PARENTS' ATTITUDE AND PRACTICE TOWARDS SEXUAL AND REPRODUCTIVE HEALTH EDUCATION TO ADOLESCENTS IN KOROGWE DISTRICT, TANGA.

By

ARCHIE MNTAMBO HELLAR, MD (POLAND)

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CERTIFICATION

The undersigned certify that he has read and hereby recommend for acceptance by the University of Dar es Salaam a dissertation entitled "PARENTS' ATTITUDE AND PRACTICE TOWARDS SEXUAL AND REPRODUCTIVE HEALTH EDUCATION TO ADOLESCENTS IN KOROGWE DISTRICT –TANGA"in partial fulfillment of the requirements for the degree of Master of Public Health.

Supervisor's Sgnature..... Kmnyika .....

Kagoma S. Mnyika, MD, MSc, PhD.

Date..... 26th September 2001 .....

DECLARATION.

I Dr.Archie Mntambo Hellar, declare that this dissertation is my own original work and that has not been submitted and will not be presented to any University for a similar or any other degree award.

CANDIDATE'S SIGNATURE.....

Date.....25 September 2007

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Last but not least, many thanks are extended to my family; my dear and beloved wife Pelimina and my son John for their unlimited moral support, encouragement and care.

DEDICATION

This work is dedicated to:

My Mother Salome and my dear late father David.

My beloved wife Pelimina, and

My Loving son John.

ABSTRACT

The aim of the study was to find out parents attitude and practices to sexual and reproductive health education towards their adolescents. The prevalence of sexual activity is very high among the adolescents with first sexual intercourse beginning in early period of life. Such behaviors make the adolescents more vulnerable to sexually transmitted infections, including the deadly disease HIV/AIDS, unintended pregnancies leading to poor social economic status, illiteracy and unemployment. Lack of knowledge and in some instance poor knowledge appears to be major problem among sexually active adolescents. This situation is correlated to reproductive health risk adolescents are exposed to. Sexual and reproductive health education is identified as one of the best method of prevention of sexuality problems. Literature review shows the necessity of including parents in education offered to adolescents. Curriculum design should be participatory with input from the community and its young people. Two hundred and fifty parents taking care of children aged between 10 to 19 years old were interviewed in the study.

The researcher's findings revealed that parents actually favour programmes, which give sex education to their children though there was relationship between acceptance of sexual and reproductive health and parent's age, religion, and level of education. The findings also revealed that parents are the most preferred source of sexual and reproductive health education to adolescents, whereas there are different ages where sexual and reproductive health education can be introduced between male and female adolescents.

TABLE OF CONTENTS **Page**

LIST OF TABLES:

LIST OF ABBREVIATIONS AND ACRONYMS: -

AIDS	Acquired Immune Deficiency Syndrome.
ARH	Adolescents Reproductive Health.
DMO	District Medical Officer.
DED	District Executive Director.
DFID	Department for Foreign international Development.
GTZ	Germany Technical Cooperation.
TDHS	Tanzania Demographic and Health Survey.
IEC	Information Education and Communication.
HIV	Human Immunodeficiency Virus.
KAP	Knowledge Attitude and Practice.
Mo H	Ministry of Health.
NACP	National AIDS Control Programme.
SRH	Sexual and Reproductive Health.
STD	Sexually Transmitted Diseases.
STI.	Sexually Transmitted Infections.
TANESA	Tanzania Netherlands Support on AIDS.
UNCEF	United Nations Children Fund.
UMATI.	Uzazi na Malezi Bora Tanzania. (Family Planning Association of Tanzania).

WORKING DEFINITIONS:

Sexuality The state of being male or female is our sexuality. Your sexuality includes your sex role, your sexual orientation and your feelings about yourself.

Your sex role Is the way you act as a result of your attitude about being male or female. Role models such as influence your early sex role Parents, father or mother or other adult you admire.

Sexuality education The term is preferred over sex education. Sexuality education's major Objective is the advancement of sexual health and should be inclusive of Biological and psychosocial variable, sexual development, communication skills, body image, gender roles, and emotional aspects. Programs endorsing sexuality education should focus on (1) Information, (2) Attitude, values and insights. (3) Relationships and interpersonal skills, (4) Responsibility (5) STDs/HIV-AIDS preventions.

Adolescents Defining the age of "Adolescents" and childhood often varies from one culture to another, Adolescent typically begins with puberty in most cultures, but the age when people considered adults varies. A young man or woman attending school may still be considered an adolescent in one culture while her/his counterpart of the same age in another may be married beginning a family and considered as an adult. In this research

	proposal the term adolescent is meant people aged 10-19 years old. WHO define adolescents as person in the 10-19 years old.
Attitudes	The way parents perceive sex education.
Positive Attitude	When the parents support teaching of sex education.
Sex education	Choice of the age for sex education Choice of the ideal sex education agent Perception of the effects of sex education positively
Negative Attitude	When parents don't support the teaching of sex education. Parents feel that sex education makes their children experiment.
Parents	Is biological parents Mother or Father. And any guardian.

1.0 INTRODUCTION

In most African cultures, parents and family members such as aunts, uncles, elder sisters and grandparents are influential sources of knowledge, beliefs, attitudes, and values for children and youth. They are role models who shape young people's perception of gender roles and influence the choices that youth make about their own sexual behaviour, parents and other family members often have the power to guide children development towards healthy sexuality as natural normal, and progressive experience within life cycle. They can help their children develop and practice responsible sexual behaviour and personal decision-making. This helps to make many adolescents away from the Sexually transmitted diseases, Human Immune defficiency Viruses (HIV), Acquired Immune Deficiency Syndrome and unwanted pregnancies, which affect them mostly.

Sexually Transmitted Infections and HIV are recognized as a major health problem in most of the industrialized and non-industrialized countries.

The World Health Organization estimated that in 1995 there were 333 million cases of sexually transmitted infections of which 65 million were in Sub-Saharan Africa, and 150 million in South East Asia. The most affected are the adolescents. One third of world's population is between 15 and 24 years of age. 85% of these young people living in developing countries. It has been estimated that about 7000 young people acquire the HIV infection every day. Worldwide young people account for more than 50% of those infected with HIV, (Gina D,Marie L, *at al* 1995) In total people who are infected with

HIV globally are about 14 million people. It was estimated that by the year 2000 between 38 million and 108 million people would have been HIV infected.

However before the era of the HIV/AIDS pandemic, sexual and reproductive health in most societies was regarded as a personal and non-discussed issue. Sex knowledge was for grown ups and never for unwedded young people or those still in schools. Up to now decision makers, influential people and parents are not willing to accept the fact that young people engage in sexual activities. They are reluctant to admit involvement of adult in sex with adolescents. In consequence they are often even more reluctant to allow that information and services to be provided to young people. This might hinder the fight against STD/HIV/AIDS among adolescents. Parents must talk the same language with SRH education provider to achieve this goal.

In Tanzania,

Tanzania like other African countries adolescents have not been spared by the HIV/AIDS epidemic, of which itself is a Sexually Transmitted Disease. Therefore Sexually transmitted diseases are among the top ten causes of disease in mainland Tanzania. Although exact statistics are not available, MoH estimates that between one and 1.5 million Tanzanians per year suffer from STI such as Gonorrhea, Syphilis and chancroid and AIDS.

A total of 8,850 AIDS cases were reported to the NACP from 20 regions in 1999, bringing the cumulative number of AIDS cases from 1983 to 118,713. Simulation model estimates that only one out of five AIDS cases are reported. NACP therefore estimates

that 44,250 cases occurred in 1999 and 600,000 cumulative AIDS cases have occurred from 1983 to 1999. The STI/HIV is extremely common in many parts of Africa and they are an immense burden on the health of the populations and the economies of many countries.

STI frequently lead to serious complications with often-irreversible consequences. Consequences of STIs are important not simply because they can cause acute symptoms such as genital ulcers and discharges but because they can have damaging long- term effects on health such as chronic pain, infertility, ectopic pregnancies, puerperal sepsis, cervical cancer and damaging effects on the foetus and new child. This is compounded by the fact that many STIs are asymptomatic in both man and women making their detection complex. Of critical importance is the fact that STIs play a significant role in the transmission of HIV.

Adolescents and the HIV/STIs crisis.

Adolescents are at more risk of contracting HIV and other STI because, among other reasons, they often have multiple short- term sexual relationships and not consistently use condoms. Available data shows large proportions of adolescents are sexually active and some of them indulge in such behaviors even before they are 14 years old (Muhondwa 1999 and Pfander 2000) the age at which students start to practice sexual intercourse is quite low. Boys start at a mean age of 11.2 years where girls at mean age of 14.0 years.

Adolescents tend to have several partners; boys more often have several sexual partners in life than girls do. Only 15% of sexually active boys had one single partner, while 85% have had several partners. Among girls 48% had one partner while 52% had several lovers, even up to more than ten. Reports also reveal that much of their sexual activities are unprotected. (TANESA, 1995, Kessy 1996, Leshabari *et al* 1997, TDHS 1997). This is also supported by a study done by (Kapiga *et al* 1992) who found that 80% of schoolboys in Bagamoyo were sexually active. Lack of knowledge and in some instance poor knowledge appears to be major problem among sexually active adolescents. This situation is correlated to the reproductive health risk adolescents are exposed to.

