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Assessment of Communication on Sexual and Reproductive Health Issues among Mizan Secondary and Preparatory School Students with Parents, Mizan Town, Ethiopia, 2016

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Abstract: Sexual and reproductive health is at the base of people's living and wellbeing, the ability to develop in a supportive environment and grow into sexually responsive and responsible adults, the ability to enjoy one's sexuality without harming or damaging oneself or one's partner, are among the unique attributes that define us as human. Many of the typical changes that occur during adolescence tend to interfere with the effectiveness and amount of interaction between parent and child. The objective of the study is to assess communication on sexual and reproductive health issues among Mizan secondary and preparatory school students with parents. Institution based cross sectional quantitative study design was conducted among Mizan secondary and preparatory school students with sample size of 356 and total population of 3436 from April, 20/4/2016 to April, 25/4/2016. The data was collected by using structured self-administered questionnaires. After the data was collected it was processed and analyzed manually by the help scientific calculator. The response rate was 100%. From the total of three hundred fifty six respondents 196(55.1%) of them were females. One hundred three 103(28.9%) of respondents were discussed at least one SRH issue with parents for the last 12 month of the study period, from those 58(56.3%) of them were females and 45(43.7%) of them were males. but majority 253(71.1%) of them didn't discussed about SRH issues with their parents. This study shows that student-parent communication on SRH issues is low, only less than one- third of the students were communication SRH. The risk for SRH problems need urgent and continues intervention as such it is necessary to equip and educate parents and students on different sexual and reproductive health issues. Therefore; there should be give school base sex education about SRH and youth friendly health service for youth and adolescents at different level of health care.

Keywords: Reproductive Health, Sexuality, Communication

1. Introduction

Background

Sexual and reproductive health is the base of peoples living and wellbeing; The ability to develop in a supportive environment and grow into sexually responsive and responsible adults; the ability to enjoy one's sexuality without harming oneself or one's partner, are among the unique attributes that define us as human [1].

Adolescents and youths people are defined by WHO as at age group 10-19 years and 15-24 years respectively. The onset of adolescence which is more or less coinciding with puberty is often influenced by manifestation of puberty [2].

Young people make up over one -quarter of the world's

population. Among those, 1.4 Billon young people live in developing countries today [3]. Population censuses and projections conducted in Ethiopia in different years show that youth and adolescents constitute a high proportion of Ethiopian population. According to the 2012 population projection, the population was reach 83.75 million and the youth population was reached to 8.3 million (9.9%). Similarly the adolescent population was reach 20.19 million (24.1%) and in 2011 secondary school age population were 7.4 million [4].

As group adolescents and youth have sexual and reproductive health needs that differ from those adults in many ways and which remain poorly understood or served in much of the world. Neglecting this population has a major implication for the future. Since sexual and reproductive behaviors during adolescence have far reaching consequences for people's lives as they develop into adult [5].

An increased incidence of HIV/AIDS infection in adolescents has leads Researchers to examine factors that influence young people's sexual behavior. One of these factors is parent -student communication about sexuality and reproductive health [6].

Over 500,000 adolescents contract gonorrhea each year, and (25%) of Acquired Immune deficiency Syndrome cases involve young adults who probably become infected with HIV during adolescence [7].

Every year 2.5-3 million teenagers acquire a STI of one kind or another. This means that approximately one out of every teen adolescent even in developed countries becomes STD-infected each year [8].

The rapid spread of the HIV/AIDS epidemic in the country is posing very serious threats of overall socio-economic and human development prospects in the country, a recent report of the MOH on HIV/AIDS situation in Ethiopia, reports the highest prevalence of HIV infection in the age group 15 to 24 (12.1%). High rates of adolescent pregnancy mean that HIV infection will affect the next generation as well, putting babies at risk of vertical transmission and creating a generation of AIDS orphans [9]. It is estimated that each year, worldwide, 15 million girls aged 15-19 years give birth and that about (11%) of children are born to adolescents [10]. Each year, more than 1 million teenagers become pregnant and (65%) of the resulting babies are born out of wed lock [11].

