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FACULTY OF MEDICINE, HEALTH AND LIFE SCIENCES

School of Psychology

An Exploration of the Psychosocial Factors Affecting the Development and Delivery of School-Based Sex and Relationships Education in Tanzania

by

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ABSTRACT

FACULTY OF MEDICINE, HEALTH AND LIFE SCIENCES

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AN EXPLORATION OF THE PSYCHOSOCIAL FACTORS AFFECTING THE DEVELOPMENT AND DELIVERY OF SCHOOL-BASED SEX AND RELATIONSHIPS EDUCATION IN TANZANIA

by Kitila Alexander Kanyama Mkumbo

Employing a mixed methods research design, in which both quantitative and qualitative research approaches were used, the research in this thesis has explored the feasibility for the development and implementation of school-based sex and relationships education (SRE) in Tanzania by (a) assessing the attitudes of parents, teachers and students towards the provision of SRE in schools and (b) analysing national school policy and curriculum frameworks with a view to identifying the status and place of SRE in the national school curriculum.

The results show that a majority of parents (more than 70%), teachers (more than 90%) and students (more than 80%) supported the provision of SRE in schools and, despite resistance to a few controversial topics, the inclusion of a wide range of SRE topics in a school-based SRE curriculum. These results suggest that, contrary to popular belief that, particularly among policy makers, parents and other stakeholders are opposed to the provision of SRE in schools, it is not the opposition itself, but the unfounded fear of opposition that has thwarted the provision of school-based SRE in Tanzania.

The results of the content analysis of the national school curriculum revealed a limited and somewhat disorganised representation of SRE, with more focus on the biological facts and information about HIV transmission and prevention than other aspects of sexual health, such as attitudes, skills and relationships. It has been argued, however, that putting HIV/AIDS in the national school curriculum provides the possibility of opening the way for a wider provision of SRE in schools in future (Harrison, 2000).

In light of the results of this research, the author has recommended several steps to be considered in introducing SRE in schools, as well as future research directions in the field of sexual health, and SRE in particular, in Tanzania.

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DECLARATION OF AUTHORSHIP

I, Kitila Alexander Kanyama Mkumbo, declare that the thesis entitled

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and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

- this work was done wholly or mainly while in candidature for a research degree at this University;
- where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- where I have consulted the published work of others, this is always clearly attributed;
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- I have acknowledged all main sources of help;
- where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- none of this work has been published before submission.

Signed: ……..

Date:…….

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Abbreviations

ACSEE	Advanced Certificate of Secondary Education Examination
AIDS	Acquired Immune Deficiency Syndrome
CSEE	Certificate of Secondary Education Examination
DHS	Demographic Health Survey
FLE	Family Life Education
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IM	Intervention Mapping
IPA	Interpretative Phenomenological Analysis
NBS	[Tanzania] National Bureau of Statistics
NGO	Non Governmental Organisation
PCA	Principal Component Analysis
PSLE	Primary School Leaving Examination
SCT	Social Cognitive Theory
SPRANS	[U.S.] Special Programmes of Regional and National Significance Community Based Education
SRE	Sex and Relationships Education
STIs	Sexually Transmitted Infections
TACAIDS	Tanzania Commission for AIDS
TDHS	Tanzania Demographic and Health Survey
TPB	Theory of Planned Behaviour
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
URT	United Republic of Tanzania
USA	United States of America
WHO	World Health Organization

Chapter 1
General Introduction

1.1 Background

In sub-Saharan Africa, the HIV/AIDS epidemic continues to exert significant toll on individuals and society, and has had profound effects on the region's economic and social development prospects. Though the sub-Saharan African region is home to just 10 percent of the total world's population, The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) estimate that more than two-thirds (68%) of the total 33.2 million people living with HIV in the world are in this region (UNAIDS & WHO, 2007).

Tanzania is among the countries in the sub-Saharan African region that still has the highest levels of HIV infection. It is estimated that 1.4 million people were living with HIV by the end of 2007, with the HIV prevalence rate of 6.5 percent among adults aged 15 to 49 (UNAIDS/WHO, 2007). As in other sub-Saharan African countries, young people are most affected by the AIDS epidemic in Tanzania. For example, it is estimated that more than 60 percent of all new HIV infections in Tanzania occur among young people aged 15-24 (Tanzania Commission for AIDS [TACAIDS], National Bureau of Statistics and ORC Macro, 2005).

Additionally, Government statistics show that teenage pregnancy has become a problem of concern, especially among schoolgirls. For example, between 2000 and 2005 alone, more than 25,000 primary school girls dropped out of school due to pregnancy (Nkolimwa, 2006). This trend clearly threatens Government efforts in closing gender gaps in education and in fighting poverty in general. The Government has therefore been concerned that teenage pregnancy, along with HIV infection, should also be contained.

Amid the growing concerns about the upward trends in HIV infection among young people, in 2000, the President of the United Republic of Tanzania declared the HIV/AIDS epidemic a national disaster (United Republic of Tanzania [URT], 2001). This declaration was the beginning of a series of HIV prevention strategies starting with the formulation of the Tanzania Commission for AIDS (TACAIDS) in 2001. Since then, the HIV/AIDS crisis has been given a high profile in all sectors in the country, with the office of the Prime Minister charged with the coordination role.

HIV prevention strategies have included the setting up of HIV/AIDS committees at local government council levels as well as supporting the sensitisation and other education programmes. As a result of these initiatives, several HIV/AIDS education programmes have been developed, mainly by Non- Governmental Organisations (NGOs), targeting young people aged 15-24 mostly out of school settings.

Several setbacks have been observed regarding the present set up of HIV/AIDS education programmes in Tanzania. Firstly, no nationwide study has been conducted to assess the level of implementation and evaluate the impact of these programmes (Schaalma, Reinders, Matasu, Kaaya & Klepp, 2004; Kaaya, Mukoma, Flisher & Klepp, 2002). As such, their efficacy in reducing young people's risky sexual behaviours related to HIV transmission remains largely unknown. Secondly, the current HIV/AIDS education programmes in Tanzania have been implemented independently of, and in isolation from, a broader sex and relationships education (SRE) programme. Thus, perhaps understandably given the seriousness of HIV/AIDS, the focus has been more on disease prevention than the promotion of overall sexual health. However, studies have shown that HIV/AIDS prevention efforts are more effective if undertaken within a comprehensive SRE framework than in isolation; this is because the behaviours related to HIV infection are integrated into a broader context of personal life styles and are situated in a wider cultural context (Wells, 1992; Boyce et al., 2007). In fact, Boyce et al. have argued that "a limited conceptualisation of human sexuality in HIV and AIDS work constitutes the major barrier to effective HIV prevention worldwide" (p. 2).

Thirdly, as noted earlier, most of the HIV/AIDS education programmes in Tanzania have tended to target young people out of school settings, with the implication that these programmes have reached only a small proportion of young people (Schaalma et al., 2004).

A number of reasons have been given for the failure to implement SRE programmes in schools. Schaalma et al. (2004) have identified three such reasons. The first reason relates to the fear that policy makers, teachers, community leaders and parents may object to the teaching of SRE programmes in schools because they feel that such programmes are too sensitive and may encourage young people to initiate sex at an early age. Second, teachers may feel uncomfortable with and may lack the necessary skills and experience in teaching their students about SRE. Third,

countries may lack supportive policies or may even have policies that constrain the teaching of SRE in schools. Additionally, as argued by Boler and Aggleton (2005), many Ministries of Education still view HIV/AIDS prevention as being the responsibility of the Ministries of Health. This perception has partly been heightened by the fact that, in many countries, most of the donor funding for HIV/AIDS work is channelled through Ministries of Health.

There is a lack of studies that have examined the position, challenges and opportunities concerning the provision of comprehensive SRE in schools in Tanzania. Thus, while there seems to be a general understanding that HIV/AIDS education and SRE programmes have not been able to find their way into the school classrooms (Vavrus, 2006; Schaalma et al., 2004), little is known about the factors that impede the delivery of these programmes in schools. Thus the research for this thesis was motivated by the need to examine the feasibility for the provision of school-based SRE in schools in Tanzania. Against this, the research has examined the psychosocial factors associated with the development and implementation of school-based SRE by (a) assessing the attitudes of key stakeholders, including parents, teachers, students and school policy makers, towards school-based SRE, and (b) analysing the national school policy and curriculum frameworks with a view to identifying the structural factors that may facilitate or impede the development and delivery of SRE in schools.

There is a large body of evidence that demonstrates that, if given a chance, school-based SRE programmes can help young people, who are not yet sexually active, to delay sexual intercourse until they are cognitively and emotionally ready for mutually beneficial and healthy sexual relationships (Kirby, 2001; Kirby, 2002a; Kirby, 2002b; Parker, 2001; Singh, Bankole & Woog, 2005). Furthermore, teaching young people about SRE has also been associated with the increase in the prevalence of effective and consistent condom and contraceptive use for those who are already sexually active (Mueller, Gavin & Kulkarni, 2008; Kirby, Laris & Rolleri, 2005; Singh et al., 2004; Wellings, Wadsworth, Johnson, Field & Whitaker, 1995).

Furthermore, research has systematically dismissed any causal association between teaching young people about SRE and sexual experimentation or increased sexual activity (Kirby et al., 2005; Wellings et al., 1995). Nonetheless, it seems natural that some young people will engage in some form of sexual experimentation, as with other behaviours such as drinking and smoking, whether or not SRE is offered to them. The difference that SRE provides is that it makes sexual experimentation

healthier by helping young people to make informed decisions and take fewer risks (Bruess & Greenberg, 2004).

1.2 Theoretical foundation for the research in this thesis

The theoretical approach adopted for this research was based on an integration of several models related to the development and implementation of health promotion programmes. Three models were particularly relevant in guiding the formulation of the research questions; these models are: Intervention Mapping, the Theory of Planned Behaviour and the Social Cognitive Theory. The following is a brief description of these models and their use in the current research.

1.2.1 Intervention Mapping

Intervention Mapping (IM) is a theory - and evidence - based framework for guiding planning, implementation and evaluation of health promotion programmes (Bartholomew, Parcel, Kok & Gottlieb, 2001). IM is a theory- and evidence - based model in the sense that it requires programme developers to base all their decisions about the programme objectives on scientific evidence and theory. The scientific evidence can be obtained from the literature (existing evidence) or by collecting new empirical data. The IM model also provides a framework for facilitating collaboration between researchers, implementers and target groups, on the one hand, and stakeholders from different backgrounds, including communities, parents and government authorities, on the other. The IM model recognises that as much as change in health behaviour may be influenced by individual knowledge, motivation and skills, it is also shaped by the actions of legislators, health authorities and school authorities as well as attitudes of communities, parents, religious institutions and other members of the society (Shaalma et al., 2004). Thus, interventions are needed to change individual health behaviours as well as to facilitate programme adoption, implementation and sustainability.

In guiding the programme planning, development and implementation processes, the IM model employs six sequential steps; namely, 1) situation analysis, 2) specifying programme objectives, 3) selecting theory based intervention methods and practical strategies, 4) designing and organising the programme, 5) specifying an adoption and implementation plan and 6) generating an evaluation plan. A description of each step is provided below.

1.2.1.1 Intervention Mapping step 1: Situation analysis

Situation analysis (also called needs assessment) is the process of identifying the needs of the target population and the facilitators for, and barriers to, achieving these needs (McKenzie and Smeltzer, 2001). Within the context of IM, situation analysis aims to: (a) identify the health problems facing the target population and the behavioural and environmental causes of the identified health problems and (b) analyse the characteristics, resources and capacities of the community for which the programme is intended. The IM model advocates a context specific approach to programme development that is responsive to the needs of a particular community in a specific geographical, economic and cultural context (Bartholomew et al., 2001).

The situation analysis begins with a description of the target group; these are the individuals who are potential recipients of the programme. For example, for this research, the potential recipients of SRE were young people attending school. This is followed by the identification and analysis of the health problem as well as the individual and environmental factors that contribute to risky behaviours. This means that the IM model acknowledges, right from the beginning of programme planning, that a health promotion programme may include several contextual levels. Thus, though the target group may be young people, the sexual health promotion programme may include activities targeting other members of the community, such as parents, teachers, school authorities, community leaders, policy makers and religious leaders.

According to Schaalma (2002), the situation analysis of environmental factors for school-based sex and relationships education (SRE) may involve several aspects, such as:

- analysis of the decision makers who are in control of sexual health promotion
- an insight into the attitudes and opinions of school-policy makers and school management regarding the provision of SRE in schools
- analysis of the place of SRE in school policy and curriculum
- insight into the attitudes of teachers towards teaching SRE
- insight into the attitudes of parents and other community members towards teaching SRE in schools
- analysis of teachers' competence to deliver SRE

- analysis of the practical barriers to the provision of school-based SRE, including number of students, teaching and learning resources and support from parents and community in general.

Schaalma argues that situation analysis of the individual factors (individual needs assessment) should involve the analysis of the psychosocial correlates of risky sexual behaviours and health promotion behaviours. Psychosocial correlates of sexual behaviour, for example, may include:

- analysis of risky sexual behaviours, such as, for example, timing of sexual debut, the level of protection and the nature of sexual partnerships
- analysis of knowledge related to HIV/AIDS and other sexually transmitted infections (STIs)
- analysis of attitudes and values regarding sexuality and SRE
- analysis of social influences on sexual behaviours.

1.2.1.2 Intervention Mapping step 2: Specifying programme objectives

Two tasks are involved in this step. The first task involves defining and selecting, based on the needs assessment results, the general programme goals. The general programme goals are the desired health promoting behaviours that programme planners envisage to achieve. Again, in line with IM, the selection of programme objectives should be based on evidence and theory.

1.2.1.3 Intervention mapping step 3: Selection of theoretical methods and practical strategies

In this step, programme planners identify theoretically based intervention methods that have proved effective in attaining the specified objectives and decide on the practical strategies to make these methods functional. An intervention method is defined as a technique derived from theory and research to realise a proximal programme objective; a strategy is defined as the practical application of the method (Aaro et al., 2006). For example, observational learning is a theoretical method, while role play and videotaped role model are the practical strategies relevant to this theoretical method. It is important that the practical strategies selected should be relevant and appropriate to the context of programme implementation settings. For

example, if video is chosen as a teaching strategy, there should be a reliable source of power, such as electricity, in a setting where such video will be shown.

1.2.1.4 Intervention mapping step 4: Designing of the intervention programme

During this step, two tasks are accomplished. First, programme developers organise the programme objectives and practical strategies into deliverable and coherent programme components and materials. Several activities are undertaken in this regard, including deciding on the scope of the programme (e.g., comprehensive or abstinence-based) and defining themes and the sequence of strategies (e.g., lectures, discussions, group assignments, etc.) as well as communication channels (e.g., print media, video, teacher or peer-led). It is also possible at this stage to come up with an appropriate name for the programme. Again, the programme materials should be relevant and appropriate to the implementation contexts.

The second task involves pre-testing the programme materials before the intervention programme can be implemented on a larger scale. Van Bokhoven, Kok and Van der Weijden (2003) recommend three steps for pre-testing the programme materials. First, the pre-test activities should test the readability and comprehensiveness of programme materials. The pre-test activities can involve experts in the programme areas and selected members of the target population. The second step involves running the intervention programme in a pilot group to test its coherence and the time schedule and to get an impression of its acceptability in the target population. The third step is to test the intervention for its effectiveness on a smaller scale by using, preferably, experimental designs, such as randomised control trials.

1.2.1.5 Intervention mapping step 5: Adoption and implementation plan

In this step, a plan for the implementation and adoption of the intervention programme is developed. The first task in this step is to set up collaborative linkage between the programme planning team (researchers) and the users. Users in this case may include teachers, school administrators and policy makers. School-based SRE programmes have been found to run more smoothly and effectively if the development and implementation processes forged close cooperation among programme planners (researchers), teachers, school administrators and policy makers (Schaalma et al., 1996). The second task in this step is for programme planners to

develop a theory- and evidence- based strategy to promote programme adoption among the key decision makers, including school administrators and policy makers. The adoption and implementation plan may involve several activities, including, for example, training teachers, designing the schedule for the programme delivery and printing and distributing the programme materials.

1.2.1.6 Intervention mapping step 6: Planning an evaluation strategy

This is the final step in the intervention mapping process. During this step, the evaluation plan and the evaluation measures are identified and developed. The plan comprises two major evaluation categories: process and impact evaluation. The process evaluation encompasses research methods and instruments that are used to examine the fidelity and completeness of programme implementation. The impact evaluation plan encompasses research methods and instruments to examine the impact the programme will have on behaviour and environmental conditions and possibly on health and quality of life outcomes.

Figure 1 summarises the steps involved in the intervention mapping process.

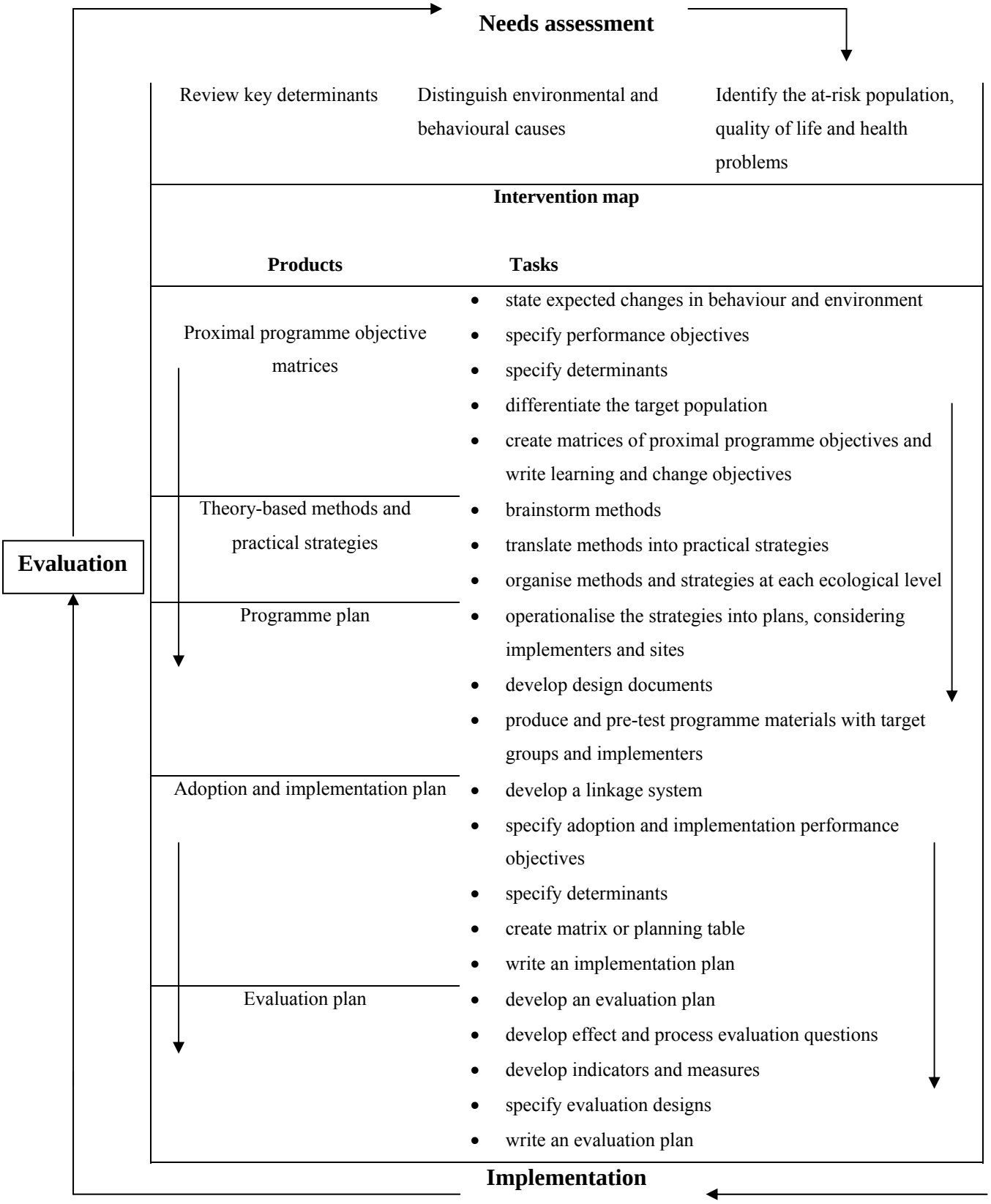

Figure 1.1. Intervention mapping (Bartholomew et al., 2001, p. 10).

1.2.1.7 Some examples of the application of Intervention mapping

IM has been applied successfully in designing, implementing and evaluating a number of health promotion programmes in developed countries. These include, for example, an AIDS risk reduction programme for Dutch drug users (Van Empelen, Kok, Schaalma & Bartholomew, 2003); HIV and sexually transmitted disease and pregnancy prevention programme (Tortolero et al., 2005) and fruit and vegetable promotion in the Netherlands (Perez-Rodrigo et al., 2005).

Although, the Intervention Mapping model was developed in the western context, it can be applied flexibly to suit different social-cultural contexts. Additionally, as observed by Tortolero et al. (2005), programme developers can adapt all or part of the IM steps depending on the circumstances of the implementation setting. For example, in the recent past, the IM model has been applied to develop sexuality and HIV/AIDS education programmes in some sub-Saharan African countries, including Tanzania and South Africa (Aaro et al., 2006; Mkumbo et al., [in press]). However, there are different challenges for applying IM in different contexts. For example, Mkumbo et al. observed that, whilst the IM model was successfully applied in planning a sexuality and HIV/AIDS education programme in Tanzania, there were several challenges at the implementation phase. According to Mkumbo et al., it was, for instance, practically impossible to adapt an existing programme as required by the IM model because none of the analysed existing SRE programmes in Tanzania met the minimum requirements of effective SRE programmes as suggested by Kirby et al. (2005). Furthermore, there was no evidence in Tanzania to support the performance objectives related to abstinence and delaying onset of sexual activities in young people. This means that it was not possible to apply all the IM steps in a logical fashion in developing the sexuality and HIV/AIDS education programme in the Tanzanian context.

1.2.18 IM summary and its application for this research

It is clear that the IM model is a complex framework involving several steps; each step in the IM model has a specific purpose and role. Overall, the IM model seeks to guide three major processes; namely, development, implementation and evaluation of health promotion programmes.

As observed earlier, the main purpose of this research was to explore the feasibility for developing and implementing a school-based SRE programme in Tanzania, in which only a few steps were practically applicable. For the purposes of the research for this thesis, therefore, only the first IM step (situation analysis) was useful and relevant; this step guided the formulation of research questions with respect to parents, teachers and students' attitudes towards school-based SRE as well as the analysis of structural factors that affect the delivery of SRE in schools. Resources did not permit the full implementation of the IM model; it is hoped that further work, employing other IM steps, will be pursued subsequently.

1.2.2 The theory of planned behaviour

The theory of planned behaviour (TPB) is a revised version of the theory of reasoned action following a discovery that behaviour is not wholly voluntary and under control; this discovery resulted in the addition of a new variable called *perceived behavioural control* and thus the change in the name (Ajzen, 1991). The predecessor of the TPB, the theory of reasoned action, suggested that a person's behaviour is determined by his or her readiness to perform that behaviour (intention), which in turn is determined by a person's degree of favourableness towards that behaviour (attitude) and his or her belief about how people he or she cares about will approve or disapprove of that behaviour (subjective norms).

The *theory of planned behaviour* posits that, in addition to attitude and subjective norms, the intention to perform a given behaviour is also determined by perceived behavioural control and, in fact, according to Ajzen (1991), this is the most important predictor of the intention to perform behaviour. Ajzen has defined *perceived behavioural control* as a person's perception of his or her ability to perform a particular behaviour. As a general rule, the more favourable the attitude and the subjective norm, and the greater the perceived behavioural control the stronger should be the person's intention to perform the behaviour in question.

Figure 2.1 presents a diagrammatic representation of the TPB.

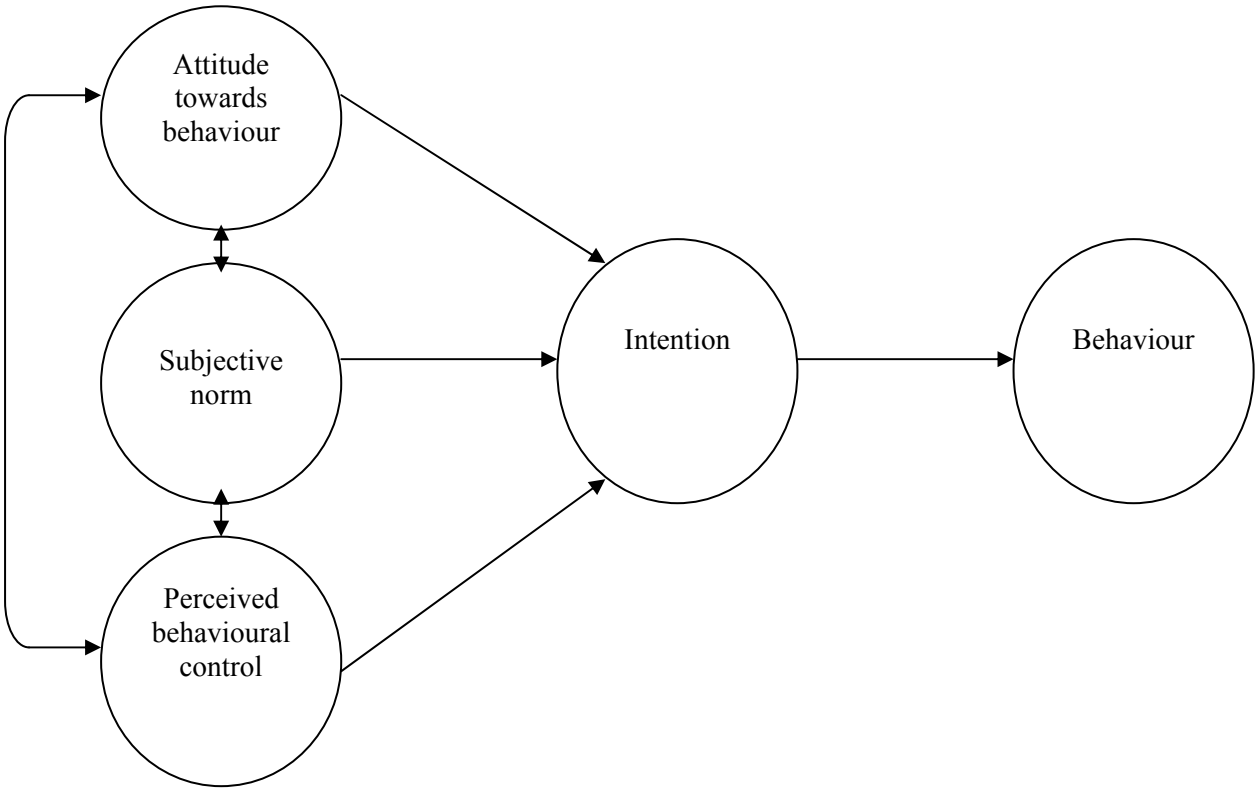

Figure 1.2. Diagrammatic representation of the theory of planned behaviour (Ajzen, 1991, p.182).

1.2.3 Social cognitive theory

Social cognitive theory (SCT) posits a multifaceted set incorporating both the personal as well as the socio-structural determinants of health behaviour (Bandura, 1998). In this regard, the social cognitive theory recognises five core determinants of health behaviour; namely, knowledge of health risks and benefits of different health practices, perceived self-efficacy, outcome expectations, health goals and perceived facilitators and social and structural impediments to the changes they seek (Bandura, 2004).

According to Bandura (2004), perceived self-efficacy is a pivotal determinant because not only does it affect health behaviour directly, but also influences other determinants. Bandura suggests that the stronger the perceived self efficacy, the higher the goal a person sets for himself or herself and the firmer his or her commitment to the goal. Perceived self-efficacy also determines how a person views the obstacles and impediments to achieving the intended goal. Thus, in the context of the social cognitive theory, knowledge and skills alone are not enough to achieve and sustain a healthy behaviour; one also needs a strong sense of self-efficacy to be able

to use them effectively and consistently under difficult circumstances (Bandura, 1998).

Figure 3 summarises the interplay and interaction of the various determinants of health behaviour according to the social cognitive theory.

The theory of planned behaviour and the social cognitive theory offer a clear basis in which the content of an SRE programme can be derived. It is clear from these theories that an effective SRE programme needs to incorporate several ingredients relevant to changing a risky sexual behaviour, including, for example, knowledge, attitudes, skills, values and social norms. It is also clear that the change in behaviour is brought about by an interplay and interaction of these ingredients rather than one of them playing a pivotal role.

Bandura (1998), based on his social cognitive theory, identifies two perspectives from which the development of an SRE programme can be based: disease model and health model. The disease model focuses on disease prevention, whereas the health model focuses on health promotion as well as disease prevention. Bandura argues that a comprehensive health education programme should be guided by a health model, which addresses both the disease prevention function as well as promoting healthy adolescent sexuality. This means that for an SRE programme to be effective in addressing young people's sexual health needs, it needs to incorporate several elements as identified in the TPB and SCT.

