HARAMAYA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

PARENT - ADOLESCENT COMUNICATION ON SEXUAL AND REPRODUCTIVE HEALTH MATTERS AND ASSOCIATED FACTORS AMONG NON-BOARDING HIGH SCHOOL STUDENTS IN SHAYGOSH TOWN, ETHIOPIAN SOMALI REGIONAL STATE, EASTERN ETHIOPIA.

MPH thesis

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COLLEGE: **Health and Medical Science**

SCHOOL: **Public Health**

PROGRAM: **Reproductive Health**

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JUAN, 2019

HARAMAYA, ETHIOPIA

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A Thesis submitted To the College of Health and Medical Science, School of

Graduate studies, Haramaya University

In partial Fulfillment Of The Requirements For The Degree Of Master Program Of Parent Adolescent Communication On Sexual And Reproductive Health Matters And Associated Factors Among Non-boarding High School Students In Shaygosh Town, Ethiopian Somali Regional State, Eastern Ethiopia.

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APPROVAL SHEET

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SCHOOL OF GRADUATE STUDIES

I hereby certify that I have read and evaluated this thesis entitled "Parent adolescent communication on sexual and reproductive health matters in Shaygosh non-boarding high school in Shaygosh town, Ethiopian Somali Region, Eastern Ethiopia" prepared by Addis Alemayehu. I recommend that it be submitted as fulfilling the thesis requirement.

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As a member of the Board of Examiners of the MPH Thesis Open Defense Examination, I certify that I have read and evaluated the Thesis prepared by Addis Aemayehu and examined the candidate. I recommended that the Thesis be accepted as fulfilling the Thesis requirements for the degree of Master of Public Health in Reproductive Health.

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BIOGRAPHICAL SKETCH

I was born on October 2, 1992 G.C in Sheleko town, Afar region, Ethiopia. I learn from nursery up to grade 6 in Sheleko elementary school and I proceed the rest class from grade 7 up to in Hawassa town, Debub region, Ethiopia. Then I join and received my BSC, in health officer from Hawassa University in 2014. As to my current professional experience I have been working in Shaygosh Health Center in Ethiopian Somali region from 2014 to 2019 as a professional Health Officer.

ACKNOWLEDGMENTS

My deepest gratitude goes to my major adviser Dr. Yadeta Desse and my co-adviser Dr. Lemessa Olijira for their continuous support and to all Haramaya instructors who supported me while I was working on this research thesis and I would also like to thank all staffs of Haramaya University School of Public Health for their moral and technical supports. Finaly but not the least I would like to thank shaygosh woreda health office and shaygosh woreda education office.

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ACRONYM AND ABBREVIATION

AIDS: Acquired Immune Deficiency Syndrome

ESA: East and South Africa

FMOH: Federal Ministry of Health

HIV: Human Immune Virus

ICPD: International Conference on Population and Development

IUCD: Intrauterine Contraceptive Device

LAC: Latin America and the Caribbean

NAYRHS: National Adolescent and Youth Reproductive Health Strategy

SRH: Sexual Reproductive Health

STI: Sexual Transmitted Infection

UNAIDS: United Nation Programmer on HIV/AIDS

UNFPA: United Nation Population Fund

VCT: Voluntary Counseling and Testing

WHO: World Health Organization

YFS: Youth Friendly Service

ABSTRACT

Introduction: Adolescents are defined by the World Health Organization as at age group 10-19 years. The onset of adolescence which is more or less coinciding with puberty is often influenced by manifestation of puberty. Parental adolescent communication is a fundamental process through which parents convey ideas, values, beliefs, expectations, information, and knowledge to their child which protects them from risky behavior. But in Shaygosh woreda the role of parent-young people communication about youth reproductive health and its current status is not well addressed while it is important to have a comprehensive community–based and institutional based data on parent communication to help putting the strategy in to practice.

Objective: To assess parent – adolescence communication on sexual and reproductive health matters and associated factors among non-boarding high school students in Shaygosh town, Qorahey zone Ethiopian Somali Regional State, Eastern Ethiopia from 19/03/2018 up to 23/03/2018.

Methods: This study was cross sectional with quantitative techniques. Data was collected from 356 students, which were selected through simple random method from the listed students name from shaygosh non boarding school. The obtained data was entered using Epidata and finally analyzed using SPSS version 20. Bivariate and multivariate analysis was done to identify the independent predictors of parent adolescent communication on sexual and reproductive health matters.

Result: - In this study, 117(32.9%) respondents discuss sexual reproductive health matters with their parents. Sex of the adolescents (AOR=2.5, 95% CI= (1.25-5.01)), educational status of mothers who read and write (AOR= 2.6, 95% CI (1.04-6.4)), adolescents who perceive discussion Crutiallity (AOR= 20.5, 95% CI (3.3-124.8)), educational status of father who complete secondary school (AOR= 5.1, 95% CI= (1.26-20.6) were associated with parent adolescent communication on SRH matters in the study area. Parent lack of interest to discuss, feeling shame and cultural taboos were the reasons for low parent adolescent communication.

Conclusion and recommendation: the study finding shows that there were low communication about sexual and reproductive health issue between parent and adolescents. Promoting parent adolescent communication on sexuality and improve peer to peer sexuality education program, promoting school sexual and reproductive health club in school and woreda health office to enhance parent adolescent communication and providing parent adolescent communication.

Key Word: parent, adolescent, communication, parent adolescent communication, factors that affect parent adolescent communication.

1. INTRODUCTION

1.1 Background

Adolescents are defined by World Health Organization (WHO) as at age group 10-19 years. The onset of adolescence which is more or less coinciding with puberty is often influenced by manifestation of puberty (Gherardi P., 1992). Adolescence is a critical period in life, during which people undergo extensive biological, psychological and social changes (WHO, 2015). And also it is a period of transition from childhood to adulthood where new behaviors are more easily learned than when in adulthood (Zemenu et al., 2015).

Before the coming of Lerner different scholars forward and write on adolescents but most of them are obsolete, of those scholars, Hall's, Anna Freud and Erik Erikson defined young people as "at risk" for behaving in uncivilized or problematic ways and therefore as being dangerous to themselves and to others (Hall, 1904; Freud, 1969; Erikson, 1959, 1968). But this frame of reference shifted in the early 1990s, as growing numbers of researchers they tried to viewed adolescence through the lens of systems theories that look at development throughout the life span as a product of relations between individuals and their world (Lerner, 2005). And viewed as “young people as resources to be developed rather than as problems to be managed” (Damon, 2004; Larson, 2000; Lerner, 2005).

WHO define Parental adolescent communication as a fundamental process through which parents convey ideas, values, beliefs, expectations, information, and knowledge to their children. Parents typically have the opportunity to communicate with their children’s thinking on a daily basis, and as such, parents can play a critical role in shaping their children as they move into adolescence and eventually into adulthood (WHO, 2004). Sexual and reproductive health is the base of peoples living and wellbeing; and is among the most essential aspects of life for adolescents and can affect many aspects of a person’s life during and after this time (Sisay et al., 2017). If adolescents are not aware of their sexual and reproductive health properly they may develop risk behaviors that may affect all life from that Risky sexual behavior acquire during adolescence, such as early sexual initiation, unprotected intercourse, and multiple sexual partner can place young people at risk of HIV infections and sexually transmitted infection (STIs), teenage pregnancy and abortion complications and like to engage in uncontrolled leisure activities, entertainment, music, alcohol, and sexual intercourse at younger age and with different people also place the adolescents at risk of their health (Seife et al., 2017).

Good family communication regarding sexual risk behaviors promotes knowledge, better sexual negotiation skills and self-efficacy and has been associated with less engagement in risky sexual behaviors (WHO, 2006; WHO, 2012). Despite its importance, communication about sexual and reproductive health is greatly influenced by the culture and social environment. Parent-adolescent communication remains challenging in many sub- Saharan African countries including Ethiopia. Initiating conversations about the sexual issues may be difficult for parents as they may be unsure as to how to approach such issues, doubt their competence in handling sexuality topics and the questions that may be raised by their adolescence or feel confused about the proper amount of information to offer (Zemenu et al., 2015). A number of studies are shown that increase parent child communication leads to a raised awareness and reduction in risky taking behavior (Tesfaye, et al. 2014). Moreover, most of information that the adolescents have come from peers of the same sex who may themselves lack adequate information or are incorrectly informed, mass media and sexual education from school are putting negative impact on adolescent sexual behavior (Kasiye et al. 2014).

Several studies also suggest the relationship of parental communication and sexual behavior of youth, Mentioned that parental guidance and strict monitoring on a child's relationships is one of the strongest protective factor against pre-marital sex that parents can provide for their children (Gumban D. et al., 2016; Parenting Positively, 2009). However, a number of factors, including lack of knowledge, skills, or comfort, may impede a parent's successful fulfillment of that role (Breuner C. and Mattson, 2016).

Having knowledge on reproductive health, puberty and sexuality and the consequence of sexual and reproductive behavior helps adolescents and youth in making responsible decision (Shaw, 2009). Traditionally it was believed that providing knowledge on SRH rights and availability of services make individuals to become sexually active (Magwaza 2007; Shaw 2009). But Study show that students received comprehensive sex education have the likelihood of reduced teenage pregnancy and delay in involving in sexual practice compared to those who have not received Sex and HIV education among youth decrease sexual risky behavior and increase the use of condom and contraceptives (Kirby 2007; Shaw 2009). Parental involvement and having open discussion with children can be one of the ways of promoting safe sexual life and poor parental involvement and lack of discussion on safe sexual life leads to lack of skill that helps adolescents to make important decision about their sexuality (Kasiye et al., 2014; Diribe, 2015).

Irrespective of number of adolescents, due to risky behavior and less communication between the parents and adolescents on SRH issue in developing countries the AIDS epidemic continues to disproportionately affect sub-Saharan Africa, especially eastern and southern Africa (ESA). More than 35million people are infected with HIV and this number is still increasing. The ESA region has only 6.2% of the world's population, but is home to half of the world's people living with HIV. In 2015, the region accounted for 46% of the world's new HIV infections and 42% of global AIDS-related deaths. An estimated 90% of new HIV infections among adults and young people in the ESA region occur through unprotected sexual transmission (UNAIDS, 2016).

There are more than one billion adolescents worldwide. Of these more than three quarter are found in developing countries where they frequently engage in risky sexual behavior, which result in unprotected sex, unwanted pregnancy, sexually transmitted infections including HIV and AIDS, unsafe abortions and other reproductive health problems that are the greatest risk to their well-being (Wasike N. et al., 2016; Sisay et al., 2017). In Ethiopia Young people (aged 10-24) represented one of the country's largest groups, comprising about 35 percent of the population. (FMOH,2010). According to EDHS 2011, Twenty-nine percent of women had begun having sex by the age of 15. Women start sexual activity about four and a half years earlier than men, Sixty-three percent of women in Ethiopia are married by age 18, compared with just 14% of men. And 1.5% of women and men age 15-49 are HIV-positive.(EDHS 2016). Less than 1% of women and 3% of men reported having two or more sexual partners in the past 12 months. And only 20% of women and 51% of men who had a non-cohabiting partner in the past 12 months reported using a condom during last sexual intercourse with such a partner. (EDHS, 2016). From several problems mainly low utilization of YFS and poor parental and adolescents communication amplified adolescents vulnerability to poor SRH outcomes, increasing their exposure to early marriage and early childbearing, unintended pregnancies, and sexually transmitted infections (STIs) (FMOH, 2010; Pathfinder International, 2012; Aboma et al., 2016).due to limited access to targeted RH services this problem become adverse to the adolescents which resides in rural areas (EFDR, 2003).

1.2 Statement of the problem

Many parents didn't discuss with their child until they discover their teen has already made difficult sexually related decision. By this time the teen has probably already engaged in sexual activity, and the child was not encouraged to discuss sexually related issues from an early age; the teen will feel uncomfortable with the subject matter at this point in time. As a result the teen might lie or tell the

parents what they want to hear in order to avoid an unsuitable situation. Since family can exert a strong influence on adolescents sexual behavior, It is important to understand the role of family influence on sexual behavior (Fine M. and McClelland S., 2006).

Parent-young people communication on Sexual and Reproductive Health (SRH) issues, nationally in Ethiopia, particular in Shaygosh town is believed to be culturally shameful and it is believed that informing adolescents about sex and teaching them how to protect themselves would make them sexually active. Due to this most female adolescents engage to unprotected sexual intercourse and this may lead to unwanted pregnancy and resulted to unsafe abortion. Although the government has identified Reproductive Health (RH) of young people as one of the priority areas in The National Reproduction Health Strategy taking the household and community as vehicles for change it is not yet put in practice. To the understanding of investigators, in Shaygosh woreda the role of parent-young people communication about youth reproductive health and its current status is not well addressed while it is important to have a comprehensive community–based and institutional based data on parent communication to help putting this strategy in to practice. Thus, the purpose of this study is to assess adolescent - parent communication about sexual and reproductive health and associated factors.

1.3 Significant of the Study

Communication between parents and adolescents about sexual and reproductive health issues and impact of this communication on youth’s and adolescent's sexual behavior has been one important research area; so The result of this study will help Shaygosh woreda health office and different nongovernmental organization that are found in Shaygosh woreda to make the program that focused on the initiation of parent-adolescent communication about sexual RH issues.

1.4 Objectives of the study

1.4.1 General Objective

To assess parent – adolescence communication on sexual and reproductive health matters and associated factors among non-boarding secondary and preparatory school students in Shaygosh town, Qorahey zone, Ethiopian Somali regional state, Eastern Ethiopia from March 19/2018 up to March 23/2018.

1.4.2 Specific Objectives

- To assess the level of parents - adolescent communication on sexual and RH issues.
- To identify factors associated with parents- adolescent communication on sexual and RH.

2. Literature Review

2.1. Level of Parent-adolescent Communication

From study in Mekele which was done in 2013, 300 (57.6%) participants reported that they had discussed about at least one topic of sexual and reproductive health with either of their parents (Zemenu et al., 2015). And study in Debremrkos in 2011 also showed that 433(60.7%) of the respondent discus at least one topic with their parents (Kasiye et al., 2014). Similar study in Yirgalem in 2013 the communication of parent with their adolescence at least one topic shows 59.1% from this 248 (37.6%) of adolescents preferred to discuss about sexual and reproductive health issues with their mothers. However, only (21.5%) of adolescent had preferred to discuss about sexual and reproductive health issues with their fathers (Zemenu and Birhane, 2015).