Many parents don't discuss with their child until they discover their teen has already made difficult sexually related decision. By this time the teen has probably already engaged in sexual activity, Communication is ineffective. The child was not encouraged to discuss sexually related issues from an early age; the teen will feel uncomfortable with the subject matter at this point in time. As a result the teen might lie or tell the parents what they want to hear in order to avoid an unsuitable situation. The parents may also feel uncomfortable discussing the subject matter with their child and will have difficult initiating such a conversation [2].

Communication about sexual and reproductive health matters is important for virtually every one now more than any other time in the history of sexual health issues. This is because adolescents are affected with the burden of unwanted pregnancy and its complication, HIV/AIDS/STI, and other sexual and reproductive related problems. Generally family communication as well as parent child discussion about sexuality both seems factors in the study of family impact on sexuality. Since family can exert a strong influence on adolescents' and sexual behavior, it is important to understand the role of family influence on sexual behavior. Thus, parent-adolescent communication regarding sexuality often is viewed as desirable and perceived by many to be effective means of encouraging adolescents to adopt responsible sexual behaviors [12].

1.1. Statements of the Problems

Many of the typical changes that occur during adolescence tend to interfere with the effectiveness and amount of interaction between parent and child. Although adults have much more experienced in life than the adolescents, the adolescents are usually not aware this fact for do not believe it. Therefore, the advice, wisdom, and directions of parents are not valued.

In United States, young people accounts for (25%) of all new HIV infection [13]. Similarly youth people make up almost one- half of the over 19 million new STD infection in America [14].

As study indicated risky sexual behaviors are mostly practicing among youth peoples in Sub Saharan Africa. Youth in this region engaged in premarital sexual intercourse with consequences like unwanted pregnancy [15]. In Ethiopia (60%) of adolescent pregnancies are unwanted resulting from unprotected sexual intercourse [16]. Feeling of discomfort experienced by parents and their adolescents in talking about adolescents RH issue can prevent effective RH communication from occurring [9]. Adolescents and youths often engage in different risky sexual behaviors that can result negative effect on their health, social, and economic consequences. Adolescents reside in rural areas, who have limited access to targeted RH services for young people contributes to and facilitate to many RH problems like unwanted pregnancy, high abortion, contract STI, among those people are most likely common because of the risky and non-voluntary nature of their sexual activities [17].

Even though parents are the primary source of information about sexual and reproductive health for their children, few effective programs that help parents positively influenced their children's sexual behavior yet exist. More researches in to science driven, skill based programs to help parent-child communication is needed [18].

1.2. Significant of the Study

Communication between parents and students 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 our

study will help to-:

A. Policy maker to make the policy that focused on the initiation of student-parent communication at different institutions like school and health institutions.
B. Health professional to give youth friendly health care services for adolescents and youths at different heath care levels.
C. School administrators and teachers to promote school based sex education in their school.
D. Other researchers as base for other studies and may initiate to conduct similar study in various parts of the country on student-parent communication about sexual RH issues.

Objective

General objective

1. To assess communication on sexual and reproductive health issues among Mizan secondary and preparatory school students with parents, Bench Maji zone, SNNPRs, in 2016

Specific objectives

1. To determine the prevalence of student-parent communication practice on sexual and reproductive health matters among Mizan secondary and preparatory school students, 2016.
2. To assess the sexual and reproductive health issues discussed between students and parents among Mizan secondary and preparatory school students, 2016.

2. Methodology

2.1. Study Area and Period

The study was conducted in Mizan Town, Bench Maji zone, SNNPRs from April, 20/4/2016GC to April, /25/4/2016GC. Mizan town is located 563km southwest of Addis Ababa and 849km from Hawassa. According to information obtained from school administrative registered office, the town has one governmental secondary school and preparatory school with 3436 total number of students attending in secondary and preparatory school from those 1822 were males and 1614 were females.