Researchers have identified three major components that should constitute SRE; namely, cognitive, affective and behavioural dimensions (Tones, 1981; Lenderyou, 1993; Bruess & Greenberg, 2004). According to Lenderyou, the cognitive dimension embodies knowledge - related aspects of SRE and is concerned with learning of information which is appropriate and congruent to children's lives and developmental level. The second dimension, affective dimension, incorporates values and attitudes and involves exploration and clarification of values and attitudes to enable young people to separate facts from myths and conceptions and to be able to make informed and principled choices. The behavioural dimension involves developing and practising skills of communication and interpersonal relationships.

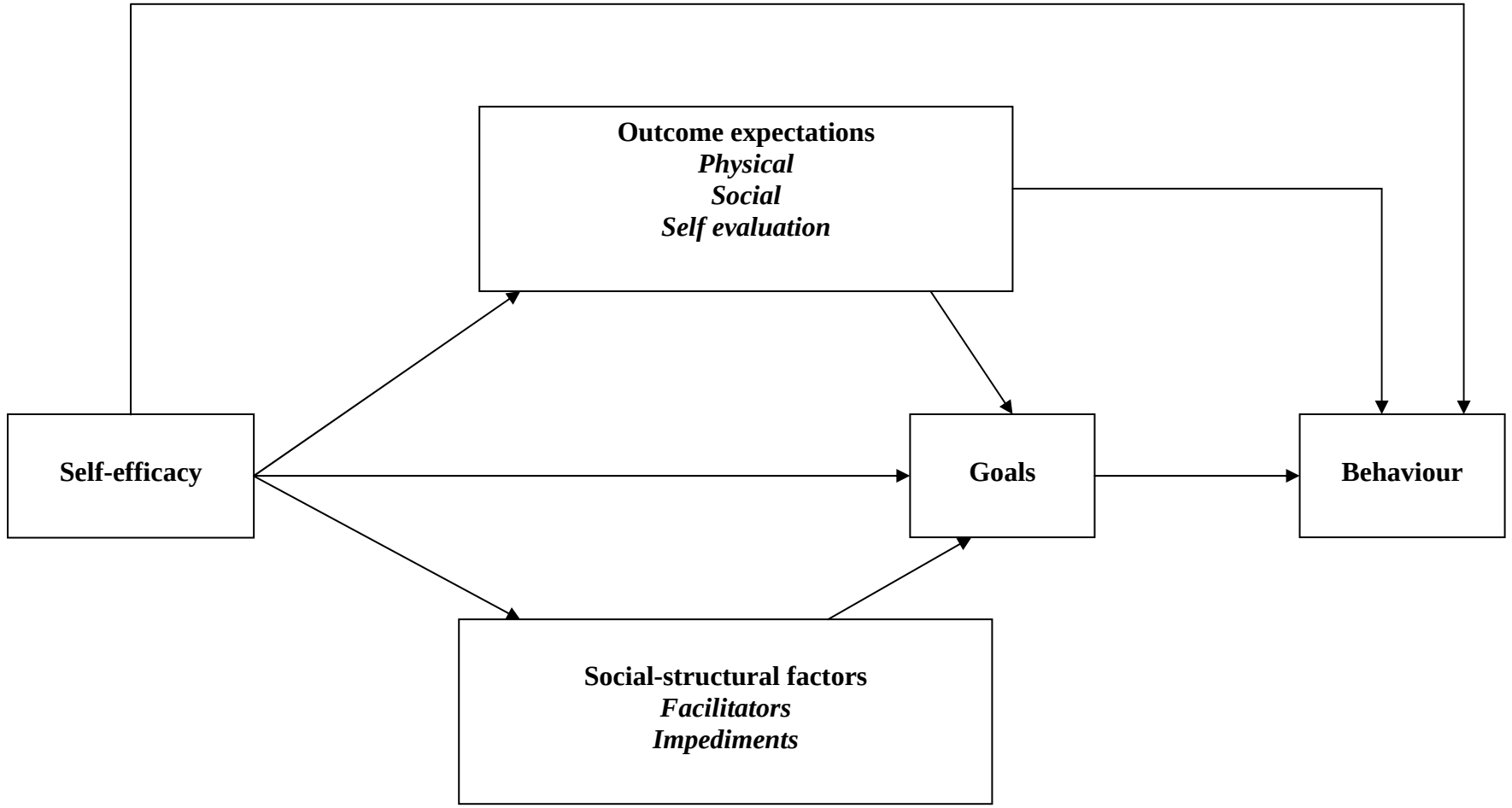

Figure 1.3: Structural paths of influence on health behaviour according to social cognitive theory (Bandura, 2004, p. 163)

One criticism of social cognition models that have been used in the development of health promotion programmes, such as the theory of planned behaviour, has been their exclusive focus on the individual and for downplaying the contextual factors that may influence individual behaviours under consideration (Ingham, 2006). Thus many of the programmes developed on the basis of social cognition models have not given due regard to the environmental and social contexts that may act as barriers to the successful implementation of such programmes.

For SRE to be acceptable and effectively implemented in a given context, it needs to strike a good balance between the theoretical content as advocated in the social cognition models and other theoretical frameworks and what is considered as socially desirable in different contexts. This implies that, while the social cognition models provide a framework for conceptualising the ideal content of SRE, the actual content and form of an SRE programme will be moderated by the psychosocial-structural factors that are characteristic of the context in which such a programme will be implemented. These include such factors as health and education policy and legal frameworks, societal norms and values as well as the views and attitudes of parents and other members of the community.

Therefore, consistent with the social cognitive theory, the development of school-based SRE should take account of the individual determinants of sexual behaviour as well as the psychosocial-structural factors that are likely to impact upon the actual content and implementation of the programme.

Figure 4 shows the interplay among the various components of a school-based SRE programme, possible moderating factors on the SRE curriculum content and the possible learning outcomes.

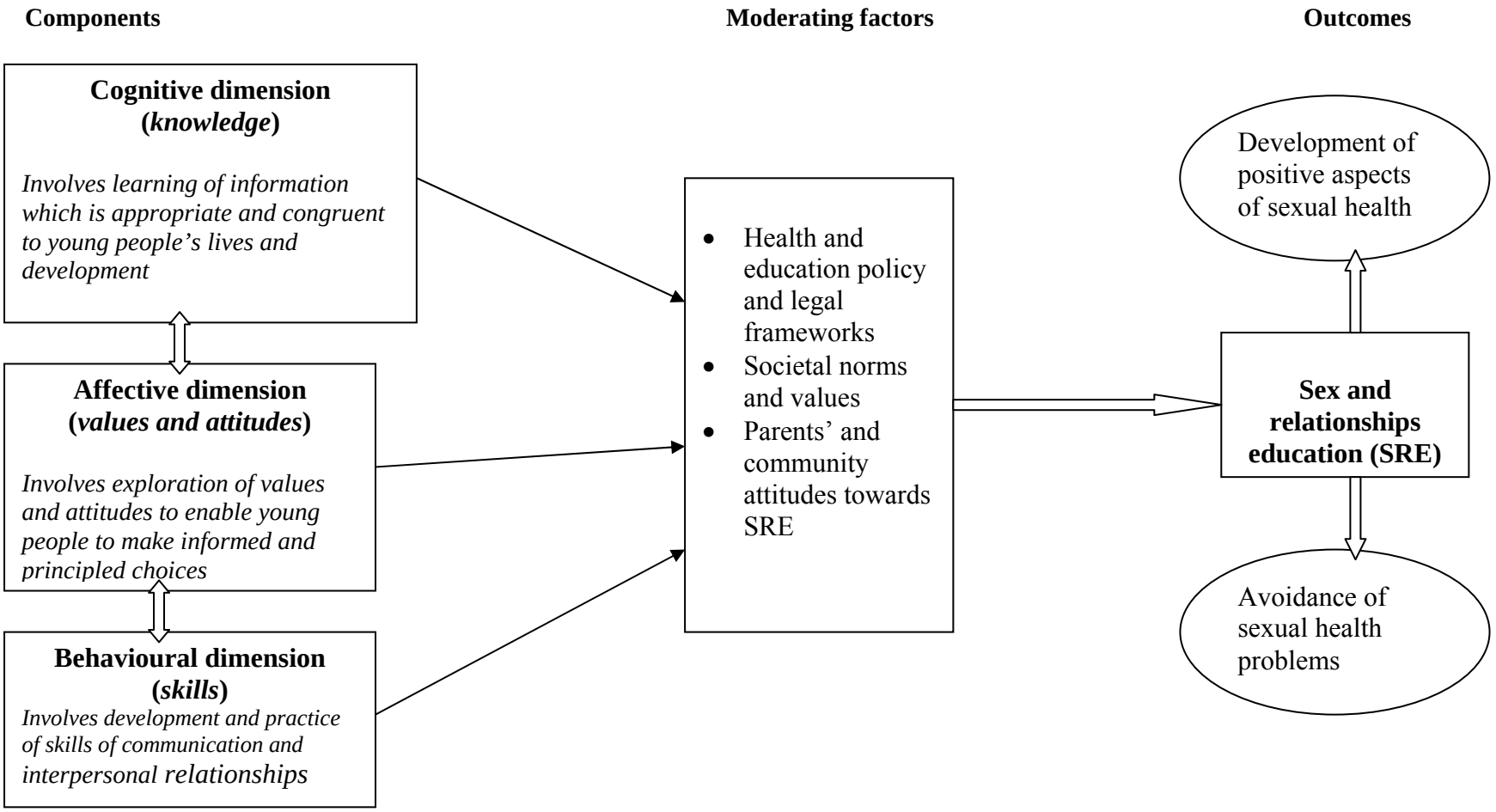

Figure: 1.4. Schematic conception of the components and outcomes of school-based SRE.

1.3 Research aims and key questions

Previous research has acknowledged the role of psychosocial and structural factors in influencing the development and delivery of the school-based SRE content in different contexts (Ingham, 2006; Schaalma, Abraham, Gillmore & Kok, 2004). Yet no research has been undertaken to examine the influence of such factors in the development and implementation of SRE in schools in Tanzania. Little is therefore known as to why comprehensive SRE is lacking in schools in Tanzania and, as such, its potential in helping young people to protect and enhance their sexual health remains largely untapped.

The research described in this thesis examined the feasibility for the development and implementation of school-based SRE in Tanzania. This has been accomplished through the examination of the psychosocial-structural factors that may act as facilitators or impediments to the development and implementation of a school-based SRE programme. The psychosocial factors examined in the research were in respect to the key stakeholders' attitudes towards school-based SRE, including parents, teachers, students and school policy makers. The research also analysed the national school policy and curricula, with a view to identifying institutional barriers to the provision of SRE in schools in Tanzania.

To this end, the aims of the research for this thesis were three fold. First, to assess the views and attitudes of key players of the education sector, including parents, teachers, students and school policy makers about school-based SRE, and how these attitudes have affected the policy and practice of SRE in schools. Second, to analyse the content of primary and secondary school curricula with a view to examining the extent to which the current national school curriculum promotes or obstructs the provision of SRE in schools. Thirdly, to examine how the school policy frameworks facilitate or impede the development and delivery of SRE in schools.

In view of the above objectives, this research has addressed three key questions regarding the provision of school-based SRE in Tanzania. Firstly, how much support is there for the provision of school-based SRE among parents, teachers and students in Tanzania? Secondly, what is the position of SRE in the Tanzanian national school policy and curriculum? Thirdly, what are the structural barriers to the development and delivery of school-based SRE in Tanzania?

Specifically, the research was guided by the following five questions:

1. What are the attitudes of Tanzanian parents, teachers and students towards the provision of SRE in schools? More specifically:
    a. which topics do parents, teachers and young people think should constitute the school-based SRE curriculum?
    b. what do parents, teachers and young people think are the appropriate grade levels to introduce SRE in schools?
    c. what constraints do parents, teachers and young people as well as school policy makers think affect the provision of school-based SRE in Tanzania?
2. Is there a difference in the attitudes towards school-based SRE between parents, teachers and young people in rural and urban settings?
3. How are social demographic factors such as age, sex and religion associated with attitudes towards school-based SRE?
4. What is the status and place of SRE in the national school policy and curriculum?
5. What are the needs and preferences of young people regarding sexual health that should be reflected and included in a school-based SRE programme?

1.4 Structure of the thesis

The thesis is organised into nine chapters that are outlined below:

Chapter 1, General Introduction, provides the background to the research as well as the objectives and research questions. The chapter also presents the theoretical foundation from which the formulation of the research objectives and questions was based.

Chapter 2 reviews the literature on the nature, impact, rationale and support for school-based SRE. It is clear from this review that, if given a chance, school-based SRE can help young people to delay the onset of sexual intercourse and protect themselves when they become sexually active. The review also reveals a variation in the level of support for SRE among key players, such as parents, teachers and students in different countries. However, a comprehensive picture on the views and attitudes of parents, teachers and students in sub-Saharan Africa is lacking as little research has been done in this area in the region.

Chapter 3 provides an overview of young people's sexual health in Tanzania. The chapter begins by defining the key terms used in the study of sexual health, including sexuality, sexual health and young people. The chapter then reviews

literature related to the trend in young people's risk taking sexual behaviours, such as the timing of sexual debut, the level of protection and the nature of sexual partnerships. The chapter further examines the reasons for young people's risk taking sexual behaviours and their implications for SRE programme development.

Chapter 4 presents the research design and methods that guided the selection and development of the instruments used to gather the data that were used to address the research questions. The chapter begins by explaining the theoretical basis for adopting a mixed methods approach in this research. This is followed by a description of the methods used to collect data as well as the techniques employed for selecting research sites and participants.

Chapters 5, 6 and *7* present and discuss the results of survey and focus group studies that examined the views and attitudes of parents, teachers and students regarding the provision of school-based SRE.

Chapter 8 is a review of the position of SRE in the national school curriculum. The chapter begins by drawing up a list of SRE related topics from the national school curriculum and then discusses the implications of these topics for a comprehensive SRE programme in schools.

Chapter 9 is the last chapter in the thesis; it provides a summary and synthesis of the key issues emerging from the research and draws the conclusions and recommendations for the thesis.

Chapter 2

Review of Literature on the Nature, Impact and Support for School-Based Sex and Relationships Education

2.1 Introduction

In Tanzania and sub-Saharan Africa in general, very little research has been conducted in the area of sex and relationships education (SRE) and, as such, little is known about the development and implementation of SRE programmes. There are, however, numerous studies elsewhere, particularly in Europe and North America, which have examined various aspects of SRE. This chapter reviews some of the key aspects of SRE that are relevant to the research aims, including the meaning of SRE, goals of SRE, forms of SRE, characteristics of effective SRE programmes and rationale and support for school-based SRE.

2.2 The meaning and goals of SRE

2.2.1 The meaning of SRE

Sex and relationships education (SRE) has always been a complex and controversial subject (McKay, 1999). Two controversies regarding the definition of this subject are particularly notable. The first controversy is the fact that there is no settled or agreed nomenclature for it; different names have been used in different countries. The name *sex and relationships education* as used in this thesis is more applicable to the United Kingdom than other countries. Other countries use different names, such as sexuality education (United States), sex education (Netherlands) and sexual health education (Canada). In Tanzania, several names have been used depending on the health concerns of young people at a particular period of time. These include, for example, sexuality education, sex education, parenthood education and family life education (FLE). Recently, owing to the growing concerns about the upward trend of HIV infection and other sexually transmitted infections among young people, sexuality and HIV/AIDS education has been adopted, with the implication that educational programmes on sexuality are now more focused on HIV/AIDS prevention than other aspects of sexual health.

Generally, the type of the name assigned to education about sex and relationships has implication in its content. Stone and Ingham (2006) have argued, for

example, that a course entitled *sex and relationships education* may be more comprehensive than a course entitled *family life education,* which tends to focus more on reproductive matters than other aspects of sexual health.

The second controversy about SRE is the fact that there is no universally acceptable definition of SRE (Harrison, 2000); there is only a collection of definitions. For example, SRE has been defined as:

> "lifelong learning about physical, moral and emotional development. It is about the understanding of the importance of marriage for family life, stable and loving relationships, respect, love and care. It is also about the teaching of sex, sexuality and sexual health". (UK Department for Education and Employment (DfEE, 2000, p. 5).
>
> "[education that] provides an understanding that positive, caring environments are essential for the development of good self-image and that individuals are in charge of and responsible for their own bodies. It provides knowledge about the processes of reproduction and the nature of sexuality and relationships. It encourages the acquisition of skills and attitudes which allow pupils to manage their relationships in a responsible and healthy manner". (National Curriculum Council, 1990, quoted in Mullinar, 1994, p.10).
>
> "a lifelong process of acquiring information and forming attitudes and beliefs and values about sexual identity, relationships and intimacy. It involves much more than teaching children about reproduction. It must include a real understanding of sexuality in its broadest terms (Lenderyou, 1993, p.10).
>
> "lifelong learning about sex, sexuality, emotions, relationships and sexual health. It involves acquiring information, developing skills and forming positive attitudes and values" (Sex Education Forum, 1999, p.1).
>
> "a lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships, and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles. Sexuality education addresses the biological, sociocultural, psychological, and spiritual dimensions of sexuality from 1) the cognitive domain, 2) the affective domain, 3) the behavioural domain, including the skills to communicate effectively and make responsible decisions" (Bruess & Greenberg, 2004,p.19).

Despite the many definitions of SRE, there are common elements that characterise most SRE programmes. Stone and Ingham (2006), for example, have suggested that, as a minimum, SRE programmes should reflect three major dimensions; namely, facts and information, relationships and interpersonal skills and values and attitudes. According to Stone and Ingham, the first dimension, *facts and information*, involves learning about the biological facts concerning the conception,

growth and development of a human being. It also involves learning about basic facts of sexual health, including the avoidance of sexual health problems such as unplanned pregnancy and sexually transmitted infections (STIs) and HIV/AIDS as well as negative psychological consequences of sexual activity.

Stone and Ingham characterise the r*elationships and interpersonal skills* dimension as involving learning to manage emotions and relationships confidently and sensitively as well as developing self-respect and empathy for others. It also involves developing decision making, critical thinking and conflict management skills as well as developing an appreciation of the consequences of decisions made.
The third dimension, v*alues and attitudes,* involves learning the importance of individual, family and societal values and moral considerations as well as understanding of moral dilemmas. This dimension can also involve learning the values of family life, marriage and stable and loving relationships as crucial environments for the growth and development of children and continuity of society.

2.2.2 Goals of SRE

It is clear, on the basis of the definitions and dimensions of SRE highlighted above, that the goals of SRE may vary from one context to another. The Canadian Guidelines for Sexual Health Education (Health Canada, 2003), for example, stipulate that the learning of SRE should involve a combination of education experiences that will enable young people to acquire knowledge about specific sexual health issues, develop the motivation and personal insight necessary to act on this knowledge, acquire the skills they need to maintain and enhance sexual health and avoid sexual health problems and help create an environment that is conducive to achieving sexual health.

In the United States, SRE is designed to help young people to: "be prepared for puberty and adolescent changes, appreciate that life changes are normal, recognise their own bodies as good, beautiful and private, learn to make decisions that take into account possible consequences and understand the place of sexuality in human life" (Bruess & Greenberg, 2004, p.16). Bruess and Greenberg have identified four main goals of comprehensive SRE. These are, first, to develop knowledge and understanding about and adequate preparation for the bodily changes that are taking place, including the onset of menstruation in girls and first ejaculation in boys. According to Bruess and Greenberg, young people need to develop adequate

knowledge of the bodily changes that take place so that they can prepare for these changes and welcome them and learn how to adjust to them. Second, to provide accurate and basic information about human sexuality, including growth and development, human reproduction, anatomy, physiology, masturbation, family life, pregnancy, childbirth, parenthood, sexual response, sexual orientation, contraception, abortion, sexual abuse and HIV/AIDS and other sexually transmitted infections.

Third, SRE provides an opportunity for young people to develop and understand their values, attitudes and beliefs about sexuality. Young people should be provided with the opportunity to question, explore and assess their sexual attitudes in order to understand their families' and societal attitudes, develop their own values, increase self-esteem and develop insights concerning relationships with others and understand their obligation and responsibilities to their families and society. Fourth, SRE aims to help young people develop relationships and interpersonal skills. To this end, according to Bruess and Greenberg, SRE programmes should help young people develop interpersonal skills such as communication, decision making, assertiveness and peer refusal skills. SRE programmes should also help young people to develop the ability to create satisfying relationships including caring, supportive, non-coercive and mutually pleasurable relationships.

According to Chilman (1990), a key goal of SRE should be to enable young people to understand and appreciate their sexuality. She argues that SRE should enable young people to appreciate the fact that their sexuality is not a thing apart, but an integral part of their total lives. As such, Chilman argues, SRE should enable young people to accept their own sexual desires as natural, but to be acted upon with a constraint that takes into account their own values and goals as well as those of significant others and the society in which they live. In this context, Chilman contends, SRE should not be seen as promoting complete freedom for young people to behave as they wish as long as contraceptives, including condoms, are used and so long as this behaviour is in private with consenting partners. Chilman challenges any form of SRE that promotes the notion that "recreational sex is fine so long as it doesn't become procreational sex" (p.124).

In addition to the above goals, given that teenage pregnancy and HIV/AIDS continue to pose a major threat to many countries worldwide, SRE should aim at helping young people avoid unwanted pregnancy as well as prevent them from HIV/AIDS and other sexually transmitted infections. SRE programmes should,

therefore, include adolescent pregnancy and HIV/AIDS prevention, both through the teaching of responsible sexual behaviours, including helping young people delay sexual intercourse until they have the cognitive and emotional maturity necessary to establishing stable relationships, and by teaching basic facts and skills about condom use, contraception and birth control, as key components.

To sum up, as a minimum, SRE aims to facilitate young people's ability to develop and maintain a healthy, satisfying and responsible sexuality (McKay, 1999). Essentially, therefore, the fundamental goal of SRE is to facilitate young people to make and carry out informed decisions about their sexual health. In order to achieve this goal, according to Reiss (1993), a comprehensive SRE programme needs to equip young people with three fundamental aspects of sexual health; namely, "relevant information, a valid and appropriate ethical framework and the skills necessary to translate a decision into action" (p.130).

The ethical aspect of SRE implies that the content and shape of SRE programmes are necessarily shaped by the social-cultural contexts in which such programmes are implemented. Additionally, as argued by Reiss, the goals of SRE are dependent on and shaped by the health needs and concerns of the society in a given time. For example, since the advent of the AIDS epidemic in the 1980s, SRE programmes in sub-Saharan Africa, a region most hit by the AIDS scourge, have been driven by the need to reduce the incidence of HIV infection among young people. Similarly, reducing the incidence of teenage pregnancy has been at the heart of SRE programmes in the UK and USA; this is partly because these countries have the highest rates of teenage pregnancies compared to other countries in the developed world.

2.3 The Impact of school-based SRE programmes on young people's sexual health.

Several studies have demonstrated that school-based SRE programmes that have been evaluated have shown consistent short term effects on improving young people's knowledge, attitudes and skills about various aspects of sexuality, as well as long-term effects on enabling young people to change risky sexual behaviours that are commonly associated with sexual health problems. Generally, evidence has systematically demystified a popular belief that SRE leads to earlier or increased sexual activity in young people (Wellings, Wadsworth, Johnson, Field & Whitaker,

1995). On the contrary, evidence suggests that a well designed and executed school based SRE programme can be effective in changing young people's sexual behaviours that lead to sexual health problems, such as HIV/AIDS and other sexually transmitted infections as well as teenage pregnancy (Kirby, 2002; Parker, 2001; Singh, Bankole & Woog, 2005). Furthermore, school-based SRE has also been widely acknowledged as one of the most effective ways to prepare young people for responsible adult life and to enable them to enhance sexual health (Aggleton & Warwick, 2002).

Grunseit, Kippax, Aggleton, Baldo and Slutkin (1997) reviewed 52 evaluation reports on the impact of SRE programmes on young people's sexual behaviours in the United States and Europe. They found that most of these programmes (with the exception of three programmes) were associated with delayed initiation of sexual intercourse for young people who were not yet sexually active. Furthermore, Grunseit et al. found that the SRE programmes they studied led to responsible and safer sex practices for young people who were already sexually active.

Kirby (2001) also reviewed several studies published in peer reviewed journals that evaluated the impact of school- based SRE programmes targeting young people aged 12-18 in the United States. Kirby reached a similar conclusion that, if given the chance, these programmes have sustained positive effects on delaying the onset of sexual intercourse and in increasing the effective and consistent condom and contraception use in young people.

Few of the SRE programmes implemented in the sub- Saharan African region have been subjected to rigorous evaluation; as such, their impact in changing young people's risky sexual behaviours and in reducing HIV infection rates remains largely unknown (Kaaya, Mukoma, Flisher & Klepp, 2002; Speizer et al., 2003; Gallant & Maticka-Tyndale, 2004). However, studies have shown that the few evaluated SRE programmes in sub-Saharan Africa and other developing countries have had similar results to those in the developed countries. For example, a review of the impact of 83 evaluated SRE programmes on reducing young people's risky sexual behaviours in both developed and developing countries, including Tanzania, found that a large majority of SRE programmes led to a delay in the onset of sexual activity for young people who were not yet sexually active and increased contraception uptake and condom use among sexually active young people (Kirby, Laris & Rolleri, 2005). Furthermore, the Kirby et al. review showed, contrary to popular belief that SRE fuels promiscuity, that SRE programmes did not lead to increased frequency of sex;

instead, they found that a significant percentage of SRE programmes surveyed reduced the frequency of sex and the number of sexual partners.

Gallant and Maticka-Tyndale (2004) also reviewed 11 published school-based HIV/AIDS risk reduction programmes for young people based in Africa; they established that SRE programmes had impact in delaying onset of sexual activities and reducing the number of sexual partners.

Apart from changing young people's sexual behaviours, SRE programmes have been found to be effective in increasing knowledge and influencing positive attitudes about sexuality. Klepp, Ndeki, Leshabari, Hannan and Lyimo (1997) evaluated an AIDS education programme which was implemented in Northern Tanzania using a randomised controlled trial; they revealed that students in the intervention group scored higher on AIDS knowledge and demonstrated more positive attitudes towards people with HIV/AIDS compared to those in the control group. Additionally, the evaluation also showed that the AIDS education programme in Tanzania had an effect in facilitating discussions about sexuality matters between parents and children.

It is clear from the foregoing discussion that, if they find their way into the school systems, SRE programmes can be instrumental in addressing the problem of HIV/AIDS, teenage pregnancy and other sexual health problems among young people in sub-Saharan Africa. However, it should be noted that, whereas a majority of evaluated SRE programmes have been successful in changing risky sexual behaviours in young people, not all of them have had direct impact on reducing the incidences of HIV infection and teenage pregnancy. For example, a randomised controlled trial evaluation of *Mema kwa Vijana* Programme in Tanzania showed that, whilst the programme decreased the number of reported sexual partners and increased reported condom use, it did not have any impact on biological markers with respect to HIV/AIDS, other sexually transmitted infections and pregnancy (Plummer et al., 2007). This implies that SRE alone may not be effective in having direct impact on sexual health problems; it therefore needs to be integrated with other health provision strategies that may be available in the community, such as youth friendly sexual and reproductive health services provision programmes.

2.4 Characteristics of effective SRE programmes

Various studies have identified different sets of criteria for assessing the effectiveness of SRE programmes depending on the context in which they were undertaken. Aggleton and Warwick (2002) have identified four principles that are associated with effective SRE programmes. First, SRE programme development needs to forge a strong partnership with young people. This enables sharing of ideas and responsibility between developers and young people and among young people themselves. Aggleton and Warwick have argued that involvement of young people in SRE programme development and implementation facilitates awareness at earlier stages and builds on their strengths.

The second principle requires that positive community values should find their way into the SRE curriculum, whilst avoiding the negative values that may impede the effective delivery of SRE. This means that SRE programme developers need to identify the positive community values that are sexual health promoting and, as far as possible, integrate them in the SRE curriculum. As a third principle, programmes need to devise mechanisms to support adults in communicating with young people about sexuality. This enables young people to benefit from both training and experiential learning. The final principle calls for the need for planning for sustainability, basing on the local needs and capacity. This need is particularly important in the African context where most of the SRE programmes, hitherto, have heavily depended upon external donors for financial support.

Recently, Kirby et al.(2005), based on the findings of their review of 83 SRE programmes in both developed and developing countries, have identified 17 characteristics of effective SRE programmes. They have categorised these characteristics into three major groups, which are *curriculum development*, *curriculum content* and *curriculum implementation*. For curriculum development, they propose that the SRE programme development process should involve different people with various backgrounds. Additionally, programme development should have a theoretical orientation with specific health goals, behaviours that affect the goals, protective and risk factors behind these behaviours and the activities addressing these risk and protective factors. Furthermore, according to Kirby et al. (2005), the programme activities should be consistent with community values and relevant to the needs of the target group. Finally, the programme should be pilot tested before being implemented on a wider scale.

As for the content of the curriculum, Kirby et al. proposed that programme developers should create a safe environment for the participation of young people and that programmes should focus on clear goals of preventing sexual health problems, including HIV/AIDS, STIs and unplanned pregnancy. Furthermore, programmes should focus on changing specific risky sexual behaviours that would otherwise lead to sexual health problems. Kirby et al. have argued further that programmes should employ a myriad of participatory instructional strategies and messages which are appropriate and relevant to the learners' social-cultural environment as well as developmental level.

