	
202	If yes, at what age does it start	_____in years	
203	**For girls only**: What was your feeling when you first started to menstruate?	1. Tension 2. Fear 3. Pleasure 4. Feeling diseased 5. Shame 6. Do not see 99. Others, specify_____	
204	Do you know STIs/HIV/AIDS? If your answer is 'No' skip to question no 206	1. Yes 2. No	
205	If yes which one do you know (circle all answer you think)	1. Chancroid 2. Syphilis 3. Gonorrhea 4. HIV/AIDS 5. Herpes simplex 99. Others (Specify)---------	
206	Do you know contraceptive methods? If your answer is 'No' skip to question no 208	1. Yes 2. No	
207	If yes which one do you know? (Circle all answer you think)	1. Pills 2. Depo provera 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	

III. Sexual attitude and behaviour of adolescents

301	Is it normal and acceptable to have sexual feeling during adolescent?	1. Yes 2. No 88. Do not know	
302	Have you ever started sexual intercourse? If your answer is 'No' skip to question no 310	1. Yes 2. No	
303	If yes at what age was your first sexual act?	_____years	
304	With whom have you made your first sex?	1. Boy/girl-friend 2. Relative 3. Unknown person	
305	With how many partner/s have you had sex?	1. One 2. Two 3. Three and above	
306	Have you ever used condom during sex? If your answer is 'No' skip to question no 308	1. Yes 2. No	
307	If yes do you use a condom consistently?	1. Yes 2. No	
308	Have you ever-experienced unwanted pregnancy? (for girls only) If your answer is 'No' skip to question no 310	1. Yes 2. No	
309	If yes how did you managed it?	1. Deliver 2. Abortion	
310	Do you accept premarital sex?	1. Yes 2. No 88. Do not know	
311	Do you think sex education is necessary? If your answer is 'No' skip to question no 313	1. Yes 2. No 88. Do not know	

312	Where do you prefer sex education to be given? (Circle all answers you think)	1. School 2. Home 3. By Friends 4. Church 99. Others, specify ……	
313	Where did you get information about sexual matters? (Circle all answer you think)	1. School 2. Media 3. Home 4. Peers 99. Others, specify……...	

IV. Adolescents perception of parental monitoring

401	What is your view to parental monitoring on adolescents?	1. Agree 2. Disagree 3. Do not know	
402	**For males only** Did parents ever forbid you to play with female?	1. Yes 2. No 3. Do not know	
403	If yes at what ages did they forbid you?	_____age in years	
404	**For females only**: Did parents ever forbid you not to play with males?	1. Yes 2. No 3. Do not now	
405	If yes at what ages did they forbid you?	_____age in years	
406	Do parents know where, when you are outside from home/school?	1. Yes 2. No 3. Do not know	
407	Do parents know with whom are you, when outside home/school?	1. Yes 2. No 3. Do not know	

V. Communication of adolescents and parents on sexual and reproductive health

501	Do you have any source of information about sexuality and reproductive health?	1. Yes 2. No	
502	From which person or from where do you learn most about sexuality and reproductive health? (More than one answer is possible)	1. My parent 2. My friends/peer 3. My partner (husband or Wife) 4. My boy or girl friend 5. Health institution 6. School 7. Religious leaders 8. Newspaper, posters 9. Radio/TV 10. Other family members 99. Others, specify--------	
503	How easy do you find talking to your father about anything important to you?	1. Very easy 2. Easy 3. Difficult 4. Very difficult 99. Others specify……..	
504	How often do you discuss sex related issues with your father?	1. Often 2. Occasionally 3. Never	
505	How easy do you find talking to your mother about anything important to you?	1. Very easy 2. Easy 3. Difficult 4. Very difficult 5. Others specify……..	
506	How often do you discuss sex related issues with your mother?	1. Often 2. Occasionally 3. Never	
507	How often do you discuss sex related issues with your friends and relatives?	1. Often 2. Occasionally 3. Never	

508	Is it important to discuss (communicate) sexual issues with parents?	1. Yes 2. No	
509	Which parent do you prefer to discuss sexual and RH issues.	1. Mother 2. Father	
510	Have you ever discussed on contraception? If your answer is 'Yes' skip to question no 512	1. Yes 2. No	
511	If you do not discuss on contraception with parents. What do you think 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 88. Do not know 99. Others, Specify ____	
512	If yes to question # 510 with whom do you prefer to discuss with?(circle all answers you think)	1. Father 2. Mother	
513	How frequent do you have discussions about contraception?	1. Very often 2. Often 3. Sometimes	
514	With whom have you discussed contraceptives with other than parents	1. Peer/friends 2. Sisters 3. Brothers 99. Others, specify_____	
515	How frequent do you discuss about contraception with other people who are not your parents?	1. Very often 2. Often 3. Sometimes	

516	Have you ever discussed on STI/HIV? If yes skip to Q 518	1. Yes 2. No	
517	If you do not discuss on STI/HIV 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 88. Do not know 99. Others, specify _____	
518	If yes for question # 516 with whom do you discuss?	1. Mother 2. Father	
519	How frequent do you have discussions about STI/HIV?	1. Very often 2. Often 3. Sometimes	
520	With whom have you discussed about STI/HIV other than parents	1. Peer/friends 2. Sisters 3. Brothers 99. Others, specify_____	
521	How frequent have you discussed about STI/HIV other than parents?	1. Very often 2. Often 3. Sometimes	
522	Have you ever discussed on sexuality? If yes skip to #522	1. Yes 2. No	
523	If you do not discuss on sexuality 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 88. Do not know 99. Others, Specify_____	
524	If yes for question # 522 with whom do you discuss	1. Father 2. Mother	

525	How frequent do you have discussions about sexuality?	1. Very often 2. Often 3. Sometimes	
526	With whom discussed other than parents	1. Peer 2. Sisters 3. Brothers 99. Others, specify_____	
527	How frequent you have discussed about sexuality?	1. Very often 2. Often 3. Sometimes	
528	Have you ever discussed about unwanted pregnancy? If yes skip to # 530	1. Yes 2. No	
529	If you do not discuss on unwanted 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 good listener. 6. Difficult and embarrassing 88. Do not know 99. Others, specify_____	
530	If yes for question # 528 with whom do you discuss?	1. Father 2. Mother	
531	How frequent you have discussed about unwanted pregnancy?	1. Very often 2. Often 3. Sometimes	
532	With whom discussed other than parents	1. Peer/friends 2. Sisters 3. Brothers 99. Others, specify_____	

533	How frequent you have discussed about unwanted pregnancy?	1. Very often 2. Often 3. Sometimes	
534	Have you ever discussed on abstinence until marriage? If your answer is yes skip to Q536	1. Yes 2. No	
535	If you don't discuss on abstinence until marriage with parents. What are the reasons? (Circle all answer you think)	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Lack of communication skill 5. Parents are not good listener 6. Difficult and embarrassing 88. Do not know 99. Others, specify_____	
536	If yes for question # 534 with whom do you discuss?	1. Father 2. Mother	
537	How frequent you have discussed about on abstinence before marriage?	1. Very often 2. Often 3. Sometimes	
538	With whom do you discussed other than parents on abstinence before marriage?	1. Peer/friends 2. Sisters 3. Brothers 99. Others, specify_____	
539	How frequent you have discussed about abstinence until marriage?	1. Very often 2. Often 3. Sometimes	
540	Have you ever discussed on condom use? If your answer is no skip to Q542	1. Yes 2. No	

541	If you don't discuss on condom use with parents, what are the reasons? (circle all answer you think)	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Lack of communication skill 5. Parents are not good listener 6. Difficult and embarrassing 88. Do not know 99. Others, specify_____	
542	If yes for question # 540 with whom do you discuss?	1. Father 2. Mother	
543	How frequent you have discussed about condom use?	1. Very often 2. Often 3. Sometimes	
544	With whom discussed other than parents	1. Peer / friends 2. Sisters 3. Brothers 99. Others, specify_____	
545	How frequent you have discussed on condom use?	1. Very often 2. Often 3. Sometimes	
546	Have you ever discussed on physical and psychological changes on puberty? If your answer is yes skip to Q548	1. Yes 2. No	
547	If you don't discuss on physical and psychological changes on puberty With parents. What are the reasons? (circle all answer you think)	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Lack of communication skill 5. Parents are not good listener 6. Difficult and embarrassing 88. Do not know 99. Others, specify_____	

548	If Yes for question # 546 with whom do you discuss?	1. Father 2. Mother	
549	How frequent you have discussed about puberty?	1. Very often 2. Often 3. Sometimes	
550	With whom discussed other than parents	1. Peer / friends 2. Sisters 3. Brothers 99. Others, specify_____	
551	How frequent you have discussed on physical and psychological changes on puberty?	1. Very often 2. Often 3. Sometimes	
552	If you have ever discussed at least one of the above issues with your parents, at what age have you started discussing it?	……age in years	
553	At what age do you think discussion on sexual and reproductive health should be started?	……age in years	
554	Do you currently discuss on the above issues?	1. Yes 2. No	
555	How do you rate parent communication skill about sexual matters	1. Low 2. Medium 3. High	

APPENDIX A2: - QUESTIONNAIRE FOR IN-SCHOOL ADOLESCENTS TRANSLATED TO THE LOCAL LANGUAGE “AMHARIC”

አባሪ 1: ለሁለተኛ ደረጃ ተማሪዎች የተዘጋጀ በራሳቸው የሚሞላ መጠይቅ

ወጣት ልጆች ከወላጆቻቸው ጋር በወሲብና ስነ-ተዋልዶ ጤና ጉዳይ ያላቸውን የመወያየት መስተጋብር ለማጥናትና የማሸሻያ መመሪያ ለማዘጋጀት የተዘጋጀ ለ3ተኛ ዲግሪ ማሟያ የምርምርጥናት መጠይቅ አዲስ አበባ፡ ኢትዮጵያ::

መለያ ቁጥር : _____

መግቢያ

ስሜ_____ ይባላል።የዚህን ምርምር መጠይቅ ለማስሞላት እያስተባበርኩ እገኛለሁ።

የምርምር ጥናቱ ሚስጥር ጠባቂነትና ስምምነት::

ይህ መጠይቅ በራስዎ የሚሞላ ነው።መልስዎት በሚስጥር የተጠበቀ ነው:: ስምዎትን መፃፍ አይጠበቅብወትም:: የሰጡት መልስ ለሁለተኛ ወገን ተላልፎ አይሰጥም:: መመለስ ያልፈለጉትን መጠይቅ አለመመለስ ይችላሉ እንዲሁም ካልተመቸወት ማቋረጥ ይችላሉ።መልስዎን በታማኝነትና በቅንነት ከመለሱልን የወጣቶችንና የወላጆችን ወሲባዊ ግንኙነት እና ስነ-ተዋልዶ ጤና መስተጋቦት ለማሻሻል መመሪያ ለማውጣት ያግዛል።ከዚህ በላይ ማብራሪያ ከፈለጉ በዚህ ስልክ ቁጥር በመደወል የበለጠ መረጃ ማግኘት ይችላሉ። አቶ አለማየሁ ቦጋለ: +251910309303. ስለ ትብብርዎ እና ተሳትፎዎ በቅድሚያ እናመሰግናለን።