However historically, the society had well-established social structures that could be used to reduce the problem of HIV/STI among adolescents. The social structure included aunts, uncles selected to mediate or facilitate communication. Today these systems are weak and in some cases they no longer exist. They have been eroded by various forms of modernization such as urban migration and schooling that provide a less conducive environment for providing guidance about sexual responsibility to young adults. Failure to meet the diverse reproductive health need of adolescents predisposes them to the risk of HIV and STIs infections, and among, girls to unintended pregnancy. A significant explanatory factor for these adolescent problems has been their limited knowledge of reproductive health. As a result, adolescents mature with little factual information and too little guidance on how to manage sexual issue.

To meet the reproductive health need, of adolescents it is critical that adolescents be provided with information to equip them with knowledge and skills that will make them able to postpone their initiation of sexual activity.

Informing Youth through Sexuality Education: -

Sexuality education for youth has long been hampered by adult concerns, that knowledge will promote promiscuity among unmarried teens. However, worldwide reviews of studies by (WHO and UNAIDS 1999) concluded that sexual education does not encourage early initiation of intercourse and lead to more consistent contraceptive use and safer sex practice.

To be effective the information delivered must help individuals understand the risk of engaging in behaviors that will lead to contacting and transmitting STIs, and be accompanied by information about behavioral alternatives such as condom use the overall of these information is to educate adolescents so that they can control the spread of STIs in community. A decrease in STIs can mean a decrease in number of stillbirths, premature birth, ectopic pregnancies, infertility, strictures in men, cases of HIV infection and AIDS.

2.0. STATEMENT OF THE PROBLEM

Sexually transmitted infections (STIs) including HIV among young people aged 15-24 years is rapidly increasing health problem all over the world. It has been estimated that over half of all HIV infections worldwide occur among people aged less than 25 years (WHO1995). In developing countries up to 60% of all new HIV infection occur among

15 – 22 years old. The impact is high burden of diseases among the population. This results to increased morbidity and mortality, resulting to serious social and economic impacts. There is a need of concerted intervention efforts from the public, private sectors and parents. Parents and other members of the family are role models who shape young people's perception of gender roles and influence the choice that youth make about their own sexual behaviors, which may be risky for HIV/STI. Parents have the responsibilities to guide children's development towards health, sexuality as natural norms, and progressive experience within the life cycle. Yet in almost all societies, educating children about sex is not a task that parents and other family members find easy. Many feel uncomfortable talking with children about the subject. Perhaps they are reluctant to expose their own lack of knowledge about the subject. It may not be clear to them how much information to give and at what age. The unfounded belief that the provision of this information will lead to young people to experiment with sex might also determine to parental communication. Many adults did not receive sexuality education themselves, and some have fears arising from their own negative sexual experiences. What many fail to realize is that giving no information or evading young people's question can send negative messages about sexuality.

When young people do not get information at home, they seek answers elsewhere- from peers, the media or their observations of other adults. This can lead to misinformation and the persistence of damaging myths, making young people vulnerable to unwanted and unprotected sexual experiences. The consequences may be unplanned pregnancies; sexually transmitted infection including HIV/AIDS. In the past, moral values imparted

to adolescents both at home and at school tended to implement and reinforce traditional norms relating to adolescents sexual behaviour. However this is not the case nowadays. Grandparents and other extended members of the family are less available to provide sex education to adolescents. Therefore traditional way of providing instructions on sex is non-existence. This seems to explain why there are more liberal sexual life styles of today's adolescents. More over the rapidly increasing level of interaction among various cultures in recent times is thought to contribute significantly to emerging change in the social life style, which in turn encourages a more liberal attitude towards sexuality among adolescents,

On the other hand cultural traditions, fear or other barriers may prevent adolescents from learning about sexuality or acting on the knowledge they have. Parents and community leaders need to support communication with their children to reinforce the knowledge that adolescents may have acquired. However before such consideration we need to know what are the parent's attitudes towards the subject practices and determinants.

3.0. RATIONALE:

HIV/STIs are a leading cause of morbidity and mortality in Tanzania and other parts of the world. Among several interventions is the provision of information, counseling and promotion of condom among adolescents. The result has not been very encouraging to date.

Source of information include schools, radio, and other media. The role of parents has not been clear so far. However parents and guardians are expected to play a leading role

since early age, to shape and influence the sexual behaviour of the child and subsequent the adolescent. Parents have been urged to play this role so that HIV/STI among adolescents can be controlled. The information from this study will shade light on the attitudes, practice and knowledge among parents towards teaching and provision of reproductive health and sex education to adolescents. This will enable Council Health Management Teams (DHMT) identify means/ ways to enhance parents participation in district plans to control HIV/STI and its consequences.

4.0. REVIEW OF LITERATURE:

Young people constitute a large and rapidly growing proportion of the population in most countries of Africa and in many parts of the world as a whole. These young people live in a rapidly changing world, faced with many pressures. Young people on the whole experience discomforting confusion, disquieting irritations and perplexities, and adjustment problems as a result of rapid social change. Furthermore, in traditional African society, the young people depended for guidance in behaviour and personal relationship on some member of the family. This teaching was gradual and continued until the child was an adult. Today, the family has had to distinguish much of the responsibility of guiding youth on these concerns. Much of the task has been left to formal education and to chance. Problem relating has been left to formal education and to chance. Effort to change young people should be attacked at their roots. Such an effort should aim to inform, teach, educate, and orient youth so that they can face the reality of their sexual life. Family Life and Sex Education Programs can be developed for children

and their parents. Such programs can inform young people realistically about the responsibilities of parenthood and the disadvantages of teenage parenthood compared to the advantages of postponing childbearing. For the parents to play their role effectively, they need to understand adolescence and be able to cope with problems related to it. Programs which aim at meeting the needs of young people should give an equal opportunity to women and men at all levels of responsibility. Some approaches to family like education are outlined. (Muriuki, 1981).

Available data from many countries indicate that the peak incidence of STIs is seen in the 15 to 29 years age group. Among sexually active adolescents, the incidence of infection is highest in the youngest. Population based survey among open community and students populations in Africa and Middle East provide evidence that prevalence of gonorrhea is high among persons aged 15-29 years, and that within the 15-29 years age band the prevalence trends to be highest among those aged 15-19 years. (WHO 1993-WHO/ADH/93.1). Data from STI clinics in Dar-es- Salaam show the youth to be highly vulnerable to chronic STI (Mhalu, F *et. al.*, 1992). Information from the National AIDS control programme generally show that youth, especially young women are also the most seriously affected population group by HIV/AIDS epidemic (NACP, 1994).

Available data shows that at least 200,000 people are infected with STIs annually and as many as 50% of the people seeking treatment for STIs in health institutions could be HIV positive,High proportion of HIV among adolescents is largely because of social and economic conditions that may predispose young people to the risk of STIs. The situation is compounded by the fact that the subjects of sexuality still remain largely confined to

the adult world in many communities. Young people are often less informed about the hazards associated with certain sexual behaviour. (Phillimon N, Bengt H, 1997.)

A school based education programme was named "NGAO" meaning shield an often-used symbol in Tanzania and particularly among Masai ethnic. The Ngao symbolize that young people should protect themselves from STI /HIV infection. The aim was to help school pupils make informed decision how to avoid HIV/STIs and related risk behaviors.

There has been a general concern that youth start sexual activity while still young. A study by (Mvandi and Simbamwaka, 1996) asserted that out of 1,572 men aged 15-54 years, 77% had their sexual experience before their twentieth birthday. The Tanzania Demographic and Health Survey (TDHS1996) found that, by the time girls reach 19years, 60% of them are already mothers. Another study by (UMATI 1996) on 13-24 years old adolescents revealed that age at first sexual intercourse is independent of knowledge on sexual and reproductive health. Thus making important the need of parents assuming role models to be very important.

The role of parents in adolescent sexualities is further emphasized by a study done by Caruso on Sex education and condom distribution: The author compared two judicial cases, which dealt with parental due process rights in the context of sex education and condom distribution in public schools. He then explores what role schools should assume regarding sex education and the prevention of unwanted teen pregnancies, HIV/AIDS, and other sexually transmitted diseases. Parents also have the primary role

in raising their children. The Alfonso and Curtis courts reached opposite conclusion on whether condom distribution programs at public schools required some form of parental involvement. Parents need to engage in their primary role as educators of their children, become aware of what schools are teaching, and provide suggestions on the content of schools' sex education programs.

(Caruso1996).

In March 1991, the Zairian International Planned Parenthood affiliate, approached the population Council to design and carry-out a sample survey to determine the proportion of parents open to providing family life education for their children, their capacity to provide it, reasons they would disapprove of such education, and the impact of sexual taboos on the dissemination and understanding of reproductive health information. The results would provide the basis for an information, education, and communication (IEC) strategy in Family Planning. Approximately 75% of parents thought that educating girls about contraception encouraged promiscuous sexual behaviour. Many reported that sex education is responsibility of other members of the family or community; husband would often assign this role to their wives, and vice versa, the parents also saw the aunt as an important source of information for the youth.