Regarding the implementation of the curriculum, Kirby et al. proposed four specific characteristics. First, programme developers should select deliverers with positive attitudes towards teaching SRE and train them about a wide range of SRE topics and teaching strategies. Second, programme developers should ensure that they get the support of appropriate authorities, such as ministries of health and education, school administrators and other gate keepers, such as parents and religious organisations. Third, programmes should endeavour to involve and overcome the barriers to young people's participation in the learning process, and fourth, all programme activities should be implemented as designed.

Clearly, the characteristics of effective SRE programmes identified by Kirby et al. (2005) are useful and, therefore, need to be taken into account in the development and implementation of such programmes. However, these should not be regarded as hard and fast rules. As observed by Gallant and Maticka-Tyndale (2004), some of these characteristics may not apply in some contexts. In the context of the HIV/AIDS pandemic in sub-Saharan Africa, for example, Gallant and Maticka-Tyndale have observed that many intervention programmes in these countries were developed without explicitly employing any theoretical orientation, and yet they were as effective in changing young people's sexual behaviours as those studied by Kirby et al. (2005). Furthermore, as argued by Tortolero et al. (2005), the Kirby et al. framework is a fairly complex process that may require its users to have a relatively sound academic exposure in certain disciplines and theoretical underpinnings. This may particularly prove difficulty for HIV/AIDS interventionists in the sub-Saharan African countries whose theoretical and academic background in programme development may be limited.

It is important to emphasise that SRE programmes should view young people as integral members of the community in which they live. As such, apart from aiming to change individual risky sexual behaviours, SRE programmes should also endeavour to address the psychosocial-structural factors that facilitate these behaviours. Therefore, as a key characteristic of effective planning, SRE programme developers should endeavour to undertake a thorough situation analysis of the contextual settings to identify the psychosocial-structural factors that may facilitate or impede the implementation of SRE programmes.

2.5 Approaches to SRE for young people

According to McKay (1999), school-based SRE programmes are generally based on two major sexual ideological premises about the nature of human sexuality and how it should be expressed; namely, "restrictive sexual ideology and permissive sexual ideology" (p.33). Proponents of a restrictive sexual ideology, McKay observes, advocate for an abstinence-only approach to school-based SRE. McKay has also observed that proponents of the restrictive ideology want SRE in schools to focus exclusively on persuading young people to refrain from any type of sexual activity until marriage.

Essentially, abstinence-only SRE programmes aim to prevent teenage pregnancy and sexually transmitted diseases, including HIV/AIDS, by promoting abstinence until marriage and they generally exclude or disparage information about condoms and other methods of contraception (Daria &Campbell, 2004). The abstinence-based SRE programmes tend to use fear-based approach as a strategy to discourage young people's sexual behaviours. Contenders of abstinence-based SRE argue that teaching young people about sex will make them want to try it, and this will increase their risk of HIV infection and other sexual health problems (Sex Education Forum, 2003).

In contrast, proponents of a permissive sexual ideology favour a comprehensive approach to SRE. The comprehensive SRE approach presents abstinence as one possible choice, but recognises that many young people may be sexually active already. Consequently, an essential feature of comprehensive SRE programmes is the provision of information about condoms and other methods of contraception and strategies for decision making (Landry, Kaeser & Richards, 1999). Proponents of the comprehensive SRE approach argue that, whilst abstaining is

clearly a good idea and should be encouraged as far as possible, there will always be some young men and women who will not choose to abstain or who have little choice due to coercion; these people deserve to be provided with information that will enable them to protect themselves against sexual health problems that may ensue should they decide to have sexual relations.

Yarber (1994) has provided the following summary on regarding the features of the comprehensive approach to SRE:

> An important and typical tenet of this [comprehensive] approach is that sexuality education should prepare adolescents for the healthy expression of their sexuality instead of focusing only on the prevention of negative consequences. The comprehensive approach not only deals with traditional areas such as reproductive biology and puberty, dating, marriage and STD, but also covers many topics historically considered inappropriate, such as sexual pleasure, noncoital sexual expression, sexuality and society, and homosexuality. This approach affirms the positiveness of sexuality while striving to prevent inappropriate sexual sharing and unprotected coitus (cited in McKay, 1999, p.64).

Another approach, which has recently gained prominence in the field of SRE, is values clarification. According to values clarification theory, many of the problems affecting young people are caused by a lack of a firm basis of appropriate morals and values. They argue that "[young] people who lack values tend to be flighty, apathetic, uncertain, inconsistent, drifting, overconforming and overdissenting" (McKay, 1999, pp. 83-84). On the other hand, McKay argues, those who develop a clear sense of what their values are tend to be "positive, purposeful, enthusiastic, proud and consistent" (p.84).

The values clarification process involves the following seven steps: "choosing freely; choosing from alternatives; choosing after consideration of the consequences; prizing and cherishing; affirming; acting upon choices; and repeating" (Raths et al., 1978, cited in McKay, 1999, p.84).

Proponents of this approach argue that values clarification should be integrated into SRE so as to make it (SRE) *value- neutral* but not necessarily *value-free* as, according to Harrison (2000), "teaching is not, and cannot be, a value free activity" (p. 32). In this context, the role of school-based SRE should be to encourage decision making in young people by facilitating them to clarify their own values and reflect on traditional values of the society in which they are a part (op.cit.). According to Harrison, the role of teachers, in facilitating values clarification, should be to

expose, rather than impose, students to and facilitate an understanding of a wide range of shared values in their society.

The effectiveness of the approaches to SRE presented above is an issue that sparks debate. However, empirical evidence has consistently shown that well planned and executed comprehensive SRE programmes are far more effective than abstinence only SRE programmes. Studies have revealed that comprehensive SRE programmes enable young people to delay sexual activity and, when they do decide to have sexual intercourse, they are more likely to use protection (Wellings, Wadsworth, Johnson, Field & Whitaker, 1995; Kirby, 2002b; Save the Children, 2002). For example, recently, using data from the U.S National Survey of Family Growth, Kohler, Manhart and Lafferty (2008) examined the effect of abstinence- only and comprehensive sex education programmes on the initiation of sexual activity and teen pregnancy. They revealed that young people who received comprehensive sex education had a lower risk of sexual activity or pregnancy than those who either received abstinence- only education or no sex education.

Unlike the comprehensive SRE approach, evidence has shown that abstinence-only SRE programmes have no effect on either delaying sexual activity or reducing pregnancy (Kirby, 2001; NHS Centre for Reviews and Dissemination, 1997). Another weakness of the abstinence-only-SRE programmes is that they may contain false or misleading information. A report of a review study in the USA, where abstinence-only-SRE approach has increasingly become popular in the recent years, revealed that over 80 percent of abstinence-based curricula used in the Special Programmes of Regional and National Significance Community- Based Education (SPRANS) contained false or misleading information about sexuality (United States House of Representatives Committee on Government Reform, 2004). The report observed, for example, that the abstinence-only-curricula contained false information about the effectiveness of contraceptives by teaching young people that "the actual ability of condoms to prevent the transmission of HIV/AIDS even if the product is intact is not definitely known" (p. 9). However, it has been well established that, if used effectively and consistently, the efficiency of condoms in preventing HIV transmission and pregnancy is more than 90 percent (Crosby et al., 2002; Hearst & Chen, 2004).

The debate about whether SRE programmes should be comprehensive or abstinence-based has taken a narrow view. Proponents of both comprehensive and

abstinence-based SRE programme see SRE from an instrumentalist point of view. A great deal of research has thus tended to demonstrate the value of SRE in so far as promotion of sexual health and prevention of sexual health problems among young people are concerned. But SRE should be seen as an important aspect of human beings and society and therefore young people deserve to have it as their right. Thus SRE should not necessarily only be justified in terms of it being an instrument for the prevention of sexual health problems. In addition to these valuable goals, there is need to promote SRE as a 'good-in-itself' value just like other values that the society strives to achieve, such as democracy, human rights and equality. Indeed, the World Health Organization (WHO) [2006] has proclaimed that since sexual health is an integral component of health, which is a fundamental human right, it should be regarded as a basic human right. It is, therefore, reasonable to argue that the denial of the opportunity of the access to SRE is "tantamount to a violation of this human right" (McKay, 1999, p.28).

2.6 Rationale for school-based SRE

A number of sources of providing sex and relationships education (SRE), both formal and informal, are possible. At a formal level, for example, SRE can be delivered through schools, colleges, universities, health care settings, public health and education programmes as well as non-governmental and religious organisations. At an informal level, peer groups, parents and other care givers and the media can be instrumental in delivering SRE.

School-based SRE has been widely acknowledged as one of the most effective ways of transmitting health related knowledge and enabling young people to adopt healthy lifestyles and avoid risky behaviours. Several reasons have been given in favour of school-based SRE. Firstly, school-based programmes are, in principle, relatively easy to organise because schools are the only place that have the potential to reach the large majority of young people in a sustainable way (UNESCO, 2003). Secondly, schools are equipped with resources such as trained teachers and teaching and learning facilities which offer a logical opportunity for providing appropriate SRE in a professional and a non-threatening atmosphere (Donovan, 1998; Bruess & Greenberg, 2004). Thirdly, schools have direct interaction with communities; they therefore offer an opportunity to integrate SRE programmes with other health programmes. SRE programmes are more successful in promoting sexual health and in

preventing risky sexual behaviours if they are integrated with family and community efforts than if schools try to do it alone (Hall, Holmqvist & Sherry, 2004).

Fourthly, studies have shown that SRE works effectively if it is provided before young people mature physically, emotionally and intellectually and before they establish patterns of sexual behaviour (Gallant & Maticka-Tyndale, 2004; Grunseit et al., 1997). Furthermore, it has been argued that many risky sexual behaviours that jeopardise sexual health in adult life are formed early in life during childhood and adolescence (Wells, 1992; Madise, Zulu & Ciera, 2007). It is therefore arguably easier to prevent risky sexual behaviours before they are formed than to try to change them after they have been formed (Hall et al., 2004). It follows that because a majority of young people in schools are in the process of development and are not yet sexually experienced, schools present an opportunity for introducing SRE programmes that could help them avoid risky sexual behaviours and the associated health consequences. Additionally, although half of new HIV infections occur in young people aged 15 to 24, prevalence rates are lowest among those aged 5 to 14 (UNAIDS, 2005). Thus teaching young people about SRE at an early age presents a 'window of hope' for preventing the spread of HIV and sexually transmitted infections (World Bank, 2002).

Fifthly, and perhaps most importantly, studies have shown that when young people are provided with information about sexuality from school, they tend to adopt positive sexual health behaviours compared to those who receive such information from other sources (Mueller, Gavin & Kulkarni, 2008; Wellings et al., 2001). For example, in their study of heterosexual sexual behaviours among young people in Britain, Wellings et al. found that early intercourse and non-use of contraception were more common among young people whose main source of information about sex was not lessons at school. This provides compelling evidence and therefore a fertile ground to argue for school-based SRE.

Despite well established evidence regarding the appropriateness of schools as channels for providing SRE, there are practical challenges that need to be observed. Indeed, DiClemente (2001) has cautioned that, although schools provide a valuable avenue for effective providing SRE, their importance should not be exaggerated as there are obvious challenges associated with using them as settings for implementing SRE programmes. These challenges include, for example, firstly, the fact that not all teachers may be willing, prepared or competent to teach SRE, especially topics related

to attitudes and values. Studies have shown that many teachers have always expressed feelings of un-preparedness in teaching topics related to SRE in the classroom situation (Donovan, 1998). This means that teachers may require special training if they are to be able to handle SRE classes effectively and efficiently; this will certainly require additional financial resources which may not be available, especially in poorer countries such as those in sub-Saharan Africa.

Secondly, despite the universal declaration for primary education, school enrolment and attendance rates are still low in many countries in sub-Saharan Africa. For example, in Tanzania, the Government report on poverty and human development for 2005 revealed that in 20 districts, the net primary school enrolment rate was less than 80 percent (United Republic of Tanzania, 2005a). This means that school-based SRE may not be accessible to all children of school-age, at least, as noted earlier, in poorer countries.

Thirdly, there is the issue of time and space for SRE in the school curriculum. In many countries most aspects of SRE are not part of the school curriculum. As such, finding time and space in the curriculum to deal adequately with SRE issues may be problematic, especially if SRE topics are not examinable (Ingham, 1993). Fourthly, because of the variability in the social-cultural constraints within a country, it is not easy to have a uniformly implemented SRE programme. Studies have shown that in many countries the most critical aspects of SRE are not part of the national curriculum; only the biological aspects related to reproduction and those associated with the prevention of HIV and other STIs are included (DiClemente, 2001). Furthermore, Hudson (1999) has observed that the demand for the mainstream subjects, in the UK, for example, has naturally marginalised SRE.

The preceding challenges regarding the use of schools as settings for implementing SRE point to the fact that school-based SRE programme alone may not be sufficient in promoting young people's sexual health and in protecting them against sexual health problems. There is therefore need to stress the importance of continuing to deliver SRE through other channels such as mass media alongside schools. Additionally, as argued by Bailey (2006), for school-based SRE programmes to be effective, they need to be integrated with other health provision services in the community.

2.7 Support for school-based SRE among parents, teachers and young people

As noted earlier, despite the strong evidence that illustrates its benefits in protecting young people against HIV/AIDS and other sexual health problems, school-based SRE remains a controversial subject that sparks public debate in many countries. The controversy surrounding school-based SRE is partly caused by lack of consensus among key stakeholders in the education sector regarding *what* should constitute SRE, *when* and *how* it should be taught, *who* should teach it and *where* it should be delivered (Fuglesang, 1997; Weaver et al., 2002; Westwood & Mullan, 2006). Many writers have underscored the need to explore, in the process of planning and developing such programmes, the extent of support among the various stakeholders, including parents, teachers and school policy makers, as well as the various ways in which the views and attitudes of these stakeholders facilitate or constrain the provision of SRE in schools (Carrera & Ingham, 1997; Singh, Bankole & Woog, 2005). Indeed, it has been argued that school-based health promotion programmes which do not take into consideration the opinions and attitudes of key stakeholders and policy and cultural contexts are doomed (Schaalma, Abraham, Gillmore & Kok, 2004). It has also been argued that the consultation process with key stakeholders is important in making the SRE programmes acceptable and relevant to the social and environmental contexts in which they are going to be implemented (Schaalma et al., 2004).

The section that follows reviews some of the literature about the support for school-based SRE among parents, teachers and young people, who are clearly the key stakeholders of the education sector in many countries (Blinn-Pike, Berger & Rea-Holloway, 2000). As observed by Mullinar (1994), consulting parents, teachers and young people on their views about school-based SRE is essential to identify the issues to be included in the SRE curriculum as well as its delivery mode. The review on the support for school-based SRE is presented in three sub-sections, covering parents' views and attitudes, teachers' views and attitudes and young people's views and attitudes.

2.7.1 Parents' views and attitudes towards school-based SRE

Studies investigating parents' views and attitudes towards school-based SRE have shown a consistent trend in which parents generally support the provision of SRE in schools. For example, a survey conducted by Weaver et al. (2002) in New

Brunswick, Canada, revealed that 94 percent of the responding parents supported the provision of SRE in schools, even though they did not share a common vision of the nature, content and timing of an ideal SRE curriculum. In their study, Weaver et al. found that 97 percent of parents wanted SRE to begin in elementary or middle school or ages 10-13. In this study, parents ranked the following topics as extremely important: *personal safety, abstinence, puberty, sexual decision-making* and *reproduction*. Ten percent of parents in this study wanted certain topics to be excluded from the SRE curriculum, including wet dreams, sexuality in the media, masturbation, sex as part of a loving relationships, homosexuality, sexual behaviour, teenage prostitution, sexual problems and concerns, pornography and sexual pleasure and orgasm.

In the UK, studies conducted both before and after the HIV pandemic have also shown a consistent trend of parents' support for school-based SRE. For example, a survey of parents' views in England reported that the majority of parents supported the provision of SRE in schools (Farrell and Kellaher, 1978). This study also showed that, as much as parents felt that they had the responsibility of educating their children about sex, a great majority of them did not actually undertake this responsibility for a variety of reasons, including difficulty and embarrassment in communicating about sex. Farrell and Kellaher reported that, whereas about 90 percent and 60 percent of parents felt that they should be involved in talking to their children about reproduction and sexual intercourse respectively, less than 50 percent of them had discussed with their children about reproduction and only about 25 percent had discussed about sexual intercourse. When asked about the ways for young people to learn about sex, about 51 percent of parents thought that the best way to learn about sex was through lessons at school.

Allen (1987) also examined the views and attitudes of parents about the teaching of SRE in schools in three cities in England. Allen reported that 96 percent of parents supported the provision of SRE in schools and that the majority of them thought that the schools were providing too little sex education to children. When parents were asked to rank the importance of topics in the SRE curriculum, the overwhelming majority of parents supported *not going with strangers* (over 90%), followed by *preparing young people for puberty* and *human reproduction* (80%). *Sexual intercourse* and *contraception* were favoured by less than 50 percent in Allen's study. Ingham (1993) also reports that 96 percent of parents in the UK expect schools

to provide SRE to their children, and that a majority of them feel unequipped to discuss with their children matters pertaining to sex.

In another study in the UK, Ingham (1998) explored parents' thoughts and opinions about a wide range of issues related to SRE, such as responsibility for teaching SRE and their concerns about school-based SRE. Ingham found that parents thought that both the school and parents should take the leading role in teaching children about various SRE topics. Only a few of the parents (less than 10 percent) thought that teaching of SRE was the school's sole responsibility. Like Farrell and Kellaher's (1978) study, Ingham's findings revealed a clear gap between what parents think and what they actually do regarding discussing about sex with their children. For example, while 91 percent of parents thought that they should take a major role in teaching young people about HIV/AIDS, 62 percent had actually discussed with their children just 'more than little' about this subject. Regarding the age at which to introduce SRE topics, Ingham's study revealed that parents preferred eight topics to be covered at the earliest age in secondary schools (ages 11-13). These were: *sexual abuse/rape, HIV/AIDS, how to say 'No', contraception, religious and moral values, homosexuality, abortion, the role of emotions* and *discussing contraception with partner*.

In their review of literature concerning, among other issues, parents' and teachers' views and the role of schools regarding SRE provision, Carrera and Ingham (1997) found that, in various studies, the majority of parents felt that the school was a crucial source of information and the safest place to discuss matters pertaining to sex. Carrera and Ingham also revealed that the majority of parents wanted their children to be fully informed about sexual risks and to be taught a wide range of SRE issues, including knowledge of protection against HIV/AIDS and early and unwanted sexual activity.

Studies in the USA have revealed similar trends regarding support for the teaching of school-based SRE as those conducted in the UK. A study conducted by the Sexuality Information and Education Council of the United States (SIECUS) in 2004, regarding public support for comprehensive SRE among US parents and voters in four states, showed that about 93 percent of parents of junior high school students believe that it is *very* or *somewhat important* to have SRE as part of the school curriculum. The study revealed further that 77 percent of parents of junior high school students and 72 percent of parents of high school students believe that SRE is *very* or

somewhat effective in helping young people avoid sexual health problems, particularly HIV/AIDS and other sexually transmitted infections (STIs).

Regarding topics to be covered in the SRE curriculum, the SIECUS study revealed that parents supported a wide range of topics, including STIs and HIV/AIDS (98-100%); human reproduction (97-99%); birth control (93-95%); abortion (83-91%); how to use contraceptive methods (85-88%); masturbation (76-81%) and homosexuality and sexual orientation (73-80%).

There is a paucity of studies in sub-Saharan Africa in general, and in Tanzania in particular, that have investigated the views and attitudes of parents concerning the delivery of school-based SRE. Some of the few studies that have been done in this area have shown contradictory parental opinions about school-based SRE in different countries in the region. For example, a focus group study conducted by Mturi and Hennink (2005) in Lesotho reported that the majority of parents supported the provision of school-based SRE. Parents in this study reported that school-based SRE would be beneficial in overcoming the difficulties parents face in discussing sex with their children.

Conversely, another focus group study in Madagascar (Rabenoro, 2004) reported that parents were strikingly opposed to any form of SRE in schools. Rabenoro observed that parents' opposition to SRE is central to Madagascar's culture and attitude to sexuality education. Rabenoro reached the following conclusion about parents' attitude towards SRE in Madagascar:

> "The fact is that sex, including the question of partners both within and outside of marriage, is considered to be part of the Creator's plan for humans. So there is nothing to learn about it. But it is considered the duty of the parent of same sex to warn the children about the social implications of sexual activity" (p.6).

In another study, Orji and Esimai (2003) conducted a survey of 400 parents in one state in Nigeria regarding their attitudes towards school-based SRE. They found that 92 percent of the parents who completed the survey supported the introduction of SRE in schools believing that it would help young people to protect themselves from unwanted pregnancy and HIV infection.

The stark difference in parents' attitudes between the two African countries, Madagascar and Lesotho, as reported by Mturi and Hennink (2005) and Rabenoro (2004) using similar research methods-focus groups-point to the fact that Africa is not

an homogeneous region when it comes to parental attitudes towards SRE. Thus the results about parents' attitudes about school-based SRE from one country cannot be generalised and applied to another country. This, therefore, underscores the need for an understanding of parents' views in different social and environmental contexts.

2.7.2 Teachers' views and attitudes towards school-based SRE

Teachers are key to the success of the implementation of an effective school-based SRE programme (Boscarino & DiClemente, 1996). In some countries, teachers are perceived by young people as the most credible and trustworthy source of information about sexuality and stand high in the list of young people's preferences of SRE deliverers (Milton, 2003). Thus it is important to take into account teachers' views and attitudes in the SRE programme development and implementation.

Studies have shown that, although teachers in different countries generally support the teaching of SRE in schools, they encounter several obstacles. Firstly, teachers often express difficulties in teaching some of the topics related to SRE, including condom use, masturbation, sexual orientation, abortion and contraception (Donovan, 1998; Milton, 2003; Munodawafa, 1991; UNAIDS, 2005). Hudson (1999) has observed that most teachers have no problems delivering SRE that consists of biological facts, but they find it difficult facilitating topics related to psychological aspects of SRE, including discussion about young people's opinions, hopes, expectation and fears concerning relationships. A recent evaluation of the teacher training for AIDS prevention programme in South Africa revealed that teachers, like parents, expressed open resistance to the teaching of condom use on the grounds that condom promotion would encourage promiscuity (Ahmed et al., 2006).

Secondly, there are concerns that teachers find it difficult to move beyond didactic methods in their teaching of SRE; they particularly express difficulties in handling participatory facilitation skills that have been found to be effective in the teaching of SRE, such as discussions, group work and role plays (Buston, Wight, Hart & Scott, 2002).

Thirdly, teachers have expressed concerns that they do not receive enough support from their colleagues and parents when it comes to teaching SRE in schools. A study of teachers' views about teaching SRE in 17 secondary schools in one city in England found that teachers reported facing criticism and resentment from other staff and parents about having to teach SRE (Alldred, David & Smith, 2003). This means

that, without the support of fellow teachers and the community in general, most teachers may find it difficult teaching SRE to children.

It is clear therefore that, as much as teachers may support the teaching of SRE in schools, they may lack the knowledge, skills and confidence to handle SRE sessions in a classroom situation. Additionally, it has been observed that the training teachers receive in conventional teacher training colleges may be insufficient in so far as teaching of SRE is concerned (Vavrus, 2006; Csincsak, Bourdeaudhuij & Van Oost, 1994). There is, therefore, need to provide special training tailored to SRE if teachers are to handle SRE topics effectively and competently in the classroom. Furthermore, there is a need for a clear policy that supports the teaching of comprehensive SRE in schools as well as social support from colleagues and community members. The lack of a clear policy on SRE and social support from colleagues and parents, alongside overcrowded classrooms, have been observed as critical barriers to teachers' successful implementation of school-based SRE (Csincsak et al., 1994).

2.7.3 Young people's views and attitudes towards school-based SRE

For SRE programmes to be successful, the opinions of the receivers (learners) of that education have to be considered and acted upon (Hilton, 2003). It is thus important to examine and take on board young people's views in the development and implementation of sex and relationships education (SRE) programmes.

The literature shows that research on young people's views and attitudes about SRE have focused on various aspects, including sources of information about sexuality, content of SRE curriculum, age and class levels to introduce various SRE topics and preference of SRE deliverers. As is the case with parents, most of the work on this area has been done in the developed countries and there is little research that has been carried out in developing countries, particularly those in sub-Saharan Africa (Kaaya, Mukoma, Flisher & Klepp, 2002; Amuyunzu-Nyamongo, Biddlecom, Ouedraogo & Woog, 2005).

Studies in developed countries have shown that young people generally support the provision of school-based SRE. Indeed, young people in the USA have expressed dissatisfaction with the lack of depth of the SRE curriculum provided in schools. An analysis of public policy reports regarding students' opinions about the provision of SRE in schools in the United showed that a majority of the students

wanted more information than they had been receiving (Dailard, 2001). According to Dailard, students specifically report needing more information about a wide range of topics, including sexual abuse, sexual orientation, HIV testing, factual information about HIV/AIDS and other STIs, how to talk with a partner about birth control and STDs and how to handle pressure to have sex.

Over the years, studies carried out in the UK regarding young people's views about school-based SRE have revealed a strong dissatisfaction and criticism about the current SRE practice in schools. Young people's views about SRE in the UK schools have included such comments as: SRE in schools is too little and comes too late; is negatively and narrowly focused on prevention of pregnancy and HIV infection; has too many videos and little or no discussion, insufficient, incomprehensive and inconsistent sessions; little or no opportunity to talk or explore ideas or opinions and too large classes or groups (Farrell & Kellaher, 1978; Allen, 1987; Ingham, 1993; Clements, Ingham, Sadler & Diamond, 1999; Hudson, 1999; Save the Children, 2002; Reeves et al., 2006).

A recent UK Youth Parliament survey of 20,000 teenagers in England about SRE practice in schools revealed that a majority of young people are dissatisfied with the type of SRE they are being taught (Frean, 2007). Frean reports that more than half of the surveyed teenagers rated the teaching of SRE in schools as *poor, very poor* or *merely average*. Frean asserts that the poor teaching of SRE in schools in the UK has left a majority of the young people ignorant of the basic ways to avoid sexually transmitted infections and pregnancy.

As stated elsewhere in this thesis, there is a paucity of studies that have systematically investigated the views and attitudes of young people about school-based SRE in developing countries. The most recent study that has attempted to address this subject was conducted by Amuyunzu-Nyamongo et al. (2005). In this study, the authors used focus group discussions to elicit young people's views and perceptions about sexual and reproductive health. The sample of the study was drawn from young people in four African countries; namely, Burkina Faso, Ghana, Malawi and Uganda. The findings showed that young people generally express positive attitudes towards sex outside marriage and that a good number of them had had sexual relationships at younger ages. Although this study did not directly explore the young people's views and attitudes about SRE, the implications of the findings showed that young people in Africa, like their counterparts in developed countries, may well need

broad coverage of SRE curriculum as opposed to abstinence only. However, there is a need for a comprehensive study that would systematically explore African young people's views and attitudes regarding school-based SRE, taking into account the different social-cultural contexts that are a characteristic of the African continent.

Chapter 3
Overview of Young People's Sexual Health

3.1 Introduction

This chapter provides an overview of young people's sexual health in Tanzania and elsewhere. The chapter begins by situating the position of adolescence and adolescent sexuality in the human sexuality development. The chapter then addresses three related issues: trends in young people's sexual behaviours, their associated consequences and factors influencing these behaviours. The chapter concludes with a discussion on the implications of young people's sexual behaviours on SRE programme development.

3.2 Definition of terms

3.2.1 Young people, youth and adolescence

Many terms are used to describe individuals in the age group of between ten and twenty four years, including young people, adolescents, teenagers and youth. These terms are often ambiguous as they connote different meanings in different contexts. The term adolescence, for example, has been defined from biological and social-cultural perspectives. The biological perspective views adolescence as a period characterised by biological changes which are largely controlled by endocrine and nervous systems (Hurlock, 1980). The biological attribute in adolescence is also explained by the pubertal phenomenon, which is marked by the attainment of sexual maturity and reproductive capacity (Papalia, Olds & Feldman, 1999).

As a social-cultural phenomenon, society tends to define adolescence in terms of the social skills acquired by, and responsibilities assigned to, young people. In many societies, adolescence begins when children become sexually mature and ends when children become lawfully and economically independent. For example, in Tanzania, people can vote or join the military at age 18, and can marry without parents' permission at 18. However, age alone does not socially give someone an adult status. In Tanzania, for instance, many people at age 21 and above are still single, still in school and still dependent on their parents for economic survival (Omari & Mkumbo, 2006). They are thus adults in the eyes of the law, but are not yet self-sufficient or living on their own. This inevitably makes adolescence to be seen as

a transition period in which adolescents are seen as individuals who are no longer children, but they are not yet adults either (Heaven, 2001).