ጥያቄዉን ለመሙላት ፍቃደኛ ነዎት? አዎ----------

አይደለሁም----------

የተቆጣጣሪ ስም፡_____ፊርማ፡_____ቀን_____

ወላጆች ከጎረምሳ/ኮረዳ ልጆቻቸዉ ጋር በወሲባዊ ግንኙነት ጉዳይ ና በስነ-ተዋልዶ ጤና ላይ የሚያደርጉትን ውይይት ለማጥናት የተዘጋጀ መጠይቅ

I. መሰረታዊና ማህበራዊ ጉዳይን በተመለከተ

ተ/ቁ	ጥያቄ	መልስ	ኮድ
101	እድሜ	……..በአመት	
102	ክፍል	1. 9ኛ 2. 10ኛ 3. 11ኛ 4. 12ኛ	
103	ጸታ	1. ወንድ 2. ሴት	
104	ሀይማኖት	1. ኦርቶዶክስ 2. ሙስሊም 3. ፕሮቴስታንት 4. ካቶሊክ 99.ሌላካለይገለፀ _____	
105	የሀይማኖት አገልግሎት በምን ያህል ጊዜ ይከታተላሉ ?	1. በየቀኑ 2. ቢያንስ በሳምንት አንዴ 3. ቢያንስ በወር አንዴ 4. ቢያንስ በአመት አንዴ 5. አልከታተልም	
106	ብሄር	1. አማራ 2. ኦሮሞ 3.ትግሬ 4. ጉራጌ 5. ወላይታ 99.ሌላካለይገለፀ_____	
107	አብዛኛውን ጊዜ የምትኖረው/ሪው ከማን ጋር ነው?	1. ከእናትና አባትህ/ሽ ጋር 2. ከእናቴ ጋር ብቻ 3. ከአባቴ ጋር ብቻ 4. ከአያቶች ጋር 5. ከዘመዶች ጋር 6 ከጓደኞች ጋር 7. ለብቻየ 99. ሌላ ካለ ይገለጽ----------	
108	የቤተሰብ ብዛት ስንት ነው?	_____በቁጥር ይገለጽ	

109	የቤተሰቦችሽ/ህ የገቢ ሁኔታ እንዴት ታየዋለሽ/ህ	1. ድሃ 2. መካከለኛ 3. ሀብታም	
110	የእናትህ/ሽ የትምህርት ደረጃ ምን ያህል ነው?	1.ያልተማረች 2. ማንበብና መጻፍ 3. አንደኛ ደረጃ(1-8) 4. ሁለተኛ ደረጃ(9-12) 5. ዲፕሎማ 6. ዲግሪ 7. ማስተርስ እና ከዚያ በላይ	
111	የአባትህ/ሽ የትምህርት ደረጃ ምን ያህል ነው?	1. ያልተማረ 2. ማንበብና መጻፍ 3. አንደኛ ደረጃ(1-8) 4. ሁለተኛ ደረጃ(9-12) 5. ዲፕሎማ 6. ዲግሪ 7. ማስተርስ እና ከዚያ በላይ	
112	የእናትህ/ሽ የስራ ሁኔታ?	1.የቤት እመቤት 2. የግል ሰራተኛ 3. የመንግስት ሰራተኛ 4. ነጋዴ 5. ገበሬ 99.ሌላካለይገለፅ	
113	የአባትህ/ሽ የስራ ሁኔታ	1. የግል ሰራተኛ 2. የመንግስት ሰራተኛ 3. ነጋዴ 4. ገበሬ 99.ሌላካለ ይገለፅ_____	
114	ሲጋራ ታጨሳለህ/ሽ?	1. በፍፁም አላጨስም 2. አንዴ ወይም ሁለቴ አጭሽ አውቃለሁ 3. አልፎ አልፎ አጨሳለሁ 4. በየቀኑ አጨሳለሁ 99.ሌላ ካለ ይገለፅ----------	
115	ጫት ትቅማለህ/ሚያለሽ?	1. በፍፁም ቅሜ አላውቅም 2. አንዴ ወይም ሁለቴ ቅሜ አውቃለሁ 3. አልፎ አልፎ እቅማለሁ 4. በየቀኑ እቅማለሁ 99. ሌላ ካለ ይገለፅ ----------	

116	የአልኮል መጠጥ ትጠጣለህ /ጫለሽ?	1. በፍፁም አልጠጣም 2. አንዴ ወይም ሁለቴ ጠጥቸ አውቃለሁ 3. አልፎ አልፎ እጠጣለሁ 4. በየቀኑ እጠጣለሁ 99.ሌላ ካለ ይገለፅ----------	
117	የኪስ ገንዘብ ታገኛለህ/ሽ	1. አዎ 2. የለም	
118	ገንዘብ የሚያስገኝ ስራ ትሰራለህ/ሽ?	1. አዎ 2. የለም	
119	ስራ ካለህ/ሽ የወር ገቢህ/ሽ ምን ያህል ይሆናል?	_____ኢትዩጵያ ብር በወር አገኛለሁ	

II. በተመረጡ ዋና ዋና የስነ-ተዋልዶ ጤና ጉዳይ ላይ ያለዎትን ግንዛቤ ለመዳሰስ የተዘጋጀ መጠይቅ

201	የወር አበባ መቼ እንደጀመርሽ ታውቂያለሽ? (ለሴት ብቻ የሚሞላ) መልስዎ እስከአሁን አልጀመርሁም ከሆነ ወደ ጥያቄ ቁጥር 204 ይለፉ	1. አዎ 2. አላቅም 3. እስከአሁን አልጀመርሁም	
202	ካወቅሽ በስንት አመት ነበር የወር አበባ ያየሽው	_____አመት	
203	የመጀመርያ ቀን የወር አበባ ሲመጣ ምን ስሜት ተሰምቶሽ ነበር ? (በሴት ብቻ የሚሞላ)	1. ጭንቀት 2. ፍርሀት 3. የደስታ ስሜት 4. የህመም ስሜት 5. መሸማቀቅ 6. እስከአሁን ድረስ የወር አበባ አላየሁም 99. ሌላ ካለ ይገለፅ----------	
204	ስለ አባላዘር በሽታ ኤድስን ጨምሮ ሰምተሽ/ህ ታውቂያለሽ/ህ? መልስዎ የለም ከሆነ ወደ ጥ.ቁጥር 206 ይለፉ	1. አዎ 2. የለም	

205	ከተዘረዘሩት የአባላዘር በሽታዎች ውስጥ የትኛውን ያውቃሉ (መልስ የመሰለህን/ሽን ሁሉ አክብብ)	1. ከርክር 2. ቂጥኝ 3. ጨብጥ 4. ኤድስ 5. አልማዝ ባለጭራ 99. ሌላ ካለ ይገለፅ----------	
206	ስለ ወሊድ መከላከያ ሰምተሸ/ህ ታውቂያለሽ/ህ? መልስዎ የለም ከሆነ ወደ ጥ.ቁጥር 208 ይለፉ	1. አዎ 2. የለም	
207	ከተዘረዘሩት የወሊድ መከላከያ ዘዴዎች ውስጥ የትኛውን ያውቃሉ (መልስ የመሰለህን/ሽን ሁሉ አክብብ)	1. የሚዋጥ እንክብል 2. በመርፌ የሚሰጥ 3. በክንድ ስር የሚቀበር 4. በማህፀን ውስጥ የሚቀመጥ 5. ኮንዶም 6. መታቀብ 7. በካሌንደር መጠቀም	
208	ድንገተኛ የወሊድ መከላከያ ያዉቃሉ	1. አዎ 2. የለም	
209	እርግዝና መቼ ሊከሰት እንደሚችል ያውቃሉ ?	1. አዎ 2. የለም	

III. የወጣቶች የወሲባዊ ግንኙነት አመለካከት እና ባህሪ

301	በወጣትነት ወቅት የወሲባዊ ፍላጎት አግባብ ነው ብለው ያስባሉ?	1. አዎ 2.. አይደለም 88. አላውቅም	
302	ወሲባዊ ግንኙነት ጀምረሀል /ሻል? መልስዎ የለም ከሆነ ወደ ጥ.ቁጥር 310 ይለፉ	1. አዎ 2. የለም	
303	ወሲባዊ ግንኙነት የጀመርህው/ሽው በስንት አመት ነበር?	_____አመት	

304	ወሲባዊ ግንኙነት የጀመርህው/ሽው ከማን ጋር ነበር?	1. ከሴት /ወንድ ጓደኛ ጋር 2. ከዘመድ 3. ከማይታወቅ ሰው ጋር	
305	ምን ያህል የፍቅር ጓደኛ ነበረህ /ሽ?	1. አንድ 2. ሁለት 3. ሦስትና ከዚያ በላይ	
306	በወሲባዊ ግንኙነት ጊዜ ኮንዶም ተጠቅመህ/ሽ ታውቃለህ/የለሽ? መልስዎ የለም ከሆነ ወደ ጥ.ቁጥር 308 ይለፉ	1. አዎ 2. የለም	
307	ኮንዶም አጠቃቀማችሁ እንዴት ነበር?	1. ሁልጊዜ 2. በአብዛኛው 3. አልፎ አልፎ	
308	ያልተፈለገ እርግዝና አጋጥሞሽ ያዉቃል?(በሴቶች ብቻ የሚመለስ) መልስዎ የለም ከሆነ ወደ ጥ.ቁጥር 310 ይለፉ	1. አዎ 2. የለም	
309	ያልተፈለገ እርግዝና ከተፈጠረ በኋላ ምን አደረግሽ?	1. ተወለደ 2. እርግዝናው ተቋረጠ	
310	ከጋብቻ በፊት የሚደረግ የወሲብ ግንኙነትን ትደግፋለህ/ሽ?	1. አዎ 2. አልደግፍም 88. አላውቅም	
311	ስለ-ወሲባዊ ግንኙነት ማስተማር አስፈላጊ ነው ትላለህ/ያለሽ? መልስዎ አያስፈልግም ከሆነ ወደ ጥ.ቁጥር 313 ይለፉ	1. አዎ 2. አያስፈልግም 88. አላውቅም	
312	ስለ-ወሲባዊ ግንኙነት ትምህርት የት ቢሰጥ የተለሻ ይሆናል? (መልስ የመሰላችሁን ሁሉ አክብብ)	1. ትምህርት ቤት 2. ቤት 3. በጓደኞች 4. በእምነት ቦታ 99. ሌላ ካለ ይገለፅ ……	