In opposite to the above result the study in Mizan town in 2016 from the total 356 respondents only 103(28.9%) of respondents reported that they had discussed about at least one SRH issues for the last 12 month of the study period with their parents (Sisay et al., 2017) and the other study in Nekemt E/ Wollega zone on parental adolescence communication in 2010 shows that only 32.5% discussed on SRH issue (Dessalegn et al., 2012). Similarly the study in Harer in 2011 also show only 206(28.76%) of the respondent had reported discussion about at least two component of RH matter in the last six month (Tesfaye et al., 2014). And the study in kenya in 2014 shows there was limited communication among male (16.7%) and female adolescents (5.5%) with their parents (Wasike N. et al., 2016).

The studies from Yirgalem majority of the students 359 (54.4%) had discussed sexual reproductive health with their friends, followed by 141 (21.4%) with sisters (Zemenu and Birhane, 2015). Similarly the study in Mizan majority 69 (84.2%) of them were discussed with their peers followed by their fathers 41 (50%) (Sisay et al., 2017). Similar study in Mekele 199 (38.2%) adolescents were communicate with mothers and 101(19.4%) with fathers (Zemenu et al., 2015). But the study in Kenya in 2014 on parent-adolescent communication on SRH was peers and friends had got highest number which was 93.7% for males and 95.1% for females (Wasike N. et al., 2016). In the United States receive sexual health information, parents and teachers were the source of information for 55% of girls and 43% of boys (Hall KS, 2016). The study in Debremarkos it is found 45.9 % it easy to discuss with their parents. The respondents were also prefer to discuss with both parents (47.6 %), with father (25.2%), mother (17.6%) and peers (9.7%) (Kasiye et al., 2014). The study In Cape Town, 31% preferred discussing with mothers, and 22% stated a preference for fathers, Dares Salaam and

Mankweng, a greater proportion of males preferred discussing with fathers in comparison to mothers 47% and 27% in, respectively (Bastien et al., 2011).

The researches in Yirgalem shows about respondents 238(36.1%) had discussed about unwanted pregnancy, 219 (33.2%) of the participants had discussed condom, 231 (33.5%) of the students had discussed about sexual intercourse, 238 (36.1%) had discussed on contraceptive methods and 262 (39.7%) of the respondents had discussed on physiological and psychological changes seen in puberty (Zemenu and Birhane, 2015). Similarly the study in Mizan out of 103 of total respondents only 31 (30.1%) of them had discussed about sexual intercourse (Sisay et al., 2017). And Study in Mizan among 103 total respondents 65(63.1%) of them had discussed about contraceptive methods (Sisay et al., 2017). Results from Mekele more than half (59%) Adolescents were discussed with friend on physiology and psychological change during puberty (zemenu et al., 2015). Similar study in Mizan out of 103 of the total respondents 62(60.2%) of them had discussed about the physiological and psychological changes that occurs during puberty (Sisay et al., 2017).

2.2 Factors associated with adolescent-parent communication about SRH

2.2.1 Socio demographic factors

The study from different areas, parents' educational status, living arrangement and level of education of respondents, Attitude towards discussing RH were found to be significantly associated with communication of adolescents with their parents about sexual and reproductive health matters (zemenu et al.,2015, Tesfaye et al.,2014, Atitegeb et al., 2016, Desalegne W et al., 2012). The study in Mekele in 2013 reveals that Adolescents whose mother's educational level 12 and above were about 3 times more likely to communicate about sexual and reproductive health matters with their parents as compared to those who had not attended formal education (Zemenu et al., 2015). Study in eastern Nekemte shows high school mothers are 1.56 times more to discuss with their adolescent than mother who are not educated.(Dessalegn et al.,2012). The cross-sectional study in Harer in 2011 as similar with the above parent who were grade 10 and above were 17.35 times more to discuss on sexual than no formal education (Tesfaye et al., 2014). In opposite to the above the study in Bodity mother who completed secondary education are 45% less likely to discuss with their adolescents on sexual and reproductive health matters.(mulugeta et al., 2016). In addition study in Debremarkose in 2012 parent who able to read and write were 2 times more likely to discuss on SRH with their child than no read and write (kasiye et al., 2014).Similar study in Gorro shows mothers who read and write

were 5.9 times more likely to discuss with their adolescents than do not read and write. (Mersha and Getachew, 2018).

Similarly, the study in Mekele adolescents whose father's educational level 12 and above were about 2 times more likely to communicate about sexual and reproductive health matters with their parent's as compared to those who had no formal education (Zemenu et al., 2015). The study in Dire-Dawa in 2011 indicates Grade 12 students were 1.6 times more likely to discuss on sexual and reproductive issue with their parent than those in grade nine (Mulatwa et al., 2014). On the contrary, study in mekele adolescents whose levels of education 12 were 0.55 less likely to communicate about sexual and reproductive health with their parents as compared to those whose educational level were grade nine (Zemenu et al., 2015). The study in Dire-Dawa indicates discussing on sexual and reproductive issues were 40% less in males compared to females' students (Mulatwa et al., 2014).Similarly the study in Nekemte males are 40% less likely to discuss on SRH than females. (Dessalegn et al., 2012). In addition to the above the study in Bodity females are 1.42 times more likely to discuss on SRH issues than males.(Mulugeta et al.,2016). On the contrary the study in Awabel woreda in 2014 shows discussing on sexual and reproductive health issue were 1.63 times more likely in males compared to females (Atitegeb et al., 2016). And also the study in Haiyk also shows males are 4.2 times more likely to discuss with their parents than males (Tefera and Niguss, 2018).

Moreover, The study in Bodity the father adolescent who were government employee are 1.13 times more likely to discuss with their adolescent on sexual reproductive health than others workers (mulugeta et al., 2016). The study in Debremarkose in 2012 adolescents who ever got SRH information was 2 times more protective than whoever not gets SRH information. And the practicing of contraceptive Condom use during first intercourse was associated with having communication about sexual and reproductive health 1.9 more like to use than not having discussion (Kasiye et al., 2014). From study in Dire-Dawa Students who use condom during their first sexual intercourse were 1.9 times more likely to have communication about sexual and reproductive health issues than those who do not use condom (Mulatwa et al., 2014).

The study in Awabel woreda in 2014 shows discussing about sexual and reproductive health were 2.46 times higher among young people who were living with their father than those living with their couple. The cross-sectional study in Harer Housewife demonstrates a 50% lower tendency to discuss RH issue compared with government employee. The study done in Bodity respondents who perceive

the Crutiallity of to discuss on SRH issue with their parent were 2.98 times more likely to discuss than not perceive to discuss. (Mulugeta et al., 2016). Similarly the study done in Debremarkos also shows adolescents who perceived the Crutiallity of discussion on sexual and reproductive health matters with their parents were 2.5 times more likely to discuss than not perceive to discuss. (Kasiye et al., 2014).

2.2.2 Sexual Behavior of adolescent students

The study in Dire-Dawa in 2011 more than one fourth (28.5%) of female students were accept premarital sex (Mulatwa et al., 2011). Similarly the research that had done in Yirgalem town on 2013 352 (53%) of the students believed that it is normal and acceptable to have sexual feeling during adolescents (Zemenu and Birhane, 2015). But Study in Mekele town secondary school students revealed that only 119 (22.8%) of the students believed that it is normal and acceptable to have sexual feeling during adolescent period (Zemenu et al., 2015).

From the study in Mekele regarding about their practice, 83 (15.9%) of the students had made sexual intercourse. The mean age when sexual practice started was 15.9 (Zemenu et al., 2015). Similarly the study in Yirgalem 145 (22%) students had made sexual intercourse the mean age was 15.5 (Zemenu and Birhane, 2015). But the researches in kenya shows the median age at first sexual intercourse is about 18 years for both men and women (Kenya Ministry of Health, 2011). In Mekele study among those who practiced sexual intercourse, 22(26.5%) reported that they made sexual intercourse with unknown person. but most 60 (72.28%) of the students made sex using condom (Zemenu et al., 2015). On the same way the study in Yirgalem 36 (24.8%) made sex unknown person but most of them about 89 students used condom (61.4%) (Zemenu and Birhane, 2015). But study in Dire-Dawa shows only 89 (13.88%) sexually active students used condom during sexual intercourse (mulatwa et al., 2011).

The researchers in Yirgalem told that 71 (48.97%) initiate sexual intercourse by themselves 29 (20%) initiate sexual intercourse by addiction, 27(18.7%) initiate sexual intercourse by peer pressure and 18 (12.4%) initiate sexual intercourse by reception (Zemenu and Birhane, 2015). In the study from Dire-Dawa approximately one-third (32.3%) student strongly disagreed having premarital sex. 234 (36.5%) of students, strongly agreed about maintain their virginity until marriage. On the other hand, 250 (39%) of respondents strongly agreed premarital sex if they use condom (Mulatwa et al., 2011).

2.2.3. Attitude and practice of adolescent students towards parental monitoring

The study in Mekele the parental monitoring shows most 344(66%) of the respondents agreed that parental monitoring to adolescents activities should be in place (Zemenu et al., 2015) and the same study in Yirgalem revealed that 498 (75.5%) of the respondents agreed parental monitoring in adolescents activities (zemenu and Birhane, 2015). and study in Debremarkos in 2012 adolescents who were asked about parental monitoring and control, 83.3 % of respondents said they are controlled by their families about where they are and what they are doing every day. From this, 56.7 % of adolescents controlled strictly, 31.5 % said liberal and 11.8 % said control in somewhat loss (Kasiye et al., 2014). The study in United States showed that more than 80% of adolescents 15 to 19 years of age received formal instruction about STIs, HIV, yet only 55% of males and 60% of females received instruction about birth control (Hall KS, 2016).

2.2.4. Knowledge of adolescents about contraceptive methods and sexually transmitted infection

The cross-sectional study in Mekele in 2013 shows that among the adolescent students, 409 (78.5%) were aware of at least one contraceptives methods from this 304 (64.1%) & 301 (57.8%) participants reported that they had heard about condom and pill respectively. However, the majority of the respondents (69.4%) didn't practice any of the methods. 247(34.6%) who ever had sexual intercourse, who used contraceptive method were 38.8 % consistently used at the time of sex, 46.3 % sometimes and 15 % when their partner allowed (Zemenu et al., 2015). And the study in Yirgalem also shows 593(89.8%) students were aware of contraceptive methods from this 409 (62%) had heard Depo-Provera & 384 (58.2%) had heard pills (Zemenu and Berhane, 2015). similar cross sectional study in Mizan town in 2016 from the total 65 (18.5%) respondents who discussed about contraceptive method majority 51(78.5%) of discussed about Abstinence followed by condom 49(75.4%). whereas only 8(12.3%) of them discussed about IUCD (Sisay et al., 2017). The researches in Dire-Dawa indicates from six hundred ninety five majority of the students, 531 (82.8%) of students knew about at least one contraceptive method that are used to prevent unwanted pregnancy. Condom (47.7%) followed by abstinence (37.1%) were mainly reported contraceptive methods to prevent unwanted pregnancy (Mulatwa et al.,2011).

The study in Yirgalem also shows 631 (95.6%) of the respondents knew about STI and HIV/AIDS. Among 528(80%) knew about HIV/AIDS, followed by Gonorrhea 310 (47%) (Zemenu and Berhane, 2015). Similarly the study in Mizan from the total 82 (23%) respondent who had discussed about Sexually transmitted infection issues majority 68(82.9%) of them had discussed about HIV/AIDS

followed by Gonorrhea 21(25.6%) whereas 20 (24.4%) and 17(20.7%) of them had discussed about syphilis and cancroids respectively (sisay et al.,2017). The study in Mekele adolescent students were asked to spontaneously mention STI. Accordingly, 415(79.7%) respondents mentioned at least one type of STI (Zemenu et al., 2015).

2.2.5. Adolescents' Reasons for not discussing with Their Parent on SRH and for not made sex

From study in Mekele secondary school among the total of 521, 221(42.4%) Adolescents were reported that they didn't discuss with parents in at least one topics of SRH. The reason was parents didn't know and shameful were 114(21.9 %) and 107(20.5 %) respectively (Zemenu et al., 2015). The study in Yirgalem also shows Communication on STI/HIV/AIDS about 318 (48.2%) did not discuss it was because of 99(15 %) shameful, 67 (10.2%) parents lack of knowledge, and another 42 (6.4%) culture (Zemenu and Berhane, 2015). And other study in Dire-Dawa shows lack of communication skill 94(22.3%) and being ashamed 89(21.0%) were a reason for failing to discuss about contraceptive (Mulatwa et al., 2014).

The other research which is done in Kenya on 2014 shows the leading factors among males were cultural norms (95.5%) and fear of discussing such issues (93.1%). The same was mentioned by female counterparts, majority of whom mentioned cultural norms (96.2%) and fear of discussing the matter (95.1%) (Wasike N. et al., 2016). From the study in Dire-Dawa the reason of premarital sex disapproval were to maintain their virginity until marriage, religious value, fear of STIs, waiting until getting older and fear of unwanted pregnancy 30.7%, 15.9%, 12.6%, 5.9%, 4.5%, respectively (Mulatwa et al., 2011).