Many writers have observed that the term young people is heterogeneous and applicable to different cultural environments, whereas the meaning of other associated terms such as adolescence and youth is largely depended upon and influenced by cultural contexts (Dehne & Riedner, 2001; Aggleton & Campbell, 2000; Caldwell, Caldwell, Caldwell & Pieris., 1998). For this reason, in this thesis, the term *young people* is used throughout, and refers to individuals roughly between the ages of ten and twenty four. However, while reporting on other studies that have used other terms such as *adolescents* and *youth*, these terms are maintained and used interchangeably with the term *young people*.

3.2.2 Sexual health

The definition of sexual health has had a long, complex and evolving history signifying different things and meanings at different times (Giami, 2002). The first comprehensive definition of sexual health was issued by a task force of the World Health Organization (WHO) in 1975, which defined sexual health as "the integration of somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love" (WHO, 2006, p.4). Following the International Conference on Population and Development (ICPD) in 1994, sexual health has been viewed as part of reproductive health. The WHO (2006) defines reproductive health as "the 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" (p.9).

More recently, the definition of sexual health has included other related terms such as sex, sexuality and sexual rights. For example, the WHO definition (unofficial) of sexual health is as follows:

> a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (WHO, 2006, p.5).

Subsequently, WHO (2006, p.5) defines (unofficially) the terms *sex, sexuality* and *sexual rights* as follows:

Sex: refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean sexual activity, but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred.

Sexuality: this is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, ethical, legal, historical, religious and spiritual factors.

Sexual rights: sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children; and
- pursue a satisfying, safe and pleasurable sexual life.

3.3 Young people and sexual health

Adolescence is a period in the lifespan of human beings during which, among other things, an awareness of sexuality emerges (Dehne & Riedner, 2005). The emergence of sexuality during adolescence poses fundamental challenges for young people, including adjusting to bodily changes, learning to deal with sexual desires, confronting sexual attitudes and values and experimenting with sexual behaviours (Crockett, Raffaelli & Moilanen, 2003).

While the physical changes associated with adolescence may be experienced by all young people worldwide, the way these changes are interpreted varies significantly in different social-cultural contexts. However, the manner in which adolescent sexuality is received seems to be similar around the world. In both developed and developing countries alike, sexuality in young people tend to be viewed as inappropriate, maladaptive and troublesome (Crocket et al., 2003; Moore & Rosenthal, 2006). Thus sexual behaviours in young people, alongside other antisocial behaviours such as substance abuse, drinking, smoking, truancy and delinquency, are matters that cause a great concern among parents and society in general. As argued by Crocket et al., this negative view of adolescent sexuality partly reflects cultural mores about non-marital sexual activity in many cultures; and, in part, it reflects genuine and justifiable concerns about potential consequences of sexual activity, including teenage pregnancy and HIV/AIDS and other sexually transmitted infections. The negative view of adolescent sexuality has perpetuated the notion that adolescence is inevitably fraught with problems and that sexuality is inherently problematic rather than a normal and healthy part of the human development process (Simmons, 1987; Wagner, 1996; Steinberg, 1998).

Consequently, most research on young people's sexual behaviour tends to focus on risky sexual behaviours and their associated consequences, such as pregnancy, HIV/AIDS and other sexually transmitted infections. This is particularly the case for sub-Saharan African countries, where research on young people's sexuality has mainly been spurred by the need to prevent the transmission of HIV infection. Thus the trend in young people's sexual health, which is a subject of the next section, are measured on the basis of epidemiological and behavioural indicators related to such aspects of sexual health as timing of sexual activity, the extent of sexual partnerships and the safeness of sexual activity (whether or not contraception

and/or condoms were used) rather than the achievement of positive outcomes of sexual health (McKay, 2004).

3.4 Patterns of sexual behaviour in young people

The literature shows that sexual behaviour in young people (as in adults) takes different forms ranging from non-coital sexual behaviours such as kissing, petting (or breast and genital touching) to sexual intercourse (Moore & Rosenthal, 2006; Crockett et al., 2003). Crockett et al. have grouped non-coital sexual behaviours in young people into three categories: fantasy, masturbation and making out.

According to Crockett et al., *erotic fantasy* is the most common form of non-coital sexual behaviour in adolescence. Coles and Stokes (cited in Crockett et al., 2003), conducted a survey of sexual behavioural patterns among a non-representative sample of 13-18-year-olds in the USA; the study findings showed that 72 percent of the young people involved in the study reported that they had sexual fantasies. Hyde and Delamater (2000) indicate that erotic fantasies in adolescence are common and healthy; they provide an opportunity for young people to recognise their sexual needs and preferences, express sexual desires and rehearse sexual encounters.

Masturbation is another common practice in young people. Katchadourian (1989) argues that masturbation is the most common source of orgasm in young people of both sexes, and the source of first ejaculation in boys. Both medical and psychological studies point out that masturbation is not harmful; but it is a healthy and normal part of growth and development which allows young people to explore their sexuality in a safe and private way and may provide an outlet for sexual tension that could otherwise interfere with important matters such as satisfactory school work (Blair & Jones, 1964; Bruess & Greenberg, 2004). Bruess and Greenberg estimate that about 99 percent of males and between 65 percent and 75 percent of females masturbate at some time in their lives.

However, though masturbation is considered normal and healthy by scientists in the field of sexual health, it remains a taboo and is generally regarded as shameful in many countries (Harrison, 2000). In such cases, therefore, one role of SRE programmes in this area should be to help young people to dispel some common myths and eradicate guilt feelings about masturbation for those who choose it as their way to express sexuality and release sexual tension.

'*Making out'* is a term used by Crockett et al. (2003) to refer to physically intimate non-coital sexual behaviours such as kissing, petting and breast and genital touching. Studies have revealed a variation in the progression from non-coital to coital sexual behaviours between one culture and the other. For example, a longitudinal study on the non-coital and coital sexual experiences of male and female adolescents aged 12-15 in the USA revealed a stark difference between black and white adolescents. While white adolescents followed a typical progression from necking through petting, genital touching to sexual intercourse, black adolescents showed no predictable sequence of sexual behaviours and many reported sexual intercourse prior to non-coital sexual behaviours (Smith & Udry, 1985). Another survey of young people's sexual behaviours in the United States showed that many of the youth did not consider oral sex and genital touching as sexual (Sanders & Reinisch, 1999). This trend has also been reported and perhaps is more common among young people in sub-Saharan Africa. In Tanzania, for example, a survey of sexual behavioural trends involving street children in Dar es Salaam reported that a majority of them regarded only penis-in-vagina intercourse as sex (Rajani & Kubrati, 1995).

Consistent with the foregoing findings, Blair and Jones (1964) have argued that non-coital sexual activities such as petting, necking and kissing are largely middle class phenomena; in lower classes these activities are viewed as "being silly and even perverse" (p.22). This means that the meaning of sexual behaviour may vary considerably from one culture to another within and between countries.

Most research on young people's sexual behaviour has focused on heterosexual intercourse rather than on the non-coital sexual behaviours. This is partly because sexual intercourse is a far riskier factor related to sexual health problems than non-coital sexual behaviours. This is particularly important in sub-Saharan Africa, where research on young people's sexual behaviours has mainly been guided by the need to reduce risky sexual behaviours that are associated with HIV and other sexually transmitted infections. However, there is need for research and SRE programmes to focus on non-coital sexual behaviours as well since non-coital sexual experiences may serve as a mechanism to delay sexual intercourse as well as a strategy to help young people accept their sexuality, notwithstanding the fact that, in some cases, they may also lead to the transmission of sexually transmitted infections.

3.4.1 Trends of sexual behaviour among young people in Tanzania

For the purposes of the present chapter, an overview of the trends of young people's sexual behaviour is limited to three common measures; namely, timing of first sex, condom use and partner number and type (Shain et al., 2003). Additionally, the review also includes forcible sexual behaviour, which is a potential risk sexual behaviour among young people in sub-Saharan African countries (Koenig et al., 2004). The review attempts to answer three basic questions concerning young people's sexual behaviour: 1) when do young people initiate sexual activity? 2) what is the nature and level of sexual partnerships? and 3) how safe is their sexual behaviour when young people do become sexually active?

The primary source of data for this review is the latest Tanzania Demographic and Health Survey (TDHS) report (National Bureau of Statistics (NBS) & ORC Macro., 2005). TDHS is part of the worldwide Demographic and Health Surveys (DHS) programme which assists countries in the collection of data related to population, health and nutrition programmes. However, data from other published sources are used where necessary and useful, particularly where referring to other countries and for years earlier than 2004-2005, which are not covered in the current TDHS report.

3.4.1.1 Timing of first sex

The age at which young people initiate sexual intercourse is one of the important determinants of the risky sexual behaviours that could lead to sexual health related problems. The age at first sexual intercourse is especially important for sub-Saharan Africa where heterosexual transmission accounts for more than 80 percent of the HIV infection among young people (UNAIDS, 2004).

According to UNAIDS (2004), throughout the world, the age at which young people experience first sexual activity has been decreasing with a significant proportion of them having become sexually active by their 15th birthday (UNAIDS 2004). A review study by Bankole, Singh, Vanesa and Wulf (2004), drawing on data from 24 sub-Saharan African countries, revealed that the age for first sexual intercourse varies across countries, and is slightly higher than the world average. This review revealed, for example, that more than 70 percent of young men in 12 countries had their first sexual intercourse before age 20. In 18 countries, 50 percent of women

aged 20-24 years had first sex at an average age of 17.5 years; the median age at first sex was 16 for the other six countries: Central African Republic, Chad, Guinea, Mali, Mozambique and Niger.

In Tanzania, as elsewhere, there are differentials in age at first sexual intercourse by sex and other background characteristics, with men initiating sexual intercourse later than women (NBS & ORC Macro., 2005). According to data from the TDHS (2005) report, the median age at first sexual intercourse for women aged 20-49 was 17 years, while for men was 18.4 years. The TDHS report also shows that the percentage of women aged 15-19 who had first sexual intercourse before age 15 have declined slightly between 1999 and 2004-05 from 15 to 11 percent. However, other studies in Tanzania have reported a slightly higher percentage of young people who initiate sex at younger age than TDHS. For example, a survey conducted in Mwanza involving a representative sample of primary and secondary school students aged 12-19 showed that the median age at first sexual intercourse was 15 for primary school students and 16 years for secondary school students (Matasha et al., 1998).

Studies employing a qualitative methodological approach have revealed a much earlier age for experiencing first sexual intercourse among young people than have quantitative studies. For example, in a focus group discussion conducted in Mwanza some young people reported having experienced first sex as young as below age 10 (Wight et al., 2005). Similarly, a community based study conducted in Mtwara, Mbeya and Iringa regions (southern part of Tanzania) revealed that about 20 percent of boys and 12 percent of girls reported having had sexual intercourse below the age of 10 years (Muhondwa, 1999; Msemwa, 2000). Although these findings raise questions about the timing of puberty among girls and boys in Tanzania, notwithstanding the legal aspects of sexual activity at such a young age, they support Singh, Bankole and Woog's (2005) argument that qualitative research techniques may be more appropriate in appealing to young people to talk and in collecting data about such sensitive topics as sexual experiences than quantitative research techniques.

3.4.1.2 Condom use during premarital sex

Unprotected premarital sexual intercourse is one of the riskiest sexual behaviours among young people, along with multiple sexual partnerships. Correct and consistent condom use is critical to preventing HIV/AIDS and teenage pregnancy among young people who are sexually active; evidence shows that condoms, if used

correctly and effectively, are about 90 percent effective for preventing HIV transmission and unwanted pregnancy (Hearst & Chen, 2004). Studies have shown that condom use is still low among a majority of young people who are sexually active in sub-Saharan Africa. A review by Bankole et al. (2004) showed that only between10 and 35 percent of the sexually active young people in the majority of sub-Saharan African countries have ever used a condom during sexual intercourse. The Bankole et al. review further revealed that condom use at most recent sexual intercourse was even lower. In 18 countries, less than five percent of the young people aged 15-19 who had sex in the last three months used a condom.

In Tanzania, condom use among young people who are sexually active is generally low despite high levels of knowledge about condom availability (Kapiga, 2005). In their cross-sectional survey of 9,283 primary school students aged 10-16 years in Mwanza, Todd et al. (2004) revealed that only four percent of young men and women who were sexually active at the time of the survey reported having used a condom in the last sexual intercourse. Another survey of primary and secondary school students aged 15-24 years in Mwanza showed that just above 25 percent of sexually active primary school children and over 50 percent of secondary school children reported having used a condom in their most recent sexual intercourse (Matasha et al., 1998). In a recent survey of 322 young people aged 15-24, it was reported that only 32.3 percent of young people used a condom in their first sex and only 37 percent of young people used a condom during their last sexual intercourse (Lema, Katapa & Musa, 2008).

3.4.1.3 Nature and level of sexual partnerships

Having multiple sexual partners is another risky sexual behaviour (especially if the sexual activity is unprotected) that is typically a characteristic of young people in many countries in sub-Saharan Africa. According to Bankole et al. (2004), a large proportion of sexually active young people in sub-Saharan African countries engaged in sexual relations with more than one partner in the previous year. Bankole et al. reported that more than 40 percent of young men in Cameroon, Chad, Cote d'Ivoire, Kenya, Mozambique and Niger had had more than one partner. The proportion is, however, less than 10 percent among women in most countries except Cameroon (14 percent) and Gabon (17 percent).

The trend of multiple sexual partnerships for young people in Tanzania is fairly similar to that in other sub-Saharan African countries. Young men tend to have more sexual partners than young women in the lifetime and in the last year. For example, nearly half of young men and one-fourth of young women in 20 regions in Tanzania in 1999 reported having sex with one or more non-regular sexual partners (MEASURE, National AIDS Control Programme [NACP] and National Bureau of Statistics [NBS], 2001). Data for Tanzania in the Bankole et al. (2004) review study showed that about 10 percent of young women and more than 30 percent of young men aged 15-30 have had more than two partners in the past 12 months. Another survey investigating the predictors of condom use among secondary school students in the northern part of Tanzania revealed that between 18 and 20 percent of males and seven and 36 percent of females aged 13-21 reported having had more than two sexual partners within a period of two to four weeks (Lugoe, Klepp and Skutle, 1996). The most recent HIV/AIDS indicator survey in Tanzania revealed similar trend of results regarding multiple partnerships, with six percent of women and 27 percent of men who had sex in the year before the survey reporting having more than one sexual partner (TACAIDS et al., 2005).

3.4.1.4 Forcible sexual behaviour

Apart from multiple partnerships and low condom use, young people engage in other potentially risk sexual behaviours such as forced sex. Studies have shown that many young women experienced first sex through rape and forced sex. A review of studies about sexual relations among young people in developing countries showed that between five percent and 15 percent of young females reported a forced or coerced sexual experience (Brown, Jejeebhoy, Shah & Yount (2001). Studies in Kenya, Tanzania, Uganda and Zambia found that between 14 percent and 20 percent of all interviewed young women aged 15-19 reported that their first sexual intercourse had been coerced (Glynn et al., 2001- cited in UNAIDS, 2004; Koenig et al., 2004; Todd et al., 2004). Similarly, another study in Burkina Faso, Ghana, Malawi and Uganda revealed that between 15 percent and 38 percent of girls reported that their first sexual experience was coerced (Moore, Awusabo-Asare, Madise, John-Langba & Kumi-Kyereme, 2007).

Evidence has also shown that some young people, especially young women, do engage in sexual relations in exchange (transactional sex) for money. A review

study of non-consensual sexual experiences of young people in developing countries showed that between 21 percent and 38 percent of girls aged 15-19 in Kenya, Mali and Zambia reported having received money or gifts in exchange for sex (Jejeebhoy & Bott, 2003). Sexual relationships between young women and older men, a phenomenon commonly referred to as 'sugar daddy', have also been reported to be fairly common in sub-Saharan Africa. For example, an in- depth interview exploring young people's experiences with infidelity, violence and forced sex in Dar es Salaam revealed that a majority of young women interviewed engaged in sex with men who were far older than themselves ['sugar daddies'] (Lary, Maman, Katebalila, McCauley & Mbwambo, 2004). Studies in Botswana and Tanzania have revealed that perpetrators of forced sex have sometimes involved authority figures, including male teachers, policemen, priests and relatives (Brown et al., 2001).

Forced sex bears formidable consequences ranging from physical to psychological effects. Forced sex, for example, poses sexual health risks, including unwanted pregnancy, HIV infection and STIs. Indeed, studies have demonstrated a strong association between women's HIV status and their prior history of violence in a relationship (Koenig et al., 2004; Lary et al., 2004). Forced sex has also been associated with psychological effects such as anxiety, depression and suicide attempts (Jejeebhoy & Bott, 2003).

Clearly, the sexual behaviours of young people take different forms in different settings. However, there appears to be a common trend that emerges across different social-cultural settings, including the fact that young people's sexual behaviour in most settings is characteristically risky, with various manifestations, including early initiation of sexual intercourse, low and poor condom use and multiple sexual partnerships. The next section discusses some of the consequences of these risky sexual behaviours on young people's sexual health.

3.4.2 Consequences of risky sexual behaviours in young people

The previous section has shown that young people's sexual activity is characterised by risk taking sexual behaviours. These risky sexual behaviours are, more often than not, likely to make young people vulnerable to a range of sexual health problems. This section discusses the potential consequences of risk taking sexual behaviours in young people. The discussion is mainly limited to those physical

consequences that are commonly reported in the literature, including sexually transmitted infections including HIV/AIDS, unwanted pregnancy and abortion.

3.4.2.1 Teenage pregnancy

Pregnancy among unmarried teenaged young people is generally assumed as unintended or unwanted and, for this reason, it is arguably one of the most reliable indicators of young women's future sexual health status and life opportunities in general (McKay, 2004). It has been observed, for example, that pregnancy related complications are much more common among young women aged 10-19 than adults (Alan Guttmacher Institute, 1996).

Statistics show that the sub-Saharan African region has the highest adolescent fertility rate and pregnancy related complications in the world (McDevitt, 1996). A review of 13 studies regarding young people's sexual health in seven sub-Saharan African countries showed that young people aged 11-13 accounted for between 39 and 72 percent of all abortion related complications in their countries (Senderowitz, 1998). A study in Uganda revealed that 17 percent of young women aged 15-18 have undergone an abortion (Noble, Cover & Yanagishita, 1996). Noble et al. also reported that the mortality rate among young women aged 15-19 was three times higher than for women aged 20-34.

In Tanzania, studies have reported that the pregnancy rate among young people increases from three percent at age 15 to 54 percent by age 19 and that 20 percent of the maternal deaths occur among young women below the age of 20 (Mpangile, 2003). Mpangile reports further that the maternal deaths occurring among young women aged 15-24 account for 40 percent of all the maternal deaths in Tanzania. It is difficult to obtain data on abortion in Tanzania because the law forbids any ground for abortion. However, hospital based data show that 50 percent of gynaecological admissions in Dar es Salaam due to abortion-related complications involved young women aged 15-24 (Rasch, Massawe, Yambesi & Bergstrom, 2004).

Apart from health related problems, unwanted pregnancies and abortions are the cause for most school dropouts in girls and subsequent psychological and social traumas such as feelings of isolation and depression in young women in sub Saharan Africa (Taffa, Klepp, Austveg & Sundby, 1999). In Tanzania, for example, teenage pregnancy is one of the main causes of incomplete education for girls. Government

statistics show that between 2000 and 2005 alone, about 15,030 school girls dropped out of school due to pregnancies (Nkolimwa, 2006).

3.4.2.2 Sexually transmitted infections

According to the WHO estimates, one in 20 young people aged 15-24 acquires an STD each year (Blum & Mmari, 2005). Blum and Mmari have noted that, although STDs remain a major public health problem in both developed and developing countries, the incidence rates are far higher in sub-Saharan Africa mainly due to poor resources for treating STDs.

In Tanzania, according to the TDHS (2005) report, two percent of women and three percent of men reported an STI in the previous 12 months. Four percent of women and two percent of men reported having had an abnormal sore or ulcer in the 12 months before the survey. The TDHS report observes, however, that these numbers may be underestimated because respondents may have been embarrassed or ashamed to admit having STIs. The TDHS (2005) data on STIs do not show variation across age and other social backgrounds, and, as such, it is difficult to estimate the proportion of young people affected by STIs.

The Joint United Nations Programme on HIV/AIDS (UNAIDS, 2004) has identified five common STIs in Tanzania; namely, urethral discharge, genital ulcers, syphilis, gonorrhoea and trichomoniasis. The UNAIDS underscores the importance of preventing STIs among young people in developing countries because their predominant mode of transmission is the same as HIV, which is sexual intercourse.

Furthermore, evidence has shown that STIs facilitate HIV transmission by increasing both HIV infectiousness and HIV susceptibility (UNAIDS 2004). This means that the detection and treatment of individuals with STIs is an important part of an HIV prevention strategy. However, it is clear that the advent of HIV/AIDS has blurred efforts to prevent other STIs to the effect that most research and intervention programmes are now more focused on HIV/AIDS than other STIs. Thus there is relatively a paucity of data on the prevalence/incidence of STIs compared to HIV/AIDS.

3.4.2.3 HIV/AIDS situation in Tanzania

The first cases of HIV/AIDS in Tanzania were reported in 1983. Since then, the epidemic has evolved from being a rare and new disease, affecting few individuals

and families, to a national crisis with multifaceted effects including economic, social and cultural (Kapiga, 2005). By end of 2007, a total of 1.4 million people had been infected with HIV in Tanzania, with an estimated national prevalence rate of 6.5 percent among adults aged 15-49 (UNAIDS & WHO, 2007).

Available data show that, as noted in Chapter 1, although young people have lower rates of HIV prevalence (only 15 percent of the people living with HIV/AIDS in Tanzania are aged 15-24) than older adults, new infection rates are higher in young people than their adult counterparts. It is estimated that about 60 percent of new infections in Tanzania occur among young people aged 15-24 (TACAIDS et al., 2005).

On average, HIV prevalence in Tanzania is slightly higher in women than in men. Estimates show that the total HIV prevalence for women aged 15-49 is 7.7 percent compared to 6.3 percent for men of the same age group (TACAIDS et al., 2005). Again, the HIV prevalence is slightly higher among young women than in young men; according to TACAIDS et al., the HIV prevalence for young women aged 15-24 is four percent compared to three percent for young men aged 15-24

Statistics on HIV/AIDS situation in Tanzania show that the prevalence is higher in urban areas than in rural areas. For example, it has been reported that the HIV prevalence rate among young men in urban areas is as three times higher as that for young men in rural areas (TACAIDS et al., 2005).

3.4.3 Why do young people engage in risky sexual behaviours?

According to Lightfoot (2007), there are two dominant perspectives about risk taking behaviours in young people. The first perspective views risk taking as troublesome and conceptualises young people as reckless who indulge in risk behaviours as a way of drawing attention and causing problems for adults. Viewed this way, adults see risk taking behaviour in young people as a negative phenomenon that may lead to serious negative consequences to the individuals and society, and therefore must be overcome. The second perspective views risk taking as opportunity and conceptualises young people as heroic, taking risks as a consequence of adventures on the path to adulthood. This perspective sees risk taking in young people as a normal phenomenon during adolescence that is not necessarily subject to negative consequences.

In view of the above perspectives about risk taking, studies on sexual health recognise that the determinants of young people's sexual behaviour are not related to individual factors alone, but also to a profound social environment that surrounds the youth. Thus most studies view sexual behaviour as having multiple and interacting influences, which can be grouped into three categories; namely, biological, psychological and socio-cultural factors (Bruess & Greenberg, 2004; Crockett, Raffaelli & Moilanen, 2003; Couch et al. 2006; Jessor, 1998). The biological aspect looks at the effect of the development of physical sexual characteristics on sexual behaviour; the psychological aspect deals with the effect of learned attitudes, feelings and responses about sexuality on sexual behaviour; and the socio-cultural aspect looks at the effect of the historical and contemporary cultural influences that affect young people's thoughts and actions about sexual behaviour (Bruess & Greenberg, 2004).

This section reviews some evidence on the effect of these factors (biological, psychological and socio-cultural factors) on young people's sexual behaviour. While special reference has been made to studies conducted in sub-Saharan African countries, many of studies reported were conducted in the western countries.

3.4.3.1 Biological influences

According to the biological perspective of sexual behaviour, sexual activity in young people is not learned but is rather a result of endocrinological hormonal influences that trigger pubertal changes that eventually culminate in sexual maturity (Halpern, 2003). According to Halpern, the pubertal changes during adolescence affect young people's sexual behaviour in three possible ways. Firstly, the rise in hormone concentration levels do trigger the first ejaculation in boys (spermache) and first menstruation in girls (menarche) as well the development of secondary sex characteristics such as breasts, beards and pubic hair. Many of these changes also bring about sex differences, which publicly signify sexual readiness. Secondly, the physical changes are accompanied by heightened romantic and sexual interest due to hormonal changes. Thirdly, the change in physical appearance may change young people's social context and opportunities for romantic and sexual activity; this opens up possibilities for dating and for socialising with other older adolescents who may be already engaging in sexual activity.

Studies have clearly established an association between pubertal changes and adolescent sexual behaviours. For example, Halpern, Udry, Campbell and Suchindran

(1993) conducted a three-year panel study involving 100 seventh and eighth grade adolescent boys in a south-eastern state in the USA to examine the influence of hormonal changes on sexual activity of young people. They found that pubertal development over a six-month period was significantly and positively related to sexual intercourse. Furthermore, they found that testosterone levels were significantly related to coital status and predicted the transition to non-virgin status.

Other writers have observed that because the age of puberty is partly inherited, it follows that individual difference in the timing of first sexual intercourse has a genetic basis (Rogers, Rowe & Buster, 1999). Rogers et al., using data from the US National Longitudinal Survey of Youth, examined the influence of genetic and environmental influences on first sexual intercourse. The results suggested a significant genetic influence in first sexual intercourse among white boys and girls. However, the genetic influence on blacks was extremely small or non-existent.

More recent research has tended to view sexual behaviour as a result of an interaction of biological and social influences (Graber, Brooks-Gunn & Galen, 1998). This perspective, called the biosocial model, recognises the influence of both biological and social factors in determining sexual behaviour. For example, Smith, Udry and Morris (1985) conducted a panel study to examine the effect of biological motivation and friends (social motivation) on the sexual behaviour of young female adolescents aged 12-15. The results showed that the effects of biological and social motivations were clearer when the two variables were considered together than separately. Smith et al. concluded that the sexual behaviour in young people may be influenced by an interaction of biological, social and other factors.

3.4.3.2 Psychological influences

Several psychological attributes have been linked to young people's risky sexual behaviours, including attitudes and values, motivation, depression, self esteem, academic aspirations and substance use and abuse (Bruess & Greenberg, 2004).

It is important to note that the three domains of development, physical, cognitive and psychosocial development, influence each other; changes in one domain of development usually lead to changes in the other domains. For example, studies have shown that pubertal changes that take place during adolescence tend to bring

about cognitive bias[1] in young people (Hall, Holmqvist, & Sherry, 2004). As a result of cognitive bias, young people perceive themselves as less vulnerable to the negative consequences of sexual behaviour, such as STIs and unwanted pregnancy. However, personal invulnerability to sexual risks is not limited to young people alone; studies have shown that people in general (young people included) routinely make incorrect judgement about their sexual conduct that potentially put them at risk for a multitude of sexual health problems (Quadrel, Fischhoff & Davis, 1993).

Attitudes and values are other psychological attributes that have been linked to young people's propensity to risky sexual behaviours. For example, first sexual intercourse has been associated with family values, cultural proscriptions as well as personal experiences (Crockett et al., 2003). Lammers, Ireland, Resnick and Blum (2000) carried out a survey study of influences on adolescents' decision to postpone onset of sexual intercourse among 26,023 American students in grades 7-12. The results showed that dual parental families, absence of suicidal thoughts, feeling of being cared by adults, greater religiosity and high parental expectations were associated with lower levels of sexual activity.

Other psychological variables that have been linked to young people's sexual behaviour include academic achievement, psychosocial adjustment, motivation and problem behaviours. It has been found that young people with higher educational aspirations and better academic performance tend to postpone first sexual intercourse for longer duration than those with lower educational aspirations and poor academic performance (Lammers et al., 2000).

Consistent with the self-determination theory[2] (Ryan & Deci, 200; Deci & Ryan, 2000), individuals are more motivated to make and sustain protective behaviours when they are doing those behaviours for personally held values (intrinsic

[1] Cognitive bias has been defined by Hall et al. as a way of thinking that distorts incoming information, such as information about personal risk or anticipated consequences.

[2] The Self-Determination Theory (SDT) [Ryan and Deci, 2000] assumes that people are active organisms, with innate tendencies toward psychological growth and development, who strive to master ongoing challenges and to integrate their experiences into a coherent sense of self. However, this natural human tendency does not operate automatically, but instead requires ongoing nutriments and supports from the social environment in order to function effectively. That is, the social context can either support or thwart the natural tendencies toward active engagement and psychological growth. Thus SDT maintains that it is the dialectic between the active organism and the social context that is the basis for predictions about behaviour, experience and development in human beings.

motivation) rather than for external reasons (extrinsic motivation). This follows that young people who are, for example, prone to peer pressure are more likely to engage in early sexual intercourse than those who can make their own decisions with little influence from external pressures.