313	ስለ ወሲባዊና ስነ-ተዋልዶ ጤና መረጃ ከየት ትሰማለህ/ሽ? (መልስ የመሰላችሁን ሁሉ አክብብ)	1. ትምህርት ቤት 2. ሚዲያ 3. ከቤት 4. ከጓደኞች 99. ሌላ ካለ ይገለፅ ----------	

IV. ወጣቶች በወላጆቻቸው ክትትልና ቁጥጥር ዙሪያ ያላቸው አመለካከት

401	የወላጆችህ/ሽ የቁጥጥር እና ክትትል ሁኔታ እንዴት ታየዋለህ/ያለሽ ?	1. አግባብ ነው 2. አግባብ አይደለም 3. አላውቅም	
402	**<u>ለወንዶች ብቻ</u>**፤ ወላጆችህ ከሴት ጓደኛ ጋር እንዳትጫወት ይከለክሉሀል?	1. አዎ 2. አይከለክሉኝም 3. አላውቅም	
403	ከተከለከልክ በስንት አመትህ ጀምሮ ነበር መከልከል የጀመርህው ?	_____በስንት አመት	
404	**<u>ለሴቶች ብቻ</u>** ፡ወላጆች ከወንድ ጓደኛ ጋር እንዳትጫወች ይከለክሉሽ ነበር ?	1. አዎ 2. አይከለክሉኝም 3. አላውቅም	
405	ከተከለከልሽ በስንት አመትሽ ጀምሮ ነበር መከልከል የጀመርሽው?	_____አመት	
406	ወላጆች የት እና በምን ስዓት ከቤት ወይም ትም/ት እንደምትሆኑ ያውቃሉ?	1. አዎ 2. አያውቁም 3. አላውቅም	
407	ወላጆች ልጃቸው ከት/ት ቤት ወይም ቤት ውጭ ከማን ጋር እና የት እንደምትውሉ ያወቃሉ?	1. አዎ 2. አያውቁም 3. አላውቅም	

V. ወላጆችና ወጣት ልጆቻቸው በወሲባዊ ግንኙነትና ስነ-ተዋልዶ ጤና ያላቸው ተግባቦት

501	ስለ ወሲባዊ ግንኙነትና ስነ-ተዋልዶ የጤና መረጃ ያገኛሉ?	1. አዎ 2. የለም	
502	ስለ ወሲባዊ ግንኙነትና ስነ-ተዋልዶ የጤና መረጃ ከማን ወይም ከየት በብዛት ያገኛሉ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ከወላጆች 2. ከጓደኞች 3. ከባለቤቴ 4. ከሴት ወይም ወንድ ጓደኛየ 5. ከጤና ድርጅት 6. ከትምህርት ቤት 7. ከእምነት አባቶች 8. ከጋዜጣ/ፖስተር 9. ከሬዲዮ/ቲቪ 10. ከሌላ የቤተሰብ አባላት	
503	ከአባት ጋር አንዳንድ ጠቃሚ ውይይቶች መወያየት ምን ያህል ቀላል ነው ብለህ/ሽ ታስባለህ/ሽ?	1. በጣም ቀላል 2. ቀላል 3. ከባድ 4. በጣም ከባድ 99. ሌላ ካለ ይገለፅ……..	
504	ከአባትህ/ሽ ጋር ስለ ወሲባዊ ግንኙነት በምን ያህል ጊዜ ትወያያላችሁ?	1. ብዙ ጊዜ 2. አልፎ አልፎ 3. መቸም ተወያይተን አናዉቅም	
505	ከእናትህ/ሽ ጋር አንዳንድ ጠቃሚ ውይይቶች መወያየት ምን ያህል ቀላል ነው ብለህ/ሽ ታስባለህ/ቢያለሽ?	1. በጣም ቀላል 2. ቀላል 3. ከባድ 4. በጣም ከባድ	
506	ከእናትህ/ሽ ጋር ስለ ወሲባዊ ግንኙነት በምን ያህል ጊዜ ትወያያላችሁ?	1. ብዙ ጊዜ 2. አልፎ አልፎ 3. መቸም ተወያይተን አናዉቅም	

507	ከጓደኛህ/ሽ እና ከዘመድ ጋር ስለ ወሲባዊ ግንኙነት በምን ያህል ጊዜ ትወያያላችሁ?	1. ብዙ ጊዜ 2. አልፎ አልፎ 3 መቸም ተወያይተን አናዉቅም	
508	ከወላጆች ጋር ስለ ወሲባዊ ግንኙነት መወያየት ጥቅም አለው?	1. አዎ 2. የለውም	
509	ከእናትና ከአባት ስለ ወሲባዊ ግንኙነት እና ስነ-ተዋልዶ ጤና ለመወያየት ማን የተሻለ ነው?	1. አባት 2. እናት	
510	ስለወሊድ መከላከያ ተወያይታችሁ ታውቃላችሁ? መልስዎ አዎ ከሆነ ወደ ጥያቄ ቁጥር 512 ይለፉ	1. አዎ 2. የለም	
511	ስለወሊድ መከላከያ ማትወያዩ ከሆነ ምክንያቱ ምንድን ነው?	1. ባህሉ ስለማይፈቅድ 2. ስለማፍር 3. እውቀት ስለሌለኝ 4. መግባባት ስለማልችል 5. ወላጆቸ ስለማያዳምጡኝ 6. ከባድና አስጨናቂ ስለሆነ 88. አላውቅም 99. ሌላ ካለ ይገለፅ ---	
512	ለጥያቄ ቁጥር 510 አዎ ካልህ/ሽ ከማን ጋር መወያየት ትመርጣለህ/ሽ ?	1. ከአባቴ 2. ከእናቴ	
513	ስለወሊድ መከላከያ በምንያህል ጊዜ ትወያያላችሁ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3. አልፎ አልፎ	
514	ስለወሊድ መከላከያ ከወላጅ ውጭ ከማን ጋር ትወያያለህ/ሽ?	1 ከጓደኞቸ ጋር 2 ከእህቶቸ ጋር 3. ከወንድሞቸ ጋር 99 . ሌላ ካለ ይገለፅ---------	
515	ስለወሊድ መከላከያ በምን ያህል ጊዜ ከወላጆች ውጭ ትወያያለህ/ሽ ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	

516	ስለኤችአይቪ ኤድስና አባላዘር በሽታዎች ተወያይታችሁ ታውቃላችሁ? መልስዎ አዎ ከሆነ ወደ ጥ.ቁጥር 518 ይለፉ	1. አዎ 2. የለም	
517	ስለ ኤችአይቪ ኤድስና አባላዘር በሽታዎች ካልተወያያችሁ ምክንያቱ ቢገለፅ?	1.ባህሉ ስለማይፈቅድ 2.ስለማፍር 3.እውቀት ስለሌለኝ 4.መግባባት ስለማልችል 5.ወላጆቸ ስለማያዳምጡኝ 6.ከባድና አስጨናቂ ስለሆነ 88. አላውቅም 99. ሌላ ካለ ይገለፅ ----------	
518	ጥያቄ ቁጥር # 516 አዎ ያላችሁ ከማን ጋር ነው የምትወያዩት?	1. ከእናት 2. ከአባት	
519	ስለኤችአይቪ ኤድስና አባላዘር በሽታ በምን ያህል ጊዜ ተወያያላችሁ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	
520	ስለ ኤችአይቪ ኤድስና አባላዘር በሽታዎች ከወላጆች ውጭ ከማን ጋር ተወያያለህ/ሽ?	1. ከጓደኞቸ ጋር 2. ከእህቶቸ ጋር 3 .ከወንድሞቸ ጋር 99. ሌላ ካለ ይገለፅ---------	
521	ስለ ኤችአይቪ- ኤድስና አባላዘር በሽታዎች ከወላጆች ውጭ በምን ያህል ጊዜ ትወያያለህ/ሽ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	
522	ስለወሲባዊ ግንኙነት ተወያይታችሁ ታቃላችሁ? መልሱዎ አዎ ከሆነ ወደ ጥያቄ ቁጥር 524 ይለፉ	1. አዎ 2. የለም	

523	ስለወሲባዊ ግንኙነት ካልተወያይችሁ ምክንያቱ ምንድንነው ?	1.ባህሉ ስለማይፈቅድ 2.ስለማፍር 3.እወቀት ስለሌለኝ 4.መግባባት ስለማልችል 5.ወላጆቸ ስለማያዳምጡኝ 6.ከባድና አስጨናቂ ስለሆነ 88. አላውቅም 99. ሌላ ካለ ይገለፅ _____	
524	ጥያቄ ቁጥር 522 አዎ ካሉ ከማን ጋር ተወያያለህ/ሽ	1. ከአባቴ ጋር 2. ከእናቴ ጋር	
525	ስለወሲባዊ ግንኙነት በምን ያህል ጊዜ ተወያያላችሁ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	
526	ስለወሲባዊ ግንኙነት ከወላጆች ውጭ ከማን ጋር ተወያያለህ/ሽ?	1. ከጓደኞቼ ጋር 2. ከእህቶቼ ጋር 3 .ከወንድሞቼ ጋር 99. ሌላ ካለ ይገለፅ---------	
527	ከወላጆች ውጭ ስለወሲባዊ ግንኙነት በምን ያህል ጊዜ ተወያያላችሁ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	
528	ስላልተፈለገ እርግዝና ተወያይተሽ/ህ ተውቃለህ/ቂያለሽ? አዎ ከሆነ መልሱ ወደ ጥያቄ ቁጥር 530 ይለፉ	1. አዎ 2. የለም	

529	ስለአልተፈለገ እርግዝና ከወላጆች ጋር ካልተወያይችሁ ምክንያቱ ምንድን ነው?	1.ባህሉ ስለማይፈቅድ 2.ስለማፍር 3.እዉቀት ስለሌለኝ 4.መግባባት ስለማልችል 5.ወላጆቸ ስለማያዳምጡኝ 6.ከባድና አስጨናቂ ስለሆነ 88. አላውቅም 99. ሌላ ካለ ይገለፅ _____	
530	ጥያቄ ቁጥር 528 አዎ ካሉ ከማን ጋር ትወያያለሽ/ህ?	1. ከአባቴ ጋር 2. ከእናቴ ጋር	
531	ስለአልተፈለገ እርግዝና በምን ያህል ጊዜ ትወያያለሽ/ህ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	
532	ስለአልተፈለገ እርግዝና ከወላጅ ውጭ ከማን ጋር ትወያያለሽ/ህ	1. ከጓደኞቼ ጋር 2. ከእህቶ ጋር 3 .ከወንድሞቼ ጋር 99. ሌላ ካለ ይገለፅ_____.	
533	ስለአልተፈለገ እርግዝና በምን ያህል ጊዜ ከወላጆች ውጭ ተወያያላችሁ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	
534	መታቀብ እሰከ ጋብቻ ድረስ በሚል ሀሳብ ተወያይተው ያውቃሉ? አዎ ከሆነ መልስዎ ወደ ጥያቄ ቁጥር 536 ይለፉ	1. አዎ 2. የለም	