2.2. Study Design

Institution based cross sectional quantitative study design was conducted among Mizan Secondary and preparatory school students in Mizan town Bench Maji zone, SNNPRs.

2.3. Populations

2.3.1. Source Population

The source population was all regular students who were attending in Mizan secondary and preparatory school.

2.3.2. Study Population

The study population were sampled students in Mizan secondary and preparatory school.

2.4. Eligibility Criteria

2.4.1. Inclusion Criteria

All students who were regular students and attending in Mizan secondary and preparatory school.

2.4.2. Exclusion Criteria

Those who didn't present at the time of data collection.

Those were seriously ill to the extent of unable to respond during data collection period.

2.5. Sample Size Determination and Sampling Technique

2.5.1. Sample Size Determination

The sample size was determined by using single population proportion formula. The following assumptions were made, marginal error (w) that was tolerated either side of the true proportion to be 5%, and using 95%confidence level and added 10% to compensate for non-response and the proportion of communication on sexual and reproductive health issues (36.9%) from research done at Debremarkos high school and preparatory school [32].

P=36.9%=0.369=communication prevalence (according to research done in Debremarkos)

W=5%=0.05 (Margin of error)

$Z\frac{\alpha 1}{2}$ =(95% Confidence interval)=1.96

$$n0 = \frac{\left(Z\frac{\alpha 1}{2}\right)^2 P(1-P)}{w^2} = n0 = \frac{(1.96)^2 0.369(1-0.369)}{0.05^2} = 358$$

Since the population was relatively small (less than 10,000) we should adjust the sample size by using correction formula as follows.

n=$\frac{358}{(1+358/3436)}$ = 324.219294=324 then added 10% non-response rate (324X10%)=32=324+32=356

2.5.2. Sampling Technique

Systematic random sampling was used to select the sample from each grade levels by using the roster of students as sampling frame. Based on the number of students, proportional allocation was allocated to ensure representation. The sample was proportionally distributed on sampling frame. Finally, the study participants were selected by systematic random sampling from each grade level.

Table 1. *Proportion of students who are selected from each grade level.*

Grade level	No. students	Proportional sample	K value
Grade 9	1280	132	10
Grade 10	1120	116	10
Grade 11	556	58	10
Grade 12	480	50	10
Total	3436	356	10