Studies have shown a close association between sexual behaviour and psychosocial adjustment. Millstein, Moscicki and Broering (1994), using data from the US National Longitudinal Survey of Adolescent Health, examined the effects of depression on young people's sexual behaviours; they found that depressive symptoms were associated with a decreased likelihood of condom use among boys and with a history of STIs among girls. Millstein et al. also observed that depressed adolescents were likely to experience feelings of hopelessness and lowered self esteem, which have a weak relationship with protective sexual behaviours. A recent study, which examined the association between depressed mood and clusters of health risk behaviours among a nationally representative sample of young people in the United States, concluded that young people who engage in multiple health-risk behaviours do so in the context of depressed mood (Paxton et al., 2007).

Another psychological attribute that has been associated with sexual behaviour is problem behaviour in which consistent associations have been established between risky sexual behaviours and other problem behaviours in young people. Ramrakha et al. (2007) conducted a longitudinal study to investigate the relationship between behavioural and emotional problems and later sexual behaviour and outcome in New Zealand's South Island. Childhood antisocial behaviours, including fighting, bullying, disobedience, delinquency, hyperactivity, anxiety and destructiveness were measured at age 5, 7, 9 and 11 years. Child antisocial scales were completed by teachers and parents of sampled children. Sexual behaviour and outcome was assessed at age 21 using the 1990 British National Survey of Sexual Attitudes and Lifestyles Scale. The results showed that higher levels of childhood antisocial behaviours, particularly involvement with delinquent peers and poor relationship with parents between ages 5 and 11, were associated with an increased likelihood of early sexual intercourse and other risky sexual behaviours, notably unprotected sex and having multiple sexual partners. On the basis of their findings, Ramrakha et al. concluded that some problem behaviours (but not all) may facilitate risk taking sexual behaviours in young people.

3.4.3.3 Socio-cultural influences

As noted in the previous sections of this chapter, little research has been done in sub-Saharan Africa and developing countries in general regarding the impact of biological and psychological factors on young people's sexual health. However, it has been argued that socio-cultural influences are more important determinants of sexual behaviour among young people in developing countries than biological and psychological factors due to a strong sense of traditional attitudes and norms (Lakshmi, Gupta & Kumar, 2007). Thus there are numerous studies that have investigated the influence that socio-cultural factors have on young people's sexual health in general and sexual behaviour in particular in sub-Saharan Africa. The guiding theoretical assumption about the socio-cultural influences is that, apart from being influenced by biological and psychological forces, sexual activity is socially constructed and that different societies tend to mould sexual urges for different social or cultural purposes. Thus, sexual behaviour is embedded in social structures and contexts from which young people look for clues as to what constitutes acceptable and unacceptable sexual behaviours (Shoveller, Johnson, Langille & Mitchell, 2004).

The most commonly identified socio-cultural influences in the literature include cultural norms, family situations, peer relations, neighbourhood situations and media. The following paragraphs review the literature regarding the influence these variables have on young people's sexual behaviour.

Cultural norms

Several studies in different countries have demonstrated consistent linkages between cultural norms and young people's propensity to risk taking sexual behaviours. Some cultures, for example, encourage premarital sex as a determination of the fertility of potential marriage partners; in other cultures, premarital sex is strongly discouraged, especially for girls, because virginity is highly prized. For example, in Nigeria a few decades ago, girls were rewarded if they kept their virginity until marriage (Omoteso, 2006). However, Omoteso argues that the trend has changed in recent years, especially in urban areas, due to the influence of western culture that young people learn from the media. In Ghana, virginity is still cherished by the traditional value system so much that young people are still not expected to have sex outside marriage (Awusabo-Asare, Abane & Kumi-Kyereme, 2004).

A participant observation study about the sexual norms and expectations for young people in rural Northern Tanzania revealed several contradictory sexual norms that impact upon young people's sexual behaviour (Wight et al., 2005). Wight et al. found, for example, that in some areas, sexual experience was viewed as prestigious and something that is intertwined with masculine identity. In these societies, when caught in sexual relations boys may be punished but not girls. Thus, in these societies, there are differential attitudes towards sexuality between boys and girls, which may as well imply different propensity to risky sexual behaviours. However, though these norms legitimatise sexual behaviours, they do not necessarily determine them (Wight et al., 2005).

Religiosity is another cultural attribute that has been found to influence sexual behaviour in young people. A study that investigated the association between religiosity and risky sexual behaviour among African-American young females in the USA found that greater religious involvement was associated with less risky sexual behaviour (McCree et al., 2003). McCree et al. found that young people who attached great importance to religion and attended religious services more frequently had higher self-efficacy to communicate with their partners about sex, had steady partners and were more likely to refuse unsafe sexual encounters.

Family situations

Several studies in the developed countries have demonstrated consistent linkages between young people's sexual behaviour and a number of family attributes, including family structure, parenting style and parent-child relationships and family's socio economic status (Young, Jensen, Olsen & Cundit., 1991; Jemmott & Jemmott, 1992; Santelli, Lowry, Brener & Robin., 2000; Wight et al., 2005).

A cross sectional survey of 1,501 African-American and white adolescents from one and two-parent homes found that living in a two-parent family was related to less sexual activity and older age at first intercourse among males; however, among females, it was the race that was important in influencing sexual behaviour rather than the family structure (Young et al., 1991). Another cross sectional survey study examining the association between family structure, parental strictness and sexual behaviour among American black male adolescents found that young people who lived with both parents used condoms more frequently than those who lived with single parents (Jemmott & Jemmott, 1992). Furthermore, Jemmott and Jemmott report

that young men who believed that their mothers were stricter than others reported less frequent coitus with fewer girls, whereas those who perceived their father as stricter used condoms more consistently. Using data from the US 1992 Youth Risk Behaviour Survey, Santelli et al. (2000) also reached a similar conclusion; that is, adolescents living in a two-parent family were less likely to engage in early sexual intercourse than those living in a single parent family. Furthermore, Santelli et al. found that adolescents whose parents had higher socio economic status, measured by parental education and family income, were less likely to engage in risky sexual behaviours.

Similar findings have been documented in sub-Saharan Africa. For example, Rwenge (2000) conducted a cross sectional survey of risky sexual behaviours among young people aged 12-25 in Cameroon; he found that young people living with only one parent were as twice likely to be sexually active as those living with two parents. In another similar study, Slap et al. (2003) conducted a cross sectional survey of sexual behaviour among a sample of 4218 secondary school students aged 12-21 in 39 schools in Nigeria. They found that students who came from polygamous families and parents with lower education were more likely to engage in risky sexual behaviours than those who came from monogamous families and whose parents had higher education levels.

Family poverty has also been linked to risky sexual behaviours in young people in sub-Saharan Africa. A review study of sexual relations among young people in developing countries cited the "sugar daddy" phenomenon, as noted earlier, as a critical factor for young people's early sexual intercourse in many African countries (Brown et al., 2001). Brown et al. report that school girls as young as 13 in such countries as Botswana and Tanzania reported having had sex with older men for financial gains because their parents were unable to meet their basic school needs. Similarly, a study of risky sexual behaviours in young people in Cameroon found that young people living in a poor household were more likely to be sexually active at the time of the survey than those living in a household with relatively high standard of living (Rwenge, 2000).

Using nationally representative survey data from four sub-Saharan African countries, Burkina Faso, Ghana, Malawi and Uganda, Madise, Zulu and Ciera (2007) investigated the link between poverty-measured by wealth quintiles-and sexual behaviour of 19,500 young people aged 12-19. They found that wealth status was associated with age at first sexual intercourse, particularly among girls, in which they

observed a higher likelihood of initiating first sex among poorer girls than wealthier girls. Additionally, they found that wealthier boys were more likely to use condoms at the last sexual encounter that poorer boys.

However, other studies, particularly in developed countries, have found that higher family income was associated with an increase in risky sexual behaviours, such as increased frequency of sexual intercourse and number of sexual partners. For example, Ku, Sonenstein and Pleck (1993), using data from the U.S. 1998 National Survey of Adolescent Males and the 1988 census, examined the effects of neighbourhood, family and individual characteristics on teenage males' premarital sexual and contraceptive behaviours. They found that young men who worked more hours and earned more income engaged in sex more frequently, had higher numbers of sexual partners and were more likely to have made someone pregnant. These results point out that greater access to financial resources at individual level may open opportunities for risky sexual behaviours. In this case, in the absence of effective SRE programmes and other health services, both great and limited economic fortunes may heighten young people's propensity to risky sexual behaviours.

Mass media

The mass media are the most valued sources of information about sexual health amongst young people in developing countries due to lack of SRE in schools and parents' reluctance to discuss sexual topics with their children (UNAIDS 1999). For example, in a questionnaire study of 1247 primary school students in Arusha town in Tanzania assessing their sources of reproductive health information, mass media was ranked first in the list of potential sources of reproductive health information (Masatu, Kvale & Klepp, 2003). However, perhaps, for sub - Saharan Africa, this may only be true for young people living in urban areas in which the mainstream mass media (television, magazines, movies, music and internet) are still predominant compared to rural areas. In Tanzania, for example, only 25 percent of the population are located in urban areas; in this context, mass media cannot be regarded as the most important source of information about sexual health for the majority of young people.

Mass media may have both positive and negative effects on young people's sexual behaviour. Young people are frequently exposed to sexual material on television, in movies and in magazines. Consistent with the social cognitive theory, young people who attend to media content that includes depictions of attractive

characters who enjoy having sexual intercourse and rarely suffer any negative consequences of sexual behaviour will be likely to imitate that behaviour (Brown, 2002). However, research on the effect of mass media on young people's sexual behaviour largely remains indicative rather than conclusive (Crockett et al., 2003; Couch et al., 2006). Furthermore, mass media have been a force to reckon with in the fight against HIV/AIDS in many sub-Saharan African countries, where it has provided a useful mode of transmission of messages related to the prevention of the pandemic.

Urbanisation and modernisation

The social and economic transformation taking place in developing countries is changing the circumstances in which people live, and has had significant influence on young people's sexual behaviour. For example, in sub-Saharan Africa, rapid urbanisation and modernisation, alongside poverty, wars and conflicts and socio-cultural factors, have been linked to risky sexual behaviour and consequently to the rapid spread of HIV infection (Buve, Bishikwabo-Nsarhaza and Mutangadura, 2002).

There are several ways in which urbanisation and modernisation have been construed as contributing to young people's propensity to risk taking sexual behaviours. Firstly, urbanisation and modernisation do replace traditional village norms for urban modern ethos with fewer restrictions on sexual behaviour (Buve et al., 2002). Secondly, as argued by Buve et al., the loss of culture and erosion of social networks are associated with antisocial behaviours, such as substance abuse and delinquency which, in turn, encourage high risky sexual behaviours in young people. Thirdly, urbanisation and modernisation of rural areas in many sub-Saharan African countries have provided the infrastructure for, among other things, greater sexual opportunity among young people by facilitating sexual experimentation and the breaking of traditional sexual values (UNAIDS, 1999).

Peer influences

During adolescence, close friends exert a major social influence on the behaviour of fellow friends. Many studies have clearly demonstrated an association between an adolescent's reported sexual behaviour and his or her friends' sexual behaviour. For example, a survey study that examined the predictors of risky sexual behaviours in African-American girls aged 12-19 in the USA showed that peer norms

predicted young people's propensity to risky sexual behaviour (Bachanas et al., 2002). Bachans et al. found that girls who reported that their friends engaged in less-risky sexual behaviours also reported engaging in less risky behaviours themselves. Another cross-sectional survey revealed related findings in which young people who reported that their friends engaged in high-risky sexual behaviours were themselves engaging in risky sexual behaviours (Millstein & Moscicki, 1995).

Similar findings have been documented in studies conducted in sub-Saharan Africa. A cross sectional survey that investigated the correlates of premarital sexual activity in school adolescents in Kenya found that adolescent males who socialise with sexually experienced peers tended to be themselves much more likely to be sexually experienced (Kiragu & Zabin, 1993). Another study of risky sexual behaviour among young people in Cameroon showed that the influence of schoolmates or friends was one of the most important reported reasons for first sexual intercourse for the majority of young people in Cameroon (Rwenge, 2000).

3.4.4 Summary

In summary, the preceding review has demonstrated that young people's sexual behaviour and health are determined by a multitude of factors ranging from biological, psychological to socio-cultural. These factors are interconnected and they influence sexual behaviour in interaction rather than in isolation. Therefore, young people's propensity to risk taking sexual behaviours should not necessarily be viewed as individual deficits, but rather as a reflection of a complex interaction of their biological, psychological and socio-cultural environment. A broad perspective of young people's risk taking behaviours is important in designing SRE programmes whose objectives go beyond changing individuals' behaviours, but also incorporate strategies to change the social environments that influence these behaviours.

The review in this chapter has also demonstrated that the contemporary research on young people's sexual behaviour in sub-Saharan Africa has mainly focused on and emphasised the importance of risky coital sexual behaviours (such as early sexual intercourse, multiple sexual partners and poor condom use) with little attention on the protective non-coital sexual behaviours. There is need for future research to focus on non-coital sexual behaviours as well; these may serve as a mechanism for promoting and prolonging abstinence, which is, by the way, arguably

less controversial among parents and other stakeholders in many sub-Saharan African countries than contraception and condom use.

Chapter 4
Research Design and Methods

This chapter describes and discusses the research design and methods employed in gathering information relevant to answering the research questions. The chapter is organised in three major sections. The first section introduces and explains the rationale for adopting a mixed methodological approach and how this approach was used in addressing the research questions. Sections two and three describe the survey design (quantitative research) and qualitative research respectively, with respect to participants, sampling procedures and instruments used.

4.1 Research design: mixed methods

The main aim of this research was to examine the potential for the provision of school-based sex and relationships education (SRE) in Tanzania. In addressing this aim, the research examined the possible facilitators and barriers associated with the development and delivery of school-based SRE at two levels. Firstly, the attitudes of key stakeholders of the education sector in Tanzania, including parents, teachers, students and national school policy makers, were assessed. Secondly, the research analysed the school policy frameworks and national school curricula with a view to identifying the structural factors that may facilitate or impede the delivery of SRE in schools. Therefore, the objectives and questions addressed in this research were diverse and multifaceted thereby necessitating the use of both quantitative and qualitative research methods to achieve balance between breadth and depth.

The choice of the quantitative research, which employed a cross sectional survey design, was necessitated by the need to collect data from diverse and as a large number of participants as possible. Furthermore, many authors have argued that survey research is useful for collecting data regarding individuals' attitudes about a social phenomenon (Mertens, 1998), which was clearly the case in this research; one of the key objectives of this research was to assess stakeholders' (parents, teachers, students and national school policy makers) views and attitudes about the provision of SRE in schools.

On the other hand, several issues motivated the choice of qualitative methodological approach. First of all, the participants involved in this research were

drawn from four different categories (parents, teachers, students and school policy makers) and from diverse social and cultural backgrounds; this means that multiple meanings and realities regarding SRE were sought from these respondents. Thus, consistent with the interpretive/constructivist research paradigm (Mertens, 1998), it was important to employ a qualitative research approach so as to gain an understanding of the constructions about SRE from the perspectives of the participants involved in the research. Second, the qualitative research was employed to identify the role of cultural values and social-political processes that influence the decisions to include or not to include SRE in the national school curriculum in Tanzania. An insight into these complex social-cultural-political processes that may impede (or facilitate) the development and implementation of SRE programmes in schools can be uncovered qualitatively rather than quantitatively. Finally, the use of qualitative research was motivated by the need to develop an SRE programme that is informed by and responsive to the interpretations and aspirations of the key stakeholders of the education process in Tanzania; namely, parents, teachers, students and policy makers.

Opponents of the mixed methods approach have argued that the quantitative and qualitative research methods cannot be combined because they rest on different theoretical assumptions. They argue that quantitative research rests on positivism (or post-positivism) which tends to regard science as an objective process of collecting observable and measurable facts, whereas qualitative research is often rooted in an interpretive paradigm, which sees reality as socially constructed, complex and ever changing (Guba & Lincoln, 1994). They argue further that because they are rooted in different theoretical assumptions, quantitative and qualitative research methods attempt to achieve different objectives and they employ different instruments and procedures in achieving these goals; as such they do not study the same phenomena and therefore they cannot and should not be mixed (Sandelowski, 2000). Sandelowski quotes Pearce (1971) who argued that combining qualitative and quantitative research methods is impractical because the two approaches have different world views; as such, "mixing them up will amount to changing the world view under investigation and that a change of world view can change the world viewed" (p. 247).

However, whilst acknowledging the sharp distinction between quantitative and qualitative research strategies, researchers have argued for a principled mixture of the two approaches within certain investigative contexts (Henwood, 2003; Fitzpatrick,

Secrist & Wright, 1998). Several writers have come to the conclusion that quantitative and qualitative research strategies can play complementary and supplementary, rather than contradictory or antagonistic, roles in research (Richardson, 2003; Thomas, 2003; Bryman, 2004). Additionally, as argued by Silverman (2005), although positivism[3] is predominantly a default option for quantitative research, it can be used within qualitative research design.

Several justifications have been suggested for combining quantitative and qualitative research. Bryman (2006) has identified five such justifications: "triangulation, complementarity, development of research instruments, initiation and expansion" (p.105). In this research, quantitative research and qualitative research approaches were combined for the purposes of triangulation and complementarity. The quantitative research, which preceded the qualitative research, was used to collect participants' views and attitudes about a wide range of school-based SRE issues, including content, timing and delivery modes (see full description of questionnaires in the next section of this chapter). The qualitative research was used, firstly, to discern the extent to which the patterns of responses gathered from the questionnaires typically emerged in the responses collected in qualitative research. Thus the qualitative research sought to corroborate the results of the questionnaire study (triangulation). Secondly, the qualitative research was used to elaborate and enhance the results of the questionnaire research by a way of finding out more about the participants' responses (complementarity).

The research presented in this thesis was done in two phases. The first phase, involving quantitative research, was carried out between July and September 2006, whereas the qualitative research was conducted between July and September 2007. The sections that follow describe the procedures employed in each research strategy with respect to participant sampling procedures, administration procedures of the research instruments and data entry, management and analysis procedures.

4.2 Quantitative research

The quantitative research employed a cross-sectional survey design to assess the attitudes of parents, teachers and students towards school- based SRE. The survey

[3] Simply stated, according to Bryman (2004), positivism is a methodological approach for understanding phenomena based on a position that for a method to be considered genuinely scientific it must be amenable to observation and measurement.

was therefore useful in determining the extent to which parents, teachers and students supported the provision of SRE in schools. The survey was also useful in examining the influence of respondents' demographic characteristics on their attitudes towards school-based SRE. Parents, teachers and students completed questionnaires with items assessing their views and attitudes towards various aspects of school-based SRE.

Additionally, the quantitative research approach was useful in examining the status and place of SRE in the current national school curriculum; quantitative content analysis was employed to disentangle SRE related topics in the Tanzanian national school syllabi.

Survey research has been acknowledged as a cost effective strategy for collecting information from a large group of participants in a short period of time (Frankel & Wallen, 2004). However, survey research has also been criticised for too much reliance on individual self-reports of their knowledge, attitudes or behaviour; as such, the validity of information given is dependent on the honesty of respondents (Mertens, 1998). Survey research is particularly problematic for research involving sensitive topics such as sexual health. Ingham (1993), for example, identifies two major problems associated with using questionnaires for researching sexual health related topics. First, many of the terms that are necessarily used in the questionnaires concerning sexual health research are ambiguous by their very nature to some or many of the respondents. Second, since questionnaires are non-interactive, it makes it impossible for researchers to clarify any misunderstandings or ambiguities experienced by respondents.

The above problems associated with survey research were minimised in the present research by piloting the instruments prior to their administration to a larger sample. Questions or response options that were observed by participants to be ambiguous were rephrased or removed from the final questionnaire. Additionally, the completion of the questionnaires was done at one place at the same time in the presence of the researcher and research assistants; this provided the opportunity for the research team to clarify any ambiguous or problematic questions or response options. Furthermore, qualitative research was conducted to corroborate and elaborate on the results gathered in the questionnaires.

4.2.1 Sampling plan and participants' selection procedures

The sampling process was done in three stages. The first stage involved selecting the participating regions[4] ; two regions were selected; namely, Dar es Salaam and Mwanza. These regions were purposively selected on the basis of two criteria. First, there was evidence that some school-based sex and relationships education (SRE) programmes had been implemented in these regions. These included, for example, the *Mema Kwa Vijana* Programme in Mwanza (Hayes et al., 2005) and the South Africa and Tanzania sexuality and HIV/AIDS education (SATZ) Programme in Dar es Salaam (Aaro et al., 2006). The researcher was involved in the latter project as a senior research assistant for two years before embarking on the PhD study at the University of Southampton. There was also evidence that these programmes were implemented in schools by teachers and that parents were somehow involved in the implementation process (ibid). Because of their involvement in the implementation process, it was anticipated that parents, teachers and young people in these regions would have formed some opinions about the delivery of SRE and would, therefore, be able to provide more informed opinion about school-based SRE than if the questionnaire had been administered to respondents who had had no experience with any form of SRE delivery. It has been suggested that answers on attitude questions can be more reliable if obtained by asking people who have had some experience with a phenomenon than by asking novice people (Mertens, 1998).

The second reason was that the population in these regions is diverse in terms of ethnicity, religiosity and locality. Because of the diverse nature of the population it was anticipated that the study would capture diverse opinion from participants across a wide range of social-cultural backgrounds and, as such, the results of the research could, with a few caveats and some certainty, be transferable and generalisable to the rest of the regions in Tanzania.

The second stage of sampling involved selecting the districts from the two regions. Again, two districts were selected; namely, Kinondoni and Sengerema. The two districts were also purposively selected on the basis of urban-rural location and their involvement in the SATZ and *Mema kwa Vijana* programmes. Besides having

[4] Tanzania is organised in twenty-six administrative regions. Each region is divided into districts which are in turn divided into divisions and wards. A ward consists of villages (for rural districts) and communities (for urban districts).

been involved in the SATZ project, according to the Tanzania Population and Housing Census Report (2002), Kinondoni is the most typical urban district in Tanzania; on the other hand, Sengerema is the only rural district in Mwanza that was involved in the *Mema Kwa Vijana* project.

At the third stage of the sampling process, participating schools were selected from each of the two districts. The detailed procedures for selecting the schools for each of the participating districts are explained below.

Both primary and secondary school students were involved in the research, and the selection procedure was slightly different between the two groups. The selection procedure for secondary school students has been detailed in the chapter reporting the results of the students' survey (Chapter 7).

For the selection of primary schools, the following procedures were followed. There are 161 primary schools in the Sengerema (rural) District, which constituted the primary school sampling frame in this district. The schools were stratified into 25 administrative wards; each ward has between five and seven schools. A random sample of five wards was selected from the population of the 25 wards (Busisi, Katunguru, Nyehunge, Sengerema and Tabaruka). From each ward, a further random sample of two schools was selected to participate in the study; thus a total of ten schools were sampled to participate in the research in the five wards.

In Kinondoni (urban) District, the sampling frame consisted of all the 24 primary schools that were involved in the SATZ programme. From these schools, a random sample of 12 schools was selected.

Thus, in both districts, 22 schools were sampled to participate in the research. However, in practice a total of 18 schools (10 schools in Kinondoni and 8 schools in Sengerema) participated in the research. Two schools from each district did not participate because the head teachers of these schools declined to take part for various reasons.

Three categories of participants were involved in the quantitative study: parents[5], teachers and students. All the participants were recruited through school authorities. The researcher approached the head teachers of the participating schools explaining the purpose of the visit and research. The researcher and the head teachers

[5] Parents in this case included both biological parents as well as carers. In some schools, it is carers rather than biological parents who participated in the study.

of the participating schools discussed the various options for recruiting students, teachers and parents.

For each school, a sample of 20 students was randomly selected from amongst students attending Classes 5, 6 and 7 and roughly aged between 10 and 16. Furthermore, each head teacher of the participating school was requested to ask at least four teachers to volunteer to take part in the study. It was further agreed that all parents of the students selected to participate in the research would also be approached to take part.

4.2.2 Research instrument used

The data collection instrument used in the quantitative research was a questionnaire. There was version of the questionnaire for each category of respondents; parents, teachers and students. Each questionnaire set consisted of closed questions and a few opened ended questions on the views and attitudes concerning school-based SRE. Most of the questions were the same for all the three categories of participants, with the exception of few specific social and demographic characteristics. However, the students' and teachers' questionnaire had additional items that were not included in the parents' questionnaire.

The questionnaires used in the research for this thesis were adapted from three questionnaires previously used in similar research in Canada. These were: *Sexual health education at school and at home: attitudes and experiences of New Brunswick parents* (Weaver et al., 2002); *New Brunswick students' ideas about sexual health education* (Byers et al., 2001) and *New Brunswick teachers' ideas about sexual health education* (Cohen et al., 2001). The permission to use these questionnaires was sought from and granted by Professor Sandra Byers on behalf of her fellow authors. Professor Byers is Chair of the Department of Psychology at the University of New Brunswick in Canada. These questionnaires were slightly modified to suit the context of participants in Tanzania.

The questionnaires were initially prepared in English. They were then translated into Kiswahili which is the working language of the participants in the research sites. The translators were hired from the National Kiswahili Council, a government organisation that is legally mandated to, among other functions, undertake official language translations in Tanzania. A different expert in the same

council carried out a back translation of the Kiswahili version into English to ensure that the original content was preserved.

The questionnaires comprised the following four main sections:
Section I: General views on the provision of school-based SRE: This section had two major questions. In the first question, respondents were asked to indicate the extent to which they agreed or disagreed with the statement that *SRE should be provided in schools in Tanzania*; there were five response options ranging from 'strongly disagree (1) to strongly agree' (5).

In the second question, respondents were provided with a list of six groups of people which can be involved in the provision of SRE, and were asked to indicate the level of involvement for each of the groups on a five response option, ranging from 'not at all involved' (1) to 'very much involved' (5). Respondents were also asked to write down any other group that they thought should be involved in the delivery of SRE to children.

Section II: Views and attitudes towards topics to be covered in school-based SRE:
In this section, respondents were provided with a list of 44 possible topics that can be included in a school-based SRE curriculum; they were asked to indicate the importance or unimportance of each topic using one of the five response options, ranging from 'not at all important (1) to very important' (5). There was also an open question which asked respondents to mention any other topics that they thought were important and should be included in the SRE curriculum.

Section III: Levels at which specific topics should be introduced in schools: In this section, respondents were asked to indicate the school level at which each of the 44 SRE topics could be introduced in schools. There were five response options: Class 4, Class 5-7, Form 1-2, and Form 3-4 and Form 5-6. Consistent with the education system in Tanzania, the terms *class* or *standard* and *form* are used to denote primary and secondary levels respectively.

Section IV: Social and demographic characteristics: In this section, respondents were requested to provide some of their personal information that was deemed important in understanding their responses. There were common items for all the three categories of respondents, including age, sex, religion and religiosity. There were, however,

some items varied for parents, teachers and students. Separate items for parents included marital/relationships status, number of children, educational level and social economic status. Separate items for teachers included teaching class, teaching qualifications and experience and whether or not they had attended a training course on SRE. There was only one separate social and demographic item for students in which respondents were asked to indicate the class level that they were currently attending.

Apart from the variation in the social and demographic items, there were also additional items for teachers and students that were not included in the parents' questionnaire. The additional items in the teachers' questionnaire concerned comfort and confidence of teachers regarding teaching of SRE in schools, in which they were asked to indicate whether they would find it easy or difficult to teach each of the 44 SRE topics. Response options ranged from 'very difficult (1) to very easy' (5).

The additional items in the student questionnaire concerned the sources of information about sexual health; students were provided with a list of several possible sources of information about sexual health and were asked to indicate how much information they have been receiving from each source on the basis of five response options ranging from 'nothing (1) to very much' (5).

The parents', teachers' and students' questionnaires used in this research are appended to this thesis as Appendices 1, 2 and 3 respectively.

4.2.3 Procedures for administering the questionnaire

4.2.3.1 Ethical considerations

Prior to the administration of the questionnaire, ethical approval was obtained from the School of Psychology, University of Southampton. In Tanzania, the University of Dar es Salaam provided the research clearance. According to regulations governing the conduct of research in Tanzania, the University of Dar es Salaam is mandated to provide research clearance for its members of academic staff. The researcher is a member of staff in the Department of Educational Psychology at this university.

The ethical approval from the University of Southampton and the research clearance from the University of Dar es Salaam were used to request permission to conduct research in the schools. This permission was provided by the Director of

Kinondoni Municipal Council for schools in the Kinondoni District and the Director of the Sengerema District Council for schools in Sengerema District.

4.2.3.2 Pilot study

The three sets of questionnaires were piloted with a small sample involving 15 parents, 15 students and five teachers in one primary school in Kinondoni District in Dar es Salaam, which was one of the participating districts in the research. The pilot study checked for any ambiguities and misunderstandings in the questionnaires. During the pilot study, participants were told that the researcher was interested in their reactions to the questions and response options rather than the specific responses. Participants were encouraged to note any ambiguities in the questions or response options that were not clear, repeated or not included. Furthermore, participants were requested to note down any additional questions that they thought were important but were not included.

Participants spent between 40 and 60 minutes completing the questionnaires. As would be expected, teachers finished earliest followed by students and parents spent the longest duration. Back in the office, participants' comments were read and a brief analysis run. Any problematic questionnaire items were noted and changes that were deemed necessary were incorporated before a final version of the questionnaire sets was produced for eventual administration to sample participants.