535	መታቀብ እሰከ ጋብቻ ድረስ የሚለውን ሀሳብ ካልተወያዩ ምክንያቱ ምንድን ነበር? (መልስ ያላችሁትን ሁሉ ያክብቡ)	1.ባህሉ ስለማይፈቅድ 2.ስለማፍር 3.እዉቀት ስለሌለኝ 4.መግባባት ስለማልችል 5.ወላጆቸ ስለማያዳምጡኝ 6.ከባድና አስጨናቂ ስለሆነ 88. አላውቅም 99. ሌላ ካለ ይገለፅ ----------	
536	ለጥያቄ ቁጥር 534 አዎ ካሉ መታቀብ እሰከ ጋብቻ ድረስ የሚለውን ሀሳብ ከማን ጋር ትወያያለሽ/ህ?	1. ከአባቴ ጋር 2. ከእናቴ ጋር	
537	መታቀብ እሰከ ጋብቻ ድረስ በሚል ሀሳብ ምን ያህል ጊዜ ተወያያላችሁ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	
538	መታቀብ እሰከ ጋብቻ ድረስ በሚል ሀሳብ ከወላጅ ውጭ ከማን ጋር ትወያያለህ/ሽ?	1. ከጓደኞቸ ጋር 2. ከእህቶቸ ጋር 3. ከወንድሞቸ ጋር 99. ሌላ ካለ ይገለፅ----------	
539	መታቀብ እሰከ ጋብቻ ድረስ በሚል ሀሳብ ከወላጅ ውጭ በምን ያህል ጊዜ ትወያያለህ/ሽ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	
540	ስለከንዶም መጠቀም ተወያይተው ያዉቃሉ?መልስዎ አዎ ከሆነ ወደ ጥያቄ ቁጥር 542 ይለፉ	1. አዎ 2. የለም	

541	ስለከንዶም መጠቀም ማትወያዩ ከሆነ ምክንያቱ ምንድን ነው ? (ምክንያትዎን ያክብቡ)	1.ባህል ስለማይፈቅድ 2.ስለማፍር 3.ግንዛቤው ስለሌለኝ 4.መግባባት ስለማልችል 5.ወላጆቸ ስለማያዳምጡኝ 6.ከባድና አስጨናቂ ስለሆነ 88. አላውቅም 99. ሌላ ካለ ይገለፅ ----------	
542	ጥያቄ ቁጥር 540 መልስህ/ሽ አዎ ከሆነ ከማን ጋር ነው?	1. ከ አባቴ 2. ከእናቴ	
543	ስለከንዶም መጠቀም ምን ያህል ጊዜ ትወያያለህ/ሽ ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	
544	ከወላጆችህ/ሽ ውጭ ከማን ጋር ትዋያያለህ/ሽ?	1. ከጓደኞቼ ጋር 2. ከእህቶቼ ጋር 3 .ከወንድሞቼ ጋር 99. ሌላ ካለ ይገለፅ_____.	
545	ስለከንዶም መጠቀም ከወላጆችህ/ሽ ውጭ ምን ያህል ትወያያለህ/ሽ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	
546	ከጉርምስና/ኮረዳነት ጋር ተያይዞ ከሚመጡ አካላዊ እና ስነልቦናዊ ለውጦች ከወላጆችህ/ሽ ጋር ተወያይተህ/ሽ ታውቂያለሽ/ቃለህ? መልስህ/ሽ አዎ ከሆነ ወደ ጥያቄ ቁጥር 548 ይለፉ	1. አዎ 2. የለም	

547	ከጉርምስና/ኮረዳነት ጋር በተየያዘ ከሚመጡ አካላዊ እና ስነልቦናዊ ለውጦች ከወላጆችህ/ሽ ጋር ተወያይተህ/ሽ የማታውቁ ከሆነ ምክንያቱ ምንድን ነው?(መልስ ነው የምትሉአቸውን ሀሳቦች አክብቡ)	1.ባህል ስለማይፈቅድ 2.ስለማፍር 3.ግንዛቤው ስለሌለኝ 4.መግባባት ስለማልችል 5.ወላጆቸ ስለማያዳምጡኝ 6.ከባድና አስጨናቂ ስለሆነ 88. አላውቅም 99. ሌላ ካለ ይገለፅ ----------	
548	ለጥያቄ ቁጥር 546 መልስዎ አዎ ከሆነ ከማን ጋር ይወያያሉ?	1. ከአባቴ ጋር 2.ከእናቴ ጋር	
549	ስለጉርምስና/ኮረዳነት በምን ያህል ጊዜ ይወያያሉ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	
550	ከወላጆች ውጭ ከማን ጋር ይወያያሉ?	1. ከጓደኞቼ ጋር 2. ከእህቶቼ ጋር 3 .ከወንድሞቼጋር 99. ሌላ ካለ ይገለፅ_____	
551	ስለአካላዊ እና ስነልቦናዊ ለውጦች በምን ያህል ጊዜ ይወያያሉ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	
552	ከላይ ከተገለፁት ጉዳዮች ቢያንስ በአንዱ ጉዳይ ከወላጆችህ/ሽ ጋር የምትወያዩ ከሆነ ስንት አመት ሲሆንህ/ሽ መወያያት ጀመራችሁ?	.....በአመት ይገለፅ	
553	ስለወሲባዊ ግንኙነት እና ስነ-ተዋልዶ ጤና ውይይት ከወላጆች ጋር በስንት አመት ጀምሮ መካሄድ አለበት ትላለህ/ሽ?	.....በአመት ይገለፅ	

554	ከላይ የተጠቀሱትን ጉዳዮች አሁን ላይ ከወላጆችህ/ሽ ጋር ትወያያላችሁ?	1. አዎ 2. የለም	
555	የወላጆችህን/ሽን ከግብረ-ስጋ ግንኙነት እና ተያያዥ ጉዳዮች ከወጣት ልጆቻቸው ጋር ያላቸውን የተግባቦት ክህሎት እንዴት ትለካዋለህ/ኪዋለሽ	1. ዝቅተኛ 2. መካከለኛ 3. ከፍተኛ	

APPENDIX B1: - QUESTIONNAIRE FOR PARENTS OF THE SELECTED IN-SCHOOL ADOLESCENTS

English version questionnaire

Adolescent-parent partnership guidelines for improving communication on sexual and reproductive health in Ethiopia.

Questionnaire code No: _____

Introduction

My name is _____. I am working for _____.

Confidentiality and consent: I am going to conduct face to face interview with you using this structured questionnaire. Your answers are completely confidential, your name will not be written on this form, and will never be used in connection with any of the information you tell me. You will not be forced to answer any questions that you do not want to answer and you may discontinue the interview process if you are not willing to proceed at any time. However, your honest and accurate answers to these questions will help us better understand about the level of parent- adolescent communication and factors affecting it on sexual and reproductive health matters and design guideline to improve communication. If you need additional information or clarification you can contact the principal investigator Mr Alemayehu Bogale through his mobile: +251910309303. We would greatly appreciate your cooperation and kind support in advance. Would you willing to participate?

If Yes, _____ (1) Continue If No, _____ (2) Stop.

Checked by supervisor:

Name: _____Signature: _____Date:_____

Questionnaire to assess parent - adolescent communication on sexual and reproductive health to be collected from the selected in-school adolescent parents

I. Socio demographic characteristics of parents

S/n	Question	Response	Code
101	What is your age	_____ in years	
102	What is your sex	1. Male 2. Female	
103	What is your religion?	1. Orthodox Christian 2. Muslim 3. Protestant 4. Catholic 5. Others	
104	What is your ethnicity?	1. Amhara 2. Oromo 3. Tigray 4. Gurage 5. Wolaiyta 99. Others	
105	Are you living with your husband/wife together?	1. Yes 2. No	
106	If you are not living with your spouse, what is the reason?	1. Divorced 2. Widowed 3. Living in other cities or countries 99. Other specify_____	
107	What is the number of your family size	_____	
108	Educational status of the parent	1. Illiterate 2. Read and write only 3. Primary school (1-8) 4. Secondary school (9-12) 5. Diploma 6. Degree 7. Masters and above	

109	Occupation of the parent	1. Housewife 2. Employed (private) 3. Employed (gov't) 4. Small scale merchant 5. Farmers 99. Others, specify_____	
110	Do you smoke cigarettes?	1. I have never smoked 2. I have tried once or twice 3. I smoke occasionally 4. I smoke daily 99. Other, specify ----------	
111	Do you chew khat?	1. I have never chewed 2. I have tried once or twice 3. I chew occasionally 4. I chew daily 99. Others, specify ----------	
112	Do you drink alcoholic beverages?	1. I have never drank 2. I have tried once or twice 3. I drink occasionally 4. I drink daily 99. Others, Specify ----------	

II. Knowledge on Major selected Reproductive health

201	Do you know when your daughter/s starts menstruation?	1. Yes 2. No	
202	If yes, at what age did your daughter start menstruating?	_____in years	
203	What was your daughters feeling when she started menstruating?	1. Tension 2. Fear 3. Pleasure 4. Feeling diseased 5. Shame 6. Do not see	
204	Do you know STIs/HIV/AIDS? If your answer is 'No' skip to question no 206	1. Yes 2. No	
205	If yes which one do you know (circle all answer you think)	1. Chancroid 2. Syphilis 3. Gonorrhea 4. HIV/AIDS 5. Herpes simplex 99. Others (Specify)---------	
206	Do you know contraceptive methods? If your answer is 'No' skip to question no 208	1. Yes 2. No	
207	If yes which one do you know? (Circle all answer you think)	1. Pill 2. Depo provera 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	

III. Sexual attitude and behaviour of parents

301	Do you think it is normal and acceptable to have sexual feeling during adolescent?	1. Yes 2. No 88. Do not know	
302	At what age would it be appropriate for an adolescent to start sexual relationship? started sexual intercourse?	_____years	
303	With how many sexual partners you had sexual intercourse during your adolescence time?	1. One 2. Two 3. Three and above	
304	Do you believe that adolescents should use condoms? If your answer is 'No' skip to question no 307	1. Yes 2. No	
305	If yes, are they expected to use consistently?	1. Yes 2. No	
306	Have you ever-experienced unwanted pregnancy? (for mothers only) If your answer is 'No' skip to question no 310	1. Yes 2. No	
307	If yes, how did you manage it?	1. Deliver 2. Abortion	
308	Do you accept premarital sex?	1. Yes 2. No 88. Do not know	
309	Do you think sex education is necessary? If your answer is 'No' skip to question no 313	1. Yes 2. No 88. Do not know	

310	Where do you prefer sex education to be given? (Circle all answers you think)	1. School 2. Home 3. By Friends 4. Church 99. Other specify ……	
311	Where do you think adolescents should get information about sexual matters? (Circle all answer you think)	1. School 2. Media 3. Home 4. Peers 99. Other specify……...	