2.3 CONCEPTUAL FRAME WORK

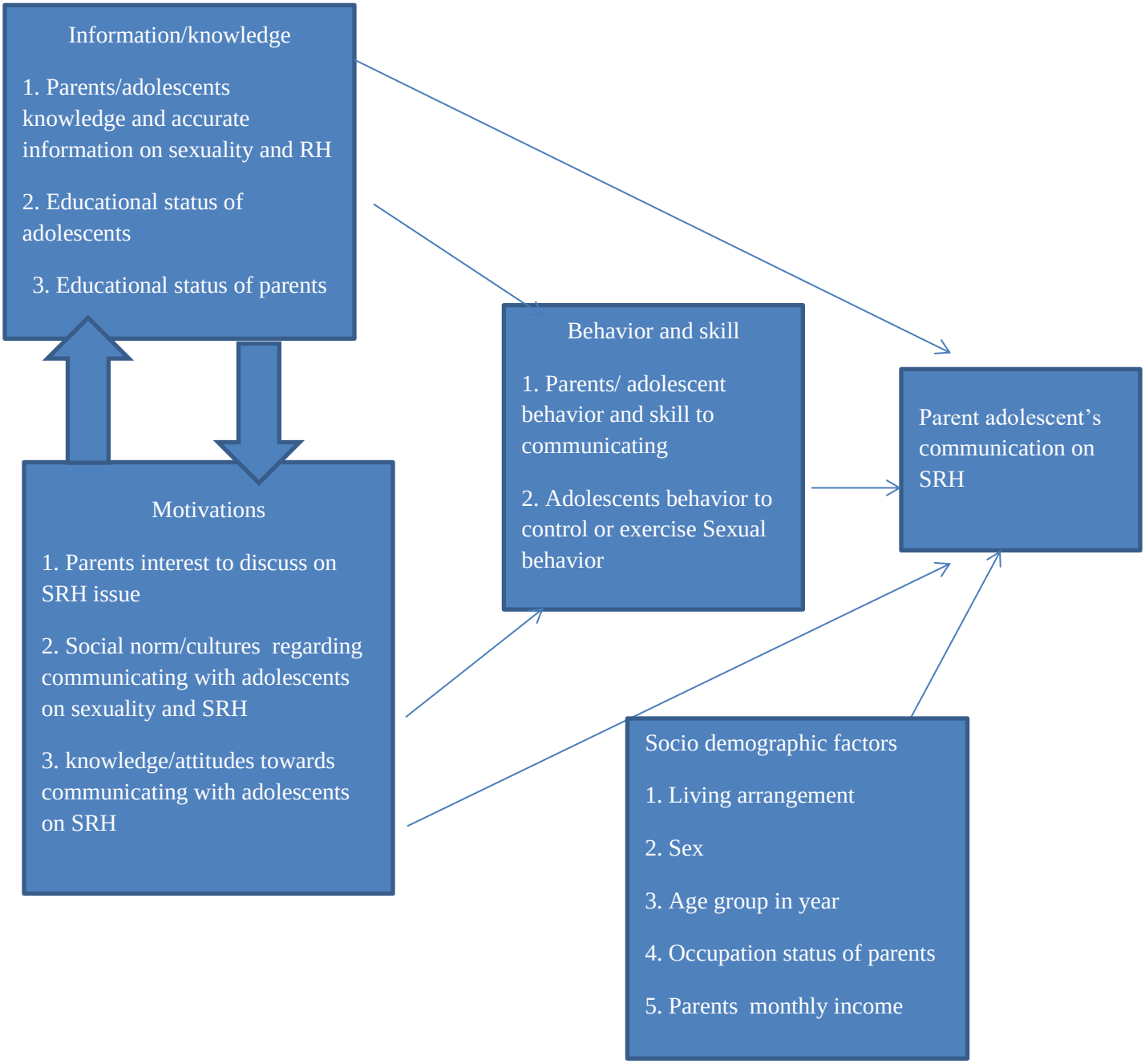

Fig. 1 conceptual frame work of parental adolescence communication on SRH by using IBM model (source: fisher and fisher, 1992)

3. METHDOLOGY

3.1 Study area:

Shaygosh is one of the nine woredas of Korahe zone Somali region of Ethiopia. Shaygosh is bordered on the southeast by Kebri Dahar, on the west by the Fiq zone, and on the north by the Degahabour zone. The largest city for Shaygosh woreda is itself Shaygosh. Shaygosh town is 120km far from the Kebridar which is zonal city of Korahe and 276 km far from Jjigjiga, capital city of Somali region and 1080 km far from Addis Ababa, capital city of Ethiopia. Shaygosh woreda have nine kebeles and from this three of them are found in Shaygosh town. In Shaygosh woreda there are seven (1-4) grade school, three (1-8) class schools and two high schools, one is governmental and the other one is NGO School which is (1-12) which is named as Shaygosh Bording School for pastoralist, and also it consisted two health center and nine health post. The only perennial river in Shaygosh is the Fafan with large valley, good for farming (Shaygosh woreda Agricultural Office, 2017).

3.2 Study period:

The study was conducted from March 19/2018 up to March 23/2018.

3.3 Study design:

The study was a school based cross-sectional study by using quantitative method.

3.4 Source population:

Students who were attending in Shaygosh non-boarding secondary and preparatory school were being the source population.

3.5 Study population:

All students who were attending in Shaygosh non –boarding secondary and preparatory school.

3.6 Inclusion and Exclusion

3.6.1 Inclusion criteria:

All students those attended in Shaygosh non-boarding secondary and preparatory school.

3.6.2 Exclusion criteria:

Students those were very sick (i.e unconscious or semi-conscious).

Students who were absent on the data collection time.

3.7 Sample size determination:

The sample size to address the first specific objective was calculated using single proportion formula the previous study in Dire-Dawa population proportion with discussing RH issue is 37 % (Mulatwa et al., 2014). Discussing RH issue prevalence was taken as P for the first objective and 95% CI, where n sample size, Z critical value at 95% CI (1.96), d- marginal error (5%). It was calculated as follows.

$$n = z2P\ (1-p)*D/d2$$

$$n = (1.96)2*\ 0.37(\ 1-\ 0.37)/\ (0.05)2$$

$$= 3.8416*\ 0.37(0.63)/\ 0.0025$$

$$=3.8416*0.2331/0.0025$$

$$= 0.8955/0.0025 = 336.8$$ and add 10% for non-response rate and became 370

n = sample size

P= anticipated prevalence

d= relative precision to anticipated prevalence

Z= confidence limit

In addition to the above in order to calculate the sample size for the second objective the investigator used the Epi info software and determines the sample size as follow see table 1.

Table 1. Sample size calculation for the second objective of considering factors associated with parent adolescence communication. To calculate the sample size by taking the assumption of power 80%, 95% confidence interval and ratio of unexposed to expose is 1.

	Zα/2 of 1-β/ power	Zα/2 of 95% certainty	P1	P2	Ratio	n1	Sample size(n1+10%)
Knowledge about reproductive health (Kasiye et al., 2014)	0.84	1.96	0.384	0.125	1:1	162	178
Residence area (Atitegeb et al., 2016)	0.84	1.96	0.288	0.159	1:1	114	126
Level of education(Zemenu et al.,2015)	0.84	1.96	0.632	0.458	1:1	278	306

Finally from the objective one and second objective the largest sample size was taken as 370.

3.8 Sampling Procedure

Shaygosh high school total have 610 students and my sample size were 370 so in order to get the sample size from the total of the student the investigator use the simple random method to select the sample of the students from each class then add each sample and it becomes total sample size of 370. The sample frame was list of the students from the school.

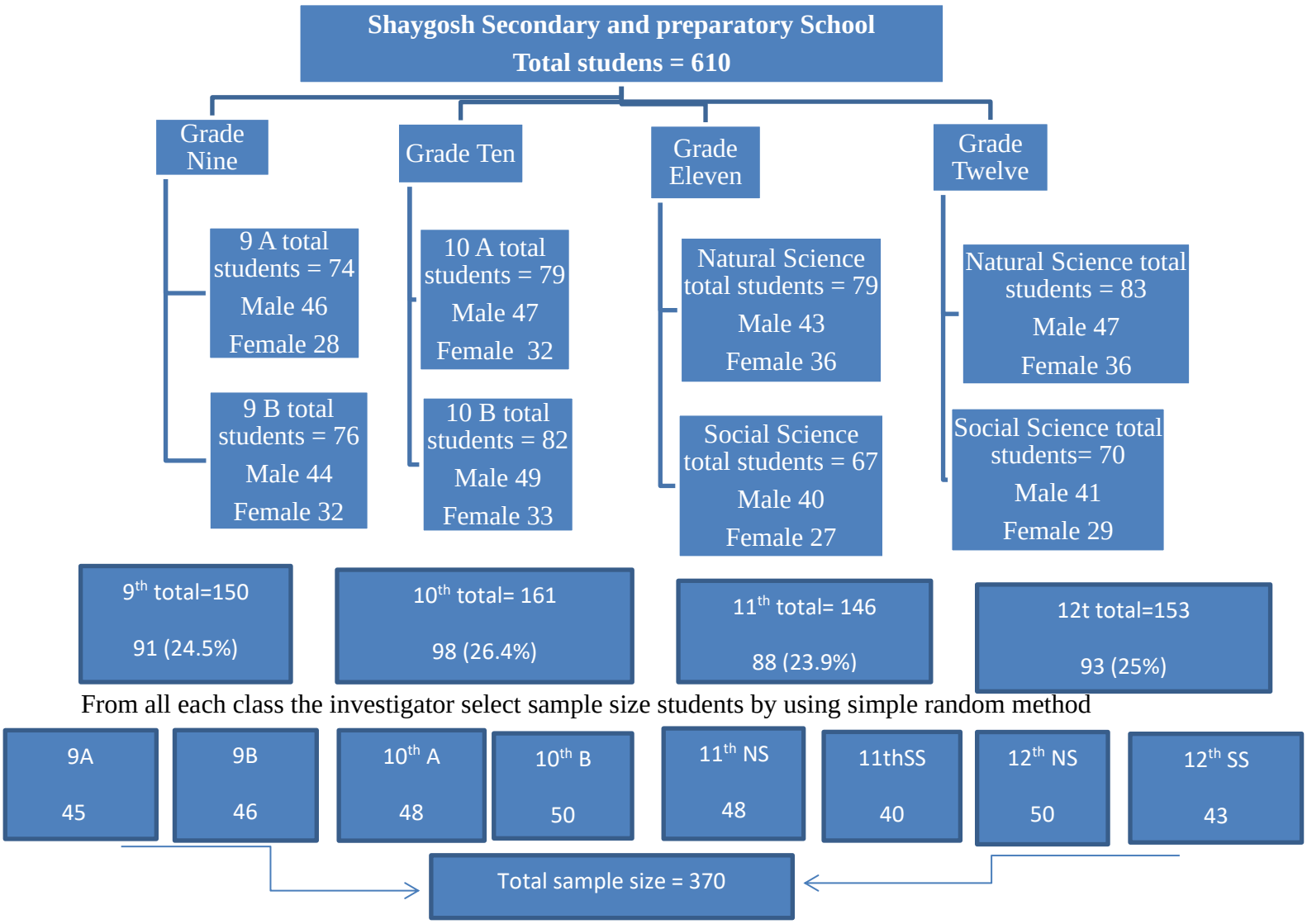

Fig. 2 Schematic presentation of sampling procedure.

3.9 Data Collection Technique

Data on parental adolescent's communication and other factors were gathered by using structured questionnaire and it was self-administered. Questionnaire was adapted from WHO standard question and relevant literatures. The questionaries' was translated to local language (Somali language) and it was consist of socio demographic characteristics, knowledge about RH, attitude towards reproductive health, and discussion of RH related question. The data was collected by trained data collectors. The principal investigator and the coordinator was strictly follow the overall activities for each activity on daily bases to ensure the completeness of questionnaire, to give further clarification and support for data collectors.

3.10 Variable (Dependent, Independent)

3.10.1 Dependent variable

- Status of parent adolescent communication on sexual and SRH.

3.10.2 Independent variables

Socio demographic characteristics: sex, age, religion, educational status, marital status, ethnicity, living arrangement, mother education, father education, occupational status.

Sexual reproductive health topic discussion: STI/HIV, Abstinence, contraception, unintended pregnancy, pre-marital sex, condom utilization, menstruation and symptoms of STI (USAID, 2015)

Factors associated with parent adolescent communication; Sex, Age, Living arrangement, educational status of mother, Educational status of Father, Attitude towards discussing RH.

3.11 Operational Definitions

Adolescent: children whose age was between 10 up to 19 year.

Parent: is a caregiver of adolescents they may be biological parent, adoptive parent and parents like grandparents or other family members (Wikipedia).

Parent adolescent communication: at least one communication or discussion on sexual and SRH topics (i.e. STI/HIV, Abstinence, contraception, unintended pregnancy, pre-marital sex, condom utilization, menstruation, sperm aches and symptoms of STI) between parent and adolescence with in the past six month.

Perceiving discussion Crutiallity: believing discussion on sexual and reproductive health matters with their parents is crucial and protects them from risky behavior.

Social norms/cultures: Shame, Culturally not accepted, lack of interest to discuss due to social factors.

3.12 Data Quality Control

The questionnaire will be prepared in English and then translated to Somali language and again translated to English to keep the validity of the questions and to increase understanding with respondents. To ensure quality of data, pre-test on 5% of the sample of the questionnaire were done in a similar school in Birkot town to know the length, content, question wording and language understand ability of the question before one weeks of the actual data collection time. Data collectors

were get training for one day on the proper collection of data. Then it was checked for wording, way of asking, and reliability of the measurement. Supervisors were check data collectors and the data that collected from the respondents for consistency. Appropriate correction was made accordingly.

3.13 Method of data processing and analysis

Data was checked for completeness and consistencies, and then cleaned, coded and entered using Epi Info version 7, then exported to SPSS version 20 and checked for missing values before analysis. (Univarate analysis) descriptive statistics using measure of central tendency and dispersion, frequencies, proportions and diagrams were used variables. Logistic regression analysis was carried out to assess determinants on parental adolescent communication and to control for possible confounders. Bivariate analysis was used to assess the strength of an association between dependent variable (parent adolescence communication) and list of independent variables and test significance of the association was tested. Odds ratio with 95% confidence interval used to measure strength of association. In conducting these tests Statistical significance was considered at a p- value of less than 0.05.Multivariate logistic regression model used to identify the important determinants by controlling for possible confounding effects and was conducted to calculate for adjusted odds ratios with a 95% confidence interval.

3.14 Ethical Approval

The study was conducted after obtaining approval and clearance from the Institutional Health Research Ethics Review Committee (IHRERC) of the college of health and medical science, Haramaya University and informed, voluntary, written and signed consent from the head of the school. Additionally; consent were obtained from the students whose age is 18 years and above and also for those students aged below 18 years informed, voluntary, written and signed consent were obtained from their parents or from their legal guardians. Confidentiality of the information and privacy of the interviewee were keep throughout the data collection and the entire study period. Their name was not written and collected data were coded.

3.15 Information dissemination

The result of this study will be disseminated to Haramaya University College of Health and Medical science Department of public health, Ethiopian Somali Regional State Health Beaurae, Shaygosh Woreda Health Office and other concerned bodies of governmental and non-governmental in the study area through reports and publication on reputable journal.

4. RESULT

4.1 Current situation of parent adolescent communication in Shaygosh

4.1.1 Socio-demographic characteristics

From this study total of 356 students participated in this study with a response rate of 96.2%, out of the total respondent 181(50.8%) were male. The mean ages of participants were 16.08 ± 1.63 SD years. 90(25.3%) of the participant were from grade 9, 88(24.7%) were from grade 10, 86(24.2%) were from grade 11th and 92(25.8%) were from grade 12th.