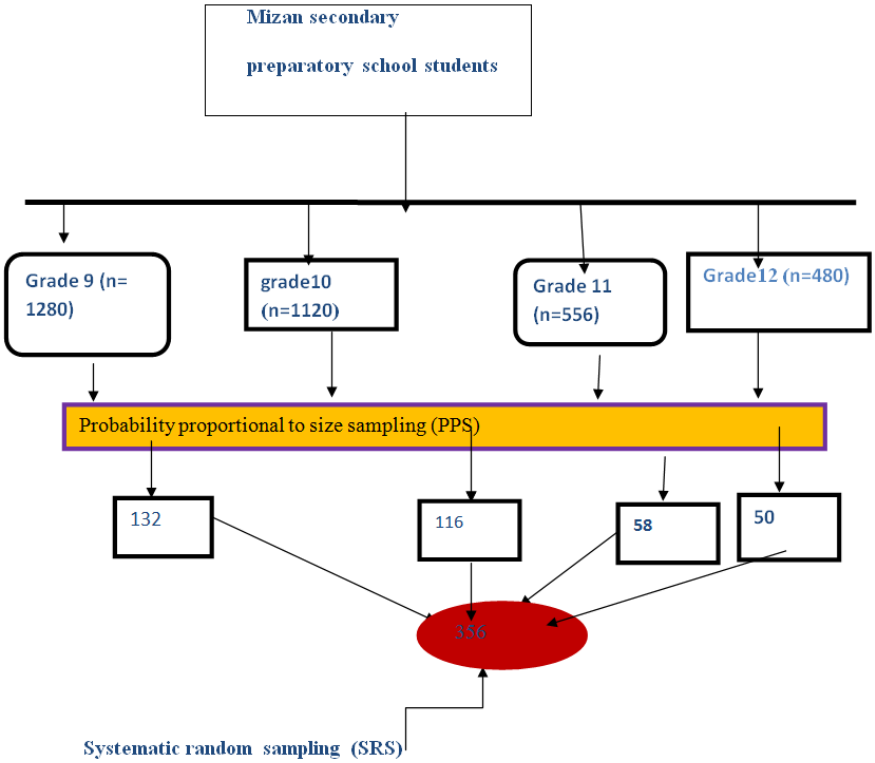

Figure 1. *Schematic presentation of sampling procedures.*

2.6. Variables

2.6.1. Socio Demographic Variables

(a) Socio demographic factors (Age, sex, Religious, Ethnicity)
(b) Educational status of the parents
(c) Family income
(d) Grade level of students

2.6.2. Study Variable

Communication of students and parent on SRH issues.

2.7. Data Collection Technique and Tools

2.7.1. Data Collection Technique

The data was collected through structured self-administered questionnaires after obtaining consent from participants. Before the data collection the questionnaires was adapted in English and translated to Amharic language in order to make the questions easily understandable and clear for respondents. The Amharic version was again translated back to English to make easy and suitable for analysis and interpretation of the data that was collected from the respondents by questioners. Translation of questionnaire was done by the investigators themselves who were three fourth year nursing students in both cases.

2.7.2. Data Collection Tools

The data was collected through structured self-administered questionnaires with close ended questions. After the questionnaires was adapted in English version and translated to Amharic version.

2.7.3. Data Collectors

Three fourth year nursing students were the data collectors who were principal investigators and they were responsible to lead the whole situation of the data collection processes, to checke the data collected consistency, completeness and editing. Discussion was done by all data collectors for one day before the pretest and a day after the pretest on the issue of, the general objective of the study, the contents of questionnaires one by one, the methodology in relation to reaching the intended goal and how to keep confidentiality and privacy.

2.7.4. Operational Definition

Parents = in this study includes biological parents, step parents or foster parents but not include siblings [19].

Pocket money = is money given to students by their parents for recreational purpose like for tea break [20].

Communication practice on SRH issues = Students who discussed at least one SRH issues in the last 12 months of the study period [37].

Sexual and reproductive health issues = in this study includes STI/HIV/AIDS, Contraceptive, Menstruation, unwanted pregnancy, premarital sex, Sexual intercourse, physical and psychological changes during puberty [38].

2.7.5. Data Quality Assurance

Data consistency and completeness was checked throughout the data collection and analysis. The three data collectors were discussed on method data collection. Questionnaire was checked on daily basis for completeness during data collection. Data was checked in the field to

ensure that all the information was properly collected. The questionnaires were pre-tested before data collection on Amman high school students.

2.7.6. Data Processing and Analysis

After the data was collected it was processed manually and by using scientific calculator. Percentage, frequency and mean were used to present participants in relation to relevant variables by using table and graph.

2.7.7. Ethical Consideration

Officially written approval letter from Mizan-Tepi University was obtained prior to the data collection. The letter was written to Mizan secondary and preparatory school administration educational office. Written consent was obtained from each study subject. Participants were told the objective of the study. They were also told that they had the right to refuse to fill the questioner any time and their answer will remain a secret.

2.8. Dissemination Plan

The result of our study will be presented at MTU, for college of health science, department of nursing and then the hard copy will be submitted to department of nursing. In addition the hard copy of the finding also will be sent to secondary and preparatory school.