IV. Parents perception on adolescent monitoring

401	What is your view on monitoring adolescents?	1. Agree 2. Disagree 3. Do not know	
402	For father only. Did you ever forbid your son to play with female adolescents?	1. Yes 2. No 3. Do not know	
403	If yes at what ages did you forbid him?	_____age in years	
404	For mother only. Did you ever forbid your daughter not to play with male adolescents?	1. Yes 2. No 3. Do not now	
405	If yes at what ages did you forbid her?	_____age in years	
406	Do you know where and when your adolescent child is outside from home/school?	1. Yes 2. No 3. Do not know	
407	Do you know with whom are your adolescent children, when outside home/school?	1. Yes 2. No 3. Do not know	

V. Communication of adolescents - parents on sexual and reproductive health

501	Do you have any source of information about sexuality and reproductive health?	Yes No	
502	From which person or from where do you learn most about sexuality and reproductive health? (More than one answer is possible)	My parent My friends/peer My partner (husband or Wife) Health institution School Religious leaders Newspaper, posters	
503	How easy did you find it to talk to your adolescent son about anything important to him?	Very easy Easy Difficult Very difficult	
504	How often did you discuss sex related issues with your son?	Often Occasionally	
505	How easy did you find it to talk to your adolescent daughter about anything important to her?	Very easy Easy Difficult Very difficult	
506	How often did you discuss sex related issues with your adolescent children?	Often Occasionally Never	
507	How often did you discuss sex related issues with your friends and relatives?	Often Occasionally Never	
508	Is it important to discuss (communicate) sexual issues with adolescents?	Yes No	
509	Which adolescent children do you prefer to discuss on sexual and RH issues.	Son Daughter	

510	Have you ever discussed on contraception? If your answer is 'Yes' skip to question no 512	Yes No	
511	If you do not discuss on contraception with your adolescent. What do you think the reasons?	Culturally unacceptable Shame Lack of knowledge Lack of communication skill Adolescents are not good listener Difficult and embarrassing 88. Do not know 99. Others, specify	
512	If yes to question # 510 with whom do you prefer to discuss on it? (circle all answers you think)	Son Daughter	
513	How frequent you have discussed about contraception?	Very often Often Sometimes	
514	With whom have you discussed other than adolescents	Peer/friends Sisters Brothers 99. Others, specify	
515	How frequent you have discussed about contraception other than adolescents?	Very often Often Sometimes	
516	Have you ever discussed on STI/HIV? If yes skip to Q 518	Yes No	

517	If you do not discuss on STI/HIV with your adolescent children. What are the reasons?	Culturally unacceptable Shame Lack of knowledge Lack of communication skill Adolescents are not good listener Difficult and embarrassing 88. Do not know 99. Others, Specify____	
518	If yes for question # 516 with whom does you discuss?	1. Son 2. Daughter	
519	How frequent you have discussed about STI/HIV?	1. Very often 2. Often 3. Sometimes	
520	With whom have you discussed other than adolescents	1. Peer/friends 2. Sisters 3. Brothers 99. Others, specify_____	
521	How frequent have you discussed about STI/HIV other than adolescent children?	1. Very often 2. Often 3. Sometimes	
522	Have you ever discussed on sexuality? If yes skip to #524	1. Yes 2. No	
523	If you do not discuss on sexuality with your adolescent. What are the reasons?	Culturally unacceptable Shame Lack of knowledge Lack of communication skill Adolescents are not good listener Difficult and embarrassing 88. Do not know	

524	If yes for question # 522 with whom do you discuss	1. Son 2. Daughter	
525	How frequent you have discussed about sexuality?	1. Very often 2. Often 3. Sometimes	
526	With whom you discussed other than your adolescent /s	1. Peer/Friends 2. Sisters 3. Brothers 99. Others specify____	
527	How frequent you have discussed about sexuality?	1. Very often 2. Often 3. Sometimes	
528	Have you ever discussed about unwanted pregnancy? If yes skip to # 530	1. Yes 2. No	
529	If you do not discuss on unwanted pregnancy with your adolescents. What are the reasons?	Culturally unacceptable Shame Lack of knowledge Lack of communication skill adolescents are not good listener Difficult and embarrassing 88. Do not know 99. Others, specify_____	
530	If yes for question # 528 with whom do you discuss?	1. Son 2. Daughter	
531	How frequent you have discussed about unwanted pregnancy?	1. Very often 2. Often 3. Sometimes	
532	With whom you discussed other than adolescents	1. Peer/friends 2. Sisters 3. Brothers 99. Others specify_____	

533	How frequent you have discussed about unwanted pregnancy?	1. Very often 2. Often 3. Sometimes	
534	Have you ever discussed on abstinence until marriage? If your answer is yes skip to Q536	1. Yes 2. No	
535	If you don't discuss on abstinence until marriage with your adolescent/s. What are the reasons? (Circle all answer you think)	Culturally unacceptable Shame Lack of knowledge Lack of communication skill Adolescents are not good listener Difficult and embarrassing 88. Do not know 99. Others, Specify	
536	If yes for question # 534 with whom do you discuss?	1. Son 2. Daughter	
537	How frequent you have discussed about on abstinence before marriage?	1. Very often 2. Often 3. Sometimes	
538	With whom do you discussed other than adolescents on abstinence before marriage?	1. Peer/friends 2. Sisters 3. Brothers 99. Others, specify____	
539	How frequent you have discussed about abstinence until marriage?	1. Very often 2. Often 3. Sometimes	
540	Have you ever discussed on condom use? If your answer is no skip to Q542	1. Yes 2. No	

541	If you don't discuss on condom use with adolescents, what are the reasons? (circle all answer you think)	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Lack of communication skill 5. Adolescents are not good listener 6. Difficult and embarrassing 88. Do not know 99. Others, specify	
542	If yes for question # 540 with whom do you discuss?	1. Son 2. Daughter	
543	How frequent you have discussed about condom use?	1. Very often 2. Often 3. Sometimes	
544	With whom you discussed other than adolescents	1. Peer / friends 2. Sisters 3. Brothers 99. Others, specify___	
545	How frequent you have discussed on condom use?	1. Very often 2. Often 3. Sometimes	
546	Have you ever discussed on physical and psychological changes on puberty? If your answer is yes skip to Q548	1. Yes 2. No	
547	If you don't discuss on physical and psychological changes on puberty with adolescents. What are the reasons? (circle all answer you think)	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Lack of communication skill 5. Adolescents are not good listener 6. Difficult and embarrassing 88. Do not know 99. Others, specify_____	
548	If yes for question # 546 with whom do you discuss?	1. Son 2. Daughter	

549	How frequent you have discussed about puberty?	1. Very often 2. Often 3. Sometimes	
550	With whom discussed other than adolescents	1. Peer / friends 2. Sisters 3. Brothers 99. Others specify_____	
551	How frequent you have discussed on physical and psychological changes on puberty?	1. Very often 2. Often 3. Sometimes	
552	If you have ever discussed at least one of the above issues with your adolescents, at what age have you started discussing it?	……age in years	
553	At what age do you think discussion on sexual and reproductive health should be started?	……age in years	
554	Do you currently discuss on the above issues?	1. Yes 2. No	
555	How do you rate adolescents' communication skill about sexual matters with their parents?	1. Low 2. Medium 3. High	

APPENDIX B2: - QUESTIONNAIRE FOR PARENTS OF THE SELECTED IN-SCHOOL ADOLESCENTS TRANSLATED TO THE LOCAL LANGUAGE "AMHARIC"

<u>አባሪ 2: ለወላጆች የተዘጋጀ በቃለ መጠይቅ የሚሞላ</u>

ወጣት ልጆች ከወላጆቻቸው ጋር በወሲብና ስነ-ተዋልዶ ጤና ጉዳይ ያላቸውን የመወያየት መስተጋብር ለማጥናትና የማሸሻያ መመሪያ ለማዘጋጀት የተዘጋጀ የ3ተኛ ዲግሪ ማሟያየምርምር ጥናት መጠይቅ አዲስ አበባ: ኢትዮጵያ

መለያ ቁጥር : _____

መግቢያ

ስሜ ---------- ይባላል።የዚህን ምርምር ጥያቄዎች በቃለ መጠይቅ ለመሙላት መረጃ እየሰበሰብሁ እገኛለሁ።

ሚስጥር ጠባቂነትና ስምምነት

ይህ መጠይቅ ከእርስዎ ጋር በሚደረግ ቃለ መጠይቅ የሚሞላ ነው።የሚሰጡን ማንኛዉም መልስ እና መረጃ በሚስጥር የተጠበቀ ነው፡ ስምዎትን መፃፍ አይጠበቅበወትም፡ የሰጡት መልስ ለሁለተኛ ወገን ተላልፎ አይሰጥም:: መመለስ ያልፈለጉትን ጥያቄ አለመመለስ ይችላሉ እንዲሁም ካልተመቸወት ማቋረጥ ይችላሉ።መልስዎን በታማኝነትና በቅንነት ከመለሱልን የወጣቶችንና የወላጆችን መስተጋቦት ለማሻሻል እንዲሁም ወሲባዊ ግንኙነት እና ስነ-ተዋልዶ ጤና መመሪያ ለማውጣት ያግዛል።ከዚህ በላይ ማብራሪያ ከፈለጉ በዚህ ስልክ ቁጥር በመደወል የበለጠ መረጃ ማግኘት ይችላሉ። አቶ አለማየሁ ቦጋለ: +251910309303. ሰለተሳተፉዎ እናመሰግናለን።

በቃለ መጠይቁ ለመሳተፍ ፍቃደኛ ነዎት አዎ----------

አይደለሁም----------

ቃለ መጠይቁን ያካሄደዉ የመረጃ ሰብሳቢው ስም:---------- ፊርማ:----------

ቀን:_____

የተቆጣጣሪ ስም:_____ ፊርማ_____ቀን_____

ወላጆችና ጎረምሳ/ኮረዳ ልጆች በወሲባዊ ግንኙነት ጉዳይ ና በስነ- ተዋልዶ ጤና ላይ የሚያደርጉትን ውይይት ለማጥናት የተዘጋጀ ቃለ መጠይቅ **(ከተመረጡ ተማሪ ወላጆች)**