From the total of study participants nearly all of 349 (98.0%) respondents were Somali by ethnicity, 4(1.1%) Tigray, 2(0.6%) Gurage and 1(0.3 %) were Oromo. Majority, 353(99.2%) of the respondent were Muslim by religion and only 3(0.8%) participants were orthodox. 350(98.3%) participant were ever attend to their religious institution from this 78 (22.3%) participant were attend daily, 117(33.4%) of participant attend at least once in a week and the rest 155(43.5%) of participant attend occasionally. From 356 participant 291 (81.7%) of the participant were live with both parent, 36(10.7%) live with the father only, 24 (6.7%) live with mother, 3(0.8%) live with the grandparent and the rest 2 (0.6%) live with their brother/sister (Table 2).

Table 2. Socio demographic characteristic study participant in Shaygosh non-boarding secondary and preparation school, Ethiopia Somali regional state, Eastern Ethiopia, March, 2018 (n= 356).

Socio-demographic variable of the student	Level	Frequency(n)	Percentage
Sex of student	Male	181	50.8 %
	Female	175	49.2 %
Age of student	10-13	22	6.2 %
	14-17	259 %	72.8 %
	18-19	75	21.1 %
Education (grade) level	9th	90	25.3 %
	10th	88	24.7 %
	11th	86	24.2 %

	12th	92	25.8 %
Ethnicity	Somali	349	98.0%
	Tigray	4	1.1 %
	Gurage	2	0.6 %
	Oromo	1	0.3 %
Religion	Muslim	353	99.2 %
	Orthodox	3	0.8 %
Ever attending service in religious institution	Yes	350	98.3 %
	No	6	1.7 %
Frequency of attending the service	Daily	78	22.3 %
	At least once in a week	117	33.4 %
	Occasionally	155	43.5 %
Living status	Both parents	291	81.7 %
	Father only	36	10.7 %
	Mother only	24	6.7 %
	Grand parent	3	0.8 %
	Brother/sister	2	0.6 %

4.1.2 socio-demographic characteristics of parent

Out of total of 356 participant parent, 353 (99.2%) participant parents were Muslim by religion and only 3(0.8%) participant parents were orthodox. Nearly all 350(99.2%) participant parents were ever attend a religious institution from this 78(22.3%) were attend the institution daily, 117(33.3%) were attend once in a week and 155(43.5%) were attend occasionally. Marital status of parents 288(80.9%) were married and living together, 33(9.3%) were divorced and 35(9.8%) were widowed. Majority, 280(78.7%) were head of family were father, 56(15.7%) mothers were head of family, 20(5.6%) were self-head.

4.1.3 Topics of discussion on the sexual and reproductive health

In this study from the total of 356 study participant the proportion of the student who had discuss on sexual and reproductive health issue with their parent was found to be only 117(32.9%) of students

discuss at least one topic about sexual issue with their parent in the past six month and from this 54 (46.1%) of the participant discuss on STI/HIV with their parent (Fig 3).

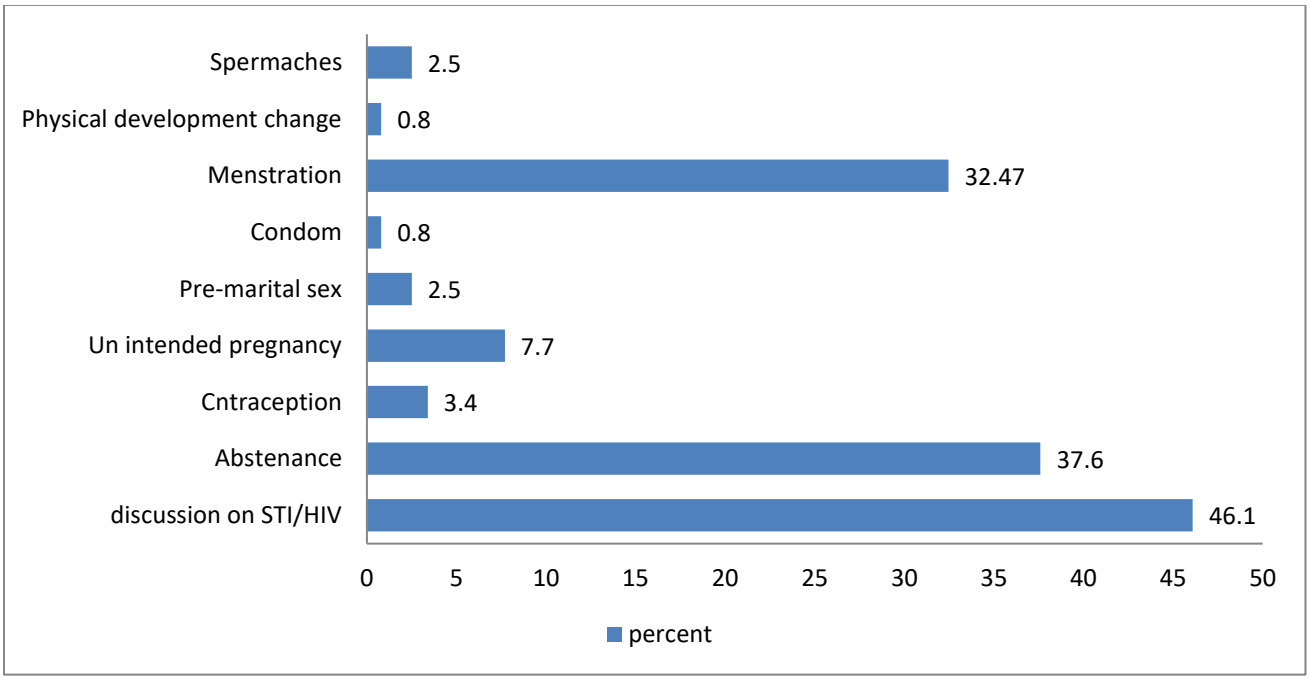

Fig 3. Topics of discussion that adolescents discuss with their parents on the sexual and reproductive health matters in Shaygosh Non Boarding high school out of 117.

4.1.4 Reason not to discuss sexual and reproductive health matters

From the total of 356 study participant the proportion of the student who had no discuss with their parents were 239 (67.1%) from this feeling shame 175 (73.22%) were major reason for not discussion (Fig 4).

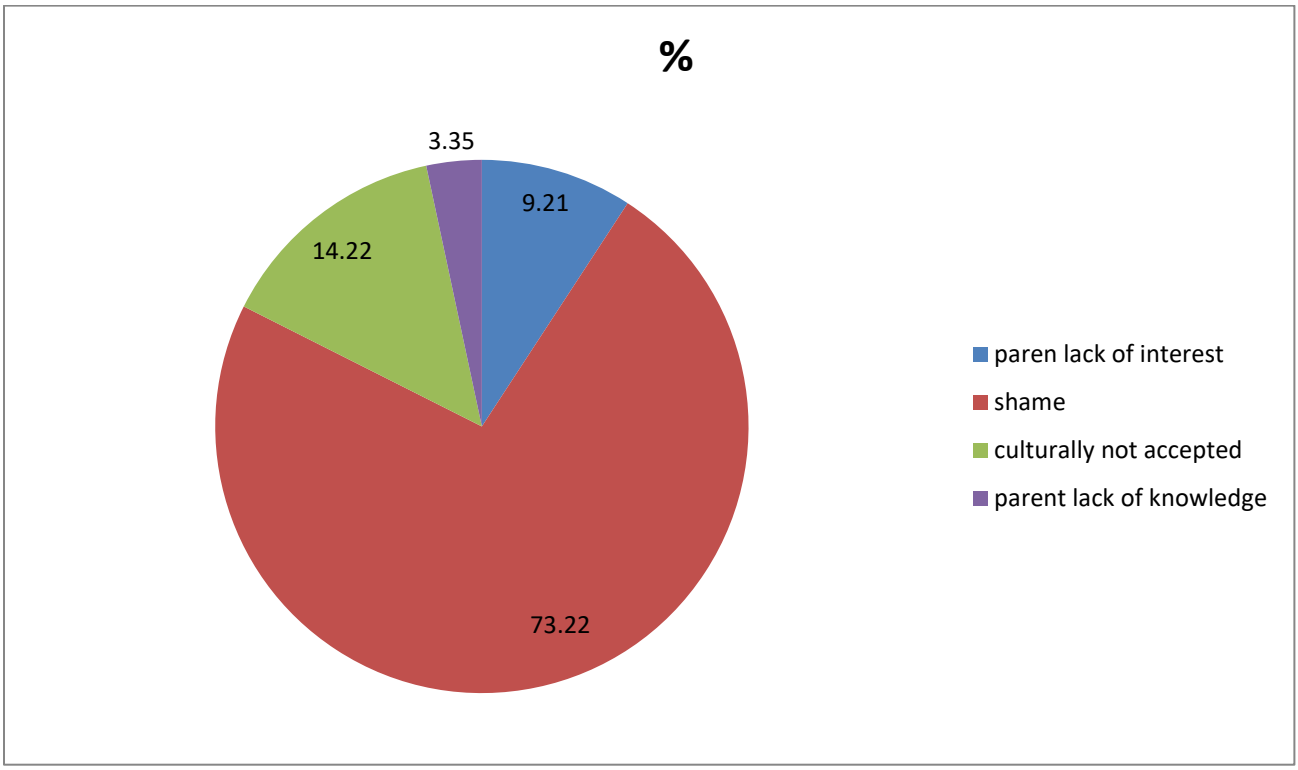

Fig 4. Adolescents reason not to discuss with their parents on sexual reproductive health matters in Shaygosh non boarding secondary and preparatory students.

4.1.5 Sexual behavior of the participants

Majority, 250 (70.2%) of a participant had no a boy/girlfriend, 107(29.8 %) have a boy/girlfriend from this most of the participant who have boy/girlfriend 63 (59.4%) meet there girl/boy friends in the school and 39(36.8%) a participant meet in village. 273 (76.7%) of the participant response it is not common to practice sexual intercourse after puberty stage. From the total of participant 64(17.97%) of participant made sexual intercourse in the last six month, 68(19.1%) had made sex in the life and from this 2(2.9%) made sex with another lady or guy who is 5 years more, 6(8.8%) made sex who is between 3-5 years old more, 13(19.1%) made sex with who is 1- 3 years more, 43(63.2%) made sex with similar age lady/guys, 4(5.9%) participant made with less than age of them.

4.1.6 Knowledge about contraceptive

About 273(76.9%) of a participant know at least about one contraceptive from this nearly all, 270(98.4 %) participant know about condom, 193(70.7%) participant know pills, 67(24.5%) know about injection (Depoprovera),1(0.4%) know Norplant but IUCD and periodic abstinence are not

known by the participants. And contraception used by the adolescent were 24(6.8 %) from this 23(95.8 %) participant/partner practice using condom, 1(4.2 %) participant / partner used a pills. The reason to use contraceptive 18 (94.7%) participant used to prevent pregnancy and 1(5.3%) participant used to prevent HIV/AIDS.

4.1.7 Knowledge of HIV/AIDS and other STIs

Majority, 302(84.83%) of the participant have ever heard about sexually transmitted disease. Out of this, 300(99.3%) participants had heard about HIV/AIDS, 43(14.2%) heard about syphilis, 10(3.3%) heard about Gonorhea and 9(1%) participant heard about Chancroid, 51(14.4%) participant had sign and symptoms of STIs and from this all 21(41.2%) participant prefer to go hospitals or public institutions, 28(54.9%) participant prefer to go private clinic and only 2(3.9%) participant prefer to go pharmacy (Table 3).

Table 3. sexual behavior, knowledge on contraceptive and knowledge of HIV/AIDS and other STIs of the participant in shaygosh non-boarding high school, Ethiopia Somali regional state, Eastern Ethiopia, March, 2018 (n= 356).

	Categories	Frequency	Percentage
Reason to decide to had sexual intercourse	Urging for a friend	11	16.2 %
	Fell in love	27	39.7 %
	Had the desired	28	41.2 %
	To get money and other gifts	0	0%
	Forced	2	2.9 %
Using condom in the first sexual intercourse	Yes	21	30.9%
	No	47	69.1%
Using of condom in the last sexual intercourse	Yes	23	33.8 %
	No	45	66.2 %
Reason not to use condom in the last sexual intercourse	It decrease pleasure	7	14.9 %
	Sexual partner objected	3	6.4 %
	Ashamed to buy	2	4.3 %
	Do not think of it	31	66.0 %
	Too expensive	3	6.4 %
	Religious reason	1	2.1 %
Number of sexual partner	One person	60	88.2 %
	Two person	8	11.8 %
	More than two	0	0 %
Reason not to made sex	To maintain virginity	81	28.1%
	Religious value	173	60.1 %

	Fear of STIs	8	2.8 %
	Waiting until marriage	13	4.5 %
	Fear of unwanted pregnancy	13	4.5 %
Frequency of using condom	Consistently at the time of sex	17	89.5%
	Occasionally	2	10.5 %
	When my sexual partner allowed	0	0 %
Reasons not use the contraceptive	Religious and cultural reasons	1	3 %
	Not available	1	3 %
	Too expensive		0
	Afraid of to ask my sexual partner	6	13.04 %
	Sexual partner objected	0	0%
	Ashamed to buy	11	23.91 %
Knowledge on HIV/AIDS	Yes	297	83.4 %
	No	59	16.6%
Source of information to HIV/AIDS	Parent	25	8.4%
	Peer	54	18.2 %
	School clubs	277	93.3 %
	Mass media	149	50.2 %
	Churches/mosques	3	1 %
It is possible for health looking person to have HIV virus	Yes	101	28.4 %
	No	255	771.6%
Do you think you are exposed to HIV/AIDS	Yes	12	3.4 %
	No	344	96.6 %
In your opinion, which can be effective method to prevent HIV/AIDS	Using condom	83	23.4 %
	To have one sexual partner	145	40.8 %
	Abstinence	330	93 %
Willingness to up take VCT	Yes	252	70.8 %
	No	104	29.2 %

4.1.8 Parent adolescent communication and monitoring(control)

From the total of 356 study participant the proportion of the student who had discuss on sexual and reproductive health issue with their parent at least one topic in the past six month was found to be only 117(32.9%). From the above result 20(17.1%) participant report that it was very easy, 15(12.8%) participant response it was easy, 28(23.9%) response it was average 40(34.2%) response it was difficult and 14(12.0%) response it was very difficult. From the participant that answer yes, 50(42.7%) said they discuss one times, 42(35.9%) participant said two times and 9(7.7%) said three times and 16(13.7%) participant said more than three times. The topic the 54(46.2%) participant were discuss on STI/HIV, 67(57.3%) were on abstinence, 44(37.6%) on contraceptive (Table 4).

