FACTORS INFLUENCING COMMUNICATION PATTERN BETWEEN PARENTS AND THEIR ADOLESCENT CHILDREN ABOUT SEX RELATED ISSUES IN MBEYA RURAL DISTRICT

BY

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A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH OF THE UNIVERSITY OF DAR ES SALAAM

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by the University of Dar es Salaam a dissertation entitled: *Factors influencing communication pattern between parents and their adolescent children about sex related issues in Mbeya rural district,* in partial fulfillment of the requirement for the degree of Master of Public Health.

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DECLARATION

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DEDICATION

This work is dedicated to my beloved wife Aloysia, my beloved son Derrick and my lovely daughter Divine.

ABSTRACT

This was a cross sectional study done in Mbeya rural district between May and June 2002. The aim of the study was to assess the extent to which the parents communicate with their adolescent children about sex related issues.

The respondents were selected using multistage random sampling technique. A structured interview was used for generating data. A total of 400 parents with children aged ten to nineteen years were interviewed. The results of this study revealed that 82.3% and 72.3% of the parents communicate about sexuality related issues to their male and female adolescents respectively.

HIV/AIDS was the most frequently discussed topic. Discussion on spermarche, menarche, and family planning were held by a small proportion of parents. Cultural restrictions and lack of time were cited as major barrier to communication.

The general knowledge of parents on sexual and reproductive health issues was found to be fairly high despite the observed gaps on specific issues. For example, only half of respondents knew that a woman can get pregnant if she has unprotected sex while standing. Also, only 6% percents of parents knew blood transfusion can transmit the AIDS virus.

Most parents preferred to be the source of sexuality information for their adolescent children. Very few mentioned the media and peers as what they would like to be sources of sex related information for their children. Parents should play their role as primary sex educators of their adolescent-children as they have suggested.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
DANIDA	Danish International Development Agency
DMO	District Medical Officer
GDD	Genital Discharge Diseases
GUD	Genital Ulcer Diseases
HIV	Human Immunodeficiency Virus
MoH	Ministry of Health
STDs	Sexually Transmitted Diseases
UNFPA	United Nations Fund for Population Activities
WHO	World Health Organization

CHAPTER: 1

INTRODUCTION

All adolescents are not the same. Many are sexually active and some are not; some are already married while others are not. Some live at home and others are on their own, even at an early age. Many go to school and many do not; some are in crisis or difficult circumstances. While their situations vary, all adolescents need and want information about their sexuality and how they can plan their families. The variability between different types makes it difficult to approach them with identical messages.

As adolescents grow they are faced with serious developmental tasks, which they must come to terms with in order to achieve necessary biological and psycho-sociological progress (Juma et al, 1999). Adolescents mature with little knowledge and too little guidance on how to manage sexual relationships. Adolescents have to be informed about the changes that accompany puberty. Sexuality as one of the development tasks may entail potential indulgence into sexual activity. Studies show that young people frequently engage in early sexual activities and have multiple sexual partners (Juma et al, 1999;Kim et al, 2001). These practices result in high rate of pregnancies, abortions, school drop out and the risk of contracting STDs including HIV/AIDS (Juma et al, 1999).

STDs frequently lead to serious complication with often-irreversible consequences. Consequences such as STDs are important not simply because they can cause genital ulcers and discharges but because they can have damaging long term sequelae such as chronic pain, infertility, ectopic pregnancies and damaging effects on the foetus and newborns (WHO, 1992). This is compounded by the fact that many STDs are asymptomatic in both men and women making their detection complex (WHO, 1992). Of critical importance is the fact that STDs play a significant role in the transmission of HIV (Campbell, 1999).

In the past, moral values that were imparted to adolescents both at home and at school tended to reinforce tradition norms relating to adolescents sexual behaviour In most tribes, they used to teach good manners and respecting elders, reproductive health and sexuality issues such as changes during puberty, what to do on handling menstruation period and the hazards of indulging in sexual behaviours (Kelly, 1981).

However this is not the case nowadays since aunts, uncles and others relatives are no longer easily available to provide sex education to adolescents.

This seems to explain why there is more liberal sexual life style among today's adolescents. More over the rapidly increasing level of interaction among various cultures in recent times is thought to contribute significantly to the emerging change in the social life style, which in turn encourages a more liberal attitude towards sexuality among adolescents (Muhondwa, 1999).

The exploratory nature of adolescent-children during the stage of psychosexual development, may lead to actively seeking information on sexual intercourse, rather than on more basic information on biological maturity due to lack of organized sources of such information within the schools or their communities. A study done in Tanzania, noted that though reproduction of both animal and plants is taught in schools, the proportion of school youth who identified the school as a primary source of human reproductive health information was low (Leshabari et al, 1997). From the same study it was found that peers and the mass media accounted for over 63% of the primary sources of information on menstruation. Also the same remarked that, surprisingly parents were reported by 21% as the primary source of information concerning puberty to school youth.

A study from Uganda reported that culturally, parents couldn't talk to their children about issues related to sexuality (Huygens et al, 1996). Even where traditional system of imparting social skills to youth exists, little is known about the coverage of various components of reproductive health.

On the other hand culture, traditions, fear or other barriers may prevent adolescents from learning about sexuality or acting on the knowledge that they have. Parents and other community members need to support communication with children in order to reinforce the knowledge and skills that adolescents may have acquired from schools, peers and other sources of such information.

However, before insisting on such parental roles, we need to know what parents know and factors, which facilitate communication of what they know with their adolescent children.

1.1 PROBLEM STATEMENT:

Nearly half of all people in the world are under 25 years old and over a billion are young people between the age of 15 and 24, (Turner, 2000). Their decisions about education, sexual relationships, marriage, and childbirth will have an enormous impact on their lives and, in turn, on their communities and nations. Therefore, need information and education so that they can protect themselves and make informed decisions regarding their reproductive health.

More than 14 million adolescents give birth each year, and a large proportion of these pregnancies are unwanted (Turner, 2000). Countless girls drop out of school each day because of pregnancy (Weiss, 1996). Half million young people acquire a sexually transmitted disease each year worldwide (Turner, 2000). Each minute, six more young people become infected with HIV virus (Turner, 2000). Studies from Tanzania has also shown a fairly large proportion of adolescents indulge in unprotected sex and most of them are ignorant about consequences of their behaviour (Kiwara, 2001; Muhondwa, 1999).

Young women and men face many risks, including unwanted pregnancy, HIV/AIDS and other sexually transmitted diseases, sexual exploitation and alienation – yet they receive inadequate information, guidance and services to help them negotiate the difficult passage to adulthood. In many parts of the world, school curricula are highly theoretical and not closely related to everyday life (Turner, 2000). Channels of communication

between teachers and students are hierarchical, and discussion is limited. The concept of guidance and counseling from teachers to students is also lacking. School programmes may fail to address certain sensitive issues because parents, educators, religions leaders or policy makers may be reluctant to surpport them. Consequently, many youth-oriented programmes do not offer the information and services that are needed, and education on sexuality, women's health, family planning and nutrition is limited. There is a need of concerted intervention efforts from the public, private sectors and parents on addressing youth sex related problems. Adolescents need to be fully informed about their sexual health and sexuality knowledge has to be imparted to them to influence their behavioural change.

Teachers, parents as well as religious leaders play only a minor role on promoting sexual health of adolescents even though they constitute a major barrier to effective intervention (Ben-zur et al, 2000). The parents are considered to be the key players in the up bringing of their own children. 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 behaviours. Parents have the responsibilities to guide children's development towards positive sexual health, facilitate perception of sexuality as natural, 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 (Nyangu, 2000). Many feel uncomfortable talking with children about the subject (Kelly 1981). 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. Many adults did not receive sexuality education themselves, and some have fears arising from their own negative sexual experiences (Nyangu, 2000). What many fail to realize is that giving no information or avoiding 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 observation of other adults. This can lead to misinformation and the persistence of damaging myths, making young people vulnerable to unwanted and unprotected sexual experiences.

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 members need to support communication with their children to reinforce the knowledge that adolescents may have acquired from other sources such as the school and other important sources of sex socialization.

This study was intending to explore the extent to which parents communicate sexuality related issues with their adolescent children and factors associated with such communication.

1.2 BROAD OBJECTIVES:

The major aim of this study was to assess the extent to which the parents in Mbeya rural district communicate with their adolescent children about sex related issues and factors associated with such communication.

1.3 SPECIFIC OBJECTIVES:

1. To determine proportion of parents who talked about sex related issues with their adolescent children.
2. To determine the kind of information parents communicated to their adolescent children on sexuality.
3. To determine the level of knowledge on reproductive health among parents.
4. To determine who the parents suggested should be responsible for teaching sex related information to their adolescents.

1.5 RATIONALE:

As the largest-ever generation of young people enters adulthood, education and correct information are required to meet their sexuality health needs (Turner, 2000). A significant number of adolescents around the world become sexually active at an age as early as twelve years, with an increase in sexual activity outside marriage (Asiimwe et al, 1997). Many youth-oriented programmes do not offer the information and services that are needed, and education on sexuality, women's health, family planning and nutrition is limited.