A study done in Warsaw Poland using questionnaire was administered by the staff of the Health Epidemiologist Office to primary schools students. The families did not exhibit sufficient skill in providing sex education for their children. However parents were identified as the most desirable source of information about sex, yet their activities in

sex education were limited, particularly with respect to sons. Girls received more attention in this regard. Mothers were more active in sex education than fathers; and the skills of parents were positively correlated to their social status, to family conditions where communication was open, and to freedom of the children. (Przewlocka T, 1994)

There are two basic problems in parents being the sex educators of their children: the hesitancy of many parents to accept the sexual and sensual nature of children, and the fact that parents themselves are living in times when sexual attitudes are being reevaluated. Study indicates that the majority of parents supported the idea of schools offering sex education programs. Yet, the view of what constituted sex education had changed. Sex educator realized that there needed to be a focus on values clarification and decision making skills as well as providing information about sexual anatomy and physiology, hygiene, reproduction, and advice to refrain from premarital sexual activity. In sex education it is now more crucial for parents to be able to open the door to discussions about all aspects of human sexuality as well as to have accurate and complete sex information for their children.

Most professional sex educators seem to feel that the ideal form of sex education would involve a cooperative effort among parents, schools, religious institutions, and interested community groups. (Kelly 1981)

A study done in Mali to assess parent's knowledge and perceptions of reproductive health services to adolescents identify barriers to contraceptive usage by adolescents,

and assess adolescents' sources of information about sexuality. The focus groups confirmed that young people in Mali are poorly informed about reproductive health and have very limited access to family planning services or treatment of sexually transmitted diseases. Few organizations exist that provide reproductive health services especially for adolescents. Communication between parents and their adolescent on sexuality and related topics is rare, while the information schools provide focuses on reproductive organs, an insufficient foundation for sex education. Adolescents are left to obtain information from where they can. (Coulibaly B, *et al* 1996).

Mandona (1996) did a study to determine Practices and attitudes of Parents towards sex education. With a study sample of 105 parents in Lusaka. She observed that parents who had received sex education in their adolescence support sex education as well. She also revealed that parents feel that the suitable age for giving children sex education lies in the range of 10-14 years, 21% of parents suggested 15-19. It seems there is a problem regarding the age at which sexual and reproductive health should begin.

There is a need to determine the mean age at which parents prefer Sexual and Reproductive Health should be introduced.

UMATI's experience in working in the field of sexual and reproductive health in Tanzania indicate that there are many source of information ranging from parents/guardians, friends, radio, television, print materials and other sources. How appropriate, correct and reliable these sources are to respective individuals remains to be

of paramount importance to look into. To a certain extent one can relate the high amount of source of information and the increasing incidences like baby dumping, abortion and related consequences in addition to the rampant spreading of sexually transmitted infections and HIV/AIDS.

5.0. OBJECTIVES

5.1.BROAD OBJECTIVE

Assess parents' attitude and practice towards sexual and reproductive health education to adolescents in Korogwe district.

5.2 SPECIFIC OBJECTIVES

1. To determine proportion of parents who support teaching of sexual and reproductive health education adolescents.
2. To determine contents of sexual and reproductive health education preferred by parents.
3. To determine the median age of male and female adolescents, by which parents accept sexual and reproductive health education can be introduced towards them.
4. To determine parent's preferred source of information on sexual and reproductive health education towards adolescents.
5. To determine social factors related to parent's acceptance of sexual and reproductive health towards adolescents.

Defining Reproductive Health

Reproductive Health is a state of complete physical, mental, social well being and not merely the absence of disease or infirmity in all maters relating to reproductive system and its functions and process. Reproductive Health there fore implies that people are able to have a satisfying and safe sex life and that they have capability to reproduce and the freedom to decide, if when and how often to do so. Implicit in this last condition are rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice. International Conference for Population Development. (ICPD 1994)

Men's reproductive Health includes Family Planning, sexually transmitted diseases prevention and treatment, sexuality and sexual disaffection, infertility and urology conditions.

DEPENDENT VARIABLE

The dependent variable for the study is Attitude and practices of parents to adolescents' sex education.

INDEPENDENTS VARIABLES.

Level of education.

Age

Exposure of parents to sex education.

Employment

Cultural beliefs.

Ethnic group. and Religion

LEVEL OF EDUCATION: - Determining the level of education. in relation to the positive/negative views in introduction of sexual and reproductive health to adolescents.

EXPOSURE TO SEX EDUCATION: Determining the relationship between parents who are exposed to sex education and their positive/negative views on introduction of SRH to adolescents.

Attitude and practices: -

To know about parent's attitude, feeling and social cultural factors which influences the decisions of Sexual and Reproductive Health towards adolescents. The approach is to see their action and practice, by measuring how many parents have positive or negative attitude according to scale, from the most least to the strongest. (Measuring strength of feeling among a standard range of possible answers.) by using answer list and probes questions.

Measuring of practice is assessing how many percentage practicing educating their adolescents or giving them Sexual and Reproductive health education.

SOCIAL FACTORS: To determine social factors which have influence on supporting of SRH towards adolescents.

ANALYSIS of Attitude:-

The respondent ware asked to give their attitude on the SRH education and will be asked to state if they agree or disagree of the following SRH issues to be taught to male or female adolescents

MALE: 1.Sexually Transmitted infections including HIV/AIDS, prevention and treatment.

2.Complications of Sexually Transmitted Diseases

3. Issues on puberty.

4.Condom use.

5.How pregnancy occur.

6.Female menstruation circle.(safe and unsafe days)

7.Safe sex.

8.Methods of family planning.

9.Identification of high risk taken.

10.Hazard of smoking and substance abuse.

FEMALE:

1.Sexully transmitted infections including HIV/AIDS, prevention and treatments.

2.Complications of Sexually transmitted infections.

3.Female menstruation circle. (Safe and unsafe days).

4.Condom use.

5. Delayed childbirth.

6.Identification of high risk taken.

7.Familly planning methods.

8.Unintended pregnancy.

9.Abortions.

10.Safe sex.

A scale of score was formulated from the highest score, which was "4" to the lowest score which was", 1" this means: -

1 = Highly accepted.

2 = Accepted.

3 = Not accepted.

4 = Highly not accepted.

The scale was as follows Positive attitude means score from 10 to 8 = Highly positive

7 to 5 = positive

6 to 4 = Negative.

3 to 1 = Highly Negative

6.0. METHODOLOGY

6.1. STUDY AREA:

The study was aimed at determining parents attitude and practice towards sexual and reproductive health education to their adolescents in Korogwe district Tanga.

The data was collected from 250 parents or guardians who were taking care of children aged between 10 – 19 years old, in their homes, between July and August 2001.

Korogwe District, Tanga Region: -

Korogwe district covers the area of 3756 square Kilometers and is one of the six districts in Tanga region, situated in the central part. Its boundaries are Handeni district in the western and southern borders. Muheza district is on the eastern part while Lushoto district occupies the northern border.

The district is divided into three zones according to the physical and climatic characteristics i.e.

The northern mountainous zone which has a cool temperature with annual rainfall of 1000-2000mm/year.

The wet lowland is from south to eastern part of the district with rainfall of 800-1000mm/year.

The arid, warm lowland occupying the western part and get an average rainfall below 800mm/year.

ADMINISTRATIVE STRUCTURE

Table. 1

The district is divided into four divisions with a total of 20 wards and 132 villages:

DIVISION	NUMBER OF WARDS	VILLAGES	TOTAL POPULATION
KOROGWE	6	30	76757
MOMBO	6	41	79972
BUNGU	4	36	57832
MAGOMA	4	25	39892
TOTAL	20	132	254453

Source: - Annual Health Care Report, Korogwe district (1999).

Total length of passable roads in the district is 472 km. Of which 110km has tarmac. The tarmaced piece is part of Dar-es-Salaam-Arusha-Tanga highway.

[Major highways are the main routes through which the STIs epidemic has spread to remote areas. Highway traffic is associated with social and sexual interactions between travelers and residents of minor settlements and trade centers (O Connor *et al* 1992)].

The northern railway line passes through the district connecting to Tanga line. It has three railway stations. Postal and telephone services are available. The major tribes inhabiting the district are the Sambaa, Zigua and Bondei. There is small proportion of other tribes who have migrated to the district as farmers or government employee. The district depends mainly on agriculture; they grow maize, rice, banana, cassava and beans as food crops. Cash crops, grown are vegetables, coffee and cardamom. Other cash crops include tea in small scale by individual farmers and large scale by big estate; also sisal is grown at big estates.

Livestock keeping is of small scale and is mainly cattle and goat keeping. There is small-scale gemstone mining in the arid areas of Kalalani and Kweisewa. Majority of women are involved in farming activities either in big sisal and tea estates or cultivating own their food and cash crops. Men are mainly involved in small business ventures, mining activities and farming.

According to education Korogwe district has literacy rate of 75%. There are 139 primary schools and 7 secondary schools, one teachers training college, one public health nurse B and one vocational training center. Only 57.6% of children enrolled for standard one

in 1992 completed standard seven in 1998 and in 1999 only 82.9% were enrolled for primary education.

6.2. STUDY POPULATION

The Study population was Parents or guardians who have male and female adolescents who are 10 to 19 years old by the time the study was conducted.

6.3. STUDY DESIGN

A cross - sectional study was conducted. The study basically focused on assessing parents' attitude and practice on reproductive health education towards adolescents.