Table 4. Socio-demographic characteristics of parent, parent adolescent communication and control in Shaygosh non-boarding high school, Ethiopia Somali regional state, Eastern Ethiopia, March, 2018 (n= 355).

Socio demographic variable of parent	Level	frequency	Percentage
Marital status of parent	Married and living together	288	80.9 %
	Divorced	33	9.3 %
	Widowed	35	9.8 %
Father occupation	Pastoralist	102	32.1 %
	Daily laborer	53	16.7 %
	Farmer	0	0
	Civil servant	97	27.2 %
	Private sector employer	16	4.5 %
	Run his own private business	51	15.7 %
Father educational level	Illiterate	85	26.7 %
	Grade 1-8	124	39 %
	Secondary	74	23.3 %
	Diploma	20	6.3 %
	Degree and above	15	4.7 %
Mothers occupation	Pastoralist	7	2.0%
	House wife	240	70.0 %
	Daily laborer	1	0.3 %
	Maid servant	0	0%

	Civil servant	27	7.9 %
	Private sector employment	6	1.7%
	Run his own private business	62	18.1 %
Mother education	Illiterate	138	40.2 %
	Grade 1-8	152	44.3 %
	Secondary	45	13.1 %
	Diploma	8	2.3 %
	Degree and above	0	0%
Crutiallity of parent adolescent communication	Yes	285	80.1 %
	No	71	19.9 %
Parent control	Yes	342	96.1 %
	No	14	3.9 %
Degree of control	Strict	162	47.4 %
	Liberal	169	44.4 %
	Loose	11	3.2 %

4.2 Factors associated parent adolescent communication

The bivariate analysis showed that, educational status of the father(AOR= 5.1, 95% CI= (1.26-20.6)), Educational status of mother (AOR= 2.6, 95% CI (1.04-6.4)), occupational status of the father (AOR= 0.05, 95% CI (0.005 -0.54)), sex of the participant (OR= 2.8, 95% CI= (1.75-4.4)), discussion Crutiallity (OR= 23.34, CI= (5.61-97.1)), having the boy/girlfriend (OR=0.43, 95% CI= (0.25-0.73), knowing of contraceptive (OR=7.23, 95% CI= (3.2-16.8)) were found to be significantly associated with parent adolescent communication on sexual and reproductive health. In addition, knowing of STI/HIV (OR= 2.7, CI= (1.3-5.6)) were also found to be significantly associated.

On the other hand, age of adolescents, educational status of adolescents, occupational status of mother, living arrangement of family were found to be not significantly associated with parent adolescent communication. Moreover, cultural taboos, parental lack of interest to discuss, feeling shame and parental lack of knowledge were also found to be not significantly associated (Table 5).

Table 5 :- Bivariate analysis on knowledge and socio demographic factors of parent adolescents communication on sexual and reproductive health matters in Shaygosh Town, Ethiopian Somali Regional State, Eastern Ethiopia, April, 2018(n=355).

Variables	Category	Parent adolescents communication on sexual and reproductive matters		COR (95% CI)	P<0.005
		Yes	No		
Sex of the participant	Male	40(22.1%)	141(61.5%)	1	
	Female	77(70.9%)	98(38.5%)	2.77[1.75-4.39]	0.000
Educational status of father	Illiterate	12(14.1%)	73(85.9%)	1	
	Grade 1-8)	23(18.5%)	101(81.5%)	1.39[0.65-2.96]	0.401
	Secondary	42(56%)	32(43.2%)	7.98[3.72-17.15]	0.000
	Diploma	16(80.0%)	4(20.04%)	24.3[6.94-85.30]	0.000
	Degree and above	11(73.3%)	4(26.7%)	16.7[4.57-61.2]	0.000
Educational status of mother	Illiterate	22(15.9%)	116(84.1%)	1	
	Grade 1-8	67(44.1%)	85(55.9%)	4.2 [2.4-7.3]	0.000
	Secondary	22(48.9%)	23(51.1%)	5 [2.4-10.6]	0.000
	Diploma	6(75.04%)	2(25.0%)	15.8 [3-83.5]	0.001
Occupational status of Father	Pastoralist	18(17.6%)	84(82.4%)	1	
	Daily laborer	10(18.9%)	43(81.3%)	1.1 [0.5-2.5]	0.851
	Civil servant	56(57.7%)	41(81.3%)	6.4 [3.3-12.2]	0.000
	Private sector employee	2(12.5%)	14(87.5%)	0.7 [0.14-3.2]	0.612
	Run his own business	18(36.0%)	32(64.0%)	2.6 [1.2-5.7]	0.014
Crutiallity of discussion	Yes	115(40.4%)	170(59.6%	23.34 [5.6-97.1]	0.000
	No	2(2.8%)	69(97.2%)	1	
Having the girl/boy friend	Yes	22(20.8%)	84(79.2%)	0.427 [0.25-0.73]	0.002
	No	95(38.0%)	155(62.0%)	1	
Knowledge on contraception	Yes	110(40.3%)	163(59.7%)	7.23 [3.21-16.8]	0.000
	No	7(8.5%)	75(91.5%)	1	
Knowledge on STI/HIV	Yes	107(36%)	190(64%)	2.7[1.31-5.56]	0.007
	No	10(17.2%)	48(82.8%)	1	

In multivariable analysis:- only educational status of mother, educational status of father, occupational status of father, having girl/boyfriend, knowledge on contraception, believing on the Crutiallity of discussion and sex were found to be significantly associated with parent adolescent communication on sexual and reproductive health matters.

Respondents who are females were 2.5 times more likely to discuss sexual and reproductive health matters with their parents than males (AOR= 2.5, 95% CI= (1.25-5.01)) and mothers who can read and write were 2.6 times more to discuss on sexual and reproductive health matters with their adolscents than mothers who were illitrate (AOR= 2.6, 95% CI= (1.04-6.4)). respondents who believe the Crutiallity of discussion on the sexual reproductive health matters were 12.7 times more to discuss than respondent were not believe on the Crutiallity of discussion on the sexual and reproductive matters with their parents (AOR=12.7, 95% CI= (2.8-58.1)).

Moreover, fathers of the respondent who complete secondary education were 5 times more to discuss on the sexual reproductive health matters with their adolescents than fathers of respondents who were illiterate (AOR=5.08, 95% CI= (1.25-20.6)). In addition fathers of the respondents who had diploma were 13 times more likely to discuss with their adolescents on the sexual and reproductive health matters than fathers of the respondents who were illiterate (AOR= 12.97 , 95% CI= (1.84-91.52)). (Table 6).

Table 6. Bivariate analysis and Multivariate analysis on knowledge and socio demographic factors of parent adolescents communication on sexual and reproductive health matters in Shaygosh Town, Ethiopian Somali Regional State, Eastern Ethiopia, April, 2018(n=355).

Variable		Parent adolescent communication on sexual and reproductive health matters		COR (95% CI)	AOR (95% CI)
		Yes	No		
Sex of participant	Male	34(29.1%)	147(61.5%)	1	1
	Female	83 (70.9%)	92(38.5%)	2.77 [1.75-4.39]	*2.5 [1.25-5.01]*
educational status of mother	Illiterate	22(15.9%)	116(84.1%)	1	1
	Grade (1-8)	67(44.1%)	85(55.9%)	4.2 [2.4-7.3]	*2.57 [1.04-6.4]*
	Secondary	22(48.9%)	23(51.1%)	5 [2.4-10.6]	0.83 [0.21-3.37]

	Diploma	6(75.04%)	2(25.0%)	15.8 [3-83.5]	-
Occupational status of father	Pastoralist	18(17.6%)	84(82.4%)	1	1
	Daily worker	10(18.9%)	43(81.3%)	1.1 [0.5-2.5]	0.35 [0.11-1.16]
	Civil servant	56(57.7%)	41(42.3%)	6.4 [3.3-12.2]	0.59 [0.14-2.51]
	Private sector employee	2(12.5%)	14(87.5%)	0.7 [0.14-3.2]	*0.05[0.01-0.54]*
	Run his own business	18(36.0%)	32(64.0%)	2.6 [1.2-5.7]	0.81[0.23-2.93]
Educational status of father	Illiterate	12(14%)	73(85%)	1	
	Grade (1-8)	23(18.5%)	101(81.5%)	1.39[0.65-2.96]	0.91[0.29-2.76]
	Secondary	42(56.8%)	32(43.2%)	7.98[3.72-17.18]	*5.1[1.25-20.57]*
	Diploma	16(80%)	4(20%)	24.3[6.94-85.29]	*13[1.84-91.5]*
	Degree and above	11(73.3%)	4(26.7%)	16.73[4.57-61.2]	-
Having girl friend	Yes	22(20.8%)	84(79.2%)	0.43[0.25-0.73]	*0.31[0.14-0.66]*
	No	95(38%)	155(62%)	1	1
Ever heard of contraception	Yes	110(40.3%)	163(59.7%)	7.23[3.21-16.78]	*6.1[1.6-23.1]*
	No	7(8.5%)	75(91.5%)	1	1
Discussion Crutiallity	Yes	115(40.4%)	170(59.6%	23 [5.6-97.1]	*12.7 [2.8-58.1]*
	No	2(2.8%)	69(97.2%)	1	1

5. DISCUSSION

The study determines the status of parent adolescence communication on sexual and reproductive health issue and associated factors in school adolescent in Shaygosh town. The study shows that only 117(32.9%) of adolescents were discuss with parent at least one topic in the last six months. Educational status of mother, occupational status of father, sex of the adolescence, Crutiallity of discussing on sexual reproductive health matters, educational status of father, having girl/boyfriend and ever heard on contraception were found to be associated with parent adolescent communication. Parent lack of interest to discuss, feeling shame, culturally not accepted and parent lack of knowledge were the reason for low parent adolescent communication.

The magnitude of parent adolescence communication in the study 117 (32.9%) was almost similar with Nekemt E/wollega which was only 32.5 % (Dessalegn et al., 2012), and this result was slightly higher than the study in Mizan which was 28.9% (Sisay et al., 2017). This was may be due to lack of access to health service and cultural factors the adolescents in shaygosh prefer to discuss with their near parents. But the finding was low when it compared with similar study in Diredawa which was 37% (Mulatwa et al., 2014), 57.6 % in Mekele (Zemenu et al., 2015), 60% in Debremarkos (kasiye et al., 2014), and 59% in Yirgalem. (Zemenu and Birhan, 2015). This was may be due to socio cultural, Educational status, Socio economic status, Religious factors, Socio demography, sample size that made the prevalence low.

In addition 50 participants were prefer to discuss with both parent, and also 50 (42.7%) participant were prefer to discuss with their mothers, which was high when compare with adolescents in Mekele which is 38.2% (Zmenu,et al., 2015), and study in Yigalem which was 37.6% (Zemenu and Birhan, 2015), and 17(14.5%) participants prefer to discuss with father only which was low when it compared to study in Debremarkos which was 25.2% (Kasiye et al., 2014), but this result was low when it compared to similar study in Mizan which was 50% (Sisay et al., 2017)

In this study mothers of respondents who read and write were 2.6 times more likely to discuss with their adolescents than mothers who were non-educated mothers (AOR=2.6, 95% CI=(1.03-6.4)). This result were higher when compared with similar study in Debremarkose mothers who read and write were 2 times more likely to discuss with their adolescents than non-educated (AOR= 2, 95% CI= (1.3-3.1)). (Kasiye et al., 2014). This could be related with Socio demographic factors, access to media, Cultural taboos the mothers of adolescent who were the victims are easily aware of what are

happen to them and tried to discus with their adolescent. But this result was lower when compared with the study done in Gorro mothers who complete primary education were 5.9 times more likely to discuss with their adolescents than mothers who were non-educated (AOR= 5.9, 95% CI=(1.2-29.70)). (Mersha and Getachew, 2018). This was may be due to Socio demographic variation, Cultural factors, Religious factors, Residents area may contribute for Gorro to discuss more than Shaygosh mothers.

Similarly fathers of respondents who complete secondary education were 5.1 times more likely to discuss with their adolescents than fathers who were non-educated fathers (AOR= 5.1, 95% CI= (1.25-20.57)). This result was higher when compared with similar study in Mekele fathers who complete secondary education were 1.8 times more likely to discuss with their adolescents than fathers who were non-educated (AOR= 1.8, 95% CI= (1.03-3.13)). (Zemenu et al., 2015). And also it was higher when compared with similar study done in Gorro fathers who complete secondary education were 1.4 times more likely to discuss about sexual and reproductive health with their adolescents than non-educated (AOR= 1.4, 95% CI= (1.2-1.9)). (Mersha and Getachew, 2018). Similarly it was also higher when compared with study in Bodity fathers who complete secondary education were 57% less likely to discuss with their adolescents than non-educated. (AOR= 0.43, 95% CI= (0.22-0.80)). (Mulugeta et al., 2016). This was may be due to socio demographic area, lack of access to media, Cultural taboos, and environmental factors that aggravate the burden of sexual health on the adolescents contribute the educated fathers in Shaygosh to discuss with their adolescents. In addition to the above fathers who had diploma were 13 times more likely to discuss with their adolescent than who were not educated. (AOR= 13, 95% CI= (1.84-91.5)). This result were higher when compared with similar study in Bodity fathers who had diploma were 1.12 times more likely to discuss on sexual and reproductive health with their adolescents than non-educated. (AOR= 1.12, 95% CI= (1.60-2.07)). (Mulugeta et al., 2016).

In addition to the above fathers occupation of private sector employer were 95% less likely to discus with their adolescents on sexual and reproductive health matters than pastoralist (AOR=0.05, 95% CI= (0.01-0.54)). This result were lower when compared with the study in Mekele fathers who employed in private sector were 1.19 times more likely to discuss with their adolescents on sexual issue (AOR= 1.19, 95% CI= (1.18-2.41). (Zemenu et al.,2015). And also this result was less when compared with study in Bodity fathers who employed in private was 33% less likely to discuss with their adolescents on sexual matters (AOR= 0.67, 95% CI= (1.03-11.9)). (Mulugeta et al., 2016). This

was may be due to Residence area, Socio cultural, socio demographic factors and religious factors that precipitate parent adolescent communication in Shaygosh.