Parents are responsible for the nurturing and upbringing of their children. They are responsible for ensuring that their children are shaped to meet societal, cultural, familial and parental expectations. Parents have the power to guide children's development towards healthy sexuality. Parents have been urged to play this role so that sex related problems including STD/HIV infections among adolescents can be controlled (Kelly, 1981). Findings from this study sheds light on what parents know about sexuality health issues and will contribute towards the prerequisites for interventions targeting youth sex related problems with parents as the point of entry. Also the findings will precipitate information for developing appropriate interventions, which aim at strengthening parent-adolescent communication on sex related issues.

CHAPTER: 2

REVIEW OF LITERATURE

Education, information and life style can affect adolescents` sexual behaviour, when they marry, how many children they will have and the well being of their future families. While the situations in which they live vary, all young people need and want information about their sexuality and reproductive health.

The age at which adolescents start to practice sexual intercourse is quite low. Available data shows large proportions of adolescents are sexually active and some of them indulge in such behaviours even before they are 14 years of age (Muhondwa, 1999 and Pfander, 2000). Boys start at a mean age of 12 years while girls at a mean age of 14 years (Pfander, 2000).

There is growing acceptance of the fact that adolescents need information and education so they can protect themselves and make informed decisions regarding their reproductive health. At the same time, it is recognized that parents have important rights and responsibilities in this regard (Kleep et al, 1994).

Despite such awareness, resistance to sexuality education persists. Some people fear that educating young people about sexuality and providing them with related information and services will lead to irresponsible sexual behaviour, although studies

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Despite such awareness, resistance to sexuality education persists. Some people fear that educating young people about sexuality and providing them with related information and services will lead to irresponsible sexual behaviour, although studies

have shown that the reverse is true (Turner, 2000). For their part, many adolescents are reluctant to seek help from adults either within their families or in professional settings (Leshabari, 1994). They therefore do not get the information, counseling or services they need.

Lack of knowledge and in some instance poor knowledge appears to be a major problem among sexually active adolescents (Burgos, 1999). This situation is correlated to the sexual and reproductive health risks adolescents are exposed to. More than 14 million adolescents give birth each year, and large proportions of these pregnancies are unwanted (Turner, 2000). Countless girls drop out of school each day because of pregnancy. Half a million young people acquire a sexually transmitted disease each year. Each minute, six more young people become infected with the HIV virus, which causes AIDS (Turner, 2000)

What surveys reveal reflect what adolescents think is expected of them rather than what happens in reality. Adolescents tend to have several partners; boys more often have several partners in life than girls do. Only 15% of sexually active boys had one single partner, while 85% have had several partners (TANESA, 1995). Among girls 48% had one partner while 25% had several lovers, even up to more than ten (TANESA, 1995). Reports also reveal that much of their sexual activities are unprotected (TANESA, 1995; Leshabari et al, 1997 and TDHS, 1996).

Young people do not want to be subjected to the moralizing of adults. To a large extent youngsters share the value of their parents in their attitudes to abortion, sexual intercourse or fidelity, but at the same time their actions are governed by other, external factors (Baldo, 1996).

Adults, for that matter parents, often talk about the rebellions, irresponsible behaviour of young people (Cavanaugh, 1994) but this often result from their own ignorance of the conditions inflicted upon adolescents by society, such as a lack of information; poor education or no access to contraceptive services.

Studies show that, parents have the desire to direct their children on sexual matters but they are unable to because of their traditional beliefs (Amukene, 1997; Kim et al, 2001). In traditional society, in most ethnic groups, parents were not allowed to speak about sex to their child. Boys and girls used to go to special initiation camps in isolated and secluded places for several weeks or months. They were taught the traditional customs of their respective ethnic group with regard to sexual behaviour. Girls who could not go to such camps were taught by either aunt, grandmother or old women (Siegrist, 1993; Abdallah, 1991). However, these traditional systems are becoming weaker and in most cases do not exist any longer.

The majority of parents express frustration in their inability to address the situation effectively to their children. Inability to address sexuality issues to children has been a

problem to many parents. In one study (Muhondwa, 1999), it was reported that some parents found it difficult to initiate talking about sexuality and sexual health but wait until when a problem arises before they talk to their children.

Efforts 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 (Akosua, 1991).

There is a need of family life and sex education programmes to be formulated to promote parent-child communication intiatives, such programs which aim at meeting the needs of young people should give an equal opportunity to women and men at all levels of responsibility (Muriuki, 1991).

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 (Muhondwa, 1999). Studies indicate that the majority of parents support the idea of schools offering sex education (Kelly, 1981; Borgart, 2000). 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).

Similarly, other studies show rare communication between parents and their children on sexuality issues and that school curricular provide focuses on reproductive organs, an insufficient foundation for sex education; hence leaving adolescent to obtain sexuality information from where they can (Coulibaly et al, 1996; Kekovole, et al 1998).

While knowledge of sexual matters is very important, it will be of little value if not utilized in ways that will help mold attitudes and decisions. Parents finding the best approaches to talking with adolescents about such sensitive subjects require forethought and patience. Parents often worry that if they discuss sex in any detail, it will give the kids ideas (Cavanaugh, 1994). But in fact, children already have plenty of ideas and actually they need to hear parent's viewpoint about them (Marsh, 1994). However, adolescents probably won't ask the parent, but parents need to take the initiative.

Parents need to acquire communication skills and should understand that brief but potent teachable moments crop up regularly throughout childhood and adolescence. Seizing these opportunities requires spending enough time with a child to allow them to take place. In one study done in a rural area in Namibia (Veiner, 1994) reported, the misguided commandment ("Do what I say, not what I do") has never worked and never will. However, this doesn't mean that mistakes, miscalculations and reckless behaviour

in parent's past invalidate what he/she says today. Some parents worry that they can't legitimately warn their children not to do what they did as teenagers. Heartfelt confessions, cautionary talks, and lessons learned at the university of hard knocks can have a profound impact on young listeners. As long as you are not setting a hypocritical double standard ("It is okay for me but not for you"), parents should not be afraid to share what they have learned the hard way (Gale, 1989).

Parents knowledge on the matters concerning sexual and reproductive health is important in the prevention of STDs/HIV/AIDS and early pregnancy among children especially adolescents (Guijarro et al, 2000). Lack of knowledge of these issues can be among the contributing factors that influence parent-child communication. Parents might be afraid of discussing these with their children probably because of the little knowledge they have on matters concerning sexuality. This was observed in a study done in Kenya that parents say they believe their children need information about how to prevent STD/HIV/AIDS, but most do not feel adequately informed to educate their children properly (KYIP, 1995). The extent of a similar problem in Tanzanian parents is not known empirically.

Nyangu, (2000) in Zambia, revealed that parent age, level of education and knowledge on STDs/HIV/AIDS were among the factors that were influencing parent child communication. As some African cultures do not encourage open discussion on sexual

matter, it is likely that communication between parents and their children is non interactive.

The role of parents in adolescent sexuality is further emphasized by a study on sex education and condom distribution in public schools (Caruso, 1996). The author explored what role schools should assume regarding sex education and the prevention of unwanted teen pregnancies, and STDs/HIV/AIDS. Parents also have the primary role in raising their children. 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 school sex education programs.

Many young people are anxious and embarrassed about sex, in part because many societies themselves are anxious and embarrassed about it (Baldo, 1996). Even young people who know how to protect themselves from HIV/AIDS often lack the social skills to do so. This proves that the families did not exhibit sufficient skill in providing sex education for their children. However, in some other studies, 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 (Asiimwe et al, 1997; Juma et al, 1999; Kekovole et al, 1998). In a Republic of South Africa study, that asked students who most influenced their decisions about sex, 37% cited their parents, while 30% cited their friends (Devoe, 2000) and the rest cited close relatives, elder siblings, teachers and elders among others.

Parents often say that young people should be taught about HIV/AIDS (Talle, 1995). In Brazil, for example, the vast majority of women interviewed in a low-income area said that they did not want their daughters to grow up as uninformed about sex as they themselves were (Weiss, 1996). In a study in Kenya over three-quarters of parents of children age 10 to 14 said that adolescents should be taught in school about HIV/AIDS and other STIs as well as about family planning and other reproductive health subjects (Kekovole et al, 1998).

Most researchers agree that parent–child communication about HIV/AIDS and sexuality should begin early so that it can evolve comfortably as the child matures (Kim et al, 2001). A single serious talk about sex as a child enters puberty is likely to be strained and awkward. Similar discussions before, however, provide the groundwork for a successful discussion (Burgos, 1999). Parent-child communication is most likely to be successful, of course, in a close loving relationship

CHAPTER: 3

METHODOLOGY:

This study was conducted in Mbeya Rural district.

The district is one of the eight districts of Mbeya region. The district is bordered on the east by Mbarali district, on the west by Mbozi district. Rungwe, Makete, and Ileje districts border to the south and Chunya district borders on the northwest.

The district has a total population of 261,876 people, of which 132,015 are females, 129,861 are males and adolescents (10-24 years) are estimated to be 55,371 and covers a total area of 2432sq.km (District profile, 2001). The district is divided into three divisions, namely Usongwe, Isangati and Tembela. These are further subdivided into 17 wards comprising 126 villages. The district headquarter is situated in Mbeya town.