6.4. SAMPLE SIZE

A study done in Lusaka on parent's attitude and SHR education adolescents towards adolescents revealed that 88% had a positive attitude and 12% had Negative attitude. (Mandona A. 1990)

Therefore according to the formula of (Armitage 1971)

The sample size was calculated using the formula:

$$n = \frac{z^2\, p(100- p)}{d^2}$$

$$n = \frac{1.96^2 \times 88(100 - 88)}{5^2} = 160$$

Whereas: - $z^2 = 1.96$

n = Sample Size.

P = is the expected proportion of parents with positive attitude towards sexual and reproductive health education to adolescents.

d = Marginal of error of 5%

The Sample Size will be ~ 200.

6.5. SAMPLING PROCEDURE: -

Multistage sampling technique was used to obtain the sample population. A list of all six wards in Korogwe division was obtained from the ward secretary. All wards ware written in separate piece of paper, then a colleague was told to select one paper, Korogwe ward was picked, all four villages ware entered in the study, at the village level, village secretary was contacted, and list of all houses with male and female adolescents was obtained, number of houses was selected using same random sampling and represented proportionally. Questionnaires ware administered to parents or guardians of the adolescents.

6.6. DATA COLLECTION TECHNIQUE:

Data for this study was collected between July and August 2001, using quantitative method

Structured interview questionnaires ware used to collect data from the targeted population parents or guardian of the adolescents; total of 22 questions ware included.

The duration for the data collection was expected to be 4weeks from second week of July.

Weekends (Saturdays and Sundays) ware also included in collecting data, because most people at these days are expected to be at their homes.

6.7. ETHICAL CONSIDERATIONS

Study of sexual behaviors implies eliciting information about the most private intimate sphere of human life and interest of the researcher might easily violate the individual right of respect and discretion.

The research was not jeopardized the physiological well being of an individual. There was critical analysis concerning the level of understanding and experience of parents addressed.

The interview was conducted in a private context. Autonomy refers to the respect of individual; his right to consent or withdraw in research with head of household consenting implies that the individuals understand what they are asked for and that they are aware that they can with draw at any stage of the interview process.

Research clearance was obtained from District Medical Officer and District Executive Director. An introductory letter was given to the secretaries and households where interview was conducted.

During data collection, the chief investigator instructed the research assistants on how to fill the questionnaire.Participants ware assured on confidentiality. Names of the interviewees ware not appear in the questionnaire. Informed verbal consent was obtained from the respondent. The study might be educative, so parents had right to ask or being explained any questions, which rose.

Data collection methods and tools: -

The data collection was done by the chief investigator and two research assistants. One was a teacher and the other was a nurse from the District hospital

Training of interviewers: -

The research assistants were trained before data collection started. They ware trained on how to arrange the setting, how to explain the objective and the procedure.

They ware trained how to put special emphasis on the anonymity and how to read out each question and to explain in local language if necessary.

Tool for data collection was questionnaire. The questionnaire consisted of both open and closed questions. The questions were formulated in English then translated in Kiswahili, and translated back by another person from Kiswahili to English.

Comparison was done and necessary adjustment was done. Before data collection, the questions were pre – tested by principal investigator together with the researcher assistants.

Material needed: -

We had sufficient questionnaire (With the code of the word).

Ball pens for researcher assistants with principle investigator

Plastic bags or files to wrap in the questionnaire of each word.

Big felt pens for labeling the different piles, from different villages.

Conducting the interviews at household level: -

Before conducting the interview we meat the villages authorities whom they introduced us to the households which interview was conducted.

We introduced ourselves to the household members, showing them an introductory letter from the district council authorities. The aim of the study was explained to them in a simple polite language. The interview was done in privacy. Both research assistants and the principle investigator was filling of the questionnaire. At the end we thank them for their cooperation.

Data management: -

The principal investigator together with the researcher assistant ensured correctness and completeness of the data. Thus at the end of each day, any incompleteness, correction was done. The research assistant with the principle investigator did auditing of the data filled in the questionnaire. This step was done before the analysis of data.

Data processing; -

Everyday after fieldwork, the chief investigator and the reach assistants passed through all questionnaires and assign serial numbers on each. Answers were categorized and coded.

Limitation of the study: -

Missing the respondent during weekdays, where most families they are out of their home for different activities. We minimized these limitations by: -

-Conducting interview during weekdays and weekends.

-Follow-ups

-Repeated visits with appointments.

6.8. DISSEMINATION

Result of the study will be disseminated to the following institute and organization

To the District Council Health Management Teams where can be used in

their district health planning for sexual and reproductive health education

Programmes.

To the Institute of Public Health, University of Dar – es - Salaam

7.1.RESULTS

TABLE 2:**Demographic data**:

Characteristics a) Age of parents.	Sex Male	 Female	Total
21-30	2 (1.7%)	21 (17.8)	23 (9.2%)
31-40	24 (20%)	44 34.4%)	68 (27.2%)
41-50	44 (36.3%)	29 22.4%)	73 (29.2%)
51-60	18 (14.9%)	25 19.4%)	43 (17.2%)
Above 60	33 (27.2%)	10 (7.7%)	43 (17.2%)
TOTAL:	121 (48%)	129 (52%)	250 (100%)
b) MARITAL STATUS			
1.married.	88 (72.7%)	96 (74.4)	184 (73.6%)
2.single	6 (5.0%)	8 (6.2%)	14 (5.6%)
3.widowed	11 (9.0%)	12 (9.3%)	23 (9.2%)
4.divorced	16 (13.2%)	13 (10.0%)	29 (11.6%)
TOTAL:	121 (48%)	129 (52%)	250 (100%)
EDUCATION			
1.no formal education.	15 (12.4%)	9 (7.0%)	24. (9.6%)
2.adult education	14 (11.6%)	10 (8.0%)	24 (9.6%)
3.primary school education	50 (41.4%)	70 (54%)	120 48.0%)
4.secondary education	23 (19.0%)	29 (22.5%)	52 20.8%)
5.collage education	19 (15.7%)	11 (8.5%)	30 (12.0%)
TOTAL	121 (48%)	129 (52%)	250 (100%)
d) OCCUPATION			
1) Peasant	74 (61.1%)	85 (66.0%)	159 63.6%)
2) Teacher	16 (13.2%)	22 (17.1%)	38 15.2%)
3). Employed	25 (20.7%)	16 (12.4%)	41 16.4%)
4) Business Man/woman	6 (5.0%)	6 (4.6%)	12 (4.8%)
TOTAL	121 (48%)	129 (52%)	250 (100%)
e) RELIGION			
1) Muslim	63 (52.1%)	57 (44.2%)	120 48.0%)
2) Catholic	24 (19.8%)	25 (19.4%)	49 19.6%)
3) Protestant	30 (24.8%)	40 (31.0%)	70 28.0%)
4) Others.	4 (3.3%)	7 (5.4%)	11 (4.4%)
TOTAL	121 (48%)	129 (52%)	250 (100%)

N = 250

Table 2. Shows the Socio- demographic characteristics of the sample of 250 parents who participated in the study.

Table shows most of the parents are in the age group of 41-50 (36.3%) for males and females at age group of 31-40 that is 34.1%.

Among the respondents 121(48%) were male while 129(52%) were female. Majority of parents are married, married male are 88(72.7%) and married women are 96(74.6%) while single male are 6(9.0%) and female are 8 (6.2%).

Widowed male are 11 (9.0%). And widowed female are 16 (9.3%). While divorced are 13 (10%).

Most of the parents are heaving Primary education, 50 (41.3%) of all male have primary education and 70 (54.2%) of all female have primary education. Among 121 male 23 (19.0%) have secondary school education while 29 (54.2%) of all female have the education.

On college education 19 (15.7%) and11 (8.5%) male and female respectively have collage education. Parents with adult education are 24 among them 14 (11.6%) male and 10 (7.8%)female have adult education compare with those without formal education are also 24 whereby 15 (12.4 and 9 (7%) of male and female respectively have not attended formal education.

Regarding occupation 74 (61.1%) are male peasants and 85 (65.89%) are female peasants. 16 (13.2%) were male teachers and 22(17.1%) were female teachers. People employed by Government and non-government organizations, males were 25 (20.66%)

and 16 (12.4%) were female. Businessman and women are 19= 63.3% and 6 (4.65%) respectively

Male Muslims are 63 (52.1%). While females were 57 (44.18%) Total number of male Protestants were 24.8% and female were 31%. Catholics comprises 24 (19.83%) male and 25 (19.37%). are females, other religion were 5.4%.

TABLE 3.

Proportions of parents who support SRH education towards adolescents.

SUPPORT S.R.H.	N.	PERCENTAGES
SUPPORT (+)	194	77.6%
DON'T SUPPORT (-)	56	22.4%
TOTAL	250	100%

Parents were asked to give their opinion whether they do support sexual and reproductive health education towards their adolescents, among 250 parents interviewed 194, which are 77. 6% were supporting and 56, which are 22.4%, were not supporting the idea.

TABLE 4 (a).

Parent's preferred content of sexual and reproductive health education to male adolescents.