I. መሰረታዊና ማህበራዊ ጉዳይን በተመለከተ

ተ.ቁ	ጥያቄ	**መልስ**	**ኮድ**
101	እድሜ	----------አመት	
102	ፆታ	1. ወንድ 2. ሴት	
103	ሀይማኖት	1. ኦርቶዶክስ 2. ሙስሊም 3. ፕሮቴስታንት 4. ካቶሊክ 99. ሌላ ካለ ይገለፅ----------	
104	ብሄር	1. አማራ 2. ኦሮሞ 3. ትግሬ 4. ጉራጌ 5. ወላይታ 99. ሌላ ካለ ይገለፅ----------	
105	የምትኖረው/ሪው ከባለቤትህ/ሽ ጋር ነው?	1. አዎ 2. አይደለም	
106	ከባለቤትህ/ሽ ጋር አብራችሁ የማትኖሩ ከሆነ ምክንያቱ ምንድን ነው?	1. በመፋታት 2. በሞት 3. በሌላ ሀገር /ቦታ ስለሚኖር/ስለምትኖር 99. ሌላ ካለ ይገለፅ ----------	
107	የቤተሰብ ብዛት?	----------በቁጥር	

108	የትምህርት ደረጃ ምን ያህል ነው?	1. ያልተማረ/ች 2. ማንበብና መጻፍ 3. አንደኛ ደረጃ(1-8) 4. ሁለተኛ ደረጃ(9-12) 5. ዲፕሎማ 6. ዲግሪ 7. ማስተርስ እና ከዚያ በላይ	
109	የስራ ሁኔታ	1. የቤት እመቤት 2. የግል ቅጥረኛ 3. የመንግስት ሰራተኛ 4. ነጋዴ 5. ገበሬ 99. ሌላካለ ይገለፅ ----------	
110	ሲጋራ ታጨሳለህ/ሻለሽ?	1. በፍፁም አላጨስም 2. አንዴ ወይም ሁለቴ አጭሼ አዉቃለሁ 3. አልፎ አልፎ አጨሳለሁ 4. በየቀኑ አጨሳለሁ 99. ሌላካለ ይገለፅ.....	
111	ጫት ትቅማለህ/ሚያለሽ?	1. በፍፁም ቅሜ አላውቅም 2. አንዴ ወይም ሁለቴ ቅሜ አውቃለሁ 3. አልፎ አልፎ እቅማለሁ 4. በየቀኑ እቅማለሁ 99. ሌላ ካለ ይገለፅ----------	
112	የአልኮል መጠጥ ትጠጣለህ /ጫለሽ?	1. በፍፁም አልጠጣም 2. አንዴ ወይም ሁለቴ ጠጥቸ አውቃለሁ 3. አልፎ አልፎ እጠጣለሁ 4. በየቀኑ እጠጣለሁ 99.ሌላ ካለ ይገለፅ----------	

II. በተመረጡ ዋና ዋና የስነ-ተዋልዶ ጤና ጉዳይ ላይ ያለዎትን ግንዛቤ ለማወቅ የተዘጋጀ መጠይቅ

201	ልጅዎ የወር አበባ መቼ እንደጀመረች ያዉቃሉ?	1. አዎ 2. የለም	
202	ካወቁ በስንት አመት ነበር?	----------አመት	
203	ልጅዎ በመጀመርያ ጊዜ የወር አበባ ስታይ ስሜቷ እንዴት ነበር?	1. ጭንቀት 2. ፍርሀት 3. የደስታ ስሜት 4. የህመም ስሜት 5. መሸማቀቅ 6. እስከ አሁን ድረስ የወር አበባ አላየችም	
204	ስለኤችአይቪ ኤድስና አባላዘር በሽታወች ሰምተሽ/ ህ ታውቂያለሽ/ህ? መልስዎ የለም ከሆነ ወደ ጥ.ቁጥር 206 ይለፉ	1. አዎ 2. የለም	
205	ስለኤችአይቪ ኤድስና አባላዘር በሽታወች ከሰሙ ከተዘረዘሩት ውስጥ የትኛውን ያውቃሉ? (መልስ የመሰለወትን ሁሉ ይንገሩን)	1. ከርክር 2. ቂጥኝ 3. ጨብጥ 4. ኤድስ 5. አልማዝ ባለጭራ 99.ሌላ ካለ ይገለፅ----------	
206	ስለቤተሰብ ምጣኔ ሰምተሽ /ህ ታውቂያለሽ /ህ? መልስዎ የለም ከሆነ ወደ ጥ.ቁጥር 208 ይለፉ	1. አዎ 2. የለም	
207	መልስዎ አዎ ከሆነ ከተዘረዘሩት ውስጥ የትኛውን ያውቃሉ (መልስ የመሰለዎን ሁሉ ይንገሩን)	1. የሚዋጥ እንክብል 2. በመርፌ የሚሰጥ 3. በክንድ ስር የሚቀበር 4. በማህፀን ውስጥ የሚቀመጥ 5. ኮንዶም 6. በካሌንደር መጠቀም	
208	ድንገተኛ የወሊድ መከላከያ ያዉቃሉ?	1. አዎ 2. የለም	

209	እርግዝና መች ሊከሰት እንደሚችል ያውቃሉ ?	1. አዎ 2. የለም	

III. የወሲባዊ ግንኙነት አመለካከት እና ባህሪ ለማወቅ የተዘጋጀ ቃለ መጠይቅ

301	በወጣትነት ወቅት የወሲብ ፍላጎት መኖር አግባብ ነው ብለው ያስባሉ?	1. አዎ 2. የለም 88. አላውቅም	
302	በስንት አመትዎ ነበር ለመጀመሪያ ጊዜ የወሲብ ግንኙነት የጀመሩት;	_____አመት	
303	ከምን ያህል ሰው ጋር የወሲብ ግንኙነት ፈፅመዋል ?	1. አንድ 2. ሁለት 3. ሦስትና ከዚያ በላይ	
304	ወጣቶች በወሲባዊ ግንኙነት ጊዜ ኮንዶም መጠቀም አለባቸው ብለው ያምናሉ? መልስዎ የለም ከሆነ ወደ ጥ.ቁጥር 306 ይለፉ	1. አዎ 2. የለም	
305	መልስዎ አዎ ከሆን ኮንዶምን ሁልግዜ መጠቀም ይኖርባቸዋል ይላሉ ?	1. አዎ 2. የለም	
306	<u>ለእናቶች ብቻ</u> : ያልተፈለገ እርግዝና አጋጥሞዎት ያዉቃል?(መልስዎ የለም ከሆነ ወደ ጥየቄ ቁጥር 308 ይለፉ	1. አዎ 2. የለም	
307	መልስዎ አዎ ከሆነ ያልተፈለገ እርግዝና ከተፈጠረ በኋላ ምን አደረጉ?	1. ተወለደ 2. እርግዝናው ተቋረጠ	
308	ከጋብቻ በፊት የሚደረግን የወሲብ ግንኙነት ትደግፋለህ/ሽ?	1. አዎ 2. የለም	
309	ስለ-ወሲባዊ ግንኙነት ማስተማር አስፈላጊ ነው ትላለህ/ያለሽ? መልስዎ አያስፈልግም ከሆነ ወደ ጥ.ቁጥር 311 ይለፉ	1. አዎ 2. አያስፈልግም 88. አላውቅም.	
310	ስለ-ወሲባዊ ግንኙነት ትምህርት የት ቢሰጥ የተሻለ ይሆናል? (መልስ የመሰለህን ሁሉ አክብብ)	1. ከትምህርት ቤት 2. ከቤት 3. በጓደኞች 4. ከእምነት ቦታ 99. ሌላ ካለ ይገለፅ ----------	

311	ስለ ወሲባዊ ጉዳይመረጃ ከየት ትሰማለህ/ሽ? (መልስ የመሰለዎን ሁሉ ይንገሩን)	1. ከትምህርት ቤት 2. ከሚዲያ 3. ከቤት 4. ከጓደኞች 99. ሌላ ካለ ይገለፅ----------	

IV. የወላጆች አመለካከት በልጆቻቸዉ ክትትልና ቁጥጥር ዙሪያ

401	በወጣቶች ላይ የሚደረገውን የቁጥጥር እና የክትትልሁኔታ እርስዎ ይስማሙበታል;	1. እስማማለሁ 2. አልስማመም 3. አላውቅም	
402	<u>ለአባቶች ብቻ</u> ወንድ ልጅዎ ከሴት ልጅ ጋራ እንዳይጫወት ከልክለዉት ያዉቃሉ?	1. አዎ 2. የለም 3. አላውቅም	
403	መልስዎ አዎ ከሆነ በስንት አመቱ ጀምሮ ነበር የከለከሉት?	_____በእድሜ ይገለፅ	
404	<u>ለእናቶች ብ</u>ቻ ሴት ልጅዎ ከወንድ ልጅዎ ጋር እንዳትጫወት ከልክለዋት ያዉቃሉ?	1. አዎ 2. የለም 3. አላውቅም	
405	መልስዎ አዎ ከሆነ በስንት አመቷ ጀምሮ ነበር የከለከልዋት?	_____በእድሜ ይገለፅ	
406	ልጅዎ የትና በምን ሰዓት ከቤት ወይም ከትም/ት ውጭ እንደሚውሉ ያውቃሉ?	1. አዎ 2. የለም 3. አላውቅም	
407	ልጅዎ ከቤት/ትም/ት ቤት ዉጭከማን ጋር እንደሚውሉ ያውቃሉ?	1. አዎ 2. የለም 3. አላውቅም	