3. Result

3.1. Socio Demographic Characteristics of Students Their and Parents

A total of 356(100%) of respondents completed this questionnaire. The response rate was 100%. Out of a total of 356 respondents 160(44.9%) were males and 196(55.1%) were females. The majority 198(55.6%) of the students were within the age group of 15-19 years. Majority 132(37%) and 116(32.6%) of the respondents were grade 9 and 10 respectively. One hundred seven 107(30.1%) of respondents were ethnically Bench followed by kefa 93(26.1%). And one hundred forty 140 (39.3%) of respondents were orthodox Christian followers whereas 127(35.7%) of them were protestant Christian by religion. The majorities 250(70.2%) of respondents were living with both father and mother. Three hundred four 304(85.4%) of study participants reported that they didn't receive pocket money monthly from their parents. While only 52(14.6%) of respondents received pocket money (Table-2). most 204(57.3%) of respondent's mothers were illiterate but only 66(18.5%) of them can only read and write. While 101(28.4%) of respondent's fathers were illiterate but only 89(25%) of them can only read and write. Two hundred sixty one 261(73.3%) of study participants didn't know amount of parental income but only 14(4%) of them had greater than 4400 birr parental income Table 2.

Table 2. *Socio demographic characteristics of Mizan secondary and preparatory students, Mizantown, Bench Maji Zone, SNNPRs, May, 2016.*

Mean	**18.84 years**	
Median	**19 years**	
SD	**±2.72**	
Variables	**Frequency**	**Percent**
Sex (n=356)		
Male	160	44.9%
Female	196	55.1%
Age (n=356)		
15-19	198	55.6%
20-24	130	36.5%
25-29	28	7.9%
Grade level of students (n=356)		
Grade ninth	132	37%
Grade tenth	116	32.6%
Grade eleventh	58	16.3%
Grade twelfth	50	14.1%
Religion (n=356)		
Orthodox	140	39.3%
Protestant	127	35.7%
Muslim	80	22.5%
Catholic	5	1.4%
Others	4	1.1%
Ethnicity (n=356)		
Bench	107	30.1%
Kefa	93	26.1%
Amhara	91	25.6%
Oromo	50	14.0%
Others	15	4.2%
Living arrangement of Students (n=356)		

Mean	**18.84 years**	
Median	**19 years**	
SD	**±2.72**	
Variables	**Frequency**	**Percent**
Withfather and mother	250	70.2%
With mothers only	48	13.4%
With fathers only	25	7%
With relatives	13	3.7%
Alone	11	3.1%
With Others	9	2.5%
Pocket money (n=356)		
Yes	52	14.6%
No	304	85.4%
How much pocket money (n=52)		
<200 birr	25	48.1%
200-500 birr	7	13.4%
>500 birr	-	-
Didn't remember the amount	20	38.5%

Table 3. *Socio-demographic characteristics of parents of Mizan secondary and preparatory school students, Mizan town, Bench Maji Zone, SNNPRs, May 2016.*

Variable	**Frequency**	**Percent**
Educational status of the father (n=356)		
Illiterate	101	28.4%
Only write and read	89	25.%
Only primary education	80	22.5%
Only secondary education	50	14.%
Certificate	18	5.1%
Diploma	13	3.7%
First degree and above	5	1.4%
educational status of mother (n=356)		
Illiterate	204	57.3%
Write and read only	66	18.5%
Only primary education	31	8.7%
Only secondary education	20	5.6%
Certificate	18	5.1%
Diploma	10	2.8%
First degree and above	7	2%
Parental income per month (birr)		
100-1500	17	4.8%
1600-3000	26	7.3%
3100-4400	38	10.6%
>4400	14	4%
Didn't know amount	261	73.3%