CONTENT.	FREQ.	%
STD,HIV/AIDS, prevention and treatment.	249	99.6%
Complication of STI.	244	98.4%
Issues on puberty.	215	89.2%
Knowledge on condom.	148	60.2%
How pregnancy occur.	152	64.7%
Menstruation circle (safe unsafe days)	143	58.1%
Spermarche.	215	93.9%
Family planning methods	198	81.8%
Identification of risk taken	244	98.0%
Hazard of smoking/substance abuse.	247	98.8%

Table shows contents of sexual and reproductive health education to male adolescents, which are preferred by parents. The lowest frequency is about female menstruation circle 58%, knowledge on condom, 60% and education on how pregnancy occurs. With highest frequency on HIV/AIDS STD prevention and treatments. Which is 99.6%.

TABLE 4 (b)

Parent's preferred content of sexual and reproductive health education to female adolescents.

CONTENT.	FREQ.	%
STD, HIV/AIDS, prevention and treatment.	249	99.6%
Complication of STI	244	98.0%
Menstruation cycle	232	94.7%
Knowledge on condom.	120	48.2%
Family planning methods	211	86.5%
Unwanted pregnancies	229	93.5%
Abortion and its complications	238	96.4%
Safe sex	189	76.2%
Delayed child birth	222	91.0%
Identification of risk taken	239	96.4%

Table shows contents of sexual and reproductive health education to female adolescents, with the lowest frequency on condom use among female adolescents 48%, and highest frequency on STD/HIVAIDS prevention.

TABLE 5.

Age at which parents prefer SRH to be introduced

AGE	MALE.		FEMALE	
	N.	%	N.	%
10	7	2.8%	39	15.6%
11	2	0.8%	19	7.6%
12	10	4.0%	69	27.6%
13	18	7.2%	26	10.4%
14	32	12.8%	14	5.6%
15	64	25.6%	20	8.0%
16	27	10.8%	0	0%
17	17	6.8%	3	1.2%
18	15	6.0%	6	2.4%
19	16	6.4%	10	4.0%
At wedding	42	16.8%	44	17.6%
TOTAL	250	100%	250	100%

Table shows that the suitable adolescent's age for receiving sexual and reproductive health education. The most preferred age is for Males 15years and for females is between 10 to 12 years old.

The median age, at which parents prefer Sexual and reproductive health education towards their adolescents, for male is when they are 15years old and for female is when they are 12 years old.

TABLE 6(a)

Relationship between parent's level of education and preferred age of male adolescents which SRH education can be taught: -

Appropriate age.for male adolescents	PARENT' LEVEL OF EDUCATION.					
	No formal N (%)	Adult N (%)	Primary N %	Secondary N (%)	College N (%)	TOTAL. N (%)
10 - 14 years	4 (16.7%)	3(12.5%	43 35.8	14 (27%).	5 16.7	69 27.6
15 - 19 years.	6 25	10 41.7	63 52.5	37(71.1%)	23 76.6	139(55.6%
At wedding Ceremony	14(58.3%)	11(45.8)	14 11.7	1 (1.92%)	2 (6.7%)	42(16.8%)
TOTAL	24 100	24 100	120 100	52 100%	30 100	250 100

Chi – square =64.82, P-Value<0.01

Table shows high significances between level of education and appropriate age at which adolescents should start getting sexual and reproductive health education. Parents with higher formal education from primary to collage education they prefer male adolescents to get sexual and reproductive health education between the ages of 15 to 19 years old.

TABLE 6 (b).

Relationship between parent's level of education and preferred age of female adolescents which SRH education can be tough

Appropriate age for female adolescents	PARENT'S LEVEL OF EDUCATION.				
	No formal Education N %	Adult Education N %	Primary Education N %	Secondary Education N %	College Education N %
10 -14 years	5 (21.0%)	7 (29.1%)	88(73.4%)	46 (8.4%)	21 (70.0%)
15-19 years.	5 (21.0%)	6 (25.0%)	16(13.3%)	5 (9.6%)	7 (23.3%)
At wedding Ceremony	14 (58.0%)	11 (45.8%)	16(13.3%)	1 (2.0%)	2 (6.7%)
TOTAL	24 (100%)	24 (100%)	120 (100%)	52 (100%)	30 (100%)

Chi – square = 65.70 P. Value <0.01.

Table 6b shows a high significances association between level of education and appropriate age at which adolescents should start getting sexual and reproductive health education. Parents with higher formal education from primary to collage education they prefer female adolescents to get Sexual and reproductive health between ages of 10 to 14 years old.

TABLE 7 (a)

Relationship between parent's marital status and adolescent's age at which parents prefer SRH education to be introduced to male adolescents

Appropriate age for male adolescents	PARENT'S MARITAL STATUS				
	Married N %	Single N %	Widowed N %	Divorced N %	Total N %
10 – 14 years.	51 (27.7%)	6 (2.9%)	4 (7.5%)	8 (27.6%)	69 (27.6%)
15 – 19 years.	102(55.5%)	7 (50%)	14(60.8%)	16(55.2%)	139(55.6%)
At wedding ceremony	31 (16.8%)	1 (7.1%)	5 (1.7%)	5 (17.2%)	42 (16.8%)
TOTAL.	184 (100%)	14 (100)	23 (100%)	29 (100%)	250 (100%)

Chi – square =3.36 P. Value = 1.0

Table shows that there is no association between marital status and age of adolescents at which parents prefer sexual and reproductive health education to be introduced.

TABLE 7 (b)

Relationship between parent's marital status and adolescent's age at, which parents, prefers SRH education to be introduced to female adolescents.

Appropriate age for female adolescents	PARENT'S MARITAL STATUS				
	Married N %	Single N %	Widowed N	Divorced N %	TOTAL N %
10–14 years.	123 (7%).	13. (7%)	13 (56%)	18(64.3%)	167(6.8%)
15-19 years.	28 (5%).	1 (6%)	5 (22%)	5 (7.85%)	39 (5.6%)
At wedding ceremony	33 (8.%)	1 (6.66%)	5 (22%)	5(17.85%)	44 (7.6%)
TOTAL	184 100	15 100	23 100	28 100	250 100%

Chi – square =3.96 P – Values =1.0.

Table shows that there is no association between marital status and age of adolescents at which parents prefer sexual and reproductive education to be introduced to adolescents.

TABLE 8 (a)

Relationship between parent's occupation and adolescent's age at which parents prefer SRH education to be introduced to male adolescents

Appropriate Age for male adolescents	PARENT'S OCCUPATION				
	PEASANTS N %	TEACHERS N %	EMPLOYED N %	BUSNESS N %	TOTAL N %
10 – 14 years.	47 (9.6%)	9 (3.7%)	10 (4.4%)	3 (5%)	69 7.6
15 – 19 years.	76 (7.8%)	27 (71.0%)	29 (70.7%)	7 (8.3%)	139 55
At wedding Ceremony	36 (22.6%)	2 (5.3%)	2 (4.9%)	2 (6.7%)	427%).
Total	159 (100%)	38 100%	41 (100%)	12 (100%)	250

Chi – square =15.40 P.Value = 0.22.

Table shows that there is no relationship between parent's occupation and the age of male adolescents at which parents prefer as an appropriate age where adolescents can start having sexual and reproductive health education in percentages. The P. Value of 0.22 confirms this, as it is higher than 0. 05.

TABLE 8 (b)

Relationship between parent's occupation and adolescent's age at, which parents, prefer SRH education to be introduced to female adolescents.

Appropriate age for female adolescents	PARENT'S OCCUPATION				
	PEASANTS N %	TEACHERS N %	EMPLOYED N %	BUSNESS N %	TOTAL N %
10 – 14 years.	94 (59%)	33 (87%)	31 (76%)	9 (75%)	167 67%
15 – 19 years.	28 (18%)	3 (8%)	7 (17%)	1 (8%)	39 16%
At wedding ceremony	37 (24%)	2 (5%)	3 (7%)	2 (7%)	44 17%
Total	159 (100%)	38 (100%)	41 (100%)	12 (100%)	250 100

Chi – square =15. 27 P. Value = 0.23

Table shows that there is no relationship between parent's occupation and the age of female adolescents at which parents prefer as an appropriate age where adolescents can start having sexual and reproductive health education.The P. Value of 0.22 confirms this, as it is higher than 0. 05

TABLE 9 (a)

Relationship between parent's religion and adolescents age at which parents prefer SRH education to be introduced to male adolescents

Appropriate age for male adolescents	PARENT'S RELIGION				
	Muslim N %	Catholics N %	Protestants N %	Others. N %	TOTAL N %
10 – 14 years.	34 (28.3%)	10(20.4%)	22 (31%)	3 (27%)	69 (27.6%)
15 – 19 years.	64 (53.5%)	30 61.2	38(54.3%)	7 (63.6%)	139(55.6%)
At wedding Ceremony	22 (18.3%)	9 18.2	10(14.3%)	1 (9.1%)	42(16.8%)
Total	120 (48%)	49 19.6%	70 (28%)	11 4.4%	250 (100%)

Chi – square = 2.75 P. Value = 0.1

Table shows that there is no relationship between parent's religion and the age of male adolescents at which parents prefer as an appropriate age where adolescents can start having sexual and reproductive health education in percentages. The P. Value of 0.99 confirms this, as it is higher than 0. 05

TABLE 9 (b)

Relationship between parent's religion and adolescents age at which parents prefer SRH education to be introduced to female adolescents

Appropriate age for female adolescents	PARENT'S RELIGION				
	Muslim N %	Catholics N %	Protestants N %	Others N %	Total N %
10 – 14 years.	86(71.7%)	31 (63.3%)	44 (63%)	6 (4.5%)	167 6.8
15 – 19 years.	11 (9.1%)	8 (16.3%)	16 (23%)	4 (6.4%)	39 15.6
At wedding Ceremony	23 (19.2%)	10 (20.4%)	10 (14%)	1 (1%)	44 17.6
TOTAL	120 (48%)	49 (19.6%)	70 (28%)	11 (4.4%)	250 100

Chi – Square = 10. 81 P. Value = 0.55.