The main ethnic groups include Safwa, Malila, Ndali and Nyakyusa. There were immigrants from Masai and Sukuma ethnic groups. Most of these ethnic groups are predominantly agro-pastoralists. Most villages consisted of a single dominant tribe and on rare occasions are mixed. The district's income depends mainly on agriculture; they grow maize, potatoes, beans, cassava, and wheat as food crops. Cash crops grown are coffee, cotton, pyrethrum, sunflower and vegetables. The district is very famous for livestock keeping due to the influx of livestock animals from Arusha, Shinyanga, Tabora

and Morogoro region. The majority of women are involved in farming activities either in horticulture or cultivating own food crops and cash crops. Men were mainly involved in small business ventures, and farming. There are a significant number of businessmen and women from other regions whom come to the district to buy farming and livestock products.

According to the council profile of 2001, the literacy rate was 76%. There are 115 primary schools and 9 secondary schools. The enrollment rate for standard one in 1994 was 69% of whom 70% completed standard seven (Council profile, 2001). Major Dar es salaam - Tunduma and Dar es salaam-Lilongwe high ways cut through the district. Highway traffic is associated with social and sexual interactions between travelers and residents of minor settlements and trade centers (O'Connor et al, 1997). These are the main routes through which the STI/HIV epidemic has spread to remote areas. Both postal and telephone services are available.

3.1 *STUDY POPULATION:*

The study population involved parents or guardians who had male and female adolescents by the time the study was conducted. This group of parents was selected in order to find out the content and the type of factors that influence parental communication with their children regarding sexuality issues.

3.2 STUDY DESIGN:

A cross-sectional study design was conducted during May and June 2002. The study was designed as part of the requirements for the Master of Public Health degree of the university of Dar es Salaam.

3.3 SAMPLING PROCEDURE:

Multistage sampling was employed to obtain the sample population. A list of all 17 wards in the district was obtained from the council director's office. All wards were written on separate pieces of paper, and one ward was randomly selected for the study using lottery method. Usongwe ward, which has 7 villages, was selected and Mbalizi village was picked randomly for the study. The village, which was picked, has ten hamlets with a total of 287 households.

At village level, the village executive officer was contacted and a list of all households within the ten hamlets was prepared. All the households were screened in order to pick households that had adolescent children, which have to be crosschecked at the time of conducting interviews. A total of 242 households were found to have at least one adolescent child. Among these, 158 households produced both male and female parents and the rest of the selected households produced either the father or mother. The interviews were conducted to each eligible parent using structured questionnaire. The interview instrument focused on different areas ranging from demographic characteristics of the parents or guardians, extent and modes of communication; parents'

or guardians` knowledge of reproductive health related issues and on the type of information usually communicated.

3.4 *SAMPLE SIZE:*

The sample size n, was determine by using single proportion formula by Kish and Leslie (1997), used in the stat calculator programme of EPI-info version 6, such that: -

$$n = \frac{Z^2P\,(100 - P)}{E^2}$$

Where Z = z-value = 1.96 (corresponding to the confidence level at 95%)

P = expected proportion of parents who communicate sexuality matters

was assumed to be 50%

E = maximum likely error, was taken at 5%

Using this formula the minimum sample size was 384 parents and guardians

For the purpose of this study a total of 400 parents and guardians were recruited for the study.

3.5 *RECRUITMENT AND TRAINING OF RESEARCH ASSISTANTS:*

Because of limited time available for carrying out the study, three research assistants were employed. One day was used for training the research assistants. The training aimed at orientating the research assistants to the study and providing them with the necessary skills for data collection. Role-play method was used to ensure that the training was successful. Research assistants also took part in pre-testing of the questionnaire at Iwala village.

3.6 *PRE-TESTING OF RESEARCH INSTRUMENT*

Prior to commencement of that study pre-testing of the interview instrument was done on 20 men and women in one village different from the study village. The aim of the pretest was to test the extent to which questions were understood by the target audience. During the process, problematic areas of the research instrument were identified and the necessary modification done before embarking to the actual field study. Following this exercise some minor corrections like rephrasing questions were done for easy understanding by the respondents. For instant, adding "I don't know" option to questions which were testing knowledge.

3.7 *DATA COLLECTION:*

A Kiswahili version of the questionnaire was used to conduct interviews. Saturday and Sundays were also used to collect data, as most people were at their respective home during weekends. The data collection was done by the principal investigator and three-research assistants in the study village during the day. At the end of each day session, the research team checked all filled questionnaire for correctness and completeness. The procedure for data collection entailed visiting the household, making a self-introduction and providing a brief explanation of the study to every respondent. Each respondent was interviewed in private and the information obtained was kept confidential. All respondents participated fully and none of them dropped out at any point of the study.

3.8 *QUALITY CONTROL OF DATA AND DATA PROCESSING:*

Completed interview schedules were sorted and studied by the principal investigator. Codes were assigned to open ended questions. Responses were then coded. Data entry, cleaning and validation were done with the assistance of an experienced computer operator using Epi info 6 programme. Data analysis for statistical associations was done using the same programme. P-values were determined at 0.05 level of significance.

3.9 *MEASUREMENT OF SEX RELATED KNOWLEDGE*

In measuring sex related knowledge a test consisting of 34 test items was instituted (see appendix 1). These items measured knowledge in three broad areas, that is; biological maturity and pregnancy which was measured by 13 items, knowledge on STDs, measured by 6 items and knowledge on HIV/AIDS, measured by 15 items. Respondents were asked to answer yes or no or don't know and correct responses were assigned a score of one, while responding otherwise were scored zero. Three levels of knowledge in regard to number of items answered correctly were formulated, less than 50%, 50%-75% and over 75%. Each of the three components was compared to some sociodemographic data of the respondents, then followed by their over all knowledge performance when all the three components are combined together leading to a composite sexuality health knowledge score (Leshabari et al 1997).

3.10 *ETHICAL ISSUES AND RESEARCH CLEARANCE:*

Study of sexual behaviour implies eliciting information about the most private intimate sphere of human life and interest of the researcher might easily violate individual rights for respect and discretion. Permission to conduct research was obtained from relevant authorities. These included the Muhimbili University College of Health Sciences and Ethics Committee, District Medical Officer and District Executive Director. Similarly, the ward and village leadership were requested for permission to carry out the study in their area of jurisdiction and to facilitate its successful implementation. Consent from the parents was solicited before conducting interviews. All responses were strictly kept confidential throughout and the respondents did not need to provide their names. They were also free to respond or not to respond to any of the questions asked. All used questionnaires were burnt after data entry.

3.11 *LIMITATION ON THE STUDY:*

The study coincided with the time that many people were still in the fields. Prior the beginning of the study it was indicated that there would be very few parents at home during the whole daylong. It was anticipated that they would not be easily available until very late in the evening. The problem was solved through giving prior information to hamlet chairpersons and in turn to the heads of the households that would be involved in the activity. Even then a few were not available and had to be followed up on the second day or occasionally in the fields. Conducting interviews even during the weekends, follow up and repeated visits with appointment are some of ways, which were used to

minimize non-respondents. There was much pressure for everyone who participated in the study wanting to be paid despite the limited finances. To solve this problem I had to use the hamlet chairpersons for a short period only but at the same time using interviewers who were conversant with the study area and would know how to trace those people who might have been missed during the house-to-house survey. Sparing more time to the specific questions during interviews enhanced recalling of the information learned during childhood.

3.12 *DEFINITIONS:*

Adolescent-children: Defining the age of "adolescents" and childhood often varies from one culture to another. Adolescence typically begins with puberty in most cultures, but the age when people considered adults varies. In this research study the term adolescent-children is meant people aged 10-19 years old. WHO define adolescents as person in the 10-19 years of age (Leshabari et al, 1994)

Parent: Is considered as biological father or mother or guardian in this study.

Parent-child communication: Dialogue between parents and their children for the purpose of the parent to impart sexual and reproductive health matters to their children.

Reproductive health: A state of complete physical, mental, and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Sexuality: Your sexuality includes your sex role, your sexual orientation and your feelings about yourself. Your sex role is the way you act as the result of your attitude

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Reproductive health: A state of complete physical, mental, and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Sexuality: Your sexuality includes your sex role, your sexual orientation and your feelings about yourself. Your sex role is the way you act as the result of your attitude

about being male or female (Braeken, 1996). Sexual health: Is the integration of the physical, emotional, intellectual and social aspects of sexual being; in ways that are positively enriching and that enhance personality, communication and love.

CHAPTER: 4

RESULTS

A total of 400 parents with adolescent-children aged 10-19 years were interviewed. Over 52% of the parents were males and the rest were females. Their age ranged from 19 years to 69 years with a mean age of 40 years and standard deviation of ±7.7 years. Most of the respondents (84%) were married and about 11% were widowed, while the rest were separated, single or divorced.

Most of parents were peasants (63.4%), one third were petty businessmen and women and the rest were employed by the formal sector.

A large majority (89.2%) of the respondents were literate with at least primary education and less than 8% were illiterate of whom the majority were women. Christianity was the predominant religion (86.6%) and only about 13% were Moslems.