4.2.3.3 Administration of the questionnaires to parents, teachers and students

The following procedures were followed in administering the questionnaires to participants. The researcher first presented the research permission letters to the head teachers of the participating schools. An appointment was then made regarding a suitable time and place to administer the questionnaires for students, teachers and parents. It was agreed in both sites that students would complete the questionnaires before parents. This decision was made because parent respondents depended on the selected students and who eventually turned up for the research. Therefore, the list of parent respondents was contingent upon the list of student respondents.

Head teachers assisted in the selection of students to participate in the study prior to the date of the questionnaire administration. Head teachers were asked to select students on a random basis, in which any student aged 10 and above and who could read and write was eligible to participate in the research. On the day of the

questionnaire administration, for each school, the selected students were divided into two groups, with each group having a maximum of 10 respondents. The two groups sat in two different class rooms where they completed the questionnaire. Each room had a trained research assistant to attend to any issue that would require clarification.

Prior to completing the questionnaire, respondents were requested to read the instructions and ask questions if they had any. They were then requested to fill in consent forms and hand them to research assistants who were in the room. After every respondent had returned the completed consent forms, respondents were then requested to start filling out the questionnaire. The whole questionnaire took approximately 45 minutes to complete.

Head teachers were requested to invite teachers on voluntary basis, and preferably one from each of the student participating classes. Teachers who were selected to participate in the study were provided with the survey materials and then asked to fill them out in their own time and return them directly to members of the research team.

Parents' questionnaires were administered in two different ways in the two study sites. For Kinondoni, each student who completed a questionnaire was provided with a parent questionnaire and the consent forms in sealed envelopes to take to their parents, and they were requested to bring them back within two days.

In Sengerema, parents whose children had taken part in the study were invited to come to a school where their children were attending. This decision was reached following the head teachers' advice that there was a possibility that some parents in this district would have difficulties filling out their questionnaires on their own, and they would therefore need assistance. Upon arrival at the school premises, parents were introduced to the purpose of the study and their role in it. It was emphasised that their participation was voluntary and that their responses would be confidential.

4.2.4 Data entry, management and analysis

Data entry was done in Dar es Salaam, Tanzania, using the SPSS for windows software package version 15.0. A great part of data cleaning was also done in Dar es Salaam, which involved checking that all values for all questions were correctly entered. Data analysis took place upon the researcher's return in Southampton, and was performed using SPSS for windows software package version 15.0.

Frequencies were run to determine the percentage of responses for various items in the questionnaire. Other analyses such as t-test, analyses of variance and logistic regression analyses were conducted to examine the variation in the responses between respondents in the two districts as well as the influence of demographic factors on attitudes towards school-based SRE. Additionally, factor analyses were conducted to reduce the number of SRE topic variables into a manageable level. These have been detailed in the sections reporting the results of the various studies conducted in the research.

4.3 Qualitative research

The purpose of qualitative research was to explore, in much greater detail, participants' view of school-based SRE in Tanzania. Within a social constructivist paradigm (Silverman, 2005), the qualitative research facilitated a closer examination of the participants' social construction of the meaning and goals of SRE in the Tanzanian context in the face of daunting challenges of the HIV/AIDS pandemic. Furthermore, the qualitative research was used to explore participants' own experiences of SRE at home and school and how these experiences shaped their views and attitudes about the provision of SRE in schools today. In short, the qualitative research aimed to corroborate and elaborate upon the results of the quantitative survey research, thereby providing a basis for painting a broader picture of what stakeholders of the education sector in Tanzania think about school-based SRE than if quantitative research had been conducted alone.

4.3.1 Design: Focus groups

Qualitative research is not an homogenous entity in that it includes several approaches, such as, for example, interpretive phenomenological analysis (IPA), grounded theory, discourse analysis, conversation analysis and narrative analysis (Smith, 2003). There is no single agreed model within qualitative research; neither is there any one approach that is naturally better than the other (Silverman, 2005; Smith, 2003). The choice of the approach depends on several factors, including, notably, the nature of the research objectives and research questions and the theoretical assumptions that a researcher makes (Silverman, 2005).

The choice of the qualitative research design for this research was guided by the need to facilitate a sharing of views as well as illuminate differences in

perspectives among participants about the provision of SRE in schools in Tanzania. As argued by Gibbs (1997), though the views and attitudes about SRE may be held by individuals independent of a group or a social setting, the social gathering and interaction can facilitate the uncovering and construction of such attitudes. It has also been argued that people's attitudes and feelings are more likely to be constructed through discussion and social interaction, especially with regard to questions related to process ("how" and "why" questions) and content ("what" questions) [Kitzinger, 1995]. Consequently, then, focus groups were chosen for this research both as strategy and a method for collecting qualitative data.

Focus groups are a data collection technique that facilitates an interaction among people of similar backgrounds to talk about their attitudes and experiences about a phenomenon (Bryman, 2004). The focus groups method is a particularly useful strategy for facilitating people to explore and clarify their views and attitudes in ways that would not easily be achieved in a one to one interview (Kitzinger, 1995). Additionally, because focus groups take the form of a natural conversation and discussion, they, arguably, provide a useful strategy for encouraging participation from people who may be reluctant to being interviewed on their own for fear of being intimidated by the formality and isolation of one to one interviews (Millward, 2006). Kitzinger (1995) has observed that the focus groups method is useful in examining not only what people think but also how and why they think the way they think. Kitzinger has also observed that focus groups are useful in exploring survey results, as was the case in this research. Focus groups in this research were used to explore the results of survey research. Focus groups therefore provided an opportunity for the researcher to cross-check the trustworthiness of the data collected in the questionnaires.

However, focus groups have been criticised in that group norms tend to silence individual voices of dissent (Kitzinger, 1995). Furthermore, the presence of others compromises confidentiality, which is a key ethical issue in social research (ibid). However, Kitzinger has argued that groups can actively facilitate discussion of taboo topics such as sexual health by enabling members of the group to break the ice for shy participants. Focus groups can also provide an opportunity for members of the groups to support each other in expressing feelings that are common to their group and which may have previously been considered as abnormal.

Another common criticism of focus groups is that the results obtained from this method cannot be generalised to a whole population. However, as argued by Rabiee (2004), generalisation is not the main aim of focus groups, albeit this was not a problem in this research; this is because the aim of the focus groups in this research, as explained earlier, was to provide qualitative elaboration for the survey responses.

4.3.2 Sampling plan and sample size

There is no consensus among researchers on the precise number of focus groups as well as the size of the group (i.e., number of participants in a group) needed in a focus group discussion session. Bryman (2004, p.349) proposes that 'when the moderator reaches the point that he or she is able to anticipate fairly accurately what the next group is going to say, then there are probably enough groups already'. Milward (2006) has suggested that the data generated after having conducted about ten focus group sessions are largely redundant.

Again, there are no fast and hard rules as to how many participants should comprise a focus group discussion. Kitzinger (1995) recommends that a group should comprise between four and eight participants. On the other hand, Milward (2006) recommends that a focus group should comprise between six and twelve participants. The key point about the size of a focus group is that it should be large enough to be able to get a sufficient range of views but not too large to the extent of making it difficult to manage. For the purposes of the research in this thesis, and in line with Wilkinson, Joffe and Yardley's (2004) recommendation on the need to over recruit, the researcher aimed to recruit nine participants a group and run at least 6 groups with each of the three categories of respondents (parents, teachers and students). Additionally, the researcher aimed to conduct two focus groups with school policy makers.

In practice, a total of 23 focus groups were conducted, with five groups for parents, five groups for teachers, 11 groups for students and two groups for school policy makers. There were more groups for students than other categories because there were more issues - as can be seen in the results section- to explore with this group than other respondents, which prolonged the attainment of the saturation of issues discussed.

4.3.3 Procedures for focus groups

The focus groups were conducted at the school premises for parents, teachers and students and at the Ministry of Education headquarter offices for focus groups held with school policy makers. The school premises were an ideal place for parents, teachers and students because they were easy to access and were assumed to be familiar and non-threatening to a majority of the participants. Schools were particularly ideal for focus groups held in the Sengerema District (rural district) as they were the only institutions in the area with sufficient public facilities such as chairs and toilets.

Three schools from each district were selected from amongst the schools that participated in the survey research. As for the survey research, recruitment of participants for the focus groups involving parents, teachers and students was done through the head teachers of the selected schools. The recruitment of policy makers was done through the office of the Chief Education Officer in the Ministry of Education and Vocational Training.

Care was taken to ensure that the focus groups were neither too homogenous nor too heterogeneous in order, on the one hand, to allow for diverse opinions and experience to emerge and, on the other, to ensure that members of the groups were comfortable in talking to each other. Thus participants were selected from the same social environment, but with varied social backgrounds such as sex, ethnicity and religion.

Upon arrival at the venue of the focus groups, participants were briefed about the objectives of the research and the purpose of the focus groups in particular. To ensure a comfortable and relaxed setting for the participants, chairs were arranged in a circle to the extent that participants were able to face each other as well as the researcher who was the moderator of the focus group discussions. Furthermore, refreshments were provided, including soda and snacks which were purchased by the researcher prior to holding focus group sessions.

The researcher also explained that participation in the focus groups was voluntary and that participants were free to leave anytime they felt they were not comfortable continuing with the discussions. To ensure confidentiality, participants were told that no names or any other identifying characteristics would be included in the data collected. The demographic information such as sex and age were recorded in

a separate sheet upon arrival of participants and before the beginning of the focus group sessions.

In each focus group meeting, the researcher was accompanied by a research assistant. The researcher moderated the focus group meetings, whereas the research assistant took notes and was responsible for checking the recording equipment during the meetings. Focus group discussions lasted for between one and two hours.

At the end of the focus group discussions, the researcher read out the debriefing statement, re-thanked participants for their time and cooperation and reiterated that all information collected from the discussions would be treated with strict confidentiality. Participants signed the forms embodying payment for fare and compensation for their time. Participants were given the researcher's contact details in case they needed clarification or help with issues that emerged in the focus groups after the sessions had ended.

As for the survey research, ethical approval and research clearance for the focus groups research were obtained from the School of Psychology, University of Southampton and the University of Dar es Salaam in Tanzania respectively.

4.3.4 Data management and analysis plan

All focus group discussions were recorded and supplemented by field notes that were taken by a research assistant. The focus group discussions were recorded digitally and transferred into computer hard disc and subsequently saved in a memory stick as a back-up copy. All the files were clearly labelled with the date, time, location and length of the focus group session and the category of respondents (parents, teachers, students or policy makers). The data were transcribed as soon as the researcher was back in the office or hotel (for focus groups conducted in Mwanza). However, it was not possible to finish all the transcriptions in Tanzania; thus almost half of the transcriptions were done in Southampton. All the focus groups discussions were transcribed verbatim; enough back-up copies were prepared and stored separately in the computer and memory sticks.

The choice of the data analysis techniques was guided by theoretical assumptions. According to Wilkinson (2003), there are two theoretical assumptions on which the analysis of focus group data can be based; namely, essentialist and social constructionist model. The essentialist model is based on the assumption that individuals have their own cognitions reflected in terms of personal ideas, opinions,

understandings and attitudes about a phenomenon, and that the role of a researcher is to elicit these cognitions by providing an opportunity for people to release them spontaneously (ibid). On the other hand, focus groups conducted within a social constructionist perspective "does not assume pre-existing cognitions located inside people's heads, but, rather, presupposes that sense-making is produced collaboratively, in the course of social interaction between people" (ibid, p. 187).

However, the researcher believed that the present research fits in both paradigms. Accordingly, thematic analysis was chosen as a method to guide the focus group data analysis. It has been argued that thematic analysis is a contextualist method meaning that it sits between the essentialist and social constructionism (Braun & Clarke, 2006). Consistent with the contextualist approach, the researcher assumed that parents, teachers, students and policy makers have their own views and attitudes about school-based SRE and that these would be elicited and elaborated through discussions and social interaction in a focus group setting.

Since the focus group research was conducted after the survey research, in which some patterns of participants' views and attitudes about SRE had emerged, theoretical thematic data analysis was applied as opposed to inductive thematic analysis[6]. Accordingly, the focus group data analysis followed the usual six phases of the thematic analysis; namely: *familiarisation with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes* and *producing the report* (Braun & Clarke, 2006). The contents of each of these phases have been summarised in Table 4.1.

[6] According to Braun and Clarke (2006), inductive thematic analysis means that the themes identified are linked to the data themselves rather than to pre-conceived theoretical interest. In contrast, the theoretical thematic analysis tends to be driven by the researcher's pre-conceived theoretical or analytic interest in the area.

Table 4.1

Phases of Thematic Analysis

Phase	Description of the process
1. Familiarisation with data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential themes
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (level 2), generating a thematic 'map' of the analysis
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names of each theme
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to research question and literature, producing a scholarly report of the analysis.

Source: Braun and Clarke (2006, p. 87).

Chapter 5

Parents' Views and Attitudes towards School-Based Sex and Relationships Education in Rural and Urban Tanzania

5.1 Introduction

The successful implementation of sex and relationships education (SRE) programmes depends on several factors, including a careful consideration of the planning, development and evaluation processes that are informed by scientific theory and evidence. Furthermore, for school-based SRE programmes to be successful, they must be supported by and acceptable to key stakeholders (Plummer et al., 2007; Singh, Bankole & Woog, 2005; Carrera & Ingham, 1997). As argued by Boyd and McKay (1996), in order for SRE to reach the classroom, it must not only survive the academic scrutiny for it to be justified, but it must also successfully overcome the stark criticism from gate keepers, including parents.

Research has shown that school-based SRE programmes are more successful when they take into consideration, in the development and implementation processes, the views and attitudes of parents (Schaalma et al., 2004). Additionally, as argued by Weaver et al. (2002), it is important to understand parents' views and attitudes towards school-based SRE because they have potential effects on school policies as well as on the SRE curriculum content and implementation.

Previous research, especially in developed countries, has revealed consistent strong support for school-based SRE among parents. Surveys conducted in the USA, UK and Canada, for example, have shown that over 90 percent of parents wanted SRE to be introduced in schools and supported a wide range of topics to be included in the SRE curriculum (Carrera & Ingham, 1997; McKay, Pietrusiak & Holowaty, 1998; SIECUS, 2004; Weaver et al., 2002).

Studies conducted in sub-Saharan African countries regarding attitudes towards school-based SRE have also revealed an overwhelming parental support for the teaching of SRE in schools. For example, a survey of parents' perspectives of sex education in Ile-Ife town, Nigeria, revealed that 92 percent of the parents (N=400) supported its introduction in schools (Orji & Esimai, 2003). Orji and Esimai also

found that parents perceived sex education as an important strategy for protecting young people against HIV infection and unwanted pregnancies as well as for enhancing healthy relationships between opposite sex. Another survey of 180 parents in Cross Rivers State, Nigeria, reported that almost 94 percent of parents supported the teaching of sex education in secondary schools (Ogunjimi, 2006). However, while these studies established the general support for school-based SRE, they did not examine what specific SRE topics parents wanted covered in the school-based SRE curriculum.

There is a paucity of studies that have systematically investigated the views and attitudes of parents towards school-based SRE in Tanzania. It cannot be assumed that the results of studies done elsewhere can accurately represent the views and attitudes of parents in Tanzania. It has been observed that people's views and attitudes related to school-based SRE are often shaped by, among other factors, social-cultural contexts and specific and general ideological inclinations (McKay, 2004; Health Canada, 2003; McKay, 1999; McKay et al., 1998). There is, therefore, a need to explore parental attitudes towards school-based SRE in different social contexts.

This study aimed at assessing parents' views and attitudes towards the provision of SRE in schools in Tanzania in order to ascertain, on the one hand, their general level of support and, on the other, what they want (and do not want) covered in school-based SRE. The specific objectives of the study were to identify: (a) the extent to which parents in rural and urban areas wanted SRE to be taught in schools; (b) the topics that parents wanted covered in school-based SRE curriculum and (c) the timing for introducing SRE in schools. The study also examined the variation in the views and attitudes towards school-based SRE between parents in the urban and rural settings.

Apart from bridging a knowledge gap regarding parental attitudes towards school-based SRE, the findings of this study are expected to assist Tanzanian school policy makers to have a better understanding of what parents want their children taught about SRE. This study is particularly timely given that it was conducted at the time when the Tanzanian Ministry of Education has been involved in reviewing the national school curricula materials with the view to, among other objectives, integrating SRE.

The study employed a cross sectional survey and focus groups for data collection. The survey method enabled the collection of data regarding parents' views

about school-based SRE, appropriate SRE topics as well as the school levels that parents thought would be appropriate to introduce various SRE topics. The focus group method facilitated the collection of qualitative data that were required to explain and corroborate the survey results.

Section 5.2 and 5.3 describe the survey method and results, while section 5.4 describes the focus group study.

5.2 Survey of parents' views and attitudes towards school-based SRE

5.2.1 Participants

Two hundred-eighty seven parents[7] were involved in the survey study; these were recruited from two purposively selected districts; namely, Kinondoni (urban district) and Sengerema (rural district). Kinondoni is an urban-based multiethnic district located in the Commercial Capital City of Tanzania, Dar es Salaam. Sengerema is a rural-based district located in western part of Tanzania in Mwanza Region. Because of the urban-rural nature of the sites, the study anticipated capturing diverse opinions of participants across a wide range of social-cultural backgrounds. Thus, a number of individual and social demographic characteristics were collected from participants, including age, sex, educational background, religion and religiosity, marital/relationship status and occupation.

In the urban district (Kinondoni), a total of 203 questionnaires were distributed to parents of children in Standards 5, 6 and 7 in 12 schools, which were selected using a systematic random sampling procedure. A total of 201 completed questionnaires were returned, with a response rate of 99 percent in this district. In the rural district (Sengerema), 148 parents were invited to complete the questionnaire; however only 86 parents turned up and completed the questionnaire, with a response rate of 58.1 percent.

Table 5.1 summarises the demographic characteristics of the responding parents in the two districts. In both districts, a majority of the responding parents were young (age 25-35) and middle aged (age 36-45), were Catholics, Protestants or Muslims, oft-attended religious services (at least once a week) and viewed religion as being very important in their lives. More than half of the responding parents in the

[7] Although the study targeted parents of children attending the selected primary schools, in some cases it is carers who turned up and completed the questionnaire. To avoid repetition all are referred as parents.

rural district were male, while the majority (58.7%) of the responding parents in the urban district were female.

Table 5.1
Demographic Characteristics of Responding Parents by District

Demographic variables	% of Respondents	
	Urban District (Kinondoni)	Rural District (Sengerema)
Age		
25-35	39.1	32.9
36-45	32.8	38.0
46-55	22.4	24.1
Over 55 years	5.7	5.1
Sex		
Male	41.3	52.5
Female	58.7	47.5
Religion		
Catholics	36.2	49.4
Protestant	24.9	32.5
Islam	36.7	11.7
Other	1.1	1.3
None	1.1	5.2
How many times do you attend religious services		
Everyday	29.0	21.1
At least once a week	56.8	69.7
At least once a month	3.4	5.3
At least once a year	6.2	-
Never attend	4.5	3.9
How important is religion in your life		
Very important	93.2	89.6
Important	4.0	5.2
Somehow important	1.7	5.2
Not important	1.1	-
Not important at all	-	-
Relationship status		
Single	18.1	8.6
Married	70.3	72.8
Cohabitating	2.7	7.4
Separated/divorced	3.3	3.7
Widow/widowed	5.5	7.4
Number of children		
No children	12.1	7.6
1-2 children	31.9	8.9
3-5 children	41.8	35.4
More than 5 children	14.3	48.1
Educational level		
No formal education	2.7	5.1
Primary education	16.1	55.1

Demographic variables	% of Respondents	
	Urban District (Kinondoni)	Rural District (Sengerema)
Secondary education	47.8	26.9
Tertiary/college education	30.6	11.5
University degree and above	2.7	1.3
Occupation		
Fulltime employment	46.1	17.5
Self employed	41.1	13.8
Farmer	3.3	60.0
Other	9.4	8.8

5.2.2 Instrument

Parents completed a questionnaire titled *Parents' views and attitudes towards school-based SRE in Tanzania*. The questionnaire was initially prepared in English; it was then translated into Kiswahili, which is the working language for the majority of participants in the study sites. The Kiswahili version was translated back into English to ensure that the original content in the questionnaire was preserved.

The questions used in the questionnaire were adapted from the Weaver et al's. (2002) questionnaire used in a similar study conducted in Canada. Although most of the questions adapted were developed in the context of Canada, they were found to be applicable in measuring the views and attitudes of parents in Tanzania; the items that were included in the questionnaire had a good reliability, with Cronbach's alpha of .93.

The questionnaire comprised three major sections. In section one, respondents were provided with four questions. In the first question, on a five response option ranging from *strongly disagree* (1) to *strongly agree* (5), parents were asked to indicate to what extent they agreed that *SRE should be provided in schools in Tanzania*. In the second question, again using the above five response options, parents were asked to indicate the extent to which they agreed that *the school and parents should share the responsibility of providing SRE to children*.

In the third question, parents were asked to indicate the school[8] level at which they thought SRE should be introduced in schools; they were given five response

[8] According to the Tanzanian education system, primary education consists of seven years from Standard (also called Class) 1 to 7 (ages 7-13).Secondary education consists of ordinary and advanced levels, with the ordinary secondary school level consisting of four years from Form 1 to 4 (ages 14-17) and the advanced secondary level consisting of two years- Form 5 and 6 (ages 18-19).

options: *Class 4, Class 5-7, Form 1-2, Form 3-4* and *Form 5-6*. Question four asked respondents to indicate their preference regarding the groups of people who should be involved in the provision of SRE. Six groups were provided; namely, *teachers, physicians or nurses, parents, professional sex educators or counsellors, religious leaders (priests and sheikhs)* and *friends*.

In the second section of the questionnaire, parents were provided with a list of 44 SRE topics and, on a five response option ranging from *Not at all important (1)* to V*ery important (5)*, were asked to indicate the level of importance they attached to each. In the third section, parents were requested to provide some personal information, including age, educational level, religion, sex and marital status.

5.2.3 Procedure

The study was conducted in July –September 2006. A letter was sent to all head teachers of the participating schools explaining the purpose of the study and requesting their schools' involvement. Schools willing to participate were asked to select teachers and student volunteers to complete a questionnaire. Thus parent participants were recruited through the list of students who completed the student questionnaire.

All parents whose children participated in the student survey were invited to complete a questionnaire. In Kinondoni (urban district), head teachers distributed the questionnaires in sealed envelopes to students in their schools, with a request that they take them home to be filled out by their parents and return them within two days. Students returned the questionnaires in sealed envelopes to their school head teachers, who subsequently returned them to the researchers.

In Sengerema (rural district), the researchers were advised by the head teachers of the participating schools that a substantial proportion of parents did not have the literacy skills to read and fill out the questionnaires on their own. With this background, it was decided that parents in this district would be invited to complete the questionnaires in the school premises with the assistance of trained research assistants. The research assistants read out each question and the corresponding response options to each of the parent with limited literacy skills. The parent then selected the preferred response which was subsequently marked by the research assistant.

Data were analysed using SPSS statistical package version 15.The percentages of respondents in favour of various aspects of school-based SRE were computed. An independent samples t-test was performed to examine the differences in the views and attitudes towards school-based SRE between parents in the rural and urban districts. Multivariate statistical analysis (MANOVA) was performed to examine the variation in attitudes towards SRE topics between parents in the rural and urban districts. Additionally, factor analysis was carried out to explore the internal structure of the SRE topics.

5.3 Survey Results

5.3.1 Views and attitudes towards basic issues related to school-based SRE

As can be seen in Figure 5.1, in both districts, a majority of parents supported the provision of SRE in schools as well as the idea that both the school and parents should share the responsibility to provide SRE to young people. Almost 75 percent of parents in the urban district (Kinondoni) strongly agreed (33.7%) or agreed (40.8%) with the statement that *SRE should be given in schools in Tanzania*. In the rural district (Sengerema), 73.1 percent of parents strongly agreed (52.6%) or agreed (20.5%) with this statement.

Similarly, in both districts, 75 percent of parents in the urban district strongly agree (43.2%) or agreed (30%) with the statement that *the school and parents should share the responsibility of providing SRE to children.* In the rural district, 74.6 percent of parents strongly agreed (49.2%) or agreed (25.4%) with this statement.

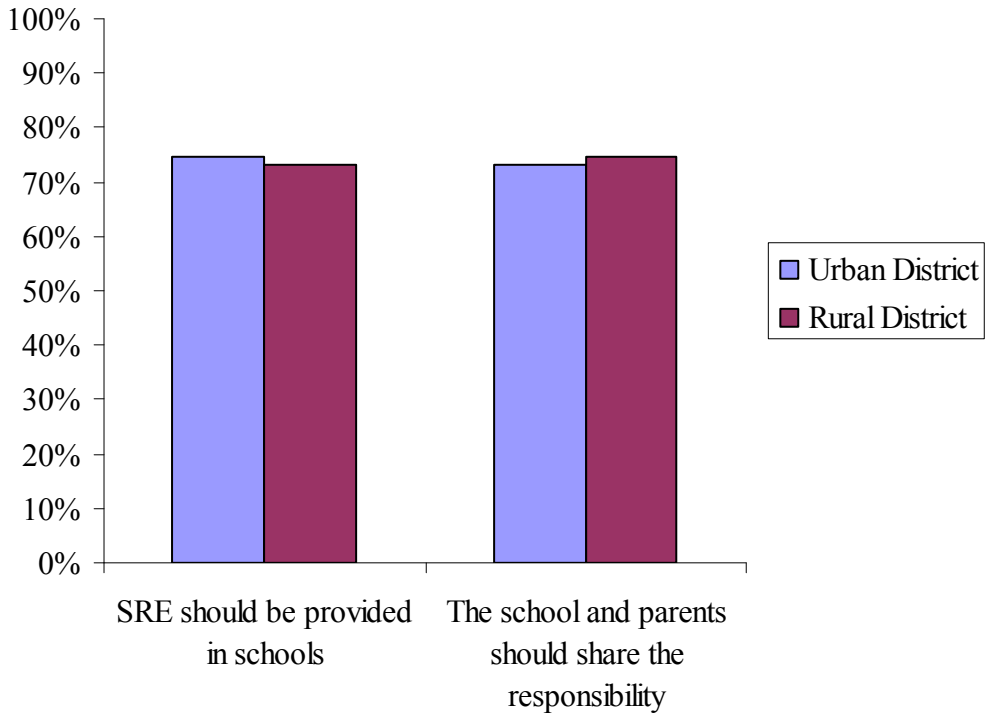

Figure 5.1. Percentage of parents in the urban and rural districts *strongly agreeing* and *agreeing* with statements: *SRE should be provided in schools* and *the school and parents should share the responsibility*.

Regarding the level to introduce SRE in schools, in both districts, as Figure 5.2 shows, the majority of parents (more than 60 percent) indicated that SRE should be introduced during primary school starting at Class 4 (age 10). For example, 36.9 percent and 27.2 percent of the parents in the urban district wanted SRE to begin at Class 4 and Class 5-7 respectively compared to only 22 percent of the parents who wanted it to begin at secondary schools levels (Forms 1-6). Similarly, in the rural district, 54.5 percent and 18.2 of percent of parents indicated that SRE should begin at during primary school at Class 4 and Class 5-7 respectively compared to only 28.3 percent of parents who wanted it to begin during secondary school level.

When parents were asked to indicate their preference regarding the groups of people who should be involved in the provision of SRE, in both districts, *professional sex educators or counsellors* and *teachers* were the most preferred groups followed by *physicians or nurses* and *parents*. *Religious leaders* and *friends* were the least preferred groups for SRE delivery (see Figure 5.3).