Table 9b shows that there is no relationship between parent's religion and the age of female adolescents at which parents prefer as an appropriate age where adolescents can start having sexual and reproductive health education in percentages. The P. Value of 0.55 confirms this, as it is higher than 0. 05

TABLE 10 (A)

Relationship between parent's tribe and adolescents age at which parents prefer SRH education to be introduced to female adolescents

Appropriate age for female adolescents	PARENT'S RELIGION				
	SAMBAA N %	ZIGUA N %	BONDEI N %	OTHERS N %	TOTAL N %
10 – 14 years.	52 (1.3%)	52 (3%)	21 (72%)	42 (65%)	167 (67)
15 – 19 years.	12 (6.4%)	14 (7%)	4 (14%)	9 (14%)	39 16%
At wedding Ceremony	9 (2.3%)	17 20%	4 (14%)	14 (21%)	44 17%
TOTAL	73 (100%)	83 (100%)	29 (100%)	65 (100%)	250

Chi = square =3.27 P. Value 1.0

Table shows that there is no relationship between parent's tribe and the age of female adolescents at which parents prefer as an appropriate age where adolescents can start having sexual and reproductive health education in percentages. The p- value of 1.0 confirms this, as it is higher than 0. 05

TABLE 10 (b)

Relationship between parent's tribe and adolescents age at which parents prefer SRH education to be introduced to male adolescents

Appropriate age for male adolescents	PARENT'S RELIGION				
	SAMBAA N %	ZIGUA N %	BONDEI N %	OTHERS N %	TOTAL N %
10 – 14 years.	24 (33%)	24 (29%)	8 (28%)	13 (20%)	79 (32%)
15 – 19 years.	40 (55%)	43 (52%)	18 (62%)	38 (58%)	139 55%)
At wedding Ceremony	9 (12%)	16 (19%)	3 (10%)	14 (22%)	32 (13%)
TOTAL	73 (100%)	83 (100%)	29 (100%)	65 (100%)	250 (100)

Chi – square =7.70 P.Value =1.0.

Table shows that there is no relationship between parent's tribe and the age of male adolescents at which parents prefer as an appropriate age where adolescents can start having sexual and reproductive health education in percentages. The P. Value of 1.0 confirms this, as it is higher than 0. 05

TABLE 11

Parents proffered source of information for SRH education to their adolescents

SOURCE.	N.	%
Parents	221	(88.4%)
Teachers	199	(80.2%)
Grand parents/aunts/uncles	77	(31.8%)
Mass media	114	(46.7%)
Rites initiation	65	(27.3%)

Table shows that among the sources of information for sexual and reproductive health education, which do parents for adolescents prefer. Parents prefer more to be given by them, which is 88%.

By teachers 80% and the least is by Rites, which is 27%.

TABLE 12.

Relationship between parents who received sex education and their support for SRH education towards their adolescents

Parents who received SRH education.	SUPPORT FOR SEX EDUCATION.					
	SUPPORT		DON'T SUPORT		TOTAL	
	N	%	N	%	N	%
Received sex education	73	(96.1%)	3	(3.9%)	76	(30.4%)
Didn't received sex education	121	(69.5%)	53	(30.5%)	174	(69.6%)
TOTAL:	194	(77.6%)	56	(22.4%)	250	(100%)

X^2=21.39, p-value>0.01

Among 250 parents whom were interviewed, total of 76 parents had received sexual and reproductive health, which is 30.4% of all the interviewers. 73 of them they are supporting of the education, which is 96.1%, compared to 174 those, which did not, received sexual and reproductive health, which is 69.6%.

TABLE 13.

Level of education and parental support for sex education towards adolescents

LEVEL OF EDUCATION.	PARENTAL SUPPORT FOR SEX EDUCATION		
	SUPPORT	DON'T SUPPORT	TOTAL
No formal education.	6 (25.0%)	18 (75.0%)	24 (9.6%)
Adult education.	8 (33.3%)	16 (66.6%)	24 (9.6%)
Primary	103 (85.8%)	17 (14.2%)	120 (48.0%)
Secondary.	50 (96.1%)	2 (3.9%)	52 (20.8%)
College	27 (90.0%)	3 (10.0%)	30 (12.0%)
TOTAL:	194 (77.6%)	56 (22.4%)	250 (I00%)

Chi – square = 82.89 P. Value <0.01

Table shows parent's level of education and support of sexual and reproductive education towards adolescents is highly significant, as the level of formal education increases as the increase of frequency of support to the education. From 33.3% of those with ought formal education to 90% with collage education. Opposite, 75% of those with ought formal education they don't support while only 10% with collage education they don't support.

TABLE 14

Parent's age and support for SRH

PARENT'S AGE	PARENTAL SUPPORT FOR SRH		TOTAL
	SUPPORT	DON'T SUPPORT	
21-30	23 (100.0%)	0 (0%)	23
31-40	67 (98.5%)	1 (1.5%)	68
41-50	65 (89.0%)	8 (11.0%)	73
51-60	27 (62.8%)	16 (37.2%)	43
Above 60	12 (27.9%)	31 (72.1%)	43
TOTAL	194 (77.6%)	56 (22.4%)	250

Chi –square = 95.79 P. Value <0.01

Table shows an association between parent's age and support to sexual and reproductive health to adolescents, high frequencies with parents aged 21 to 31years old 100%. As the ages increases the low the frequencies those above 60years old has frequency of 27%.

TABLE 15.

Relationship between parent's religion and support for SRH

Education towards adolescents

RELIGION	PARENTAL SUPPORT FOR SRH		TOTAL
	SUPPORT	DON'T SUPPORT	
Muslim	94 (78.3%)	26 (21.7%)	120
Catholics	34 (69.4%)	15 (30.6%)	49
Protestant	58 (82.9%)	12 (17.1%)	70
Others	8 (72.7%)	3 (27.3%)	11
TOTAL	194 (77.6%)	56 (22.4%)	250

Chi – square = 12.82 P. Value <0.01.

There is association between parent's religion and support to sexual and reproductive health to adolescents, Catholics with the least frequencies support of 69%

TABLE 16

Relationship between parent's occupation and support for SRH

Education towards adolescents

OCCUPATION	PARENTAL SUPPORT FOR SRH		TOTAL
	SUPPORT	DON'T SUPPORT	
Peasant	113 (71.1%)	46 (28.9%)	159
Teacher	36 (94.7%)	2 (5.3%)	38
Employed	36 (87.8%)	5 (12.2%)	41
Businessman/woman	9 (75.0%)	3 (25.0%)	12
TOTAL	194 (77.6%)	56 (22.4%)	250

Chi – square =3.29 P. Value = 0.36

Table16. Shows there are no association between parent's occupation and support for sexual and reproductive health education towards adolescents; this is supported by the P. value of 0.36

TABLE 17.

Support for SRH education according to ethnic groups

TRIBES	PARENTAL SUPPORT FOR SRH		TOTAL
	SUPPORT	DON'T SUPPORT	
Sambaa	61 (83.6%)	12 (16.4%)	73
Zigua	62 (74.7%)	21 (25.3%)	83
Bondei	23 (79.3%)	6 (20.7%)	29
Others	48 (73.8%)	17 (26.2%)	65
TOTAL	194 (77.6%)	56 (22.4%)	250

Chi – square = 2.47 P. Value = 0.50

Table shows there is no association between parent's tribe and support for sexual and reproductive health education towards adolescents; this is supported by the P. value of 0.50, which is above 0. 05

TABLE 18

Frequency of parents who discuss sexual issues with their adolescents

PARENTS WHOM DISCUS SRH ISSUES TO ADOLESCENTS.	YES.	NO.	PERCENTEGE
TOTAL	184	66	74.0%

Table18. Shows 74.0% of parents who discuss sexual and reproductive issues with their adolescents, and 26% they do not discuss SRH. with their children.

TABLE 19.

Relationship between parents' level of education and discussion of sexual and reproductive issues

PARENTS WHO DISCUS SRH ISSUES TO ADOLESCINTS	PARENTS LEVEL OF EDUCATION.					
	No formal education N %.	Adult education N %	Primary education N %	Secondary education N %	Collage education N %	
YES	11 6%	17 (9.2%	87 47.3	46 25%	23 12.5	184
NO	13 19.7	7 10.6	33 50%	6 9.0%	7 10.6	66
TOTAL	24	24	120	52	30	250

Chi – square = 15.75 p. value <0.01.

This table shows that parents with high level of education they do discus with their adolescents on sex issues, compared to those with out formal education.

this shows an association with level of education. it is proved by the p value<0.01 of which shows the association.

TABLE 20.