Table 1: Percentage distribution of social demographic characteristics of the study sample

Characteristics	Sex		Total
	Male N=209	Female N=191	N=400
I: Age of parents			
≤ 34	11.0	31.9	21.0
35 – 44	46.9	55.0	50.8
≥ 45	42.1	13.1	28.3
Total	100.0	100.0	100.0
II: Level of education			
None	4.4	11.0	7.5
Adult education	3.8	2.6	3.3
Primary education	72.2	75.4	73.7
Secondary education and above	19.6	11.0	15.5
Total	100.0	100.0	100.0
III: Religion			
Roman Catholic	18.6	20.9	18.8
Other Christian	65.6	68.1	67.8
Moslems	15.8	11.0	13.4
Total	**100.0**	**100.0**	**100.0**

Extent of parent-adolescent communication on sex related issues

One aim of this study was to look at the extent which parents communicate with their adolescent children on issues related to sexuality. Over 80% of the parents talked to male adolescents, but only a few did so very frequently as summarized in Table 2. The higher the education level of the parent, the more likely that the parent, would communicate with his/her adolescent child on issues related to sex. For example only 18% of illiterate parents talked to their adolescent children about sex and related issues compared to 42% among those with secondary education or higher.

Table 2: Variation percentage in the extent of parental communication with adolescents on sexuality related issues by sex of the adolescents

Extent of communication	Sex of the adolescents	
	Male (%) N=350	Female (%) N=354
Very frequently	21.7	26.0
Frequently	16.3	11.6
Rarely	44.3	34.7
Never	17.7	27.7
Total	**100.0**	**100.0**

$\chi^2 = 15.9$ P=0.001

The proportion of parents who talked to adolescent boys about this topic was higher than that discussed similar issues with adolescent girls.

Table 3: The percentage distribution of parents' age and the extent of communication with their adolescent boys regarding sexuality issues

Extent of communication	Age of parents (Years)		
	≤34 N=61	35 – 44 N=182	≥45 N=107
Very frequently	41.0	17.6	17.8
Frequently	13.1	17.6	15.8
Rarely	26.2	46.2	51.4
Never	19.7	18.6	15.0
Total	**100.0**	**100.0**	**100.0**

$\chi^2 = 20.9$ P – value = 0.0083

The tendency to talk frequently to boys decreased with increasing age, varied from 41% among parents aged 34 years and younger to about 18% for those aged 45 years and above as summarized in Table 3. The similar picture emerged when looking at communication between parents and female adolescents, as can be observed in Table 4.

Table 4: The percentage distribution of parents' age and the extent of communication with their adolescent girls regarding sexuality issues

Extent of communication	Age of parents (Years)		
	≤ 34 N=61	35 – 44 N=182	≥ 45 N=107
Very frequently	48.5	25.1	13.1
Frequently	8.8	12.3	12.1
Rarely	25.0	34.1	42.1
Never	17.6	28.4	32.7
Total	**100.0**	**100.0**	**100.0**

$\chi^2 = 28.74$ P-value = 0.00035

The proportion of parent who never talked to their adolescent girls about sex and related issues increased with increasing age varying from 18% among younger parents to nearly 33% among parents aged 45 years and older.

Table 5: Percentage distribution of parents' economic activities and the extent of communication with their adolescent boys regarding sexuality issues

Extent of communication	Parent's economic activity		
	Peasant N=217	Petty business N=107	Employed N=26
Very frequently	18.4	29.0	19.2
Frequently	16.1	9.3	46.2
Rarely	49.3	38.3	26.9
Never	16.2	23.4	7.7
Total	**100.0**	**100.0**	**100.0**

$\chi^2 = 29.6$ P – value = 0.00025

Parents who were peasant were generally less likely to talk to their adolescent boys on sexuality issues compared to other occupational categories as summarized in Table 5. Almost 66% of peasants in this study rarely or never talked to their adolescent boys about sex compared to 62% of those who were petty business men/women and about 35% of those who were employed. A similar trend was observed when the data was examined with a focus on similar communication with adolescent girls as it is shown in table 6 below.

Table 6: Percentage distribution of parents' economic activities and the extent of communication with their adolescent girls regarding sexuality issues

Extent of communication	Parent's economic activity		
	Peasant N=222	Petty business N=107	Employed N=25
Very frequently	19.4	37.4	36.0
Frequently	11.7	8.4	24.0
Rarely	40.1	29.9	8.0
Never	28.8	24.3	32.0
Total	**100.0**	**100.0**	**100.0**

$\chi^2 = 23.25$ P-value = 0.003

Factors that hinder communication between parents and adolescent children

An attempt was made to find out why some of the parents never talked to their adolescent children. Culture appears to be the major contributory factor and this was more pronounced among male (43.3%) compared to female parents (33.4%). Also lack of time due to different activities was cited as a communication barrier especially among female parents. About one in ten of these parents said they did not know what to talk

about, a problem which was more prevalent among mothers compared to fathers. These findings are summarized in Table 7.

Table 7: Percentage distribution of reasons that hindered communication between parents and adolescent-children regarding sexuality and parenting matters by sex of the parents

Reasons of not communication	Sex of the parents		Total
	Male N=60	Female N=39	N=99
Very busy, not time	33.3	43.6	37.4
Not my responsibility	16.7	5.1	12.1
Don't know what to tell	6.7	17.9	11.1
Culture not allow	43.3	33.4	39.4
Total	**100**	**100**	**100**

$\chi^2 = 9.81$ P – value = 0.04

The proportion of those who felt they lacked what to tell the children was higher among female compared to male parents.

The contents of parent-child communication on various sex related issues

This study also looked at what the parents communicate with adolescent children regarding sexuality related matters. The issues involved, ranged from pubertal

development, pregnancy, STDs/HIV/AIDS to sexual activities and related consequences. Generally it appears HIV/AIDS and STDs dominated the type of issues discussed and not much attention was given to discussion on menarche especially among boys as summarized in table 8.

Table 8: Proportion of parents who discuss various sex related topics with adolescent children by the sex of the child

	Sex of adolescents	
Sexuality issues	**Male %**	**Female %**
Spermarche	15.5	18.1
Menarche	7.9	13.1
Pregnancy	10.3	22.8
Parenting	16.1	25.0
Family planning	12.1	11.0
STDs	24.6	21.7
HIV/AIDS	42.5	32.6
Sexual activities and its consequences	21.7	21.1

Specific attention was also paid to the kind of sex related issues, which parents talked to boys and girls separately. The summary of contents of what is discussed with male adolescents is summarized in table 9.

Table 9: Variation of sexuality contents of what parents discuss with male adolescents by sex of the parents: -

Contents	Sex of parents		Total proportion (%)
	Male (%)	Female (%)	
Spermarche	32 (17.7)	21 (13.1)	15.5
Menarche	11(6.0)	16 (10.0)	7.9
Pregnancy	17 (9.4)	18 (11.3)	10.3
Parenting	31 (17.1)	24 (15.0)	16.1
Family planning	20 (11.1)	21 (13.1)	12.1
STDs	57 (31.5)	27 (16.9)	24.6
HIV/AIDS	90 (49.7)	55 (34.4)	42.5
Sexual activities and its consequences	45 (24.9)	29 (18.1)	21.7

HIV/AIDS appear to be a topic mostly discussed between adolescent boys and their parents even though less than 43% did so. Half of the male parents discussed HIV/AIDS with their adolescent boys and only a third of female parents had similar discussion. Very few parents (8%) discussed menarche with boys and less than 16% talk about spermarche. The kind of sex related information parents discussed with their adolescent girls is summarized in table 10.

Table 11: Percentage distribution of what parents discuss on sexuality related issues to male adolescents in relation to selected sociodemographic characteristics of the parents

Demographic Characteristics of parents	Sex related issues discussed N=341							
	Spermarche	Menarche	Pregnancy	STDs	HIV/AIDS	Parenting	Sex	F/Planning
Sex:								
Male	17.7	6.1	9.4	31.5	49.7	17.1	24.9	11.1
Female	13.1	10.0	11.3	16.9	34.4	15.0	18.1	13.1
Age:								
≤ 34	3.4	6.9	3.4	13.8	32.4	12.1	15.5	8.6
35 – 44	18.3	6.9	11.4	25.1	44.6	17.1	19.4	12.0
≥ 45	17.6	10.2	12.0	29.6	50.0	16.7	28.7	14.0
Level of education:								
None and Adult education.	25.0	2.5	15.0	35.0	50.0	7.5	25.0	5.0
Primary education	12.1	7.7	9.3	20.2	37.5	16.5	20.6	13.4
Secondary and above	24.5	13.2	11.3	37.7	60.4	20.8	24.5	11.3
Religion:								
Roman	19.1	5.9	7.4	32.4	57.4	22.1	30.9	11.9
Christians	11.8	6.0	7.7	18.2	34.5	12.3	18.2	10.0
Moslems	26.4	17.0	24.5	41.5	56.6	24.5	24.5	20.8

Matters pertaining to spermarche, menarche and pregnancy appear to be given low priority among sex related issues discussed by parents with adolescents. Levels of education and religion did not have a significant influence on what is discussed. A higher proportion of male parents talked about HIV/AIDS and STDs compared to female parents and these discussions increased with increasing age of the parents.