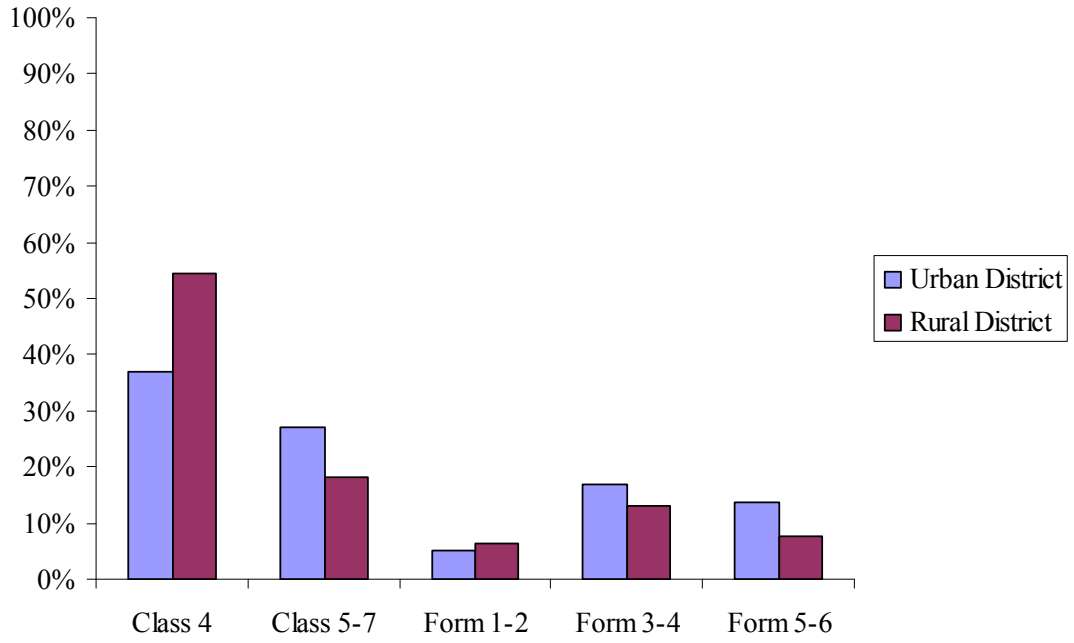

Figure 5.2. Percentage of parents in the urban and rural districts indicating the class level at which SRE should be introduced in schools

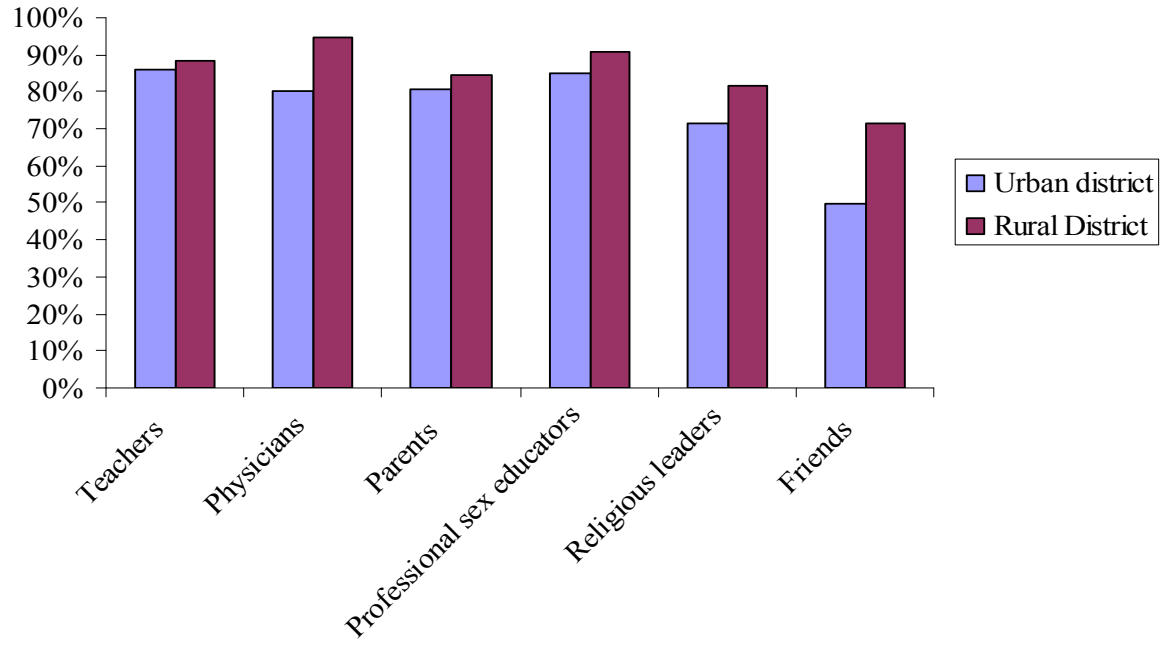

Figure 5.3. Percentage of parents indicating their preference of possible SRE deliverers in schools by district

5.3.2 Effects of parents' demographic characteristics on their attitudes towards school-based SRE

A logistic regression analysis was performed with *SRE should be provided in schools in Tanzania* as Dependent Variable (DV) and age, sex, educational level, employment status and religion as Independent Variables (IVs). Prior to running the logistic regression analysis, the scores for the DV were recoded into two categories; non-affirmative responses were scored as "No" and coded *0* and the affirmative responses were scored as "Yes" and coded *1*. Similarly, the dichotomous independent variable (sex) was recoded into two values coded as either 0 (male) or 1 (female).

A total of 287 cases were analysed and the Hosmer and Lemeshow Test showed that the model predicted the effect of independent variables on the parents' attitudes towards school-based SRE (X^2 (8, N=287)=9.642, p=.291. The model accounted for between 5.3 % (Cox & Snell R Square=.053) and 8.1 % (Nagelkerke R Square=.081) of the variance. Overall, the model showed that 78.1% of predictions were accurate.

Table 5.2 presents coefficients and the Wald statistic and associated degrees of freedom and probability values for each of the predictor variables. The table shows that only age predicted parents' attitudes towards school-based SRE. The values of the coefficients revealed that younger (aged 25-35) and middle aged (36-45) parents were more likely than older parents (aged 46 and above) to agree with the statement, *SRE should be provided in schools* by an odd ratio of 0.64 (95% CI 0.43 and 0.97), implying that the older a person gets, the odds of him or her reporting positive attitudes towards the provision of SRE in schools decreases by a factor of .64.

Table 5.2

Variables Entered in the Parents' Logistic Regression Equation with the Resultant Coefficients

		B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I.for EXP(B)	
		Lower	Upper	Lower	Upper	Lower	Upper	Lower	Upper
Step	Age	-.441	.208	4.482	1	.034	.643	.427	.968
1(a)	Education	.135	.143	.886	1	.347	1.144	.864	1.514
	Occupation	-.069	.198	.122	1	.727	.933	.633	1.375
	Religion	-.306	.215	2.030	1	.154	.737	.484	1.122
	Sex(1)	-.288	.387	.554	1	.457	.750	.351	1.600
	Constant	2.926	.978	8.960	1	.003	18.656		

Variable(s) entered on step 1: Age, Education, Occupation, Religion, Sex.

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5.3.3 Parents' views on the importance of topics to be included in the school-based SRE

Respondents were provided with a list of 44 possible SRE topics to be included in a school-based SRE curriculum. They were then asked to indicate the level of importance they attach to each topic using five *Likert scale type*- criteria ranging from *Not at all important* (1) to *Very important* (5).

To aid in conceptualisation, the responses to the 44 topics were subjected to factor analysis (described in section 5.3.7) for the purpose of reducing the number of variables into a more comprehensible size. In line with Brace, Kemp and Snelga's (2006) recommendation, all variables with a KMO (Kaiser-Meyer-Olkin Measure) of less than .5 were removed from the analysis. This resulted in 25 variables on which parents' rating of the perceived importance of topics and their preference of the class to introduce these topics was based.

The results on parents' views about the inclusion of topics in the SRE curriculum are summarised in Table 5.3. The median (preferred to the mean score due to skewed distribution) of parents' responses shows that parents supported a wide range of topics to be included in the SRE curriculum. Five topics were most popular among parents in the urban district (Kinondoni), with a median of 5 indicating that they rated these topics as *very important*. These topics were *personal safety, puberty, the effects of drugs, alcohol and tobacco abuse, STDs and HIV/AIDS* and *sexual coercion and assault*. Twelve topics were most popular among parents in the rural district (Sengerema), with a median response of 5; namely, *personal safety, puberty, reproduction and birth, birth control methods, teenage pregnancy and parenting, sexual problems and concerns, family types and roles, dealing with peer pressure to be sexually active, the effects of drugs, alcohol and tobacco abuse, sexual decision making, STDs and HIV/AIDS* and *sexual coercion and assault*.

Perhaps surprisingly, as shown in Table 5.3, parents in the rural district (Sengerema) were more likely than their counterparts in the urban district (Kinondoni) to support the inclusion of topics that are usually regarded as controversial in the teaching of SRE; namely, *masturbation, homosexuality* and *condom use.* For example, parents in the urban district (Kinondoni) rated *masturbation* and *condom use* just as *somewhat important* (median=3) while their counterparts in the rural district (Sengerema) rated these topics as *important* (median=4). Similarly, parents in the

urban district rated *homosexuality* as *not important* (median=2) while their counterparts in the rural district rated this topic as *somewhat important* (media response 3).

Table 5.3

Importance Parents Assigned to Possible Topics in the SRE Curriculum by District

	Urban District (Kinondoni) N=179-198				Rural District (Sengerema) N=74-79			
	Mean	Median	Mode	Std Deviation	Mean	Median	Mode	Std Deviation
1. Correct names of genitalia	3.7	4	4	1.3	3.9	4	5	1.3
2. Personal safety	4.4	5	5	0.9	4.4	5	5	1.0
3. Body image	3.6	4	4	1.2	3.7	4	5	1.4
4. Puberty	4.3	5	5	1.0	4.4	5	5	0.9
5. Reproduction and birth	3.8	4	4	1.2	4.2	5	5	1.2
6. Birth control methods	3.6	4	5	1.3	4.2	5	5	1.2
7. Pregnancy and parenting	4.0	4	5	1.1	4.6	5	5	0.8
8. Sexual problems and concerns	3.9	4	5	1.3	4.0	5	5	1.4
9. Family types and roles	3.9	4	5	1.3	4.0	5	5	1.4
10. Sexual behaviours	2.9	3	1	1.5	3.8	4	5	1.4
11. Attraction, love and intimacy	2.7	3	1	1.4	3.2	4	4	1.5
12. Sex as part of a loving relationship	2.6	2	1	1.5	3.4	4	5	1.5

	Urban District (Kinondoni) N=179-198				Rural District (Sengerema) N=74-79			
	Mean	Median	Mode	Std Deviation	Mean	Median	Mode	Std Deviation
13. Being comfortable with the other sex	3.2	3	4	1.3	3.8	4	5	1.4
14. Dealing with peer pressure	3.9	4	5	1.2	4.2	5	5	1.2
15. Communicating about sex	2.8	3	1	1.5	3.5	4	5	1.6
16. Pornography	2.2	2	1	1.5	3.0	3	1	1.7
17. The effects of drugs abuse	4.2	5	5	1.3	3.8	5	5	1.6
18. Abstinence	3.3	4	4	1.4	3.4	4	4	1.5
19. Sexual pleasure	2.8	3	1	1.5	3.4	4	4	1.4
20. Sexual decision making	4.0	4	5	1.2	4.3	5	5	0.9
21. Safer sex (condom use)	2.9	3	1	1.5	3.9	4	5	1.3
22. STDs and HIV/AIDS	4.3	5	5	1.2	4.1	5	5	1.5
23. Sexual coercion and assault	4.1	5	5	1.3	4.2	5	5	1.3
24. Masturbation	2.9	3	1	1.6	3.3	4	5	1.5
25. Homosexuality	2.5	2	1	1.5	2.9	3	1	1.6

Note: Response options: 1=*Not at all important*, 2=*Not important*, 3=*Somewhat important*, 4=*Important* and 5= *Very important*.

5.3.4 Preferred class levels for introducing specific SRE topics

Parents were asked to indicate the class levels that they thought would be appropriate to introduce each of the 44 topics in the school-based SRE curriculum. There were four main response options reflecting the school system in Tanzania; namely, Class 4, Class 5-7, Form 1-2 and Form 3-4.

Table 5.4 shows the results for the parents' preferred class levels to introduce various SRE topics in the two districts. Again, to enhance comprehensibility, the results reported here are for the 25 basic SRE topics. The table shows that a majority of parents in both districts wanted many of the topics to be introduced at Class 5-7. However, a substantial percentage of parents (more than 30 percent) wanted some of the topics to be introduced at a much earlier level at Class 4; these include *personal safety, STDs and HIV/AIDS* and *the effects of drugs, alcohol and tobacco abuse*.

Table 5.4
Percentage of Parents Indicating Class Levels at which Specific SRE Topics Should be Introduced in Schools

	Urban District (Kinondoni) N=176-199				Rural District (Sengerema) N=75-78			
	Class 4	Class 5-7	Form 1-2	Form 3-4	Class 4	Class 5-7	Form 1-2	Form 3-4
1. Correct names of genitalia	16	65	8	4	31	50	6	1
2. Personal safety	31	62	7	0	43	51	5	0
3. Body image	12	23	33	15	27	27	13	16
4. Puberty	7	74	10	2	26	57	4	5
5. Reproduction and birth	6	67	14	8	21	56	4	11
6. Birth control methods	10	58	15	17	29	41	6	24
7. Pregnancy and parenting	23	34	16	27	37	41	6	17
8. Sexual problems and concerns	15	60	13	12	29	51	8	12
9. Family types and roles	11	40	20	29	20	46	8	26
10. Sexual behaviours	6	40	22	32	22	49	7	22

	Urban District (Kinondoni) N=176-199				Rural District (Sengerema) N=75-78			
	Class 4	Class 5-7	Form 1-2	Form 3-4	Class 4	Class 5-7	Form 1-2	Form 3-4
11. Attraction, love and intimacy	5	40	27	29	23	46	1	29
12. Sex as part of a loving relationship	3	38	22	37	19	48	10	22
13. Being comfortable with the other sex	5	95	0	0	32	68	0	0
14. Dealing with peer pressure	18	63	7	13	39	44	5	12
15. Communicating about sex	8	31	23	38	28	35	10	28
16. Pornography	33	44	12	11	43	35	4	18
17. The effects of drugs abuse	32	52	7	10	43	40	9	8
18. Abstinence	6	51	18	21	19	43	19	10
19. Sexual pleasure	6	56	20	13	18	70	1	4
20. Sexual decision making	4	36	33	21	15	51	15	11
21. Condom use	5	39	20	32	25	48	10	12
22. STDs and HIV/AIDS	31	59	3	1	40	46	5	4
23. Sexual coercion and assault	27	17	27	18	38	18	13	22
24. Masturbation	6	45	21	23	22	59	6	6
25. Homosexuality	9	47	22	17	25	48	8	12

5.3.5 Factor analyses for topics

A factor analysis was performed on the topics in order to reduce the total number of variables to a more manageable size and to explore the patterns and internal structure of the SRE topics. The application of the factor analysis aided the exploration of whether the variables could be used as operational representatives of the constructs underlying the three dimensions of the SRE curriculum; namely, cognitive, affective and behavioural dimensions. Thus, the confirmatory factor analysis approach was used as opposed to explanatory factor analysis approach (see Gorsuch, 1974).

The 44 topics were subjected to principal component analysis (PCA) using SPSS Version 15. Prior to performing PCA, the suitability of data for factor analysis was assessed. An inspection of the correlation matrix showed that the various indicators of factorability were good; there were many coefficients of .3 and above; the Kaiser-Meyer-Olkin (KMO) value was .875, exceeding the recommended value of .6 (Field, 2005). The Barlett's Test of Sphericity reached statistical significance ($p<.0005$), supporting the factorability of the correlation matrix.

The PCA revealed the presence of nine components with eigenvalues exceeding 1 (11.745, 3.665, 3.499, 2.345, 1.740, 1.457, 1.294, 1.126 and 1.068). However, an inspection of the screeplot revealed a clear break after the fifth component (see Figure 5.4). Thus, it was decided to retain five components for further analysis; this was further supported by the results of Parallel Analysis, which showed only five components with eigenvalues exceeding the corresponding criterion values (see Table 5.5) for a randomly generated matrix of the same size (44 variables x 287 respondents). For a component to be retained for further analysis after the PCA, its eigenvalue must be larger than the criterion value from the parallel analysis (Pallant, 2005).

Table 5.5

Comparison of Eigenvalues from Principal Components Analysis (PCA) and the Corresponding Criterion Values Obtained from Parallel Analysis

Component number	Actual eigenvalue from PCA	Criterion value from parallel analysis	Decision
1	11.745	1.8481	accept
2	3.665	1.7463	accept
3	3.499	1.6764	accept
4	2.345	1.6195	accept
5	1.740	1.5677	accept
6	1.457	1.5145	reject
7	1.294	1.4696	reject
8	1.126	1.4287	reject
9	1.068	1.3822	reject

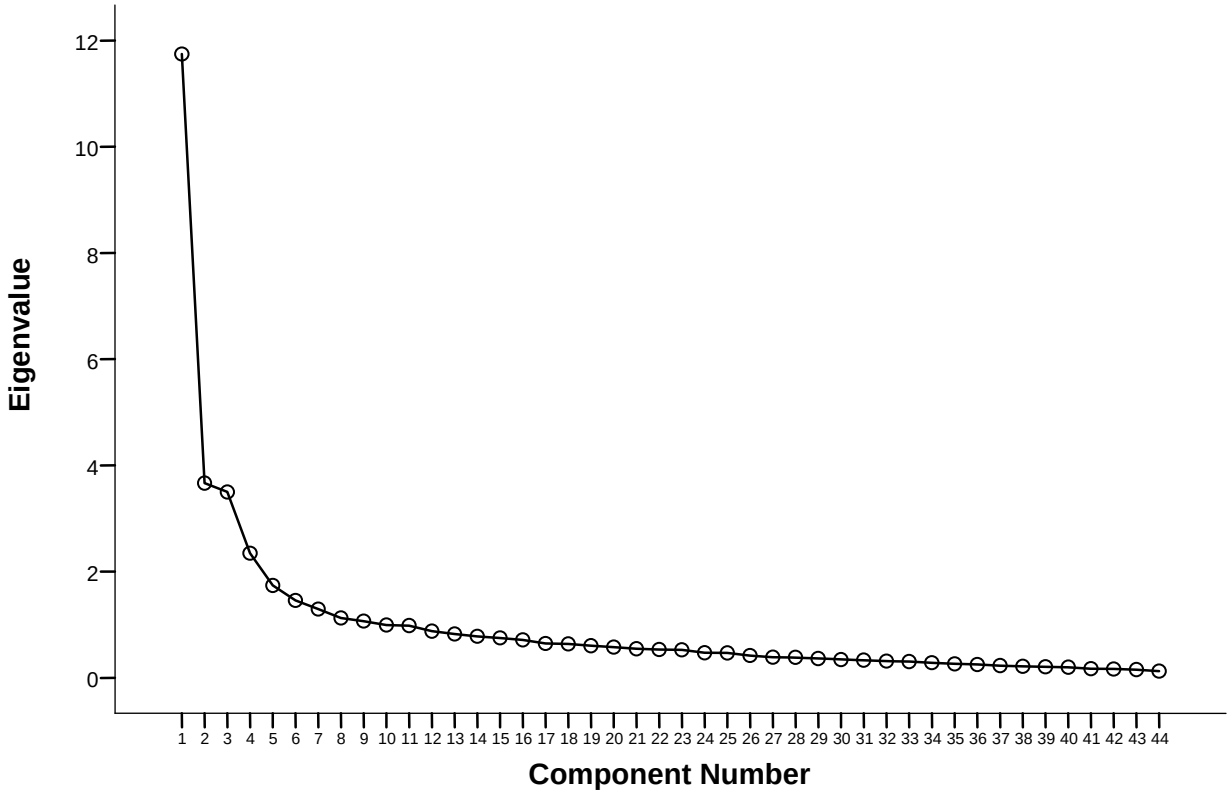

Figure 5.4. Screeplot of the 44 school- based SRE topics

A further inspection of the rotated component matrix (see Appendix 5) showed that only three components (factors) had more than five variables. According to Gorsuch (1974), at least five variables are required for each component/factor to be able to attribute such a factor into a meaningful interpretation. Thus, only three components were considered for interpretation into a possible three dimensional structure of a school-based SRE curriculum from parents' perspective. The three components clearly reflected the three dimensions (cognitive, affective and behavioural dimensions) of SRE curriculum as indicated in Figure 1.4 in Chapter 1. The variables for each of the three dimensions are indicated in Table 5.6.

Table 5.6

Components of SRE Dimensions as Extracted from Rotated Matrix of Factor Analysis

Cognitive dimension (facts and information)	***Affective dimension (attitudes and values)***	***Behavioural dimension (relationships and interpersonal skills)***
1. Menstruation 2. Puberty 3. Body image 4. Pregnancy 5. Correct names of genitalia 6. Wet dreams	1. Communicating about sex 2. Attraction, love and intimacy 3. Sex as part of a loving relationship 4. Sexual behaviours 5. Homosexuality 6. Pornography 7. Being comfortable with the other sex 8. Masturbation	1. Sexual behaviours other than intercourse 2. Masturbation as an alternative to sexual intercourse 3. Appropriate/inappropriate touching 4. Common myths concerning sexuality 5. Abstinence as an alternative to sexual intercourse 6. Reduction of fears and myths about sexuality matters 7. Sexual pleasure

Total scores were computed and reanalysed to assess the rating of importance for each of the three SRE dimensions. As is shown in Figure 5.5, topics under the cognitive (facts and information) dimension were perceived as far more important than topics in the other two dimensions; 71.4 percent and 80.3 percent of the parents in the urban and rural districts respectively rated topics under this dimension as very important or important. Topics under the affective dimension were particularly least popular among parents in the urban district whereby less than 40 percent of them rated topics under this dimension as very important or important compared to more

than 50 percent of the parents in the rural district who rated topics under the affective dimension as very important or important.

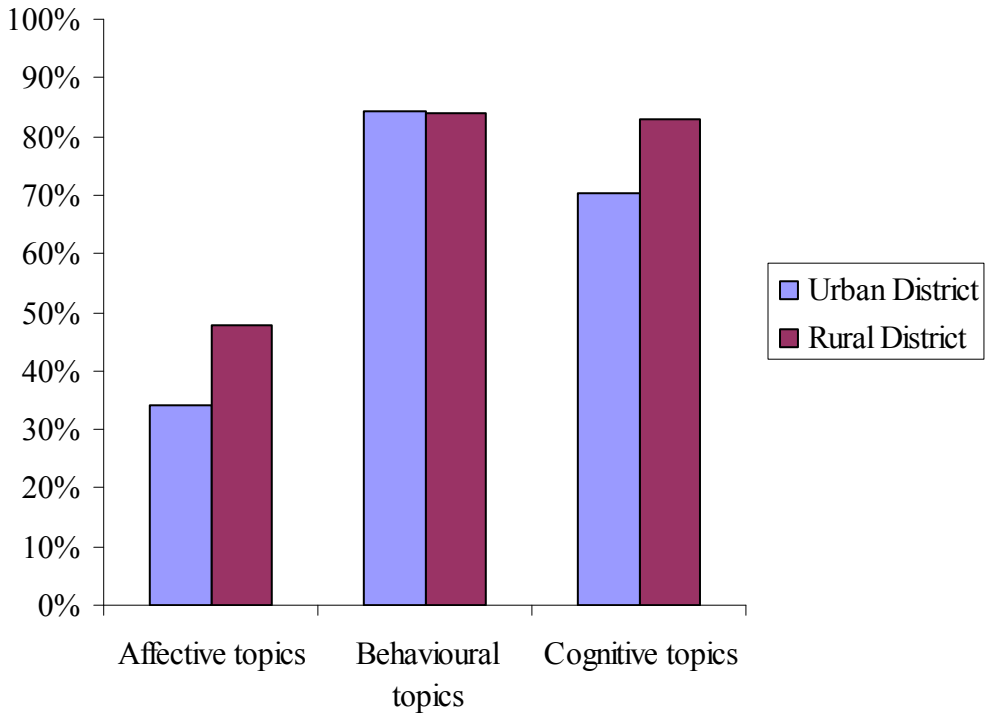

Figure 5.5. Percentage of parents in the urban and rural districts indicating that the three SRE dimensions are *very important* and *important*

5.3.6 Variation in the attitudes towards SRE between rural and urban parents

An independent-samples t-test was conducted to investigate the variation in attitudes towards school-based SRE between rural and urban parents. There was no statistically significant difference in scores measuring attitudes towards the statement, *SRE should be provided in schools* between rural parents (M=3.90, SD=1.46) and urban parents (M=3.71, SD=1.39); t (272) =-1.00, p=.32. The magnitude of the difference in the means was very small (eta squared=.004).

A one-way between groups MANOVA was performed to examine the variation in perceived importance of SRE topics between rural and urban parents. The dependent variables were the three SRE dimensions (Cognitive, Affective and Behavioural dimensions), whereas location of respondents was the independent variable. The Box's Test of Equality of Covariance Matrices had a significance level

of .945 indicating that there was no violation of the homogeneity of variance-covariance matrices assumption.

The results of one- way MANOVA revealed a statistically significant difference between rural and urban respondents on the combined variables: F (3,194) =4.93, p=.003; Wilks' Lambda=.93; partial eta squared=.07. However, when the results for the dependent variables were considered separately, the only difference to reach statistical significance, using a Bonferroni adjusted alpha level of .017, was the *affective dimension*: F(1,196)=13.77, p<.0005; partial eta squared=.022.

An inspection of the mean scores indicated that parents in the rural district (M=3.67, SD=1.07) perceived the affective dimension topics more favourably than their counterparts in the urban district (M=3.04, SD=1.03). This means that there was somewhat a stronger support for the inclusion of controversial and sensitive topics in the school -based SRE curriculum among parents in the rural district than those in the urban district.

5.4 Summary

This survey has demonstrated that an overwhelming majority of parents supported the teaching of SRE in schools. The survey has also shown that the majority of parents supported the inclusion of a wide range of topics in the SRE curriculum. However, the survey results have also revealed opposition of parents to the inclusion of some SRE topics that are considered controversial in the field of sexual health, including homosexuality and masturbation.

When the survey results regarding the perceived importance of SRE topics were analysed with respect to the three dimensions of SRE, it emerged that the parents' support was strong for *knowledge* and *relationships and skills dimensions* but lower for *attitudes and values dimension*.

The next section presents the results of the focus group study which explored, among other issues, some of the parents' reasons for their objection against the inclusion of some SRE topics, especially those in the attitudes and values dimension.

5.5 Focus group study results

The focus group study aimed to provide explanation for some of the issues that emerged from the survey results. This involved four groups (two groups in each of the two participating districts), with group sizes ranging from four to eight participants.

Participants for the focus group study were selected from amongst parents who completed the survey using the following procedures. From each of the two participating districts, Kinondoni Urban District and Sengerema Rural District, three schools were randomly selected. Then the head teachers of each of these schools were requested to invite between five and nine parents to take part in the focus group discussions. As for the survey study, parents were informed that participation in the focus group discussions was voluntary and that the research would adhere to the standard ethical procedures, including strict observance of confidentiality.

The demographic characteristics of parents who participated in the focus group discussions were roughly the same as those who completed the survey (see Table 5.1). However, the parents who took part in the focus group study were slightly older (mean age 49.6) than those in the survey study, with mean age of 39.5.

The focus group data were analysed using a theoretical thematic analysis approach (see Section 4.3.4 in Chapter 4 for a description of this approach). Four main issues emerged from the thematic analysis of parents' focus group discussion data representing their comments about a wide range of issues related to the provision of school-based SRE. These are presented and illustrated below.

5.5.1 Reasons parents gave for NOT teaching SRE in schools

Though a majority of parents (more than 70 %) who completed the questionnaire supported the provision of SRE in schools, a substantive proportion of other parents (more than 25 %) objected to it. It was thus important to explore the reasons that parents gave for not supporting the teaching of SRE in schools.

The results of the focus group study show that some parents opposed the teaching of SRE in schools for the fear that it would make children experiment with sex at an early age, as one parent explained in the quoted remarks below:

> *I have tried to deal with children; kids like to try to do anything that they are being refused to do. For example, if you tell kids something that is new to them, they develop curiosity and they want to know more and more. So, if you start telling them about sexual relationships between boys and girls, I tell you,*

in other words you will be asking them to go and try (male parent, age 44, rural district).

This parent went on to say that:

I am saying this from my practical experience. There are youth programmes concerning HIV/AIDS that were conducted by AMREF which I was involved as one of their facilitators in 1999. What I saw was like we were sensitising them [young people] to engage in sexual relationships. I taught in something like five or six schools, ehee, but I saw that the more I taught young people about these things, the stronger the interest they developed to practice what I was refusing them to do, in this case sex, you see. So, I realised that this was precisely because I was teaching very young children. So, like I said earlier, children always want to test the limits, ehee, they do exactly what you are telling them not to do. Therefore, when we will start teaching this education [SRE] in schools, I tell you, the other day all kids will be practising sex!

Other parents also supported the foregoing views by saying that:

You know what, when you teach a young person a new thing he or she wants to try. So if we teach them about sex, they will definitely want to put into test what they will have learnt in the class, as a result they will get problems including HIV/AIDS. Now is that what we want? (Male parent, age 52, rural district).

My only worry is this, if today these kids are not taught this education [SRE] and yet they are doing sex, many of them doing it at very young ages, now what if they were taught SRE? Won't they become experts of sex? Don't you think that they will be doctors and professors of doing sex? How are we going to cure them if they become such experts in doing sex? *(male parent, age 63, rural district).*

Well, what I know is that if you teach students mathematics, you expect them to use this knowledge in their daily life, now if we teach this education (SRE) what will happen after they have learnt about it? (Male parent, age 48, urban district)

Other parents opposed the teaching of SRE in schools for reasons based on cultural and traditional values. They argued that teaching young people about issues of sex was not in line with the Tanzanian traditional and cultural values, and that SRE was a western thing that would corrupt the minds of children:

I think our biggest problem with our education today is that we are taking too much things from other countries, especially from the developed countries. All this is aimed to make our children to despise our traditional values and respect those of the developed countries. So, even this education, what you call sex and relationships, falls on this same category. It is just a way to promote their values and downplay ours. May be time has not yet come for these

things, we should leave them to the white people; ehee, these things to be taught to African kids, ehee, I think we are going too far (male parent, age 70, rural district).

ahaaa, even me I think I want to join my colleagues who have just spoken; teaching our children about sex at their age I think is not proper. I think we are heading to a situation where we are going to kill the traditional values and culture of our nation. Look here, even us we did not learn about these things when we were as young as them. As age goes on, they will come to a point of understanding these things just automatically (male parent, age 44, rural district).