3.2. Communications of Students with Parents About SRH Issues

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 but 253 (71.1%) of them didn't discussed about SRH issues with their parents. (Figure 2). Out of 103 respondents who had discussed about SRH issues 82(79.6%) of them were discussed about sexual transmitted infections. But majority 69 (84.2%) of them were discussed with their peers followed by their fathers 41 (50%). Among 103 total respondents 65(63.1%) of them had discussed about contraceptive methods with their peers 46(70.8%) and mothers 31(47.7%). Out of 103 of the total respondents 62(60.2%) of them had discussed about the physiological and psychological changes that occurs during puberty, from them 38(61.3%) discussed with their peers followed by their mothers 25(4.2%) but only 6(9.4%) of them discussed with their fathers. From 103 total respondents 58 (56.3%) of them had discussed about premarital sex. Out of them 33(56.9%) discussed with their peers followed by mothers 25(43.1%). Among 58 female participants who discussed about SRH issues 41(70.7%) of them had discussed about menstruation but majority of them had discussed with peers 35(85.4%) followed by sisters 32(78%). Where as 25(61%) and 3(7.3%) of them discussed with their mothers and fathers respectively. Out of 103 of total respondents only 31 (30.1%) of them had

discussed about sexual intercourse out of them 20 (64.5%) of them discussed with peers and 9(29%) of them discussed with their sisters Table 4.

Table 4. *Showing mizan secondary and preparatory school students that they had discussion on different topics of SRH Mizantown, Bench Maji zone, SNNPRs. May, 2016.*

SRH issues discussion		**Yes**	**103**	**28.9%**	**Male**	**45(43.7%)**	
					Female	**58(56.3%)**	
		No	**253**	**71.1%**	**Male**	**115(45.5%)**	
					Female	**138(54.5%)**	
Topic discussed	**(n=103)**	**With whom they have discussed**					
		Father	**Mother**	**Sister**	**Brother**	**Peers**	**Others**
STI	82(79.%)	41(50%)	39(47.6%)	37(45.1%)	28(34.2%)	69(84.2%)	11®→(13%)
Contraceptive	65(63.1%)	12(18.5%)	31(47.7%)	28(43.1%)	11(16.9%)	46(70.8%)	8□→(12.3%)
Pubertalchange	2(60.2)	6(9.4%)	25(40.2%)	22(35.5%)	16(25.8%)	38(61.3%)	2(3.2%)
Premarital sex	58(56.3%)	15(25.8%)	25(43.1%)	14(24.1%)	3(5.2%)	33(56.9%)	2(3.4%)
Unwanted pregnancy	58(56.3%)	9(15.5%)	34(58.6%)	23(39.7%)	7(12.1%)	41(70.7%)	3(5.1%)
Menstruation (n=58)	41(70.7%)	3(7.3%)	25(61%)	32(78%)	5(12.2%)	35(85.4%)	1(2.4%)
Sexual intercourse	31(30.1%)		3(9.7%)	9(29.0%)	5(16.0%)	20(64.5%)	

□=teachers, Relatives, ®=teachers, Religious leaders

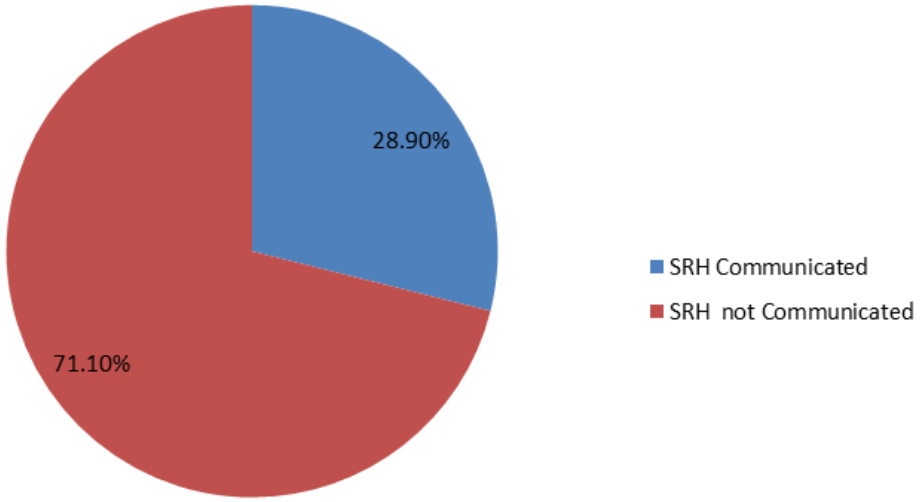

Figure 2. *Percent Distribution Of SRH Communication Among Mizan Secondary and Preparatory School Students With Parents, Bench Maji Zone, SNNPRs, May, 2016.*