Table 10: Variation of sexuality contents of what parents discuss with female adolescents by sex of the parents

Contents	Sex of parents		Total Proportion (%)
	Male (%)	Female (%)	
Menarche	15 (8.3)	46 (29.3)	18.1
Spermarche	11(6.1)	33 (21.0)	13.1
Pregnancy	21 (11.7)	56 (35.7)	22.8
Parenting	31(17.3)	53 (33.8)	25.0
Family planning	11(8.3)	26 (16.6)	11.0
STDs	26 (14.4)	47(29.9)	21.7
HIV/AIDS	45 (25.0)	65 (41.4)	32.6
Sexual activities and its consequences	26 (14.4)	45(28.7)	21.1

Again just like was the case with adolescent boys, HIV was the most common topic discussed with adolescent girls. Interestingly the proportion of mothers who discussed HIV/AIDS issues with adolescent girls was much higher (41.4%) compared to that of fathers (25%). Generally it appears talking to adolescent boys about HIV/AIDS is more common compared to girls for reasons, which were not explored. Parenting issues appeared to be discussed more frequently with female compared to male adolescents.

However, the tendency of discussing parenting issues to adolescent boys was increasing with the increasing education level of the parents. This is contrary to the pattern, which emerged when the extent of what was discussed with female adolescents was explored (see the table 12 below).

Table 12: Percentage distribution of the kind of sexuality related issues parents talk to female adolescent in relation to selected sociodemographic characteristics of the parents

Demographic characteristics of parents	Sex related issues discussed N=337							
	Spermarche	Menarche	Pregnancy	STDs	HIV/AIDS	Parenting	Sex	F/Planning
Sex:								
Male	6.1	8.3	11.7	14.4	25.0	17.3	14.4	8.3
Female	21.0	29.3	35.7	29.9	41.4	33.8	28.7	16.6
Age								
≤ 34	10.8	10.8	13.8	18.5	24.6	18.8	16.9	6.2
35 – 44	24.5	17.2	30.8	27.2	40.8	28.4	24.3	16.0
≥ 45	10.7	7.8	15.5	14.6	24.3	20.4	18.4	5.8
Level of education:								
None and Adult education.	25.0	15.0	27.5	20.0	35.0	30.0	22.5	15.0
Primary education	16.4	13.1	20.9	19.7	31.1	23.5	18.9	9.4
Secondary and above	20.8	11.3	28.3	32.1	31.1	22.6	30.2	15.1
Religion:								
Roman	22.1	16.2	20.6	23.5	36.8	26.5	19.1	13.2
Christians	15.4	11.9	22.0	19.8	30.0	22.6	22.5	8.4
Moslems	26.2	14.3	31.0	28.6	40.5	28.6	16.1	21.4

When the type of issues discussed with female adolescents was examined, it was noted that a higher proportion of female parents talked about STDs/AIDS compared to males. Women also had a relatively higher proportion of respondents who talked to their daughters about menarche, parenting and sex in general compared to male parents. It was a point of interest to note that illiterate parents discussed menarche and parenting issues more frequently to their adolescent girls compared to those parents with higher education. The issues related to HIV/AIDS were discussed more frequently among Moslems than it was the case among Christians.

The level of Reproductive Health knowledge among the parents

Before insisting on parent-child communication on sexuality related matters, there is need to find out what parents know and the extent to which they are prepared to share such knowledge with their children. In this study an attempt was made to measure the level of reproductive health knowledge among parents. As pointed out earlier there were a total of 34 knowledge test items, of which 13 were focused on pregnancy, six measured knowledge on STDs and 15 for HIV/AIDS. Generally, the majority of the respondents were well informed and over 90% of respondents scored more than 50% of the test items as summarized in Table 13. However, those who scored more than 75% were less than fifteen percent. Nearly 3.0% of the parents scored zero in the STDs test items. The level of knowledge was not related to sex, age, level of education and religion of the parents. However, more than 95% of the parents indicated that there was a need to strengthen their knowledge and communication skills when interacting with

adolescents on sexual health, family planning, parenting and STDs/HIV/AIDS prevention matters.

Table 13: Percentage distribution of Reproductive Health knowledge by the selected demographic characteristics of the parents

Characteristics	Percentage of parents who scored			Total (N)
	Less than 50%	50-75%	More than 75%	
Sex				
Male	8.2	79.8	12.0	100 (208)
Female	7.9	77.5	14.7	100 (191)
Age				
≤ 34	3.6	78.6	17.8	100 (84)
35-44	8.4	79.3	12.3	100 (203)
≥ 45	10.6	77.9	11.5	100 (113)
Level of education				
None and adult education	8.6	84.5	6.9	100 (58)
Primary education	9.6	77.2	13.2	100 (280)
Secondary education and above	0.0	80.6	19.4	100 (62)
Religion				
Catholics	6.3	74.7	19.0	100 (79)
Other Christians	9.0	78.0	13.0	100 (255)
Moslems	8.0	84.0	8.0	100 (50)

The lowest score on the test given was 8 and highest score was 32 compared to the expected maximum score of 34, which none of the respondents attained. None of the respondents got all tested items wrong and therefore scored a zero. The knowledge of the parents was not influenced by age, education level or religion. Both male and female parents were equally well informed of reproductive health issues. However, examination of specific reproductive health components revealed interesting results as outlined below.

Knowledge on pregnancy

There were 13 pregnancy test questions and none of the parents scored zero. About a quarter of the parents scored less than 50% of the items and there were only two parents or guardians who got all the questions right. The mean score was 7.8 points and the standard deviation was ±1.8 points.

Table 14: The percentage distribution of correct responses obtained from the test items on pregnancy

Item tested	Percentage distribution of correct responses
Correct explanation on the meaning of spermarche	95.8
Correct explanation on the meaning of menarche	99.3
There is a specific period along the menstrual cycle when conception is more likely to occur	92.5
Conception is more likely at about mid-cycle	31.1
Kissing alone can not lead to pregnancy	86.5
Doing penetrative sex while standing can lead to pregnancy	51.0
Pregnancy is possible before seeing first menses	31.8
Abstinence is a method of family planning	26.1
Pills is a method of family planning	88.7
Condom is a method of family planning	55.3
Injectables are a family planning method	66.4
Intrauterine cervical device is a family planning method	36.8
Barrier such as foams, cervical cap are family planning	20.3

While a fairly large proportion of respondents scored nearly 100% in some items, misconceptions appear to be fairly high. For examples, only 26% knew abstinence is one of the ways of avoiding pregnancy and 45% did not know condom use also prevents pregnancy. The safe period during a normal menstrual cycle was known to only 31% of the respondents and less than 32% knew it is possible for a sexually active girl to conceive before her first menstrual period.

Almost half of the respondents were not aware that a woman can equally conceive even by having sexual intercourse while standing. Among these, the tendency was that, the lower the educations level the higher the ignorance as it was expected. More than three percent of the respondents could not mention any modern family planning method.

Whereas only a quarter of parents cited abstinence as a family planning method, over half of them identified it as the preventive measure of HIV/AIDS. The difference may be explained by the tendency that education to the public on both issues is usually given seperately with varying emphasis. However, in both cases, the issue of condom use is almost equally assimilated. These results indicate that the education on similar and related issues regarding sexuality should cover all important areas concurrently.

The areas where misconception where highly prevalent are those whose knowledge is critical for prevention of pregnancy and related consequences.

Table 15: Percentage distribution of pregnancy knowledge scores by selected demographic characteristics

Characteristics	Percentage of parents who scored			Total (N)
	Less than 50%	50-75%	More than 75%	
Sex				
Male	28.4	58.2	13.4	100.0 (208)
Female	19.4	61.3	19.3	100.0 (191)
Age				
≤ 34	15.5	66.7	17.9	100.0 (84)
35-44	19.2	62.1	18.7	100.0 (203)
≥ 45	38.9	50.4	10.6	100.0 (113)
Level of education				
None and adult education	41.4	39.6	19.0	100.0 (58)
Primary education	22.5	64.3	13.2	100.0 (280)
Secondary education and above	14.5	58.1	27.4	100.0 (62)
Religion				
Catholics	13.9	63.3	28.8	100.0 (79)
Other Christians	26.7	58.0	15.3	100.0 (255)
Moslems	20.0	66.0	14.0	100.0 (50)

The level of knowledge on pregnancy increased with increasing level of education level as summarized in Table 15. For example, while about 40% of those with adult education or illiterate scored 50-75% in the test, this proportion increased to over 58% among those with secondary or higher education. These variations were statistically significant (χ^2 = 25.2, p-value=0.000). The results also revealed that, knowledge on pregnancy

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Characteristics	Percentage of parents who scored			Total (N)
	Less than 50%	50-75%	More than 75%	
Sex				
Male	28.4	58.2	13.4	100.0 (208)
Female	19.4	61.3	19.3	100.0 (191)
Age				
≤ 34	15.5	66.7	17.9	100.0 (84)
35-44	19.2	62.1	18.7	100.0 (203)
≥ 45	38.9	50.4	10.6	100.0 (113)
Level of education				
None and adult education	41.4	39.6	19.0	100.0 (58)
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Catholics	13.9	63.3	28.8	100.0 (79)
Other Christians	26.7	58.0	15.3	100.0 (255)
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matters decreased with increasing age and the variations were statistically significant (χ^2 = 25.2 and p-value of 0.000)

Knowledge of sexually transmitted diseases

This component of the parents' knowledge was measured using six questions. Nearly 3.0% of the respondents scored a zero in this component and only 13.2% scored 75% and above. The percentage of parents who knew different types of STDs is summarized in table 16 below.