V. ወላጆችና ወጣቶች በወሲባዊ ግንኙነትና ስነ -ተዋልዶ ጤና ያላቸው ተግባቦት

501	ወላጆች ስለወሲብና ስነ-ተዋልዶ ጤና መረጃ ያገኛሉ?	1. አዎ 2. የለም	

502	ስለወሲባዊ ግንኙነትና ስነተዋልዶ ጤና መረጃ ከማን ወይም ከየት በብዛት ያገኛሉ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ከወላጆቼ 2. ከጓደኞቼ 3. ከባለቤቴ 4. ከጤና ድርጅት 5. ከትምህርት ቤት 6. ከእምነት አባቶች 7. ከጋዜጣ/ፖስተር 8. ከሬዲዮ/ቲቪ 9. ከሌላ የቤተሰብ አባላት 99. ሌላ ካለ ይገለፅ--------	
503	ከጎረምሳ ልጅዎ ጋር አንዳንድ ጠቃሚ ውይይቶች መወያየት ምን ያህል ቀላል ነው ብለህ/ሽ ታስባለህ/ሽ ?	1. በጣም ቀላል 2. ቀላል 3. ከባድ 4. በጣም ከባድ 99. ሌላ ካለ ይገለፅ……..	
504	ስለ-ወሲባዊ ግንኙነት ከወንድ ልጅህ/ሽ ጋር በምን ያህል ጊዜ ይወያያሉ?	1. ብዙ ጊዜ 2. አልፎ አልፎ 3. ተወያይተን አናውቅም	
505	ከሴት ልጅዎ ጋር አንዳንድ ጠቃሚ ውይይቶች መወያየት ምን ያህል ቀላል ነው ብለው ያስባሉ?	1. በጣም ቀላል 2. ቀላል 3. ከባድ 4. በጣም ከባድ 5. ሌላ ካለ ይገለፅ……	
506	ስለወሲባዊ ግንኙነት ከሴት ልጅዎ ጋር በምን ያህል ጊዜ ይወያያሉ?	1. ብዙ ጊዜ 2. አልፎ አልፎ 3. ተወያይተን አናውቅም	
507	ከጓደኛ እና ከዘመድ ጋር ስለወሲባዊ ግንኙነት በምን ያህል ጊዜ ትወያያላችሁ? ?	1. ብዙ ጊዜ 2. አልፎ አልፎ 3. ተወያይተን አናውቅም	
508	ከወጣቶች ጋር ስለወሲባዊ ግንኙነት መወያየት ጥቅም አለውይላሉ?	1. አዎ 2. የለዉም	

509	ስለወሲባዊ ግንኙነት እና ስነ-ተዋልዶ ጤና ለመወያየት ከወንድ ወይም ሴት ልጆች የትኞቹ የተሻሉ ናቸው?	1. ወንድ ልጆች 2. ሴት ልጆች	
510	ስለቤተሰብ ምጣኔ ተወያይታችሁ ታቃላችሁ? መልስዎ አዎ ከሆነ ወደ ጥያቄ ቁጥር 512 ይለፉ	1. አዎ 2. የለም	
511	ስለቤተሰብ ምጣኔ ማትወያዩ ከሆነ ምክንያትዎ ምንድን ነው ?	1. ባህሉ ስለማይፈቅድ 2. ስለማፍር 3. እውቀት ስለሌለኝ 4. መግባባት ስለማልችል 5. ልጆች ስለማያዳምጡኝ 6. ከባድና አስጨናቂ ስለሆነ 88. አላውቅም 99. ሌላ ካለ ይገለፅ _____	
512	ጥያቄ ቁጥር # 510 መልስዎ አዎ ከሆነ ከማን ጋር መወያየት	1. ከወንድ ልጅ ጋር 2. ከሴት ልጅ ጋር	
513	ስለ-ቤተሰብ ምጣኔ በምን ያህል ጊዜ ይወያያሉ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3. አልፎ አልፎ	
514	ስለቤተሰብ ምጣኔ ከልጆዎ ውጭ ከማን ጋር ይወያያሉ?	1. ከጓደኞች ጋር 2. ከእህቶች ጋር 3. ከወንድሞች ጋር 99. ሌላ ካለ ይገለፅ---------	
515	ስለቤተሰብ ምጣኔ ከልጅዎ ውጭ በምን ያህል ጊዜ ይወያያሉ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3. አልፎ አልፎ	
516	ስለኤችአይቪ ኤድስና አባላዘር በሽታወች ከልጅዎ ጋር ተወያይተው ያዉቃሉ? መልስዎ አዎ ከሆነ ወደ ጥያቄ ቁጥር 518 ይለፉ	1. አዎ 2. የለም	

517	ስለኤችአይቪ ኤድስና አባላዘር በሽታወች ከልጀዎ ጋር ካልተወያያችሁ ምክንያቱ ቢገለፅ?	1. ባህሉ ስለማይፈቅድ 2. ስለማፍር 3. እወቀት ስለሌለኝ 4. መግባባት ስለማልችል 5. ልጆች ስለማያዳምጡኝ 6. ከባድና አስጨናቂ ስለሆነ 88. አላውቅም 99. ሌላ ካለ ይገለፅ ----------	
518	ጥያቄ ቁጥር # 516 መልስዎ አዎ ከሆነ ከማን ጋር ነው	1. ከወንድ ልጅ ጋር 2. ከሴት ልጅ ጋር	
519	ስለኤችአይቪ ኤድስና አባላዘር በሽታ በምን ያህል ጊዜ ይወያያሉ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3. አልፎ አልፎ	
520	ስለኤችአይቪ ኤድስና አባላዘር በሽታ ከልጆዎ ውጭ ከማን ጋር ተወያይተዋል?	1. ከጓደኞች ጋር 2. ከእህቶች ጋር 3. ከወንድሞች ጋር 99. ሌላ ካለ ይገለፅ---------	
521	ስለኤችአይቪ- ኤድስና አባላዘር በሽታ ከልጆዎ ውጭ በምን ያህል ጊዜ ይወያያሉ?	1. በጣም ብዙ ጊዜ 2. ብ ዙ ጊ ዜ 3 . አልፎ አልፎ	
522	ስለወሲባዊ ግንኙነት ከልጅዎ ጋር ተወያይታችሁ ታዉቃላችሁ? አዎ ከሆነ መልሱ ወደ ጥያቄ ቁጥር 524 ይለፉ	1. አዎ 2. የለም	
523	ስለወሲባዊ ግንኙነት ካልተወያይችሁ ምክንያቱ ምንድን ነው ?	1. ባህሉ ስለማይፈቅድ 2. ስለማፍር 3. እውቀት ስለሌለኝ 4. መግባባት ስለማልችል 5. ልጆች ስለማያዳምጡኝ 6. ከባድና አስጨናቂ ስለሆነ 88. አላውቅም 99. ሌላ ካለ ይገለፅ	
524	ጥያቄ ቁጥር #522 መልስዎ አዎ ከሆነ ከማን ጋር	7. ከወንድ ልጄ ጋር 8. ከሴት ልጄ ጋር	

525	ስለወሲባዊ ግንኙነት በምን ያህል ጊዜ ተወያያላችሁ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3. አልፎ አልፎ	
526	ስለወሲባዊ ግንኙነት ከልጆዎ ውጭ ከማን ጋር ተወያያለህ/ሽ?	1. ከጓደኞች ጋር 2. ከእህቶች ጋር 3. ከወንድሞች ጋር 99. ሌላ ካለ ይገለፅ---------	
527	ስለ ወሲባዊ ግንኙነት ከልጆዎ ውጭ በየምን ያህል ጊዜ ተወያያላችሁ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3. አልፎ አልፎ	
528	ስላልተፈለገ እርግዝና ከልጆችዎ ጋር ተወያይተው ያውቃሉ? አዎ ከሆነ መልሱ ወደ ጥያቄ ቁጥር 530	1. አዎ 2. የለም	
529	ስለአልተፈለገ እርግዝና ከልጆችዎ ጋር ካልተወያይችሁ ምክንያቱ ምንድን ነው ?	1. ባህሉ ስለማይፈቅድ 2. ስለማፍር 3. እወቀት ስለሌለኝ 4. መግባባት ስለማልችል 5. ልጆች ስለማያዳምጡኝ 6. ከባድና አስጨናቂ ስለሆነ 88. አላውቅም 99. ሌላ ካለ ይገለፅ _____	
530	ለጥያቄ ቁጥር 528 መልስዎ አዎ ከሆነ ከማን ጋር	1. ከሴት ልጆ ጋር 2. ከወንድ ልጆ ጋር	
531	ስለአልተፈለገ እርግዝና ከልጅዎ ጋር በምን ያህል ጊዜ ይወያያሉ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3. አልፎ አልፎ	
532	ስለአልተፈለገ እርግዝና ከልጅዎ ውጭ ከማን ጋር ይወያያሉ?	1. ከጓደኞች ጋር 2. ከእህቶች ጋር 3. ከወንድሞች ጋር 99. ሌላ ካለ ይገለፅ_____	

533	ስለአልተፈለገ እርግዝና ከልጅዎ ውጭ በምን ያህል ጊዜ ተወያያላችሁ??	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3. አልፎ አልፎ	
534	መታቀብ እሰከ ጋብቻ ድረስ በሚል ሀሳብ ከልጅዎ ጋር ተወያይተው ያውቃሉ? አዎ ከሆነ መልስዎ ወደ ጥያቄ ቁጥር 536 ይለፉ	1. አዎ 2. የለም	
535	መታቀብ እሰከ ጋብቻ ድረስ ካልተወያዩ ምክንያቱ ምንድን ነበር? መልስ ያላችሁትን ሁሉ ያክብቡ	1. ባህሉ ስለማይፈቅድ 2. ስለማፍር 3. እወቀት ስለሌለኝ 4. መግባባት ስለማልችል 5. ልጆች ስለማያዳምጡኝ 6. ከባድና አስጨናቂ ስለሆነ 88. አላውቅም 99. ሌላ ካለ ይገለፅ ----------	
536	ጥያቄ ቁጥር #534 መልስዎ አዎ ከሆነ መታቀብ እሰከ ጋብቻ ድረስ ከማን ጋር	1. ከወንድ ልጅ 2. ከሴት ልጅ	
537	ከጋብቻ በፊት መታቀብ በሚል ሀሳብ በምን ያህል ጊዜ ተወያያላችሁ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3. አልፎ አልፎ	
538	ከጋብቻ በፊት መታቀብ በሚል ሀሳብ ከልጅዎ ውጭ ከማን ጋር ይወያያሉ?	1. ከጓደኞች ጋር 2. ከእህቶች ጋር 3. ከወንድሞች ጋር	
539	መታቀብ እሰከ ጋብቻ ድረስ በሚል ሀሳብ ከልጅዎ ውጭ በምን ያህል ጊዜ ይወያያሉ ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3. አልፎ አልፎ	
540	ስለኮንዶም መጠቀም ከልጅዎ ጋር ተወያይተው ያውቃሉ?መልስዎ አዎ ከሆነ ወደ ጥያቄ ቁጥር 542 ይለፉ	1. አዎ 2. የለም	