Relationship between parent's religion and discussion of sexual and reproductive issues to adolescents

PARENTS WHO DISCUSS SRH ISSUES TO ADOLESCENTS	PARENT'S RELIGION				
	MUSLIM N %	CATHOLICS N %	PROTESTANTS N %	OTHERS N %	TOTAL N %
YES	89 (79.5)	34 (69.4%)	54 (77.1%)	4(36.4%)	184
NO	31 (20.5)	15 (30.6%)	13 (22.9%)	7(63.6%)	66
TOTAL	112	49	70	11	250

Chi = square = 10.52 P. value <0.01

The table shows that there is association between parent's religion and discussion about sexual and reproductive issues with adolescents.

TABLE 21.

Relationship between parents who received sexual and reproductive health education and discussion of SRH issues to adolescents.

PARENTS WHO DISCUSS SRH ISSUES TO ADOLESCENTS	PARENTS WHO RECEIVED RSH EDUCATION				
	YES		NO		
	N	%	N	%	
YES	67	(88%)	117	(67%)	
NO	9	(12%)	57	(33%)	
TOTAL	76	(100%)	174	(70%)	

Chi – square = 11.91 P. Value <0.01

Table 20 shows that parents who received sexual and reproductive health education many of them they do discuss sexual and reproductive health issues to their adolescents which is 88% compare to 12% who does not. Out of 174 parents which is 70% whom did not receive sexual education only 67% do discuss with adolescents and 33% they don't discuss.`

TABLE 22

Parent's' attitude on introduction of sexual and reproductive health education towards adolescents.

ATTITUDE	PARENT'S GENDER.		TOTAL
	MALE	FEMALE	
POSITIVE (+)	86 (71.1%)	114 (88.3%)	199 (80 %)
NEGATIVE (-)	35 (28.9%)	15 (11.7%)	50 (20 %)
	121 (48.4%)	129 (51.6%)	

The scale of positive attitude was combined between highly accepted and accepted, for the matter of practical and not accepted and highly not accepted regarded as negative attitude.

71.1% of male and 88.3% of female has positive attitude on sexual and reproductive education towards adolescents.

8.0. DISCUSSION

In most African cultures people do believe that, it is the grand parents or respected elderly people's responsibility to give sex education to their children. With the event HIV/AIDS and gradually disintegration of the extended family bonds, Parents now obliged to take over the role with the help of other sources like mass medias and teachers. The question was, do these parents willing sexual and reproductive health to be introduced to their adolescents.

Sociodemographic data. The majority of respondents were in the age group between 41 to 50s years (36.3%) who are male and 30 to 40years (34.4%) are females. Most of them are married. 88 (72.7%) of males are married and 96 (74.4%) are females.

This provides a good indication for an environment suitable for proper upbringing of children. The relevance of marriage to sexual behaviour of children was revealed by Rodgers who stated that most children from single parents home are prone to sexual promiscuity than those from the married couple homes. This means marriage couples they do practice on sexual education to their adolescents.

Proportion of parents who support sexual and reproductive health education to adolescents:

The study revealed that majority of parents 194 (77.6%) are in support of adolescents to get the education, while 56 (22.4%) are not for the idea. This presents a contrary view to the researcher's assumption, which state that parents are heaving unfounded belief that provision of sexual and reproductive health will lead young people to experiment with sex. The result is supported by another research done by Mandona (1996) in Lusaka

Zambia where she noted that 86% of parents support for sexy education to be provided to adolescents, while 14% disapprove it. Another study done by Zairian Population council to determine the proportion of parents open to provide family life education for their children, their capacity to provide it, reason they would disapprove of such education, and the impact of sexual taboos on the dissemination and understanding of reproductive health information. The result was 75% of parents thought that educating girls about contraception encourage promiscuous sexual behaviour.

In determining the content of sexual and reproductive health education to adolescents.

Among the contents of sexual and reproductive health education, HIV/AIDS prevention to male adolescents was supported by 96.6% of the parents interviewed, and same content in female adolescents it was supported by 99.6 % of respondents, compared to condom promotion to females where it was supported by 48% of respondents and to male was supported by 60%of parents. Researchers assumption is that parents may have views that promoting condoms to adolescents may lead to increase in sexual activities among girls, other assumption is that, parents may be not aware of female condoms which are now promoted. Study by (Florence Mbaga 2000) on perception on female condom as means for sexual empowerment for protection against HIV infection among barmaids; Kinondoni Municipality in Dar es Salaam, She noted that in protected sex 80% were looking at male condoms, only 3.4% for female condoms as a means of rescue. This poses a question on familiarity of the device. Parents may believe that male

is responsible for safe sex than female partner the role of parents in adolescents sexuality education is emphasized by a study done by (Caruso 1996) on sex education and condom distribution. The author reached conclusion that Condom distribution programs at public schools requires some form of parental involvement. Parents need to engage in their primary role as educators of their children, become aware of what schools are teaching, and provide. Suggestions on the content of schools sex education programs. The result also is supported by a research done by Zairian International Planned Parenthood affiliate to determine the proportion of parents open to providing family life education for their children, their capacity to provide it, reason they would disapprove of such education, Approximately 75% of parents thought that educating girls about contraception encouraged promiscuous sexual behaviour.

Determining the adolescent's median age at which parents prefer sexual and reproductive health education starts to be given.

The study shows that majority of parents prefer different ages at which male and female adolescents could start receiving sexual and reproductive education, most of parents prefers girls to start earlier 10 to 12 years than boys at 15 to 16 years old. The median age for girl's 12years old and boys at 15years old. This is mainly because many adolescents start sexual activities much earlier before marriage. This is supported by a study conducted by Leshabari (1998) where he revealed that nearly half of youth aged 14 years and younger were sexually active and the rate s increased to 60% among those aged 18years and older. Another study by Muhondwa (1999) and Pander (200) also revealed that despite evidence of potential dangers of consequences of unprotected sex

among adolescents available data shows that lager proportion of adolescents are sexually active and some of them indulge in such behaviours even before they are 14 years old. As many parents used the Swahili says *"Samaki mkunje yungali mbichi"* means you have to bend the fish while still afresh. So majority of parents prefer this education to be given as earlier as possible. Though there are parents 16.8% and 17.6% for male and female respectively they prefer this education to be given during wedding ceremony regardless of the age. The study is also supported by another study done in Makete and Mtwara district. It was revealed that age at first sexual debut for girls and boys is11-14 years which is 43.8%and45.4% respectively (Mtwara) The study differ from the study of Mbunda (1988) who revealed that 15% of boys over 5% of girls reported coital experience by the age of 12 years, these rate increases to 85% and 91% among boys and girls by the age of 24years. Another survey on knowledge, attitude and practice of adolescents with regard to reproductive health and STIs including HIV/AIDS by Pfender in Lindi region revealed that the age at which students starts to practice sexual intercourse is quite low. Boys start at mean age 12.2 years whereas girls the mean age at first sex intercourse is 14years.The study is supported by another sex education research programme in Cameroon revealed that 24% of 234 school children aged11 to 16 years had experienced sexual contact by the age of 13 for girls and 15 for boys. This shows how early these adolescents starts indulging in sexual activities.

Preferred agents for sexual and reproductive health education to adolescents: -

The study demonstrated that most parents prefer agent for giving sex education to adolescents to be parents.88.4%followed by teachers 80% and Mass media 46%grand parents. Aunts, and uncles 31% and Rites 27%. In some cultures, parents and family members such as aunts, uncles, elder sisters and grandparents are influential source of knowledge, beliefs attitudes and value for children and youth. They are role models who shape young people's perception of gender roles and influence the choices that youth make about their own sexual behaviuor. Findings are supported by Rodgers who confirmed that Sex education is infarct a responsibility of parents, although it is often avoided. It is evidence from the literature that it is the parents responsibility to give sex education because they are the one who provide an environment in which the children are socialized, furthermore the findings is supported by a study conducted by Parlos, in Nigeria, revealed that there was higher contraceptive use among university teenagers who discussed sexuality with parents than those who did not. It is therefore affirmed that parents can make profound impact on the sexuality of their children. When young people do not get information at home, they seek answers elsewhere, from peers, media or their observations of other adults. This can lead to misinformation and persistence of damaging myths, making young people vulnerable to unwanted pregnancy, STD, HIV and low self esteem. On Mass media, there is a number of social changes among them is the process of media liberalization. Since the beginning of the 1990s many journals and newspapers have appeared, as well as independent radio stations, and TV channels. The mass media have become increasing influential, highliting and disseminating a broad

range of ideas views and position the mass media are in position to influence and form public opinion. This is true in giving information and knowledge on reproductive behaviour. The question is what type of knowledge do adolescents acquire from the family members and mass media in relation to reproductive health?

A study done by Goergen 1999, in Youth involvement in the development of media for the promotion of Adolescent Reproductive Health (ARH). The lesson learned is involving youth as the key collaborators for media development is feasible, cost effective and a good way to reach young people's mind and heart, necessary condition to have an impact on their attitudes and their behaviour.

Social factor related to parent's acceptance of sexual and reproductive health to adolescents.

Age: There is relationship between parent's age and acceptance of sexual and reproductive health education to adolescents, most parents with old age are not in support for the education while younger parents are in support. This may be due to most young parents are exposed to education which made them perceive the benefit of the education to adolescents.