Table 16: The percentage distribution of sexually transmitted diseases known by parents including HIV/AIDS (N=393)

Type of STDs	Parents who know it
Gonorrhoea	81.2
Syphilis	77.6
Genital discharge	27.2
Genital ulcers	23.9
Inguinal swellings	21.4
HIV/AIDS	85.0

HIV/AIDS was the most commonly known STDs followed by gonorrhoea and syphilis. However, inguinal swellings, genital ulcer and genital discharge diseases were familiar to only a few of the respondents. Most of parents (81%) who had secondary education

and above scored more than half of the STDs test items compared to 71% of those without formal education as summarized in Table 17. However the difference was not significant.

Table 17: Percentage distribution of sexually transmitted disease knowledge scores of parents by selected demographic characteristics

Characteristics	Percentage of parents who scored			Total (N)
	Less than 50%	50-75%	More than 75%	
Sex				
Male	24.0	61.1	14.9	100.0 (208)
Female	28.3	60.2	11.5	100.0 (191)
Age				
≤ 34	21.4	57.2	21.4	100.0 (84)
35-44	23.6	64.5	11.8	100.0 (203)
≥ 45	33.6	56.6	9.7	100.0 (113)
Level of education				
None and adult education	29.3	55.2	15.5	100.0 (58)
Primary education	26.8	60.0	13.2	100.0 (280)
Secondary education and above	19.4	69.4	11.2	100.0 (62)
Religion				
Catholics	25.3	55.7	19.0	100.0 (79)
Other Christians	24.3	62.4	13.3	100.0 (255)
Moslems	28.0	66.0	6.0	100.0 (50

The results revealed that, the younger the parent higher the knowledge on STDs. (χ^2=10.2, p-values = 0.03). The majority (78.6%) of parents aged 34 years and below scored more than half of the STDs test items right compared to 66% of those aged 45 years and above.

Knowledge of HIV/AIDS

The mean score in this component of the knowledge scale was 9.8 points and the performance of the parents ranged from three to 15 scores with standard deviation of ±2.2 points. There were only three respondents who correctly answered all selected items and none of the interviewed parents scored zero. Overall level of knowledge was not that bad, 16.1% scored less than 50% and 21.7% scored 75% or more. The knowledge score on HIV/AIDS were independent of education level, sex and religion of the parents.

Despite the observed high level of knowledge, serious misconceptions were revealed. For example, less than 3% knew that HIV positive women should avoid becoming pregnant due to consequences of pregnancy to her and her child. Surprisingly, despite all the efforts in educating people about transmission of HIV only 6% of the respondents knew that HIV can be acquired through blood transfusion. Table 18 below summarizes the distribution pattern of HIV/AIDS knowledge among the studied parents.

Table 18: The percentage distribution of correct responses for test items on the HIV/AIDS knowledge scale

Item tested	Percentage distribution of correct responses
Vaginal douching soon after having unprotected sex can't prevent HIV infection	82.8
Penile cleaning soon after having unprotected sex can't prevent HIV infection	83.3
Healthy looking person can already be infected with HIV	95.8
A mosquito bite doesn't transmit HIV	81.8
Sharing utensils with AIDS patient can't lead to HIV infection	77.3
Breast feeding can lead to HIV infection of a child fed by an infected mother	69.5
One can get infected with HIV even from the first intercourse	94.0
There is on cure for AIDS	95.0
HIV infection can be prevented	75.4
Abstinence can prevent HIV infection	52.1
Condom can prevent HIV infection if one indulge in unsafe sex	51.6
Faithfulness is one of the HIV prevention methods	35.5
Use of sterilized equipments can prevent HIV infection	10.4
HIV can be acquired through blood transfusion	6.0
Women infected with HIV should avoid becoming pregnant	2.8

Nearly 17% of the respondents believed that cleaning of sex organs immediately after sexual intercourse can prevent the spread of HIV infection. Also, 24.6% of female parents and 12.0% of men believed that mosquitoes can transmit HIV infection and

these beliefs were more predominant among parents without formal education. Looking at the issue of AIDS patients care, about 23% of the respondents believed that, sharing domestic utensils with AIDS patient can lead to HIV transmission as shown in Table 18.

Table 19: Percentages distribution of HIV/AIDS knowledge scores of parents by selected demographic characteristics

Characteristics	Percentage of parents who scored			Total (N)
	Less than 50%	50-75%	More than 75%	
Sex				
Male	14.9	62.0	23.1	100.0 (209)
Female	17.3	61.2	21.5	100.0 (191)
Age				
≤ 34	6.0	61.9	32.1	100.0 (84)
35-44	18.7	63.1	18.2	100.0 (203)
≥ 45	18.6	59.3	22.1	100.0 (113)
Level of education				
None and adult education	20.7	62.1	17.2	100.0 (58)
Primary education	15.4	62.1	22.5	100.0 (280)
Secondary education and above	14.5	59.7	25.8	100.0 (62)
Religion				
Catholics	16.5	48.1	35.4	100.0 (79)
Other Christians	15.3	65.5	19.2	100.0 (255)
Moslems	20.0	60.0	20.0	100.0 (50)

Table 19 shows that lower the age of the parent, higher the knowledge on HIV/AIDS (χ^2 =12 an p-value=0.01). Among the parents who were aged less than 34 years old, only

6% scored less than half of HIV/AIDS test items compared to nearly 19% of older groups.

Nearly 25% of the respondents were not convinced that HIV infection can be prevented. However, about half of the respondents did not opt for condom use as the preventive measure of HIV infection.

Parents' view on HIV infection among adolescents

According to parents' views on what they feared most when their daughters practiced sex with men, most of them (65.5%) feared the risk to HIV infection than of pregnancy (30.5%). Less than 2% reported fearing of family and community members' reputation.

Looking at parents` views on HIV/AIDS education in school, almost one out of every five believed HIV/AIDS education in schools facilitates the spread of the virus among pupils/youth. One parent said, *"Mafundisho ya ukimwi mashuleni ni kuwafundisha watoto tabia mbaya na kuwafanya washawishike kuanza kufanya mapezi/ngono"* which means that, *"Such education will encourage youh to indulge in unacceptable behaviours and it encourage them to early sexual experience "*. This explains the persistent beliefs parents have, that this education will make their children become more sexually active. One parent who believed HIV/AIDS education in schools is not good, said, *"wacha bwana, hawa waalimu nawajua watawaaribu watoto wetu na kulala nao tu*" which means, *"Exposing these children to such new information by the teachers whom I know,*

believe me or not, this provides room for teachers to ruin them by playing sex with them".

Parents' choice of sources of sexuality information for adolescents

Various sources of sexuality information were suggested for both male and female adolescents with the parents themselves carrying the larger weight on most of the issues. Surprisingly, the media and peers were preferred by very few parents. The media which is currently cited as the major source of information was the least cited. Although religion appears to have a strong influence on the debate on sexuality information, a negligible proportion of parents preferred religious leaders to have a role in educating male adolescents as summarized in tables 20 and 21.

Table 20: Percentage distribution of suggested source of information for sexual and reproductive health for male adolescent

Who is suggested	Proportion of suggestions as given by parents					
	Sexual health N=383	Parenting N=383	Family planning N=371	STD/HIV /AIDS N=378	Fatherhood N=381	Marital life N=399
Father	91.6	91.4	83.6	90.5	91.6	94.0
Mother	20.4	26.6	20.5	21.4	21.8	94.0
Relatives	6.8	7.0	6.2	5.8	5.0	13.8
School	6.0	6.3	8.9	12.2	3.7	2.3
Health workers	5.7	6.0	9.4	14.0	3.0	4.0
Peers	1.8	0.8	1.4	1.9	0.0	0.7
Media	0.5	0.3	1.9	1.9	1.1	1.3
Religious leaders	0.5	0.5	1.0	1.5	1.3	10.6

The father was predominantly preferred as the source of information on most issues to adolescent boys. Female parents were only suggested to teach marital life by a large proportion of respondents. Peers were suggested as a source by a negligible proportion of respondents and religious leaders were also minimally accepted. Schoolteachers and health workers were preferred by few parents in most of the issues except in HIV/AIDS where about one in ten parents cited them as a preferred source.