On the other hand the result of this study on sex of adolescent, females adolescents were 2.5 times more likely to discuss sexual reproductive matters with their parents than males (AOR=2.5, 95% CI (1.25-5.01)). This result was higher when compared with similar study in Diredawa who male were 40% less likely to discuss on sexual reproductive health matters with parents than females (AOR= 0.6, 95% CI= (0.4-0.9)). (Mulatwa et al., 2014). And also it was higher compared with the study in Eastern Nekemte whose males were 40% less likely to discuss sexual reproductive health topics with their parents than females (AOR=0.6, 95% CI= (0.4-0.9)). (Dessallegn w., 2012). Similarly this result were higher when compared to similar study done in Bodity, females were 1.42 more likely to discuss on sexual reproductive health matters than male (AOR= 1.42 95% CI (1.08-1.90)). (Mulugeta et al., 2016). This was may be higher due to environmental factors, cultural factors, lack of accessibility to media and shortage of health facility may force or encourage discussing with their parents on SRH issues. But in opposite to the above the study done in Awbele shows those male adolescents were 1.63 times more likely to discuss sexual reproductive health matters than females (Atitegeb et al., 2016). And also the study in Haik shows males were 4.2 times more likely to discuss than females (AOR = 4.203% CI (0.1 – 0.4)) (Tefera and Niguss, 2018). This was may be due to Socio demographic, Cultural factors (mostly related with FGM which was lower in Awbele) this may decreased STI and pelvic inflammatory disease to females and also decrease disease associated with long term complication of FGM were the most contributing factors to became low in Awbele and Haik towns.

Respondents who have boy/girlfriend were 69% less likely to discuss on the sexual and reproductive health matters with their parents than respondents who have not boy/girlfriend (AOR=0.31, 95% CI= (0.14-0.66)). This result were align with similar study in Nigeria which was 75% less likely to discuss on sexual and reproductive health matters (AOR=0.25, 95% CI= (1.26-2.99)). (Katrina B., 2012). But it was lowest when compared with similar study in Bodity which was adolescents who had boy/girlfriend had 9% less likely to discuss on sexual and reproductive health matters than adolescents who had no boy/girlfriend (AOR=0.91, 95% CI= (0.76-0.93)). (Mulugeta et al., 2016). And also it was lower when compared with similar study in Awbele which was adolescents who had boy/girlfriend were 1.1 times more to communicate with their parents than adolescents who had no boy/girlfriend (AOR=1.1, 95% CI= (2.02-4.73). (Atitegeb et al., 2016). This increment in Awbele

could be related that Socio cultural, educational status of parents, good accessibility of media for the adolescents which contribute positively for the discussion of parent adolescent on sexual and reproductive matters.

Furthermore, respondents who perceive the Crutiallity of discussion on sexual and reproductive health matters with their parents were 12.7 more time to discuss sexual reproductive health matters with their parents than respondents who did not perceive the Crutiallity of discussion on sexual reproductive health matters with their parents (AOR=12.7, 95% CI= (2.8-58.13)). This result were higher when compared to similar study in Bodity the participant who perceive Crutiallity of discussion on sexuality with parents were 2.98 times more likely to discuss on the sexual and reproductive health matters (AOR=2.98, 95% CI= (1.05-1.96)). (Mulugeta et al., 2016). And also it was higher when compared to the study done in Debremarkos adolescents who believed on the important of discussion were 2.5 times more likely to discuss on the sexual and reproductive health matters with their mothers than adolescents who did not believe on the importance of discussion on the sexual and reproductive health matters with their parents (AOR= 2.5, 95% CI= (1.5-4.8). (Kasiye et al., 2014). This may be due to Socio demographic factors, Cultural factors, Religious factors, Residents area, lack of access to media and lack of health facility in Shaygosh may negatively affect adolescents life and forced to develop Crutiallity of discussion this may leads to increase the association more.

Finally respondents who know at least one contraception had 6.1 times more likely to discuss on sexual and reproductive health matters than respondents who didn't know at least one contraception (AOR=6.1, 95% CI= (1.56-23.1)). This result were higher when compared with similar study done in Haik adolescents who know at least one contraception were 1.3 times more likely to discuss on the sexual and reproductive health matters than who didn't know any contraception (AOR= 1.29, 95% CI=(3.01-5.41). (Tefera and Niguss, 2018). Similarly this result were higher when compared with similar study done in Mizan adolescent who know at least one contraception were 2.6 times more likely to discuss on sexual and reproductive health matters than who didn't know any contraception (AOR =2.6, 95% CI= (0.14-0.52)). (Sisay et al., 2017). This result were also higher when compared with the study done in Debremarkose adolescents who knows at least one contraception were 2.1 times more likely to discuss with their parents on sexual and reproductive health matters than adolescents who didn't know at least one contraception (AOR= 2.1, 95% CI= (1.11-4.05)). (Mekwanint et al., 2018). This could be related with Cultural factors, Lack of access to media in

Shaygosh may force the adolescents in Shaygosh to choose and prefer their parents to discuss on contraceptive and other sexual and reproductive matters.

5.2 strength and limitation of the study

The strength of the study was the investigator uses well-structured quantitative data presents however it has limitation that it didn't use the qualitative data, it was based on self-reported and it might be affected by social desirability bias because of sensitive nature and cultural barrier for open discussion. Since the study design was a cross-sectional cause and effect relationship could not be established. Analytical study design is recommended for further research.

6. CONCLUSION AND RECOMMENDATION

6.1 Conclusion

The study finding shows that there were low communication about sexual and reproductive health issue between parent and adolescents. Adolescents who believe on Crutiallity, educational status of mother, occupational status of father, sex of the adolescents, and educational status of father, having girl/boyfriend and ever heard on contraception had association with having communication about sexual reproductive health. Cultural taboos, lack of knowledge and feeling shame were negatively affects parent adolescent communication on sexual matters.

6.2 Recommendation

Based on this study result and from the investigator recommended For Shaygosh Woreda Health Office: Strengthen health education programs on sexuality and SRH, Mainstreaming adolescent sexual reproductive health with other health service and Cooperatively work with other stakeholder to increase the awareness of adolescents; For Governmental Stakeholder: Improve peer to peer sexuality education program, promoting school sexual and reproductive health club in school; For the Local NGOs: Work in collaborating with the Woreda Health Office to increase the awareness and knowledge of adolescents to protect themselves from risk behavior. Finally the investigator recommend for other scientific community for further study with a different study design like a prospective cohort study design is recommended to address cause and effect relationship between dependent and independent variable.

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8. APPENDIX

Annex I: Participant Information sheet and informed voluntary consent forms for adolescents that age 18 and above.

My name is _____. I am working as a data collector for the study being conducted in this school based research by Addis Alemayehu, who is studying for his master degree at Haramaya University, the College of Health and Medical science. You are selected to participate in this study, hence I kindly request you to give me your time to explain me about some of the questions.

The study title

Parent Adolescent communication on sexual and reproductive health matters and associated factors among Shaygosh non-boarding secondary and preparatory school students in Shaygosh town, Qorahay zone, Ethiopian Somali Regional State, Eastern Ethiopia.

Purpose of the study

The result and the finding of this study can be used as an input for woreda program planner during designing strategy to preserve adolescents from the early marriage unwanted pregnancy and other sexual and reproductive health problems, And to develop parent adolescent communication on SRH issue. More over the main purpose of this study is to write a thesis as a partial requirement for the fulfillment of a Master's Program in reproductive health for the principal investigator.

Procedure and duration

I will be interviewing you using a questionnaire to provide me with pertinent data that is helpful for the study of parent adolescence communication on sexual and SRH. There are 63 questions to answer. The interview will take about 30 to 40 minutes, so I kindly request you to spend to me this time for the interview.

Risk and Benefit

The risk of being participating in this study is very minimal, but only takes a few minute from your time. There would not be any direct payment for participating in this study. However, the finding from this research may provide important information for the positive parent adolescent communication planning and provision of service.

Confidentiality

The information you will provide us will be confidential. There will be no information that will identify you in particular. The findings of the study will be general for the study adolescents and will not reflect anything particular of individual person. The questionnaire will be coded to exclude showing names.

Right

Participation for the study is fully voluntary. You have the right to declare you to participate or not in the study. If you agree to participate, you have the right to stop the interview and examinations at any time and this will not label you for any loss of the benefits which you otherwise are entitled. You do not have to answer any question that you do not want to answer.

Contact address

If there are any questions at any time about the study or the procedure, please contact:

Name: Addis Alemayehu Gebre

Mobile: +251913293324

E-mail: addualemayehu@gmail.com

As well as contact address of the responsible institutional Health Research Ethics Review Committee (IHRERC) at office phone 0254662011 or P.O Box 235, Harer-Ethiopia.

Declaration of informed Voluntary Consent for participant

I have read/ to me the participant information sheet. I have clearly understood the purpose of the research, the procedures, the risk and benefit, issues of confidentiality, the rights of participating and the contact address for any queries. I have been given the opportunity to ask question for things that may have been unclear I was informed that I have the right to withdraw from the study at any time or not to answer any question that I do not want. Therefore, I declare my voluntary consent to participate in this study with my initial (signature).

Name and signature of participant: ……..... Date: ……

Name and signature of data collector: …… Date: …….

Annex II: Information sheet and informed voluntary consent form for head of school.

My name is _____. I am working as a data collector for the study being conducted in this school based research by Addis Alemayehu, who is studying for his master degree at Haramaya University, the College of Health and Medical science. I kindly request you to lend me your attention to explain you about the study and your school being selected as the study setting.

The study title

Parent – adolescen communication on sexual and reproductive health matters and associated factors among shaygosh non-boarding secondary and preparatory school students in Shaygosh town, Qorahay zone, Ethiopian Somali Regional State, Easten Ethiopia.

Purpose of the study

The finding of this study can be of a paramount importance the school and woreda health office to plan intervention program to prevent early marriage, unwanted pregnancy and other sexual reproductive health problems on the adolescents; thereby improved adolescent sexual reproductive health in general. Moreover, the aim of this study is to write a thesis as a partial requirement for the fulfillment of a master's program in Reproductive Health for the principal investigator.

Procedure and duration

I will be interviewing the adolescents by using questionnaire to provide me with pertinent data tht is helpful for the study. There are you using a questionnaire to provide me with pertinent data that is helpful for the study of parent adolescence communication on sexual and SRH. There are 63 questions to answer where you will fill the self-administered questionnaire. The questions will take about 30-40 minutes, so I kindly request you to spare me this time for the interview.

Risk and Benefit

The risk of being participating in this study is very minimal, but only takes a few minute from your time. There would not be any direct payment for participating in this study. However, the finding from this research may provide important information for the positive parent adolescent communication planning and provision of service.

Confidentiality:

The information you will provide us will be confidential. There will be no information that will identify the participants in particular. The findings of the study will be general for the study adolescent and will not reflect anything particular of individual person. The questionnaire will be coded to exclude showing names. No reference will be made in oral or written reports that could link participants to the research.

Right

Participation for the study is fully voluntary. The participants have the right to declare to participate or not in the study. If they decided to participate, they have the right to withdraw from the study at any time and this will not label them for any loss of the benefits which they otherwise are entitled. They do not have to answer any question that they do not want to answer.

Contact address

If there are any questions at any time about the study or the procedure, please contact:

Name: Addis Alemayehu Gebre

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E-mail: addualemyehu@gmail.com

As well as contact address of the responsible institutional Health Research Ethics Review Committee (IHRERC) at office phone 0254662011 or P.O Box 235, Harer-Ethiopia.

Declaration of informed Voluntary Consent for participant

I have read the participant information sheet. I have clearly understood the purpose of the research, the procedures, the risk and benefit, issues of confidentiality, the rights of participating and the contact address for any queries. I have been given the opportunity to ask question for things that may have been unclear. I was informed that participants have the right to withdraw from the study at any time or not to answer any question that they do not want. I am also informed that the school has the right to stop this study from being conducted in the school if any misdeeds and unethical procedure are observed during the data collection process in the school premises. Therefore, I declare my voluntary consent on behalf of shaygosh secondary and preparatory school management to allow this study to be conducted in the school with my initial (signature).

Name and signature of head of school: ……..... Date: ……

Name and signature of data collector: …… Date: …….

Annex III: Information sheet and informed voluntary consent form for parents whose child is less than 18 years

My name is _____. I am working as a data collector for the study being conducted in this school based research by Addis Alemayehu, who is studying for his master degree at Haramaya University, the College of Health and Medical science. You child is selected to participate in this study, hence I kindly request you to give me your time to explain me about some of the questions.

The study title

Parent adolescent communication on sexual and reproductive health matters and associated factors among Shaygosh non boarding secondary and preparatory school students in Shaygosh Town, Qorahay zone, Ethiopian Somali Regional State, Eastern Ethiopia.

Purpose of the study

The result and the finding of this study can be used as an input for woreda program planner during designing strategy to preserve adolescents from the unwanted consequence to develop parent adolescent communication on SRH issue. More over the main purpose of this study is to write a thesis as a partial requirement for the fulfillment of a Master's Program in reproductive health for the principal investigator.

Procedure and duration

I will be interviewing your child using a questionnaire to provide me with pertinent data that is helpful for the study of parent adolescence communication on sexual and SRH. There are 63 questions to answer. The interview will take about 20 to 30 minutes, so I kindly request you to spare your child to me for the interview.

Risk and Benefit

The risk of being participating in this study is very minimal, but only takes a few minute from your time. There would not be any direct payment for participating in this study. However, the finding from this research may provide important information for the positive parent adolescent communication planning and provision of service.

Confidentiality

The information you will provide us will be confidential. There will be no information that will identify your child in particular. The findings of the study will be general for the study adolescents and will not reflect anything particular of the individual person. The questionnaire will be coded to exclude showing names. No reference will be made in oral or written reports that could link participants to the research.

Right

Participation for the study is fully voluntary. You have the right to declare your child to participate or not in the study. If you decide to participate, you have the right to stop your child from the study at any time and this will not label them for any loss of the benefits which they otherwise are entitled. They do not have to answer any question that they do not want to answer.

Contact address

If there are any questions at any time about the study or the procedure, please contact:

Name: Addis Alemayehu Gebre

Mobile: +251913293324

E-mail: addualemayehu@gmail.com

As well as contact address of the responsible institutional Health Research Ethics Review Committee (IHRERC) at office phone 0254662011 or P.O Box 235, Harer-Ethiopia.

Declaration of informed Voluntary Consent for participant

I have read the participant information sheet. I have clearly understood the purpose of the research, the procedures, the risk and benefit, issues of confidentiality, the rights of participating and the contact address for any queries. I have been given the opportunity to ask question for things that may have been unclear. I was informed that my child has the right to withdraw from the study at any time or not to answer any question that he/she do not want. Therefore, I declare my voluntary consent to participate my child in this study with my initial (signature).