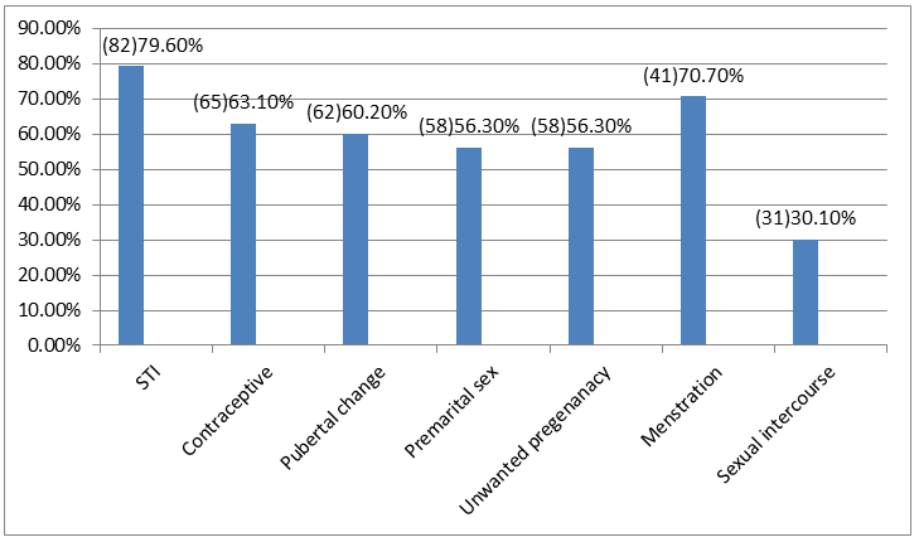

Figure 3. *Proportion of students communicated about different SRH topics in Mizan secondary and preparatory school students, Bench Maji Zone, SNNPRs, and May, 2016.*

3.3. Communications of Student's About Contraceptive Methods

From the total 65 respondents who discussed about contraceptive method majority 51(78.5%) of discussed about Abstinence followed by condom 49(75.4%). where as only 8(12.3%) of them discussed about IUCD Table 5

Table 5. *Showing communication of Mizan secondary and preparatory school students on contraceptive methods, Town, Bench Maji, SNNPRs, May 2016.*

Variables (n=65)	Frequency	Percent
Abstinence	51	78.5%
Condom	49	75.4%
Pills	45	69.2%
Depo-Provera	41	63.1%
Implant	10	15.4%
IUCD	8	12.3%
Others	2	3.1%

3.4. Communication of Students About Sexually Transmitted Infections

From the total 82 respondent who had discussed about Sexual and reproductive health issues majority 68(82.9%) of them had discussed about HIV/AIDS followed by Gonorrhea 21(25.6%) where as 20(24.4%) and 17(20.7%) of them had discussed about syphilis and cancroids respectively Table 6.

Table 6. *Showing communication of Mizan secondary and preparatory school students on sexual transmitted infections, Mizan town, Bench Maji, SNNPRs, May 2016.*

Variables (n=82)	Frequency	Percent
HIV/AIDS	68	82.9%
Gonorrhea	21	25.6%
Syphilis	20	24.4%
Candida	17	20.7%
Other	13	¥→15.9%