Tribe: -Tribes and culture behaviors in Korogwe district has no influences in supporting sexual and reproductive health education to adolescents. All indigenous tribes in Korogwe have similar cultural behavior, excluding the immigrants from other districts. The study shows that all of them their in support of the education.

Religion. There is a strong relationship between religion and support for sexual and reproductive health education, the study revealed that there is relationship between parent's religion and sexual and reproductive health education to adolescents and acceptance. 78.3% of Muslims and 82.9% of protestants they do support the education to be given to adolescents. In comparison with Catholics whereas only 69.3% they do support the education. This is according

to their beliefs in condom promotion, which is not encouraged, they like adolescents to abstain from sex.

Level of Education: - The study revealed that level of education has a role to play in acceptance of sexual and reproductive health. It was found that people with high education more of them are in support of the education. Parents whom had received Sexual and reproductive health education previously majority of them do support the education to adolescents. The assumption is that they have perceived the benefits of the education to adolescents. Knowledge is the leading determinant to decisions taken (practice) and knowledge opens the attitude and practice choice, so parents with formal education are often more willing to favor in school sex education.

9.0. RECOMMENDATIONS: -

1. The Government and Non Government Organizations should incorporate the aspect of sexual and reproductive health education in their programs, aimed at changing the negative attitude of parents regarding Sexual and reproductive health educations.

2. Curriculum design should be participatory with inputs from the community and its adolescents. Designing curricula and trainers manuals should be a broad- based activity, working with key Government agencies; NGOs and family members of youth and young people will give strong reality base.

3. Efforts should be done by Government and district councils to educate parents and other adult members, the benefits of educating youth on sexual and reproductive health. Also parents should know what contents to be taught to adolescents. Parents should know that they are the Primary sexual educators of their children.

4. Appropriate settings for educational programs include parents – teacher associations, Social or civic clubs, labor unions, religious groups and other organizations whose members are likely to be parents of children or adolescents

5. Parent's education can open the door for other types of interventions. Parents and other members who participate in education programs are often more willing to favor other efforts, such as in school sex educations. They do so because they understand what will be taught or that they are ill equipped to educate their children about sexuality and reproductive health.

10.0. FURTHER STUDIES. A study should be done to know the Parent's level of knowledge on sexual and reproductive health if it is enough to educate the new generation of adolescents, in regarding to HIV/AIDS and STD preventions.

11.0. SUMMARY:

The study aimed at determining parent's attitude and practice towards Sexual and Reproductive Health Education to their adolescents in Korogwe district Tanga. The data were collected from 250 parents or guardians who were taking care of children aged between 10 to 19 years in their homes.

The study revealed that parents have a positive attitude towards sexual and reproductive health education to their children. However it was evidence from the study that parents holds different views about sex education. This implies that the type of sexual and reproductive health education offered to children varies from one family to another, which is due to differences in conceptualization of sex and reproductive health education.

Governments or District councils involvements in this problem is essential in consolidation of various activities of institutions concerned with adolescents and parents sex education programmes. There is a demand of integration of various activities of sex educations agents and planning for the educations to parents and adolescents.

Young people have rights to information and education that affects their health. But what impact does sexual health education have?

A WHO review of programmes around the world, recently updated by UNAIDS, found that sex education does not lead to earlier or increased sexual activity, contrary to what many parents feared. The review concluded, instead that: -

Good quality education programmes help delay first intercourse and protect sexually active young people from HIV, STD and pregnancy.

The UNAIDS review found that effective programmes share certain features: -

-They have specific aims both delayed first intercourse and protected intercourse.

-They encourage the learning of skills (the same skills that also help build self confidence and avoid unwanted pregnancy, sexual abuse and substance use)

-They discuss clearly the result of unprotected sex and the way to avoid it.

-Help young people "Personalize" the risk through role-playing.

-They reinforce group values against unsafe behaviour both at school and in the community.

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REFERENCE

Buga, G.A., Amoko, D.H., Ncayiyana, D. (1998). Sexual behaviour contraceptive practice and reproductive health among adolescents in rural Transkei *International family planning perspectives,* Vol.21, No. 1

Caruso, S. (1996) Sex education and condom distribution. *Notre Dame Journal* of law, Ethics and Public Policy.10 (2): 663-76.

Charles, E.L. (1993). Source of sex education in relation to self-esteem and attitude towards AIDS precautions among college students. *Psychological report, series No.14.*

Cianciara, D., Moscicka M., Przewlocka., (1994). The competence of families in providing sex education to children. *Journal of public health.* 45(3): 263-72.

Coulibaly, B., Eckert, E., Sow T. (1996) Result of the focus groups; the case of Mali. Document No PIP 118079.

Gina D., Marie, L., Peter, L. (1996). Control of Sexually Transmitted Diseases *A handbook for the design and management of programs. AIDSCAP/Family Health International.*

ICPD., UNFPA. (1995): Population and Development: Programme of Action of the International. *Conference on population and Development* Vol. 1 New York

Kelly, GF, Parents as sex educators. In: Brown L, ed. Sex education in the eighties: the Challenge of healthy sexual evolution. *New York, Plenum*, 1981.101-13 Perspectives in Sexuality Behavior.

Kessy,A. (1996). Prevalence and risk factors for HIV and other STD among youth in Moshi Rural District Unpublished Master of Medicine *Dissertation* University of Dar es Salaam.

Kamtchoing, P., Takougang, I., Ngoh, N. (1997). Sexuality of adolescent's students in Yaonde Cameroon *Adolescents spring*; 31(121): 179-91.

Kopoka, PA., (1999). *A research study* on National Adolescents Reproductive Health Needs Assessment.

Kapiga, SH., Lwihula, GH., Shao, JF., Hunter, DJ.(1995) "Predictors of AIDS knowledge, condom use and high-risk sexual behavior among women in Dar es Salaam, Tanzania". *International Journal STD AIDS 6(3):* 175-83.

Leshabari, MT. (1998). Factors Influencing School teenager Sexual behaviour in Dar-es-salaam. Schools, (Unpublished) Doctor of Science *Thesis,* The Johns Hopkins University School of Public Health Baltimore, USA.

Muhondwa, E. (1999). Adolescent Sexuality and HIV/AIDS in Mtwara Rural and Makete district. *A report of study commissioned by UNICEF Tanzania office.*

Mandona, A. (1996). A study to determine the attitudes and practices of parents to sex education of their children research study, Lusaka Zambia. *A research study submitted to the school of medicine, department of post basic nursing, in partial fulfillment of the requirements of the Bachelor of Science degree in nursing.*

Mbaga, F. (2000). Perception of female condom as means for sexual empowerment for protection against HIV infection among barmaids; Kinondoni Municipality Dar es Salaam. *Dissertation submitted in partial fulfillment for the requirements for the degree of Master of Public Health in the University of Dar es Salaam.*

Mpangle, GS, Leshabari MT, Kaaya, S, Kihwele,DJ. (1998). "Abortion and unmet Need for contraception in Tanzania. The role of male partners in teenage induced abortion in Dar es Salaam"*African Journal of Reproductive Health* 2(2): 23-34.

Matasha, G. *et al* (1996). A study on condom use among Mwanza primary school students A *research Study.*

Mbunda, WM. (1990). The power of Extended family social cultural control on adolescent premarital pregnancy among Wamatengo of Mbinga district. *MA Dissertation, Demographic Unit UDSM.*

Mpangile, GS., Leshabari, M.T., and Kihwele, D.J (1992) Factors Associated with induced pregnancy in public hospitals in Dar es Salaam, *Unpublished WHO Report* Dar es Salaam: Family Planning Association of Tanzania (UMATI)

Muriki P (1991) Problem of youth in Africa *Africa Link,* Dec; 2-6.Africa Link.Dec; 2-6

NACP (1999), National AIDS Control Program. HIV/AIDS/STI *Surveillance report No. 14, Dec1999.*

.Nicoll *et al* (1996) MoH- Zambia, *dissemination* seminar on sexual and reproductive health on adolescents..

.Ndubani, P., Hojer, B. (1997). Sexual behaviour and sexually transmitted diseases among young men in Zambia.*Journal Health Policy and Planning* 16(1); 107-112.

O'connor, P., Leshabari,MT, Lwihula,G. (1992) Ethnographic Study of the Truck stop Environment in Tanzania.*Family Health International Durham NC.*

Palos, K., (1995). Impact of the family on the sex lines of adolescents. *Journal adolescents,* 16: 74-85.

Regina,G., Babette, P., Juma, B., Akwilina, M. (1999). Youth involvement in the development of media for the promotion of Adolescent Reproductive Health. Approaches developed and tested in Tanzania. *A case study in Lindi.*

TANESA (1995). Tanzania Netherlands Project to Support HIV/AIDS control in Mwanza region. HIV Infection and Behaviour in four fishing village on Lake Victoria Tanzania. *TANESA working paper* NO.2 *–Mwanza.*

Rodgers R. (1974) Sex Education Cambridge University press London. Pg 50 – 69.

UNAIDS. (1998). Young People and HIV/AIDS. *UNAIDS Briefing paper – Geneva.*

.W.H.O. (1993). Sexual transmitted diseases in developing world: *A review of published data, Geneva:* WHO/ADH/93.1

WHO (1989). The Health of Youth *reform and teen parents slow Report*

Pg. 18 -- 19. Geneva Pg 63.

Walter G, et al (1994) *Public policy updates welfare.*