Name and signature of parent. Guardian: ……..... Date: ……

Name and signature of data collector: …… Date: …….

Annex IV: English Version Questionnaire

I. Background Information

No	Questionnaire	Answer
101	School name	----------
102	Education (grade) level	1. 9th 2.10th 3.11th 4. 12th
103	Sex	1.Male 2.Female
104	Ethnicity	1.Somali 2.Oromo 3.Amhara 4.Tigray 5.Gurage If any other ……
105	How old were you at your last birthday?	----------
106	Religion	1.Muslim 2.Orthodox 3.Protestant 4.Catholic If other , please specify _____
107	Have you ever attended services in the mosque or other religious institution?	1.Yes 2.No
108	If your answer is yes for Q. 106, how often are you attending these services?	1.Daily 2.Atleast once in a week 3.Occasionally
109	With whom are you living at present?	1.Bothparents 2.Father only 3.Mother only 4.Grandparents 5.Brother /sister If other , please specify _____

II. Socio-economic and Demographic Background of Parents

	Question	Answer

201	Parental religion	1.Muslim 2.Orthodox 3.Protestant 4.Catholic If other , please specify _____
202	Have your parents ever attended services in the churches or other religious institution?	1.Yes 2.No
203	If your answer is yes for Q. 202, how often are they attending these services?	1.Daily 2.Once in a week 3.At least once in a month
204	Marital status of your parents?	1.Married and living together 2.Divorced / separated 3.widowed If other , please specify _____
205	Who is the family head in your house?	1.Father 2.Mother 3.Brother/sister 4.Self head
206	Is your father alive? (if No escape to Q. 209)	1.Yes 2. No
207	If yes for Q. 206 What is your father's educational level	1.Illiterate 2.Grade(1-8) 3.Grade(9-12) 4.12 plus 1-3 years training 5.First Degree and above
208	Father's occupation	1.Pastoralist 2.Dailylaborer 3.Farmer 4.Civil servant 5.Private sector employee 6.Run his own private business
209	Is your mother alive? (if No escape to Q. 212)	1.Yes 2.No
210	If yes for Q. 209 What is your mother's education level	What is your mother's education level 1.Illiterate 2.Grade (1-8) 3.Secondary 4.Diploma 5.First Degree and above

211	Mother's occupation	1.Pastoralist 2.House wife 3.Daily laborer 4. Maid servant 5.Civil servant 6.Private sector employee 7.Run her own private business
212	How much is the total monthly income of your family?	……

III. Parent – Adolescent communication and control

NO	Question	Answer
301	Do you discuss at least one about sexual issues with your parents?	1.Yes 2.No
302	If yes for Q. 301 How easy you find it to discuss about sexual issues with your parents?	1.Very easy 2.easy 3.average 4.Difficult 5.Very difficult
303	In the past six month how many times you discuss on the sexual issue with your parents	1.Only one times 2.Two times 3.There times 4.More than three times
304	In which topics you discuss it is possible to circle more than one	1.STI/HIV 2.Abstinence 3.Contraception 4.Unintended pregnancy 5.Pre-marital sex 6.Condom utilization 7.Menstruation 8.Physical development change 9.Spermaches
305	With whom you always prefer to discuss about sexual issues?	1.Both parents 2.Father only 3. Mother only

306	Why you prefer that you choice on the Q. 305	b/c she /he is 1.easy to me 2.more open to me 3.has more knowledge than other family
307	Do you believe that parents open discussion on sexual issues with adolescents is crucial for future sexual behavior of adolescents?	1.Yes 2.No
308	If NO for Q. 301 Reason for not discussion on SRH issue;	1.Parental lack of interest to discuss 2.Shame 3.Culturally not accepted 4.Parents lack of knowledge or skill
309	Do your parents' control where you are and follow what you are doing?	1.Yes 2.No
310	If yes for Q.305 What is the degree of control?	1.Strict 2.Liberal 3.Loose

IV. Sexual Behavior

NO	Question	Answer
401	Do your close friends have a boy/ girlfriend (lover)?	1.Yes 2.No
402	Do you have a boy/ girlfriend (lover)? (if No, escape to Q. 406)	1.Yes 2. No
403	If yes for Q.402, how old were you when you first had a boy /girl friend?	……..
404	Where you meet with your boy/ girl friend?	1.Inschool 2.In village 3.In church If other, please specify _____
405	Is it common for everyone to practice sexual intercourse after puberty stage?	1.Yes 2.No
406	Are you practiced sexual intercourse? (if No escape to Q.501)	1.Yes 2.No
407	If yes for Q. 407, how old were you when you had sexual intercourse for first time?	----------

408	Have you had sexual intercourse in the last 6 months?	1.Yes 2.No
409	Why did you decide to have sexual intercourse?	1.Urging for a friend 2.Fell in love 3.Had the desired 4.To get money&other gifts 5.forced If other , please specify __
410	How much older or younger was/ is the person with whom you had/ have your first sexual intercourse?	More than 5 years old 1 Between 3-5 years 2 Less than 3 years old 3 An age like me 4 less than my age 5
411	Did you use condom in your first sexual intercourse?	1.Yes 2.No
412	Did you use condom during the last time of your sexual intercourse?	1.Yes 2.No
413	If your answer is No for Q.411 AND 412 what is the reason behind it?	1.It decrease pleasure 2.Sexual partner objected 3.Ashamed to buy 4.Do not think of it 5.Too expensive 6.Religious reason If other , please specify…….
414	How many sexual partners do you have so far?	1.With one person 2.With two person 3.More than two person
415	If the answer is no for Q. 408 what is the reason behind	1.to maintain their virginity until marriage 2.religious value 3.fear of STIs 4.waiting until getting older 5.fear of unwanted pregnancy

V. Knowledge of Contraceptive

NO	Question	Answer
501	Do you know any contraceptive Method?	1. Yes 2.No

502	If yes for Q.501 which method do You know? (may have multiple answer)	Yes No Condom 1 2 Pills 1 2 Injection 1 2 IUD 1 2 Norplant 1 2 Periodic abstinence 1 2
503	Have you / your partner ever used any Contraceptive method? If no escape to Q. 507	1.Yes 2.No
504	If yes for Q.505, which method did you/Your partner used? (may have multiple answer)	Yes No Condom 1 2 Pills 1 2 Injection 1 2 IUD 1 2 Norplant 1 2
505	How often did you use the contraceptive method?	1.Consistently at the time of sex 2.Occasional 3.When my sexual partner allowed If other please specify……
506	What was the reason for using the method? (may have multiple answer)	Yes No To prevent pregnancy 1 2 To prevent HIV/AIDS 1 2 To protect other STIs 1 2
507	If you have not used contraceptive Method at all or have not used Consistently, what is the reason?	1.Religious and cultural reason 2.Not available 3.Too expensive 4.Afraid of to ask my sexual partner 5.Sexual partner objected 6.Ashamed to buy If other, please specify……

VI. Knowledge of HIV/AIDS and Other STIs

NO	Question	Answer
601	Have you ever heard of sexually transmitted infection (STIs)?	1.Yes 2.No

	If no escape to Q.605	
602	If yes for Q. 601, which of STIs have you ever heard about? (may have multiple answer)	Yes / No Syphilis 1 2 Gonorrhea 1 2 Cancroids 1 2 HIV/AIDS 1 2
603	Have you ever had sign and symptom of (sexually transmitted infection) STIs?	1.Yes 2.No
604	If yes for Q. 603, where did you go for treatment?	1.Hospital or public health institution 2.Private clinic 3.Pharmacy for purchasing of medicine If other, please specify……
605	Do you know about HIV/AIDS?	1.Yes 2.No
606	If yes for Q.605, from which sources of information have you learned about HIV/AIDS? (you may have multiple answer)	Yes / No Parents 1 2 Peers 1 2 School clubs 1 2 mass media 1 2 Churches/mosques 1 2
607	Is it possible for a health looking person to have HIV virus?	1.Yes 2.No
608	Do you think you are exposed to HIV/AIDS?	1.Yes 2.No
609	In your opinion, which can be effective method to prevent HIV/AIDS? (you may have multiple answer)	Yes / No Using condom 1 2 To have one sexual partner 1 2 Abstinence 1 2
610	Willingness to up take VCT	1.Yes 2.No

Thank you

Annex V: Afsomali version of the participant (18 and above) information sheet and voluntary consent form

Magaacaygo waa …… waxan ka shaqa nayaaururinta xog cilmiboodhis, taas oo laga uruurin doono bulshoda. Waxa aan wax ka bartaa jaamacada Haramaya, qoybta caafimaadka, waxaana diyaariyeaa mastaka degree. Waxa aan aad idiinka codsanayaa inaad waqti yar isiisaan siaan cilmibaadhista idiinku sharxo.

Ciwoonka cilmiboodhisto: Wacyigalinta arimaha galmada iyo caafimadka taranka waalidinta da,yarta iyo arimaha laxidhiidha ee dugsiga sarre ee degmada shaygosh.

Ujeedada cilmibaadhista: naatiijada kazoo bixidoonta cilmibaadhistan waxa ay aadmuhiim ugu tahay degmada caafimaadka shaygosh sii loo qorsheeyo cafimadka taranka walimida dalyeroo iyo istcmalka qorshaaytan qoyska. Ujeedada kalana waa qorista cilmiboodhista oo qoyb ka an daamaystirka shahadada loo yaqaan mastarka dhigriga waa public health.

Nidoomka la raacayo iyo mudado: waxa aad samayn doonaa waraysi anoo isticmaalaya suaalo warqad ku diyaarsan si aad iisiisaan xog muhiim. Ah oo iga caawisa cilmiboodhistan. Su'aalaha waa 63 , waxa ayna qaadann 30-40 daqiqo kaliya.

Faa. Iidada iyo khasaarahka: khasaarahu waa.yar bixiso faa.iidaduse aad ayayubadanthay natiijada cilmi baadhisteni waxay aad nwhiim uxohay qorshaynxa qoynka ee shaygosh

Kalsoonida: xogta aad bixis waa inay noqotaa mid aad ku kalsoonannkarto wan soonananhexo, maadaama aanon wan warbixinaa oo shaqgiyon kuu cadaynaysa jirin. najiijoda cilmibadaadhistauna waa mid siguud loo bandhigi doono. Magocaayna laguma qoridiomo worooqaha.

Xuquuq: kaqaybgalka calmibaaduistani waa mid robixiawaaga ku xiduun. Hodii aad go'aen eatid inaad ku qoyb gosui, waxa aad kartaa inaad iskis dayhid goor wista. Waxa wale ood iska duyn worxaa inaanod ka jawaasin su'aasin oonod robin.

Adhraska: hadii aad was solaala qobxid waxa aad igla soo xiduiidui warxaa.

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Haramaya University College of Health and Medical Science Institutional Health Research Ethical Review Committee: Phone No- +251254660708 P.O.BOX- 235, Harar

Qoybta ogolaansho bixinta:

Waan akhriye warqada warbixinta eek a qayb qaataha. Waxaan sicad u fahmay ujeedada daraasaadka, Qaabka hawsha loo qabto, faaiidada & khasaaraha, muhiimada sirqarinta, xuquuqda kasooqaybqaadashada & suaal kasta o meesha lala xiriirayo. Waxaafurssad la iiseirey inaan waydiiyo waxyaabaha aan cadayn. Waxa la igu wargaliyey in ilmahaaguu uu xuquuq uleyeyhay in uu iska daayo waabarashada xiliga uu doono ama uun ka jawaabin suaalaha uun doonaya. Sidaas darceed, waxaan si iskay ali u cabaynaya in uu ilmahayguka qayb qalo waxbarashadaan saxiixayga.

Magaca iyo saxiixa kagaybgalaha ……. Taarikada ……..

Magaca iyo saxiixa aruuriyaha …….. Taarikada ……

Annex VI: afsomali version of the participant parent's information sheet and voluntary consent form

Magaacaygo waa …… waxan ka shaqa nayaaururinta xog cilmiboodhis, taas oo laga uruurin doono bulshoda. Waxa aan wax ka bartaa jaamacada Haramaya, qoybta caafimaadka, waxaana diyaariyeaa mastaka degree. Waxa aan aad idiinka codsanayaa inaad waqti yar isiisaan siaan cilmibaadhista idiinku sharxo.

Ciwoonka cilmiboodhisto: Wacyigalinta arimaha galmada iyo caafimadka taranka waalidinta da,yarta iyo arimaha laxidhiidha ee dugsiga sarre ee degmada shaygosh.

Ujeedada cilmibaadhista: naatiijada kazoo bixidoonta cilmibaadhistan waxa ay aadmuhiim ugu tahay degmada caafimaadka shaygosh sii loo qorsheeyo cafimadka taranka walimida dalyeroo iyo istcmalka qorshaaytan qoyska. Ujeedada kalana waa qorista cilmiboodhista oo qoyb ka an daamaystirka shahadada loo yaqaan mastarka dhigriga waa public health.

Nidoomka la raacayo iyo mudado: waxa aad samayn doonaa waraysi anoo isticmaalaya suaalo warqad ku adigu eyal diyaarsan si aad iisiisaan xog muhiim. Ah oo iga caawisa cilmiboodhistan. Su'aalaha waa 63, waxa ayna qaadann 30-40 daqiqo kaliya.

Faa. Iidada iyo khasaarahka: khasaarahu waa.yar bixiso faa.iidaduse aad ayayubadanthay natiijada cilmi baadhisteni waxay aad nwhiim uxohay qorshaynxa qoynka ee shaygosh

Kalsoonida: xogta aad bixis waa inay noqotaa mid aad ku kalsoonannkarto wan soonananhexo, maadaama aanon wan warbixinaa oo shaqgiyon kuu cadaynaysa jirin. najiijoda cilmibadaadhistauna waa mid siguud loo bandhigi doono. Magocaayna laguma qoridiomo worooqaha.

Xuquuq: kaqaybgalka calmibaaduistani waa mid robixiawaaga ku xiduun. Hodii aad go'aen eatid inaad ku qoyb gosui, waxa aad kartaa inaad iskis dayhid goor wista. Waxa wale ood iska duyn worxaa inaanod ka jawaasin su'aasin oonod robin.

Adhraska: hadii aad was solaala qobxid waxa aad igla soo xiduiidui warxaa.