¥=genital herpes, Chlamydia

4. Discussion

4.1. Socio Demographic Characteristics of Students and Parents

From the total 356 of respondents 160(44.9%) of them were male and 196(55.1%) were females. The minimum and maximum age of respondents was 15 and 29 years respectively. The mean age of respondents was 18.84 years and the median age of respondents was 19 years and the standard deviation of age of the respondents was (SD=±2.72), The study done in Addis Ababa had standard deviation of (SD=±1.25) (19). The difference may be due to variation of geographical area. From the total of 356 of respondents only 14(4.0%) of respondents reported their parental income was greater than 4400 birr, the study done in Addis Ababa (13%) of respondents had parental income of >4400 birr (19). This difference may be due to socio economic difference of the society. Majority (85.4%) of respondents reported that they had no any pocket money given to them but only (48.1%) of them had pocket money of less than 200 birr, The study done in Wolega (55%) of respondents had pocket money less than 200 birr [20]. This may be due to the socio economic and cultural difference of the society.

4.2. Communication of Students About SRH Issues with Their Parents

This study has attempted to assess communication on sexual and reproductive health issues among preparatory and high school students with parents in Mizan secondary and preparatory school Bench Maji Zone, SNPRs, 2016.

In this study, (28.9%) of respondents had discussed at least one SRH issues with their parents, in the study conducted in Debremarkos (36.9%)of respondents had discussed at least one SRH issue with their parents [32]. This difference may be due to demographic and cultural difference and difference in accessing of SRH information. From the total of 103 respondents 82(79.6%) of them discussed about STI this result is less than study done in Harar (96.76%) and greater than study done in Nekemte (47.6%) [34, 42]. This difference may be duecultural difference of the society. Out of the total 103 respondents 65(63.1%) of them had discussed about contraceptive methods, the study done in south west Nigeria (70.5%) of respondents and study done in Mekele (35.3%) of respondents had discussed about contraceptive methods with their parents [41, 43]. This difference may be due to cultural variation of the society, difference for the accessibility of information about SRH issues and variation of knowledge of students and parents about contraceptive, in our study from the total of 58 female participants who were discussed about SRH 41(70.7%) of them had discussed about menstruation with their parents, the study done in Wolega (10.4%) of female respondents had discussed about menstruation, study done in south west Nigeria (87.1%) of female respondents had discussed about menstruation [20, 41]. This variation may be due cultural difference of the society and method of data collection of the study.

In our study from a total of 103 respondents 58(56.3%) of them had discussed about premarital sex, the study done in Mekele (44.7%) of respondents had discussed about premarital sex with their parents and the study done in northwest Ethiopia (15%) of study participants had discussed about premarital sex with their parents [43, 44]. This variation may be due to cultural difference of the society. In this finding out of 31 total respondents who had discussed about sexual intercourse only 3(9.7%) of them had discussed with their parents about sexual intercourse. This result is much less than finding done in Nigeria (36.8%) and finding done in Mekele (35.7%) [41, 43]. This difference may due to the cultural difference of the society to communicate about sexual intercourse. In our research finding from the total respondents who had discussed about contraceptives majority 51(78.5%) of them had discussed about abstinence. This

finding is less than the finding done in Nigeria (97.5%) but it is much greater than the study conducted in North West of Ethiopia (24.9%) [41, 44]. May difference is due to the variation in knowledge of the students and parents about contraceptive and methodology of the study.

5. Conclusion and Recommendation

5.1. Conclusion

In this study students' communication with their parents on sexual and reproductive health issues was found to be low that means majority of the students didn't communicate on SRH with their parents. From the total respondents who had discussed about SRH issues majority of them discussed about STI followed by contraceptive with their parents.

5.2. Recommendation

This study shows that student-parent communication on SRH issues is low, only less than one- third of the students were communicating on SRH issues. The risk for SRH problems need urgent and continues intervention as such it is necessary to equip and educate parents on different sexual and reproductive health issues. Therefore policy makers should make policies and programs that address to adolescents and youth's reproductive health problems by identifying individual and cultural factors that negatively affect parental communication about SRH issues. School administrators and teachers should give school based sex education and create awareness about sexual and reproductive health. In addition to this health professional who gives health services at different levels should give youth friendly health services and counseling services and further study should be done on student- parent communication.

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