Table 21: Percentage distribution of who the parents suggest should be responsible for sexual and reproductive health education for female adolescent

Who is suggested	Proportion of suggestions as given by parents					
	Sexual health N=391	Parenting N=394	Family planning N=394	STD/HIV/AIDS N=394	Motherhood N=394	Marital life N=399
Father	18.4	18.0	14.0	16.2	15.5	94.0
Mother	92.3	95.2	93.7	94.7	97.7	94.0
Relatives	3.8	3.8	3.3	2.0	6.1	13.8
School	3.6	4.1	6.1	9.6	3.3	2.3
Health workers	6.1	4.3	12.4	10.4	3.8	4.0
Peers	1.5	0.8	2.3	2.0	0.0	0.7
Media	1.8	1.5	2.8	3.0	0.0	1.3
Religious Institutions	1.5	0.5	0.5	0.5	0.5	10.6

The mother was the most preferred source for sexuality information for girls. Unlike in the case of boys, few parents cited fathers as preferred source for most of sex related issues for female adolescents. Few parents preferred health workers for family planning and STDs/HIV/AIDS information source. A negligible proportion of parents preferred the media, peers and religions institutions. Only 16% parents cited male parents as appropriate teachers for female adolescents on STDs/HIV/AIDS. School teachers were preferred by less than 10% of respondents this also being the case for health workers.

Table 22: Frequency distribution of who parents suggest should be responsible for providing information on parenting to male adolescents by the sex of parents

	Sex of the parents		
Who is suggested	Male (%)	Female (%)	**Total** (%)
Father	188 (92.6)	162 (90.5)	350 (91.4)
Mother	35 (17.8)	67 (26.3)	102 (26.6)
Relatives and	8 (2.0)	19 (8.4)	27 (7.0)
Peers	0 (0.0)	3 (1.2)	3 (0.8)
School	9 (2.5)	15 (5.0)	24 (6.3)
Health workers	9 (2.0)	14 (4.5)	23 (6.0)
Media	1 (0.3)	0 (0.0)	1 (0.3)
Religious institutions	0 (0.0)	2 (0.8)	2 (0.5)

The father was suggested as the major source of parenting education for male adolescents by both male and female parents. Less than 27% suggested mothers as potential source of such information. The role of the school was cited by only 6% of the respondents. Religious institutions were suggested by a negligible proportion of parents. In the past relatives used to play a key role in socializing boys but only 7% of respondents cited them as an important source now.

Table 23: Frequency distribution of who parents suggest should be responsible for parenting education to female adolescents by sex of parents

	Sex of the parents		
Who is suggested	Male (%)	Female (%)	**Total** (%)
Father	34 (14.0)	37 (17.1)	71 (18.0)
Mother	205 (98.6)	170 (96.8)	375 (95.2)
Relatives	5 (3.3)	10 (4.9)	15 (3.8)
Peers	1 (0.3)	2 (1.0)	3 (0.8)
School	5 (1.5)	11 (5.3)	16 (4.1)
Health workers	3 (1.5)	14 (6.4)	17 (4.3)
Media	2 (0.5)	4 (1.5)	6 (1.5)
Religions institutions	2 (1.0)	0 (0.0)	2 (0.5)

Table shows that most of parents (95.2%) preferred parenting education for girls to be the responsibility of the mothers. The proportion of both male and female parents who supported this was very high. The father was perceived to have a minimal role in this and only 17% of female parents and 14% of male parents were of the opinion that fathers have a role in this.

Table 24: Frequency distribution of who parents suggest should be responsible for marital life education to adolescents

	Sex of the parents		
Who is suggested	Male (%)	Female (%)	**Total** (%)
Father	201 (96.2)	175 (91.6)	376 (94.0)
Mother	197 (94.3)	179 (93.7)	376 (94.0)
Relatives	32 (7.7)	26 (6.8)	58 (7.3)
Peers	0 (0.0)	3 (1.0)	3 (0.7)
School	3 (1.4)	6 (3.2)	9 (2.3)
Health workers	3 (1.4)	13 (6.8)	16 (4.0)
Media	1 (0.6)	3 (2.7)	4 (1.3)
Religions institutions	13 (11.4)	29 (24.1)	42 (10.6)

Results show that, both father and mother were equally and highly preferred by 94.0% of the parents to offer marital life education to adolescents. However, their preferences were not supported by the extent of what they know over various vital issues of reproductive health. For example, only one third of parents were conversant with issues of menstruation cycle and few respondents correctly described some pregnancy and contraception matters.

In general, the results have revealed that despite majority of parents reported communicating sexuality related issues with both male and female adolescents the

communication was insufficient. Also there were knowledge gap and serious misconceptions among parents on various reproductive health issues. The father and mother have predominantly been preferred by most of parents to give education on various sex related issues.

CHAPTER: 5

DISCUSSION

In most African cultures people believe that it is the grand parents or respected elders' responsibility to give sex education to their children (Barnett, 1997). Yet the extended family structures are no longer functioning in most societies. The main aim of this study was to assess the extent to which the parents communicate with their adolescent children on sexuality health related issues.

The results of this study revealed that two third of parents rarely or never communicated with their adolescent children on issues related to sexuality. The findings were supported by Bang et al (1989) who noted that from other countries across the world, there is also evidence that young people and adults only talk infrequently to one another about sex. The fact that 62% of parents rarely or never talked with adolescent children about sex raise concerns about the role parents can play in control of sex related problems.

One study done by Weiss (1996) found that, young people who openly communicate about sexual matters with their parents, especially mothers, are less likely to be sexually active or (if girls) become pregnant before marriage.

A study in India found that parents and family members were reluctant to discuss sexual matters with young people (Bang et al, 1989). In Tanzania, women interviewed in a variety of contexts reported that they were told very little about sex and reproduction

prior to marriage. Realizing this gap the Tanzanian government introduced family life education in school curricular. However according to Leshabari et al (1997) it was observed that children spend less than 25% of their time in school and the rest of their time was spent at home and in the community. Therefore, the homes as well as community are important areas to take the central role of educating adolescents.

This study revealed that the proportion of parents who communicate with their adolescent-children regarding sexual and reproductive health issues decreases with the increasing age of parents. This may be attributed by the observed trend in this study that, the majority of the younger parents were much more knowledgeable about most reproductive health matters compared to older age groups. This suggests that it is important to strengthen the knowledge of parents on sex related issues before insisting on the effective communication between them and their adolescent children on Reproductive Health issues.

Among the parents who never communicated with their adolescents, about fourty percent did not do so because of cultural restrictions. This could be true as it was also reported in one study by Huygens et al (1996), that, culturally, parents couldn't talk to their children about issues related to sexuality. In the past, sexuality knowledge and skills were imparted to children through elders and traditional ceremonies. However, this trend has weakened in these recent times following disintegration of extended families and a decline in initiations ceremonies in most communities. During this study, less than

4% of parents suggested these more traditional kinds of sources of information for their female children.

Unfortunately, some traditional initiation ceremonies are blamed for the increasing of risks for HIV among the youth hence disapproving their importance and encouraging parents to take charge (Talle, 1995). For example, among the Maasai of East Africa the relationship among male peers is so close that, after circumcision, the initiates share wives and girlfriends.

Some parents mentioned that they did not communicate with their adolescents-children because they didn't know what to tell them on sexuality issues. It may not be clear to them how much information to give and at what age. The study has revealed that, despite reports that most parents have high knowledge on menstrualation, only one third of them correctly knew when a sexually active woman with a normal menstrual cycle, is most likely to conceive. However, this can perhaps be attributed to fears amongst parents that arise from their own negative sexual experiences as Nyangu (2000) put forward.

Parents need to engage in their primary role as educators of their children to reinforce the knowledge they have and what they acquire from daily social interactions. Above all, with the advent of HIV/AIDS and disintegration of the extended family bonds,

parents are now obliged to take over the role of giving sex education to their children as most of the respondents have suggested.

It has been shown from this study that, discussion on sex related issues was predominantly among the employed wage-earning parents compared to those in other forms of occupation. This can be attributed by the fact that most of these parents have higher education and stable incomes compared to other groups. This is supported by a study done in Zimbabwe (Wilson et al, 1994), which found that traditional channels of communication about sex and marriage have economic factors, with poor families almost not communicating with their children and that the information is no longer obtained from family members, but from the media, schools and friends.

HIV/AIDS was the predominant discussed issue with adolescents by most of the parents. Despite most of parents being knowledgeable of pubertal development issues, the subject was least communicated. Discussing more on HIV/AIDS and neglecting pubertal development issues suggests that the discussions with adolescents were insufficient.

Results have shown that lack of knowledge is one of reasons hindering interactive communication between parents and their adolescent children. More than two third of parents didn't know that a girl at around puberty can get pregnant even before seeing her first menses if she indulge in unprotected sex. Also only half of the parents knew that sexual intercourse while standing can still lead to pregnancy. It was also reported by

Kelly (1981) who stated that, almost in all societies, many parents feel uncomfortable talking to their children about sexuality. Perhaps they are reluctant to expose their own lack of knowledge about anatomy, physiology, or other related information.

However, this trend was predominant among illiterate parents. A quarter of female parents didn't know that sharing domestic utensils with AIDS patients cannot lead to the transmission of HIV infection. These damaging myths can interfere with the delivery of the expected care to these patients from the rest of the family and indeed the community at large.