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Haramaya University College of Health and Medical Science Institutional Health Research Ethical Review Committee: Phone No- +251254660708 P.O.BOX- 235, Harar

Qoybta ogolaansho bixinta:

Waan akhriye warqada warbixinta eek a qayb qaataha. Waxaan sicad u fahmay ujeedada daraasaadka, qaabka hawsha loo qabto, faaiidada & khasaaraha, muhiimada sirqarinta, xuquuqda kasooqaybqaadashada & suaal kasta o meesha lala xiriirayo. Waxaafurssad la iiseirey inaan waydiiyo waxyaabaha aan cadayn. Waxa la igu wargaliyey in ilmahaaguu uu xuquuq uleyeyhay in uu iska daayo waabarashada xiliga uu doono ama uun ka jawaabin eyedaa/ isaagu suaalaha uun doonaya. Sidaas darceed, waxaan si iskay ali u cabaynaya in uu ilmahayguka qayb qalo waxbarashadaan saxiixayga.

Magaca iyo saxiixa waalidka/ addihaarka ……. Taarikada ……..

Magaca iyo saxiixa aruuriyaha …….. Taarikada ……

Annex VII: Afsommali version Suaalaha fomka

i. Iska warbixinta qofka

No	Suaalaha	Jawab
101	Magaca iskulka	…….
102	Heerja waxbarashada	1.9aad. 2.10aad. 3.11aad. 4.12aad.
103	Jinsiyada	1.Lab. 2.Dhadig.
104	Dadadu waa imisa?	…….
105	Qa'abta	1.Somali 2.Oromo 3.Amhara 4.Tigray 5.Gurage If any other ……..
106	Diinta	1.Muslim 2.Orthodox 3.Catholic 4.Protestsnt Kukele hadad hayso…….
107	Masajika mad tagta ama kinisada?	1.Haa 2.Maya
108	Haday suaasha 106 jawabtedu tahay sax xiliamd tagaysa?	1.Markasat 2.Todobadki mar. 3.Markad la kulanto
109	Yad la noshay labadada walid?	1.Aabaha iyo Hooyoda 2.Hooyad oo kaliya 3.Aabaha oo kaliya 4.Ayayda oo kaliya 5.Walalka ama walasha Ama qofkale ……

ii. Dadka walidka ah dhaqalahodu waa side

No	Sualaha	Jawabaha
201	Diinta walidinta	1. Muslim. 2.Orthodox 3.Catholic 4.Protestantes kukele hadad hayso…….
202	Qoskinu may ku xidhan yihin masajidka ama kinisada?	1.Haa 2.Maya
203	Haday suaasha 202 jawabtedu thy ha xilima?	1.Malinkasta

		2.Todobadki hal mar 3.Markad la kulanto
204	Hoyada iyo aabah may is aban ?	1.Ila imaka way is qaban 2.Way is furen 3.Abaha ama hoyada midba dhintay Ama wax kale …….
205	Xafada yaa laga amaar qata?	1.Aabaha oo kaliya 2.Hooyada oo kaliya 3.Walalka/Walasha 4.Gabiginaba
206	Abaha muu nol yhy (hadu dhintay ku bood suaasha 209)?	1.Haa 2.Maya
207	Haday suaasha 206 jawabtedu ha thy heerka waxbarshadisa aabah?	1.Baroo la'an 2.Calaska (1_8) 3.Dugsiga sare 4.Diploma 5.Dhigrigi ugunhoreya iyo wax ka sareya
208	Abaha Muxu ka shaqeya	1. Xoolo dhaqato 2.Malinkasa wuu shaqeya 3.Reer badiye 4.Shaqale dawladed 5.Shaqale la adigsado 6.Shaqadisa ka shaqaysta
209	Hooyada may noshahay (haday dhimatay ku bood suaasha 212)?	1.Haa 2.Maya
210	Haday jawabtu ha thy (heerka waxbarashadeda)	1.Baro la'an 2.Calaska(1_8) 3.dugsiga sare 4.Diploma 5.Dhigrigi ugu horeyay iyo wax ka sareya ma qadatay
211	Maxay ka shaqaysa hoyada	1.Xoolo dhaqato 2.Guriga . 3.Malin shaqayso. 4.Shaqalo guri . 5.Shaqalo dawleda 6.Shaqale la adigsado. 7.Shaqadeda ka shaqaysa .
212	Qoska mushaharka so galaya bishi waa imisan?	……

iii. Walidka may leyihin xidhidh wada hadal

No	Suaalah	Jawabaha

301	Miyad kalahadashada walidka galmada ama soo saarista galmada?	1.Haa 2.Maya
302	Haday suaasaha 301jawabtu ha tahay inaad kawada hadashan?	1.Aad fudud 2.Fudud 3.deb mechirtu 4.adag tahay 5.aad adagthay
303	Lixdibilood oo udanbaysay imisa jer kala hadashay galmada soosaarinta galmada walidka	1.Halxisho 2.Labo cisho 3.Sadex cisho 4.sadexcisho inkabadan
304	Ciwaan ayaad kala kaashatay inaad koobabto waa suurto-gal inkabadan hal	1.Galmada 2.Kalinimo 3.Kohortag 4.Uur aan loobaahneen 5.Galmada guurka hortiis 6.Galabka kondomka 7.Dhiigga haweenka 8.Isbedel duleedka 9.Biyaha raga
305	Yaad marwalba jeceshahay inaan kala kaashato arrimaha galmada?	1.Labada waalid 2.Aabaha kali 3.Hooyo kali
306	May idin xakameyen walidintinu	1.sababthay iyeda/ esegaa waa; waydudahay aniga 2.imbadan ayaay ifurantahay amiga waxay haysataa aqoon badan kabadan 3.kuwakale
307	Mad amin san thy inad ka shekaysan sida galmada?	1.Haa 2.Maya
308	HADDI maya tahay Q301 sababtuwaxaayen in aadan kala hadal soosaaritanka galmada	1.Walidaka oo aan xisaynaynin in aad kala hadashid 2.xishood 3.dhaqanka oo aqbalaynin 4.walika oo aqoonlahayn 5.xirfad la aan 6.walika oo mashquul ah
309	Walika miyu kugu ilaaliya halka tagaysid ama waxaa qabanaysid?	1.Haa 2.Maya
310	Haddi haa tahay Q305 waa maxay darajada ilaali taanka?	1.Darantahay 2.Dhax- dhaxaad 3.Hoose

iv. Dabecada galmada

No	Suaasha	Jawabaha

401	Saxibka kugu dhow saxibad mu leyahay?	1.Haa 1.Maya
402	Adigu saxib miyad ledahay? (hadanad samaynin ku bod suaasha 406)	1.Haa 2.Maya
403	Haday suaasha 402 jawabtedu sax thy (imisa jirbad ahayd xiligad bilowday saxibtinimada)?	……
404	Xagebad ku kulantan saxibad?	1.Iskulka 2.Xafadaha 3.Masajidka kinisada Ama mel kale……
405	Hadad uu galmotay markad qan gadhay ma waxad is lahayd dhib ma leh?	1.Haa 2.Maya
406	Adigu mad amaysay galmo? (hadanad samaynin ku bod suaasha 501)	1.Haa 2.Maya
407	Haday suaasah 407 jawabtedu thy ha (imisa jirbad ahayd markad samayay say galmada?	……
408	Mad galmotay 6bilod ee ugu danbeyay?	1.Haa 2.Maya
409	May ka goan thy inad galmoto?	1.Adigo saxibada uu danaynaya 2.Madamod xisanaysay 3.Si aan lacag uu helo iyo 4.fa iido laygu qasbay Fadlan ii sheg wixi kaled haysid ……..
410	Qofki ugu horeya eed la galmota imisa jirbu ahaa ama imisa sano ayuka wayna?	1.Ka wayna 5 sano 2.Inta uu dhaxaysa 3-5 sano 3.Inka yar 3 sano 4.Isku daban ahayn 5.Ka yar dadayda
411	Mad isticmashay marki kugu horaysay galmada?	1.Haa 2.Maya
412	Mad is ticmashay marki kugu danbaysay eed galmodo condam?	1.Haa 2.Maya
413	Hadau suaasha 411-412 jawabtedu thy maya (maxa sababy eed uu isticmali wayday)?	1.Raxadu yareya 2.Madamo anan donahayn Madamo an ka cabsanayo iin 3.Ibsado 4.Man xasusan 5.Madamo qali yhy 6.Xiligan donayo madamonan helahayn 7.Dintu madamoyna ogalayn Fadlan ii sheg wixi kaled hysid……..

414	Ila imisa qofbad la galmotay?	1.Hal qof 2.Laba qof 3.Iyo laba wixi kabadan
415	Haddi su aashu mayaa tahay 408 waa mxay sababtu gadasheeda?	1.Joogteyaay bikradayda ilaa in ta aan ka qursanay 2,Diin ama qimaha 3.Cabsi waxay ka cabsonayasaa in samayso galmada sti 4.maxaa usuugaya ilaa inta an ka waynaanayo 5.Cabsi ama aan rabin uurledahay

v. Habka uurka

No	Suaalah	Jawabaha
501	Miyaad taqaana hab uun lagaga hortago uurka?	1.Haa 2.Maya
502	Haday tahay haa su aasha(501) Habkeed taqaana? (Waxay yeelan kartaa jawaabo intaas kabadan)	Haa Maya Cinjir(condom) 1 2 Kaniini(pills) 1 2 Irbad(injection) 1 2 IUD(Qalab lagiliyo makaanka gudihiisa oo loogahortago uurka) 1 2 Norplant(Qaab loogo hortago uurka kaa soo ladhigo kaniini(capsule) dubka hoostiisa)1 2 Periodic abstinence(xiliyada uurka aan laqaadin ee ku salayasan wakhtiga) 1 2
503	Miyaad Adiga/saaxiibkaa(ninkaaga) waligiin isticmaasheen habka kahortaga uurka? Haday tahay Maya Tag suasha 509	1.Haa 2.Maya
504	Haday tahay Ha suasha 503 habkee Adi iyo saaxiibkaa/ninkaaga aad isticmaasheen? Waxay yeelan kartaa jawaabo badan)	Haa Maya Cinjir(condom) 1 2 Kaniini(pills) 1 2 Irbad(injection) 1 2 IUD(Qalab lagiliyo makaanka gudihiisa oo loogahortago uurka) 1 2 Norplant(Qaab loogo hortago uurka kaa soo ladhigo kaniini(capsule) dubka hoostiisa)1 2 Periodic abstinence(xiliyada uurka aan laqaadin ee ku salayasan wakhtiga) 1 2
505	Si kasta ha ahate mad isticmashay habahkan?	1.Kuly malmod 2.Kolkol 3.Aniga sxbty merka fishay
506	Maxay ahayd sababta ad uu isticmashay hababkan ?	1.Si aan uga hortago uur 2.Si aan uga hortago IDS 3.Si an uga hortago xanunada ku gudba galmad

507	Hadad isticmashid uurka ka hortaga hababka dhamantod ama adan isticmalin si jigta ah (maxay sababtu ahayd)?	1.Din ahan ama dhaqan ma ogala 2.Adbay qali uutahay 3.Waxan ka cabsana inad ii waydisa 4.Xidhidh galmo ma uu jedo 5.Wad ka xishonaysa 6.Hadad wax kale oo dheriya ad haysid ii so qor

vi. Aqonta cudurada hiv/aids iyo xanunada ku gudba dhalmada

No	Suaalaha	Jawabaha
601	Miyad waliga ma qashay galmo layskugu gudbinayo jermis? Haday tahay Maya Tag suasha 605	1.Haa 2.Maya
602	Hadi ay suaasha lagu waydiyay ee 601 ay jawabtu ha thy kalaykugu gudbiyo galmada mad maqashay miyad haysa wax jawabo ku adaan?	1.Syphilis 2.Gonorrhea 3.Chancroide 4.HIV/aids
603	waliga miyad calamadisay waxad aragtaylayskugu gudbiyo galmada?	1.Haa 2.Maya
604	haday suaashu 603 jawabtedu thy ha xagebad iskaga dawaysay?	1.Cispital oo he calamiya 2.Ama mel gar lo leyahay 3.Ama farmasiga an 4.qadanaysid dawada Hadadawaxkale hayso ii so sheg ……
605	Wax miyada ka taqana AIDS?	1.Haa 2.Maya
606	haday suaasha 605 jawabtedu thy ha xagebad ka arag tay ama ad ku baratay HIV/AIDS? (waxaad kaga jawaabi kartaa jawaabo intaas badan)	Haa Maya Walidka 1 2 Peers 1 2 Xulka iskulka 1 2 War bahiyaha 1 2 Kinisad ama masajid 1 2
607	Qof inu cafimad qabo is modayay xanunka hiv ga mu ku dhex Nolan kara?	1.Haa 2.Maya
608	Miyad uu malaynaysa inu qabo HIV/AIDS?	1.Haa 2.Maya
609	Fikirikaaga, habka wax ku oolka ah ee lagaga hortagikaro HIV/AIDS? (waxaad kaga jawaabi kartaa jawaabo intaas badan)	Haa Maya Isticmaalda cinjirka 1 2 In hal qof basa lagu ekaado 1 2 In la iskadaayo 1 2
610	Rabitaanka in lafahmo Ama la iska baadho VCT(Goobaha si iska ah la isaga baadho HIV)	1.Haa 2.Maya

Annex VIII: Curriculum vitae

1. Personal information

Name: Addis Alemayehu Gebre

Date of birth:- 02/02/1992 G.C

Place of birth:- Sheleko, Afar region

Marital status:- single

Nationality:-Ethiopian

Phone number:-+251913293324

2. Educational background

From 1990-1995E.C. (from grade 1- 6); Scheleko elementary school.

From1996_1999 E.C (from grade 7 -10) Mount olive elementary and secondary school, Hawassa

In 2000 E.C (grade 11^{th}) Debub Ethiopia Academy.

In 2001 E.C (grade 12^{th}) Hawassa Evangelical Secondary and Preparatory school.

From 2002- 2005 Hawassa University

3. Language ability

Language	Speaking	Reading	Writing
Amharic	Excellent	Excellent	Excellent
English	Excellent	Excellent	Excellent
Somali	Good	Good	Good

4. Qualification

BSc Degree in public health

5. Work experience

- 4 years of work experience as a public health officer in korahe zone of Ethiopian Somali Regional State.

6. Competencies

-Able to work and have experience of working in difficult environmental conditions

-Have taken LMG work place and team based course a total of 75 contact hour by FMOH in collaboration with Ethiopian Somali regional state Health Beaurae and Haramaya Univerisity

_Have taken Facilitated training on woreda health management

_Have taken national course on Planning and Management of Malaria program

_Have taken GTP -2 training for medium managers.

-Have taken IMNCI (integrated management of neonatal and childhood illnesses)