541	ስለኮንዶም መጠቀም ማትወያዩ ከሆነ ምክንያቱ ምንድን ነው ? ምክንያት ነው የሚሉትን ነገሮች በሙሉ ይንገሩን	1. ባህሉ ስለማይፈቅድ 2. ስለማፍር 3. ግንዛቤው ስለሌለኝ 4. መግባባት ስለማልችል 5. ልጆች ስለማያዳምጡኝ 6. ከባድና አስጨናቂ ስለሆነ 88. አላውቅም 99. ሌላ ካለ ይገለፅ ----------	
542	ለጥያቄ ቁጥር 540 መልስዎ አዎ ከሆነ ከማን ጋር ነው?	1. ከወንድ ልጅ ጋር 2. ከሴት ልጅ ጋር	
543	ስለኮንዶም መጠቀም በ ምን ያህል ጊዜ ይወያያሉ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	
544	ስለኮንዶም መጠቀም ከልጅዎ ውጭ ከማን ጋር ይወያያሉ?	1. ከጓደኞች ጋር 2. ከእህቶች ጋር 3 .ከወንድሞች ጋር 99. ሌላ ካለ ይገለፅ_____.	
545	ስለኮንዶም መጠቀም ከልጅዎ ውጭ በምን ያህል ጊዜ ይወያያሉ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3. አልፎ አልፎ	
546	ከጉርምስና እና ኮረዳነት ጋር ተያይዞ ከሚከሰቱ አካላዊ እና ስነልቦናዊ ለውጦች ሁኔታ ከልጆችህ/ሽ ጋር ተወያይተህ/ሽ ታውቂያለሽ/ህ? መልስህ/ሽ አዎ ከሆነ ወደ ጥያቄ ቁጥር	1. አዎ 2. የለም	

547	ከጉርምስና/ኮረዳነት ጋር በተየያዘ ከሚመጡ አካላዊ እና ስነልቦናዊ ለውጦች ከልጆችህ/ሽ ጋር ተወያይተህ/ሽ የማታውቂ ከሆነ ምክንያቱ ምንድን ነው?(መልስ ነው የምትሉአቸውን ሀሳቦች ይንገሩን	1.ባህል ስለማይፈቅድ 2.ስለማፍር 3.ግንዛቤው ስለሌለኝ 4.መግባባት ስለማልችል 5.ልጆች ስለማያዳምጡኝ 6.ከባድና አስጨናቂ ስለሆነ 88. አላውቅም 99. ሌላ ካለ ይገለፅ ----------	
548	ለጥያቄ ቁጥር 546 መልስዎ አዎ ከሆነ ከማን ጋር ይወያያሉ?	1. ከወንድ ልጅ ጋር 2. ከሴት ልጅ ጋር	
549	ስለጉርምስና /ኮረዳነት በምን ያህል ጊዜ ይወያያሉ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	
550	ስለ አካላዊ እና ስነልቦናዊ ለውጦች ከልጅዎ ውጭ ከማን ጋር ይወያያሉ?	1. ከጓደኞች ጋር 2. ከእህቶች ጋር 3 .ከወንድሞች ጋር 99. ሌላ ካለ ይገለፅ_____	
551	ስለአካላዊ እና ስነልቦናዊ ለውጦች ከልጅዎ ውጭ በምንያህል ጊዜ ይወያያሉ ?	1. በጣም ብዙ ጊዜ 2. ብዙ ጊዜ 3.አልፎ አልፎ	
552	ከላይ ከተገለፁት ጉዳዮች ቢያንስ በአንዱ ጉዳይከልጅዎጋር ምትወያዩ ከሆነ ስንት አመት ሲሆን ጀምሮ መወያያት ጀመራችሁ?	.....በአመት ይገለፅ	
553	ስለ ግብረ - ስጋ ግንኙነት እና ስነ-ተዋልዶ ጤና ውይይት ከልጆች ጋር በስንት አመትጀምሮ መካሄድ አለበት ይላሉ?	.....በአመት ይገለፅ	
554	ከላይ የተጠቀሱትን ጉዳዮች አሁን ላይ ከልጅዎ ጋር ይወያያሉ?	1. አዎ 2. የለም	

555	ልጅዎን ከወሲባዊ ግንኙነት እና ተያያዥ ጉዳዮች ያላቸውን የተግባበት ክህሎት እንዴት ይለኩታል?	1. ዝቅተኛ 2. መካከለኛ 3. ከፍተኛ	

APPENDIX C: APPROVED ETHICAL CLEARANCE AND PERMISSION LETTERS

UNISA university of south africa

UNISA HEALTH STUDIES HIGHER DEGREES ETHICS REVIEW COMMITTEE

Date 25 May 2020

Dear Alemayehu Bogale Mesfin

NHREC Registration # : REC-012714-039
ERC Reference # : **HSHDC/973/2020**
Name : Alemayehu Bogale Mesfin

Student #: 67130909
Staff #:

Decision: Ethics Approval from 25 May 2020 to 25 May 2023

Researcher(s): Name Alemayehu Bogale Mesfin
Address
E-mail address alemayehubog@gmail.com, telephone # +251 910309303

Supervisor (s): Name Prof GB Thupayagale-Tshweneagae
E-mail address tshweg@unisa.ac.za, telephone # 079 054 3655

Working title of research:

Adolescent-parent partnership guidelines for improving communication on sexual and reproductive health in Addis Ababa, Ethiopia

Qualification: PhD

Thank you for the application for research ethics clearance by the Unisa Health Studies Higher Degrees Ethics Review Committee for the above mentioned research. Ethics approval is granted for three (3) years.

*The **medium** **risk application** was **reviewed** by a Sub-committee of URERC on 7 April 2020 in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment. The decision will be tabled at the next Committee meeting on 2 June 2020 for ratification.*

The proposed research may now commence with the provisions that:

1. The researcher will ensure that the research project adheres to the relevant guidelines set out in the Unisa Covid-19 position statement on research ethicsattached.

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

2. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
3. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the Health Studies Research Ethics Committee HSREC@unisa.ac.za.
4. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
5. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.
6. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
7. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
8. No field work activities may continue after the expiry date (25 May 2023). Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

The reference number ***HSHDC/973/2020*** *should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signatures :

PP

Chair of HSREC : Prof JM Mathibe-Neke
E-mail: mathijm@unisa.ac.za
Tel: (012) 429-6443

Executive Dean : Prof K Masemola
E-mail: masemk@unisa.ac.za
Tel: (012) 429-6825

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UNISA university of south africa

Ref. No. UNISA-ET/KA/ST/29/18-02-2022 18th February, 2022

Addis Ababa City Administration Education Bureau

Addis Ababa

Dear Madam/Sir,

The University of South Africa (UNISA) extends warm greetings to you and staff members of your esteemed Bureau. By this letter, we want to certify that Mr. Alemayehu Bogale Mesfin (student number 67130909) is a PhD student in the Department of Health Studies at the University of South Africa. Currently, he is at the stage of data collection on his doctoral research entitled "***Adolescent-parent partnership guidelines for improving communication on sexual and reproductive health in Addis Ababa, Ethiopia***."

This is therefore to kindly request you to assist the student to get access to data sources from schools under your administration. We would like to thank you in advance for all the assistance that you would provide to the student.

Sincerely,

UNISA-ETHIOPIA CENTER
P.O.BOX:13836
ADDIS ABABA
TEL+251912191483

pp. Dr. Tsige GebreMeskel Aberra
Director

University of South Africa
P.O.Box: 13836, Addis Ababa, Ethiopia
Ethiopia - Regional Learning Centre
Telephone: +251 11 435 2244/ +251 11 435 0078
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UNISA university of south africa

Ref. No. UNISA-ET/KA/ST/29/18-02-2022 18th February, 2022

Addis Ababa City Administration Education Bureau

Addis Ababa

Dear Madam/Sir,

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This is therefore to kindly request you to assist the student to get access to data sources from schools under your administration. We would like to thank you in advance for all the assistance that you would provide t

Sincerely,

pp. Dr. Tsige GebreMeskel Aberra
Director

Sisay Endale Tadesse
A.A. Education Bureau Office Head

APPENDIX D: LANGUAGE AND TECHNICAL DECLARATION

Supplier Database No: MAAA0450241
PostNet Suite #40
Private Bag X04
Menlo Park 0102
Mobile: 060 530 1165
Email: noteworthy@myconnection.co.za / honey@myconnection.co.za

20 November 2023

TO WHOM IT MAY CONCERN

This serves to confirm that the PhD thesis entitled: *Adolescent-Parent Partnership Guidelines for Improving Communication on Sexual And Reproductive Health Issues in Addis Ababa, Ethiopia.*

By: **ALEMAYEHU BOGALE MESFIN**, Department of Health Studies, UNISA.

has been professionally edited by one of our accredited English mother-tongue language editors. The accuracy of the content of the final work remains the authors' responsibility.

Dr MC Steyn

Scribing, Proof-reading and Editing Services

APPENDIX E: TURNIT IN SIMILARITY REPORT

Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

The first page of your submissions is displayed below.

Submission author:	A B MESFIN
Assignment title:	Proposal DRAFT
Submission title:	Final PhD thesis work on the title "ADOLESCENT-PARENT PAR ...
File name:	67130909_AB_Mesfin_final_thesis_work_29_Nov_2023.docx
File size:	444.24K
Page count:	100
Word count:	27,147
Character count:	158,447
Submission date:	29-Nov-2023 03:48PM (UTC+0200)
Submission ID:	2241918025

CHAPTER 1 - ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Adolescence is the period of the most rapid and formative phases of human development. The fast-changing physical, cognitive, social, emotional and sexual development that takes place during adolescence demands special attention. It is that period of formative and dynamic transitions, when young people take on new roles, responsibilities, and identities. In the world today, 1.3 billion adolescents account for 16% of the global population (UNICEF 2022). Globally, adolescents, both females and males, face health risks, particularly associated with sexuality and reproduction. Adolescent pregnancy is a global public health concerns with clearly known causes and impacts on health, social and economic consequences (WHO 2023b). Several sexual and reproductive health (SRH) behaviours and awareness issues are shaped during adolescence that mark cultural transitions including female genital mutilation, early marriage, and childbirth (Ayalew & Nigatu 2018).

Each year, late adolescent girls between the age range of 15-19 years, in low- and middle-income countries (LMICs) have an estimated 21 million pregnancies. Among these, almost half, 10 million are unintended that result to an estimated 12 million births. More than a quarter of these adolescent pregnancies, 5.7 million, end in abortion with the majority being carried out in unsafe conditions (UNFPA 2022:3). Around one in three women in LMICs begin childbearing during adolescence, 19 years and younger. Close to half of first births to adolescent child mothers are to those aged 17 years and younger and 6% are to child mothers aged 14 years and younger. A girl who has her first birth at 14 years or younger has, on average, 2.2 births before she reaches 20 years of age. A girl with a first birth between the ages of 15-17 years has, on average, 1.5 births before she is 20. Once an adolescent girl becomes a mother, she has a one-in-five chance of experiencing another adolescent birth within two years. Such short birth intervals come with considerable health risks. More than half of all repeat births in adolescence occur within 23 months of a previous birth (UNFPA 2022).

Approximately 12 million late adolescent girls and at least 777 000 girls under 15 years of age give birth each year in developing regions. Pregnancy related complications are

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