As the result of knowledge gap, parents will tend to shy away from actively educating youth about issues relating to sexuality. What may fail to realize is that giving no information or avoiding adolescents` questions can send negative messages about sexuality.

When adolescent-children do not get information at home, they seek answers elsewhere-from peers, the media or their observations of other adults. This study has shown that the majority of parents did not prefer these sources, however, their reasons of not supporting them were not explored by this study.

Helping parents and other adults in the family to effectively educate adolescents about sexuality and to discuss the subject in the context of a loving family requires a concerted effort by introducing parent education programme.

As long as the parents are not opening doors to let the children get the information on sexuality issues, these result predict low acceptance of reproductive health services among adolescents and prone to HIV infections and low self esteem. This is supported by Shoop (1994), who revealed that, teens who reported previous discussions on sexuality with their parents were seven times more likely to feel able to communicate with a partner about HIV/AIDS than those who have not had such discussions.

The reasons as to why large proportion of parents were not able to communicate sexuality issues to their children of opposite sex is explained by African culture that doesn't encourage open discussion on matters concerning sexuality (Weiss et al, 1996) Some parents are still under the influence of traditional beliefs that forbids them to speak of sexuality matters to their adolescent-children.

In the past, parents depended on uncles, aunts and grand parents to impart knowledge and skills of sexuality to their children (Talle, 1995). However, a study by Wilson et al, (1994) found that adolescent were not preferring these sources and they described, information from aunts and uncles was so generalized, one-sided, authoritarian and prescriptive. Therefore, with the advent of HIV/AIDS and contradicting position of extended families, parents are now much more obliged to take over the role of giving sex education to their children.

However, parents need to be equipped with communication skills so as to make their communication with adolescents more interactive. The Ministry of Health has recently produced guidelines on parent-child communication for educating parents on effective communication regarding sexuality issues.

The study has shown that most of parents (85%) in the study areas were worried and have impression that STDs prevalence among the youth was very high. They mentioned gonorrhoea, genital ulcer diseases and HIV/AIDS as the most prevalent STDs. However, it is not uncommon to encounter such powerful images towards youth among parents. As stated by Friedman (1993); some parents believe that young people are of their nature untrustworthy and sexually promiscuous and that giving them information about sex will make adolescent more sexually active. Despite such worries, study done by Kirby (1999) found that HIV/AIDS education programs do not encourage the start of sexual activity, do not increase the number of sex partners and do not increase the frequency of sex among adolescent. He also stressed that, some programmes that included discussion of contraception delayed the onset of sexual activity and increased the likelihood of condom use. It is time now the parents should begin urging their adolescents to be safe rather than to stay pure.

This is similarly reflected in Turner's (2000) report, which stated that despite adolescents being confronted with the possibility of pregnancy and HIV/AIDS, yet they lack information and services to protect themselves. It further stated, in Vietnam, for

example, while adolescents make up only 12 to 14 per cent of the population, they account for 25 per cent of abortions and 50 per cent of HIV infections (Turner, 2000). Also reports from Bolivia have shown that, 30% of all women are mothers by the age of 19. The situation is repeated in many countries and Tanzania is no exception.

To address these challenges, there is need to provide greater access to youth-friendly information and services and to advocate for policies that recognize the rights of adolescents and promote their reproductive health.

Over 90% of the parents preferred both father and mother to be responsible for sexual health STD/HIV/AIDS and parenting education to their adolescents, school and health workers have been preferred by about 15 per cent. This might be indicating that parents want to play their role as they stay with their children for most of the time. This is consistent with Leshabari (1994) who observed that children spend more than seventy five percent with their parents and the community.

This makes homes as well as the community suitable areas of primary importance for educating children on matters concerning sexuality.

On the other hand, the media and peers have been negligibly preferred by parents to be responsible educator of adolescent children on sexuality related matters. This may be indicating that some parents are still having doubts over the extent the media can

perform in their locality. It is worth noting that information obtained from the newspaper, radio and television is not exhaustive and its coverage in rural areas is still low. Some parents don't read newspapers and of course, some do not have radio and television.

Local drama groups should be strengthened and encouraged to include sexual and reproductive health messages in their entertainment activities. This will provide an alternative line of communication to complement on what is obtained from other sources. Elsewhere the media is relied upon more than in the past to provide information and guidance about sex and sexual relationships.

The parents' low preference to peers as a source of sexuality information may be contradicting with adolescent preferences as it was put forward by Helitzer-Allen (1997). In one study done in Malawi found that sixty percents of girls reported of having learned about menstruation from friends and not from their parents or advisors as traditionally occurred. It seems parents were not aware of the evidences that suggest that peers have became a more important source of knowledge, advice and support.

The religious institution has been preferred by only 1.5% of parents to educate on sexual health, family planning and STDs/HIV/AIDS. The religious leaders usually preach about good behaviours and have greater access to the majority of the population. It appears parents do not see their role in sex related education for adolescent children.

Some parents felt that there is a gap between what they know and what they would like to deliver to their children. On preparing boys and girls for the onset of puberty, parents will need to talk about pubertal development and many other kinds of affectionate touching. Therefore, parents should be taught on different issues concerning pregnancy, family planning and prevention of STD/HIV/AIDS to strengthen on what already known to them and being able to deal with the emerging myths.

About one fifth of parents did not prefer HIV/AIDS education to be taught in schools. They pointed out that, this will encourage bad behaviour among pupils and creating opportunities for teachers to ruin them. Their fears correspond to what was reported by Jejeebhoy (1998), that teachers feel embarrassed to talk about the topic of sex, and ill prepared for teaching about sexual matters. It is important that, teachers they be offered training and support so as to undertake this kind of work with adolescents, and so as to be able to work with parents and community leaders in preparing the grounds for it to take place. Important challenges therefore remain in relation to efforts to promote the sexuality health of adolescents in ways attuned both to social and cultural contexts and local needs. Teachers have to work very closely with parents and the community for successful implementation of HIV/AIDS education programme in schools.

As Cavanaugh (1994) said, indeed sex is like a car that begins rolling down a hill. At first the hill is nearly flat, but then it becomes progressively steeper. The further you go,

the harder it is to stop. Since the right time to have sex will be some years away, it will be important to make sure that the car doesn't roll very far before the wedding night.

This means that the adolescent child want to have a clear idea on what his or her boundaries are and how to maintain them effectively, well before the first socializing with the opposite sex begins.

It is important the programme to strengthen parents knowledge on various sexuality issues and communication skills to be adopted. Always, talking about sensitive subjects requires forethought and patience. Parents, family members and teachers need skills of talking about sex and sexuality to their adolescents. Following the gradual disintegration of the extended family bonds, parents now obliged to take over the role with the help of other sources like teachers, peers, mass media and religious institutions.

CHAPTER: 6

CONCLUSION AND RECOMMENDATIONS

This part presents conclusion from the study and provides recommendations for improvement of the communication between parents and their adolescent children regarding sexual and reproductive health matters in Mbeya rural district. The information obtained will provide a basis not just for encouraging parent child communication but also for making it effective.

CONCLUSION

This study has revealed that, a large proportion of parents communicate with both their male and female adolescents regarding sexuality matters. However, only a few do so frequently.

STD/HIV/AIDS, parenting and pregnancy were highly discussed by the majority of parents, however, other basic issues like, menarche; spermarche, sex and family planning were lowly covered.

Cultural restrictions, lack of time, ignorant on sexuality and thinking not their responsibility are major reasons which were reported by parents who never communicated with their adolescents on sexuality matters.

Generally, majority of parents have shown to be knowledgeable of reproductive health issues, however, there are serious gaps and misconceptions when looking at various specific issues.

These parents have indicated that, they are willing to take charge breaking cultural restrictions and talk to their adolescents about sex related issues. However, the majority of parents do not prefer other sources of sexuality information to complement their efforts on addressing adolescent sex related problems.

The parents were eager to learn about the subject to improve their knowledge and communication skills of the reproductive health issues. The communication skills needed to respond to adolescent children's questions, convey sexual values and attitudes, and seize appropriate opportunities to initiate discussions about sexuality and other reproductive health issues.

RECOMMENDATIONS

1. There is a need for parents to be equipped with sufficient knowledge of various sexual and reproductive health issues in order to communicate with their adolescent-children effectively.

2. The parents have to be involved in the whole process of organizing other sources of the sexuality information for their children. This is important, as it will provide views from the parents and their involvement in such programs for better sustainability.

3. Efforts should be made to educate parents and other family members to strengthen the parent-child communication on sexuality matters. Parents should accept that they are the primary sexual educators of their adolescents-children. Both father and mother should feel free to provide education to their children of opposite sex.

4. Educational messages addressing similar and related issues regarding sexuality matters should be given concurrently to strengthen peoples' understanding.

5. The contents of sexual and reproductive health matters the parents deliver to their adolescent children have to be comprehensive. Should include all essential components, ranging from pubertal development to issues pertaining HIV/AIDS.

FURTHER STUDIES

1. Further studies to determine parents' views on the role played by other sources of sexuality information to their children have to be conducted.

2. More operational research are required to determine young people's view on the parent obligation to effect sexuality communication in both urban and rural areas. This is important to involve the youth before investing much to parents' education programmes.

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