I don't think if this subject is meant for Africans, this is for people in Europe where they talk sex things in front of their children, not us (male parent, age 54, urban district).

Other parents objected to the teaching of SRE in schools for lack of confidence in teachers/schools to deliver this education to their children:

All I can say is that we should not confuse children with dirty talks about sex; I don't know safe sex, NO! What do you think is going to happen if they teach it at school and we don't do anything at home? They will just confuse kids with dirty and bad information. So, the least we can allow is if they just teach, we should also teach at home. I tell you if they teach at school and nothing happens at home, it will be like playing music to a goat! You cannot really trust teachers on these things (female parent, age 62, rural district).

However, some parents promptly opposed the idea that teachers cannot be trusted to teach SRE at schools; they argued that that teachers have the knowledge and skills which parents lack. They wondered that if teachers were even allowed to beat children at school how could they not be trusted to teach SRE, as one parents remarked:

I don't think if teachers can mislead the children, I mean we trust teachers in so many things, we even allow them to beat our children, why can't we trust them on this issue? So, for me, I just want to repeat that we parents can't do this job; it should be left to schools (male parent, age 55, rural).

5.5.2 Reasons parents gave for teaching SRE in schools

Parents gave various reasons for supporting the teaching of SRE in schools. Some of the parents thought that SRE would equip young people with information and skills they need in protecting themselves against HIV infection and other sexual health problems, as illustrated by their remarks quoted below:

I support the idea that SRE should be taught in schools because it will help young people to avoid the dangerous diseases which are so rampant now days, especially HIV/AIDS (female parent, age 42, urban district).

Other parents saw SRE as an important tool for equipping young people with life skills required not only for the prevention of HIV/AIDS and other sexual health problems, but also for enabling them to live productively in the society in which they are a part. They argued, for example, that SRE was instrumental in instilling good manners in children and young people. Parents also argued that schools were the right place to teach young people about SRE because they have trained teachers.

For me, I think this education [SRE] should be taught in schools. This will enable children to understand various things concerning their life because I believe this education covers more than issues of sex. And let's face the fact that issues of sex are personal issues and it is the individuals who should decide what to do with their sexuality; if they are taught at school how to deal with their sexuality it will help them enormously when they decide to have sex. Even if they are not going to be taught at school, they will still learn from the society through media and other means, but the trouble is in society they learn all the bad things. We expect that if they get this education though schools, they will be able to make proper decisions about sexual matters because schools have trained teachers who know how to deal with children (female parent, age 50, urban district).

Let this education be taught in schools. It will relieve us [parents] of the burden of warning our children about bad manners. Those who oppose this education do so because they don't know its benefits. The idea that we should not discuss about sex openly is quite strange because we know children these days start having sex at a very young age compared to our times. Even if this education is not taught in schools they will still do it; may be if they're taught it will help them to protect themselves against the dangers of HIV/AIDS and many other problems in the society (female parent, age 42, urban district).

Parents who supported the teaching of SRE in schools rejected the notion that teaching young people about SRE would lead them to experiment with sex at an early age. They argued, somewhat liberally, that young people should not be treated exceptionally in the society by wanting them to practice chastity while everybody else was not, as illustrated by the following comments:

I think this question of saying they will practice sex is nonsense; this is inevitable because even now they are doing sex without even being taught, and unfortunately they are doing it wrongly and ignorantly. Even us adults, look at our church leaders, they always tell us not to engage in sex outside our marriages, ehee, adultery, but we do exactly what they tell us not to do! So it is not about the children alone. Even these church leaders are doing exactly

what they are preaching us not to do (laughs). So, for me I wanted to say that there is no human being who is perfect, whether a child or an adult, which is why I think this education should just be taught and let everybody decide what to do, but do so knowledgeably (male parent, age 36, urban district).

5.5.3 Parents' awareness/knowledge and satisfaction of current SRE in schools

It was clear during the focus group discussions that some parents were aware of some aspects of SRE being taught in schools. However, they were oblivious of the exact content and amount of SRE that was being covered in the school syllabi. Most of the SRE aspects that parents seemed aware of being taught in schools were the biological aspects related to HIV transmission and prevention and reproduction.

I remember one science book that my daughter showed me, I think standard 6 or 7, there is a topic on reproduction, and there is also something about child development including girls developing breasts and things like those. There is also biology, reproductive organs for both male and female, all these things are there. There is also a section about sexually transmitted diseases, so I think, yes, there is something there; children are being taught about these things. But for me I don't know if what they are getting is enough or not (male parent, age 55, rural district).

I think this education is being taught, but how much, I have no idea. I once saw some charts in my grand daughter's exercise book, where they drew pictures of male and female reproductive organs, but now I don't know if they are still doing these (female parent, age 62, rural district).

I think this education is now taught in schools, especially in science syllabus. And I have a feeling that children like this subject very much. But, honestly, I don't know how much and what specific things they teach (male parent, age 37, rural district).

I think they are being taught some aspects of this education. I know, for example, that children are taught about self awareness and how the body functions; but I don't know if this is what you call sex and relationships education!(male parent, age 54, urban district)

5.5.4 Parents' attitudes towards teaching controversial topics in schools

5.5.4.1 Attitudes towards teaching condom use

Parents expressed different opinion regarding teaching of condom use in schools. As would be expected, parents were generally divided into two groups, those who objected to the idea of teaching condom use and those who supported.

Parents who objected to the teaching of condom use cited different reasons. Some thought that teaching condom use is teaching bad manners and would spoil and corrupt children's minds.

> *I think the message should be that sex is not a good thing at their age, not that it can be done in the right way, No! Teaching condom use to children is teaching bad manners, period! (Female parent, age 62, rural district).*

Other parents thought that teaching condom use will be tantamount to licensing children to start sexual intercourse:

> *As a parent, I am of the view that this topic should never be taught in schools. Because if you tell them that you can't get pregnancy or AIDS if you use a condom, it is like telling them that sex is no longer dangerous, it is fine, you can have sex whenever you want, this way we will see many children starting sex at a very young age, it should not be taught (male parent, 55, rural district).*

> *Now, when you talk about condom to children, ooh my God, for what? I don't know what is your aim really? This is like giving them tools to go and do sex peacefully and safely, it is actually arming them. I can't understand this thing. I don't think if this is right, this topic should be out of question, out completely (male parent, age 44 rural district).*

Other parents thought that primary school children were too young to be taught condom use; it will just confuse them and it will destroy the respect between teachers and students:

> *You know what if we allow this issue to be taught in schools, it will bring a big confusion. How will the kids study? Kids will think they are the same as their teachers, it will all be teasing, no education there. Teachers will lose respect, the school will just be like a bar (female parent, age 62, rural district).*

> *In my view children should not be taught condom use because they still are too young. I think they should just insist on abstinence; they will be told of condom use at a later age, not now (female parent, age 46, urban district).*

As noted earlier, not all parents in the focus groups were opposed to the inclusion of condom use as one of the topics in the SRE curriculum. Parents who supported the teaching of condom use gave various reasons, notably as a strategy to protect young people against HIV infection. Parents in support of teaching condom use argued that a majority of school children were already sexually active and denying them the opportunity to use condoms would not stop them from having sex. They also

argued that sex came before condoms; therefore condoms should not be blamed for young people's interest in sex.

> *I want to insist very strongly that condom use should be taught. First of all, we should understand that we are in a war, a big war against HIV/AIDS which is wiping out our nation. So, condom use must be taught to these children because they are already doing sex. We should understand that the problem here is not condom, rather it is sex. It is sex that came earlier before condom came. If we accept the fact that, as much as we don't want, our children are already doing sex, then we will be able to understand why it is important to teach condom use. I am sure teachers are not stupid; they will be careful whilst teaching to ensure that they strike a good balance between the importance of telling kids to abstain and using condoms. They will also tell kids about the safety of condoms (male parent, age 37, rural district).*

> *I think that children should be taught all aspects of SRE including condom use. When we say that they should be taught it is not that we're asking them to go and put what they are taught into practice. It is about equipping them with the necessary skills when they decide to have sex even at a later age. The important thing is that we should always insist that sex is not good at their age. However, when they feel they are ready they should be well equipped with protection strategies. This question of saying they will try is baseless. For example, children are taught about Nigerian geographical features, but it doesn't mean that after they leave the class they will go to Nigeria; not all things taught in the classroom are put into practice (female parent, age 50, urban district).*

Some parents, though were in support of the inclusion of condom lessons in the school curriculum, thought that condom use should not be taught to all children in schools. They argued that it should be taught only to children from Standard 5 (age 11) onwards.

> *First of all I say that condoms should be taught in schools. However, we have to be careful with age. I don't think if it is proper to teach condom use to young children, especially those who are in standard 4 and below (male parent, age 46, urban district).*

5.5.4.2 Attitudes towards covering homosexuality

The survey results showed that an overwhelming majority of parents in both urban and rural districts were opposed to the inclusion of homosexuality as part of the school-based SRE curriculum. It was thus important to explore, by way of focus groups, the reasons parents give for opposing the teaching of homosexuality in schools.

The analysis of the focus groups showed that parents opposed the teaching of homosexuality mainly for traditional and cultural reasons. Unanimously, homosexuality was seen as too heretic to be associated with African-ness. Parents also argued that teaching young people about homosexuality will teach them bad manners.

> *I think that this subject [homosexuality] should not be taught because it will teach children bad manners (female parent, 46, urban district)*

> *I want to say categorically that homosexuality is out of question; it should never be taught to our kids. This is the last thing I will accept my kid to hear about in the schools. Homosexuality is not normal, and trying to teach it is like trying to normalise it (male parent, age 52, rural district).*

Although a majority of parents were opposed to the teaching of homosexuality in schools, a substantial proportion of them, particularly in the rural district, were also supportive of its inclusion in the SRE curriculum. For example, 41.3 percent of the parents in the rural district rated homosexuality as very important (26.7 %) or important (14.7%). Paradoxically, the analysis of the focus groups showed that even those parents who supported the teaching of homosexuality, as demonstrated in the transcripts below, did so for somewhat questionable reasons, in which they would only support the inclusion of homosexuality if its teaching would exclusively involve explaining the negative aspects associated with being homosexual. For example, they said that homosexuality is a disease and therefore children should be taught about it so as to avoid it. Other parents even likened the dangerousness of homosexuality as a disease to HIV/AIDS.

> *For me I say that homosexuality is not our business, it is not part of the problem we have in our country, so why bother with it? (Male parent, 44, rural district).*

> *For me I say that this is [homosexuality] a disease like any other disease, and I think it is as dangerous as AIDS. So let our kids be taught about so that they can avoid it (Male parent, 50, urban district).*

> *What we don't understand is the fact that homosexuality has become part of us and some of our children are already spoilt. Even in schools some of the kids have become victims of homosexuality. Now if this is the case, what are we avoiding? If we don't teach it our youngsters will continue to be in the dark, they won't know how to avoid it. So for me I suggest that this subject*

[homosexuality] should also be taught so that we can give our boys and girls skills to avoid it (male parent, 56, rural district).

5.6 Discussion

The results of this study have shown that a vast majority of parents in both districts (urban and rural) supported the provision of SRE in schools. Almost three-quarters of parents in both districts supported the view that SRE should be provided in schools in Tanzania. Furthermore, the results show that the majority of parents thought that SRE should begin to be taught at primary school level particularly between Class 5 and 7 (age 11 and 14).

The results of this study are consistent with findings of previous studies, notably those conducted in developed countries using relatively similar survey instruments. For example, survey studies conducted in Canada have consistently revealed that over ninety percent of parents support the teaching of SRE in schools (McKay, Pietrusiak & Holowaty, 1998; Weaver et al., 2002). Similarly, a study conducted by SIECUS (2004) involving parents in different states in the USA showed that more than ninety percent of parents in the participating states supported the provision of SRE in schools. A recent cross-sectional survey of Greece parents' attitudes about teaching SRE in schools showed that a majority of parents wanted SRE to begin before adolescence (Kirana, Nakopoulou, Akrita & Papaharitou, 2007).

The results also show that, although parents supported the inclusion of a wide range of topics in the SRE curriculum, they objected to the inclusion of some topics that have for long been regarded as controversial, including condom use, homosexuality and masturbation. However, and perhaps surprisingly, while condom use was unpopular among the responding parents in the urban district, it was quite popular among parents in the rural district, with almost three-quarters of the parents in this district rating condom use as very important or important compared to just a third of their counterparts in the urban districts. Indeed, the results of MANOVA confirmed that parents in the rural district supported the topics under the affective dimension, which comprise topics on attitudes and values, more favourably than their counterparts in the urban district.

The variation in attitudes towards condom use and other controversial topics between rural and urban based parents could be partly be explained by the fact that parents in the rural district seemed, as demonstrated during the focus group

discussions, to have had a greater exposure to SRE than their counterparts in the urban district. The positive attitude towards condom use and other controversial topics demonstrated by parents in the rural district could particularly be attributed to the *MEMA Kwa Vijana* Programme which has been running in the district since 1998. Although it targeted young people, this programme actively involved parents and teachers in the planning, development and implementation of the HIV/AIDS education programme (Plummer et al., 2007).

The results of the focus groups demonstrate that parents support and object to the teaching of SRE in schools for various reasons. Generally, it is clear that a majority of parents supported the teaching of SRE in schools as a strategy for protecting young people from HIV/AIDS and other sexual health problems, which implies that the disease prevention approach to SRE is more favourable to parents than the sexual health promotion approach. The results of the focus groups also reveal that the fear that teaching young people about SRE may fuel promiscuity is still pervasive among many parents.

Although the results of the survey revealed a substantial proportion of parents, especially in the rural district, who seemed to have supported the inclusion of homosexuality in the SRE curriculum, the results of the focus groups suggest that the reasons for supporting it were as controversial as the topic itself. For example, rather than viewing the teaching of homosexuality as an opportunity to promote tolerance to diversity in beliefs and respect for individual choices and minority rights, some parents wanted homosexuality to be included in the SRE curriculum so as to teach young people its 'negative effects' and how blasphemous and heretic it was to be a homosexual. This shows that quantitative research alone may not suffice to paint a complete picture about parents' attitudes about such sensitive topics as SRE unless it is corroborated and complemented with qualitative research. In this case, qualitative research was clearly useful in revealing the attitudes of parents towards homosexuality, and particularly the parents' reasons for accepting and rejecting its inclusion in the school-based SRE curriculum.

This is the first major study that has systematically assessed the attitudes of parents towards the provision of school-based SRE in Tanzania. One of the strengths of the study has been the involvement of parents in rural and urban districts as well as the use of both quantitative and qualitative methodological approaches, which facilitated the disentangling of a wide range of opinions about school-based SRE from

a relatively large number of parents from diverse social backgrounds. However, the study was limited to two districts only; therefore, the extent to which the results can be generalised to the rest of the districts in Tanzania is only indicative rather than conclusive.

Chapter 6

Teachers' Attitudes and Comfort about Teaching School-Based Sex and Relationships Education

6.1 Introduction

The effectiveness of school-based SRE depends on, among other factors, the effectiveness of teachers who implement it (Cohen, Sears, Byers & Weaver, 2004). Furthermore, it has been argued that the extent to which teachers implement the school-based SRE curriculum is largely dependent upon and influenced by their attitudes towards it (Paulussen, Kok & Schaalma, 1994). Indeed, one of the central characteristics of an effective SRE programme is the level at which teachers are willing and show positive attitudes towards teaching it (Kirby et al., 2005). It is in this context that several authors have recommended that teachers' attitudes and confidence about teaching SRE be assessed prior to engaging them in the delivery of SRE programmes (Paulussen et al., 1994; Oshi, Nakalema & Oshi, 2004; Mathews, Boon, Flisher & Schaalma, 2006).

Though there has been a plethora of studies that have examined the attitudes of teachers towards teaching SRE in schools in developed countries, there has been a paucity of such studies in sub-Saharan Africa. For example, a review of literature conducted for this thesis did not come across any study that assessed teachers' attitudes towards school-based SRE in Tanzania. This study was conducted in an attempt to bridge this gap in knowledge.

This chapter presents the results of the survey and focus group studies that assessed teachers' attitudes and comfort about teaching SRE in schools. The study employed both quantitative (survey) and qualitative (focus groups) research methods. While the survey study was instrumental in assessing the teachers' attitudes towards school-based SRE, the focus groups study facilitated an understanding of the factors behind these attitudes as well as the barriers that teachers and school policy makers thought thwart the effective teaching of SRE in schools.

The chapter is organised in three major sections: method, results and discussion. The method section is further subdivided into three major subsections describing the participants, instrument and procedure used in data collection.

The results of the survey are presented in four major sections. The first section covers results on teachers' views and attitudes towards the general issues related to the provision of school-based SRE, including whether or not they support the view that SRE should be provided in schools and the level at which they thought it should be introduced. The second section presents results on teachers' attitudes towards the inclusion of various topics in the school-based SRE curriculum. The third section of the results presents the teachers' views about whether they would find it easy or difficult to teach SRE topics in schools. The last section examines the association of teachers' demographic characteristics and their views and attitudes towards school-based SRE.

6.2 Survey study method

6.2.1 Participants

Forty eight teachers in 12 schools in the urban district (Kinondoni) and 38 teachers in eight schools in the rural district (Sengerema) were requested to complete the questionnaires. However, only 38 teachers in the urban district and 32 teachers in the rural district actually volunteered to complete the questionnaire, giving a response rate of 79.2 percent and 84.2 percent for the urban and rural districts respectively. The overall response rate for both districts was 81.4 percent.

Table 6.1 summarises the demographic characteristics of responding teachers. The majority of teachers in the urban district were aged 25-35 (57.9 percent), while the majority of teachers in the rural district were aged 46-55 (36.7 percent) and 25-35 (30 percent). In both districts, the majority of respondents were female; 63.9 percent and 55.2 percent of the respondents in the urban and rural districts were female respectively.

A majority of the responding teachers (42.1%) in the urban district reported belonging to Catholics, while the majority of those in the rural district (50%) reported belonging to Protestants. In both districts, more than 90 percent of the responding teachers reported attending religious services either *every day* or *at least once a week* and that religion was *very important* in their life.

The majority of teachers in the urban district (92.1%) and rural district (73.3 %) held a certificate in education (Grade A) as their teaching qualification. The majority of teachers in the urban district (42.1%t) had teaching experience of less than 5 years, while the majority of teachers in the rural district (53.3%) had teaching

experience of more than 15 years. About 57 percent of teachers in the rural district indicated having attended some training programmes in teaching SRE, compared to 42 percent of teachers in the urban district.

Table 6.1
Demographic Characteristics of Responding Teachers by District

Demographic variables	% of Respondents	
	Urban District (Kinondoni) N= 38	Rural District (Sengerema) N= 32
Age		
25-35	57.9	30.0
36-45	21.1	23.3
46-55	21.1	36.7
Over 55 years	-	10.0
Sex		
Male	36.1	44.8
Female	63.9	55.2
Religion		
Catholics	39.5	50.0
Protestant	42.1	40.0
Islam	18.4	3.3
Other	-	3.3
None	-	3.3
How many times do you attend religious services		
Everyday	23.7	16.7
At least once a week	73.7	76.7
At least once a month	2.6	3.3
At least once a year	-	3.3
Never attend	-	-
How important is religion in your life		
Very important	94.7	89.3
Important	5.3	10.7
Somehow important	-	-
Not important	-	-
Not important at all	-	-
Teaching qualification		
Certificate in education (Grade A)	92.1	73.3
Certificate in education (Grade B)	-	20.0
Diploma in education	2.6	3.3
University degree	-	3.3
No formal teaching qualification	5.3	-
Teaching experience		
Less than 5 years	42.1	23.3
5-10 years	10.5	6.7
10-15 years	23.7	16.7
More than 15 years	23.7	53.3
Have you attended any training course on SRE?		
Yes	41.7	56.7

Demographic variables	% of Respondents	
	Urban District (Kinondoni) N= 38	Rural District (Sengerema) N= 32
No	58.3	43.3

6.2.2 The instrument and procedure

Teachers completed a questionnaire entitled *Teachers' views and attitudes towards school-based SRE in Tanzania* (Appendix 2). The questionnaire had the same set of questions as for the parents' questionnaire that has been described in Chapter 4, with the exception of one additional item and some specific demographic characteristics as shown in Table 6.1. The additional item on the teachers' questionnaire contained questions on the comfort regarding teaching SRE; teachers were provided with a list of 12 SRE topics and, for each topic, they were asked to indicate the level of comfort they would find in teaching each topic on the basis of a five-response scale ranging from *Very difficult* (1) to *Very easy* (5).

Teachers were randomly selected to participate in the study with the help of head teachers of the participating schools. All teachers in the participating schools were eligible to complete the questionnaires because teachers of primary schools in Tanzania are mandated to teach all subjects in the school curriculum. The researcher distributed the questionnaires to the head teachers of the participating schools together with a covering introductory letter and consent forms, with a request that the questionnaires be returned to the researcher within a week.

Data were entered and analysed using SPSS statistical package Version 15. The percentages of respondents in favour of various aspects of school-based SRE were computed and were used to assess the extent to which teachers supported the provision of SRE in schools. Independent samples t-test was performed to explore the variation in the views and attitudes towards school-based SRE between teachers in the urban (Kinondoni) and rural (Sengerema) districts. Logistic regression analysis was performed to examine the effects of teachers' demographic characteristics on their views and attitudes about school-based SRE. Multivariate statistical analysis (MANOVA) was conducted to explore the association between teachers' demographics and their perceived importance of SRE topics.

6.3 Results of the survey study

6.3.1 Teachers' attitudes towards basic issues related to school-based SRE

As can be seen in Figure 6.1, in both districts, an overwhelming majority of teachers supported the provision of SRE in school as well as the idea that the school and parents should share the responsibility to provide SRE to children. For example, 92.2 percent of teachers in the urban district (Kinondoni) agreed (42.1%) or strongly agreed (50.1%) with the statement that *SRE should be provided in schools*. In the rural district (Sengerema), 90 percent of teachers either agreed (30%) or strongly agreed (60%) with the statement. Again, in both districts, 90 percent of the teachers either strongly agreed or agreed with the statement that *the school and parents should share the responsibility of providing SRE to young people*.

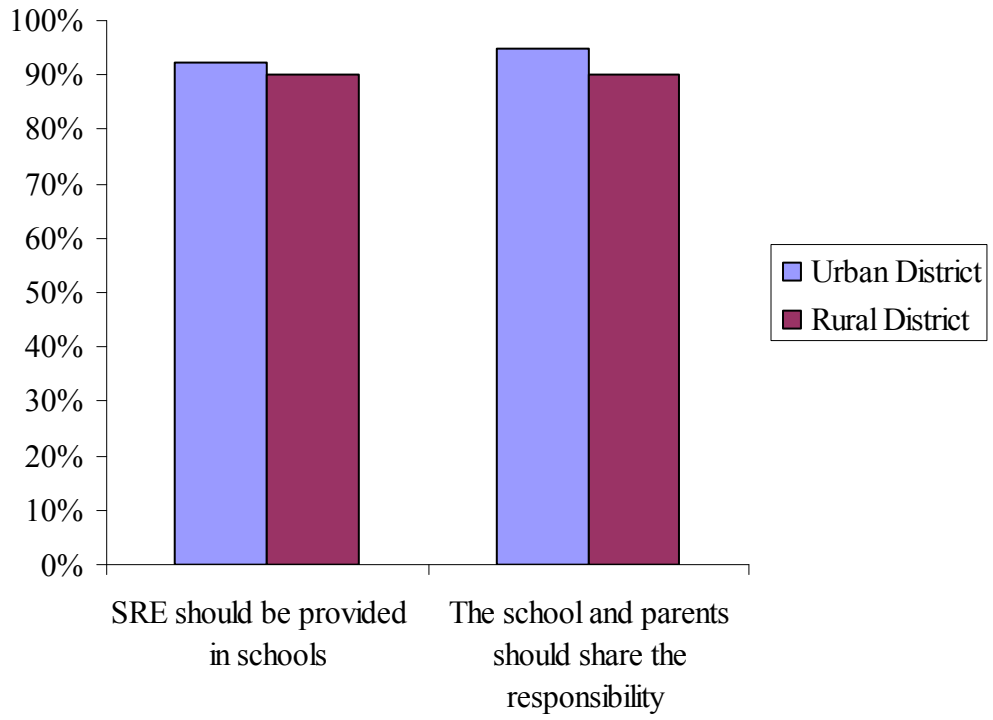

Figure 6.1. Percentage of teachers in the urban and rural districts agreeing with statements: SRE should be provided in schools and the school and parents should share the responsibility

When asked to indicate the class level during which SRE should be introduced in schools, 71 percent of the teachers in the urban district and 94 percent of the teachers in the rural district indicated that SRE should begin at primary school level

between Class 4 and 7 (see Figure 6.2). The paired- samples t- test revealed a statistically significant difference in teachers' preference of the school level to introduce SRE between the primary school level (M= 4.14, SD=1.12) and the secondary school level (M= 2.39, SD= 1.46): t (58) =6.224, p< .0005. The eta squared statistic (.40) indicated a large effect size. However, a one-way between groups MANOVA revealed no statistically significant difference in the preference of the school level to introduce SRE in schools between teachers in the urban and rural districts: F (2, 56) = 2.053, p= .138; Wilks' Lambda= .932.

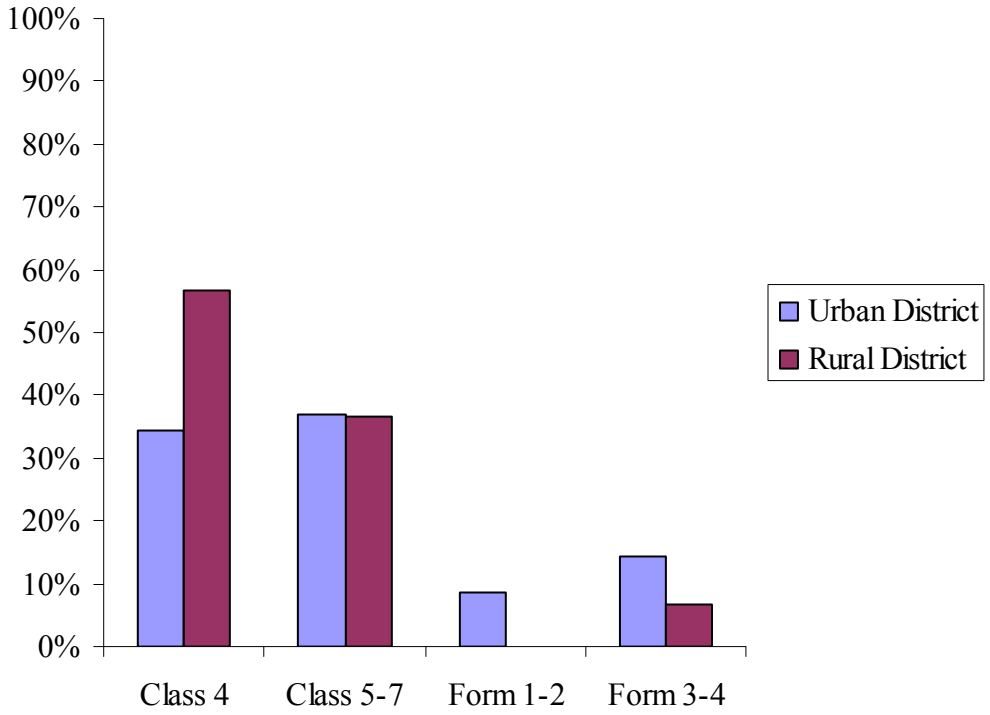

Figure 6.2. Percentage of teachers in the urban and rural districts indicating the level at which SRE should be introduced in schools.

Note that, according to the Tanzanian education system, Class 4 to 7 are primary school levels corresponding to ages 10 to 14 and Form 1 to 4 are ordinary secondary school levels corresponding to ages 15 to 17.

When asked to indicate the extent to which *teachers, physicians or nurses, parents, professional sex educators or counsellors, religious leaders* and *friends* should be involved in the provision of SRE to young people, as shown in Figure 6.3, more than 90 percent of the teachers in both districts indicated that four of the six possible SRE providers (*teachers*, *physicians or nurses*, *parents* and *professional sex educators or counsellors*) should be involved or very much involved in the provision

of SRE to young people. *Teachers* were the most preferred SRE providers by teachers in both districts; 97.3 percent of the teachers in the urban district indicated that teachers should be very much involved (60.5 percent) or involved (36.8 percent) in educating young people about SRE. In the rural district, 96.7 percent of teachers indicated that teachers should be very much (76.7 percent) or much involved (20 percent). *Friends* were the least preferred SRE providers by teachers in both districts; only 50 percent of teachers in the urban district indicated that this group should be very much involved (28.9 percent) or much involved (21.1 percent) in educating young people about SRE. In the rural district, 58.6 percent of teachers indicated that this group should be very much involved (34.5 percent) or much involved (24.1 percent).

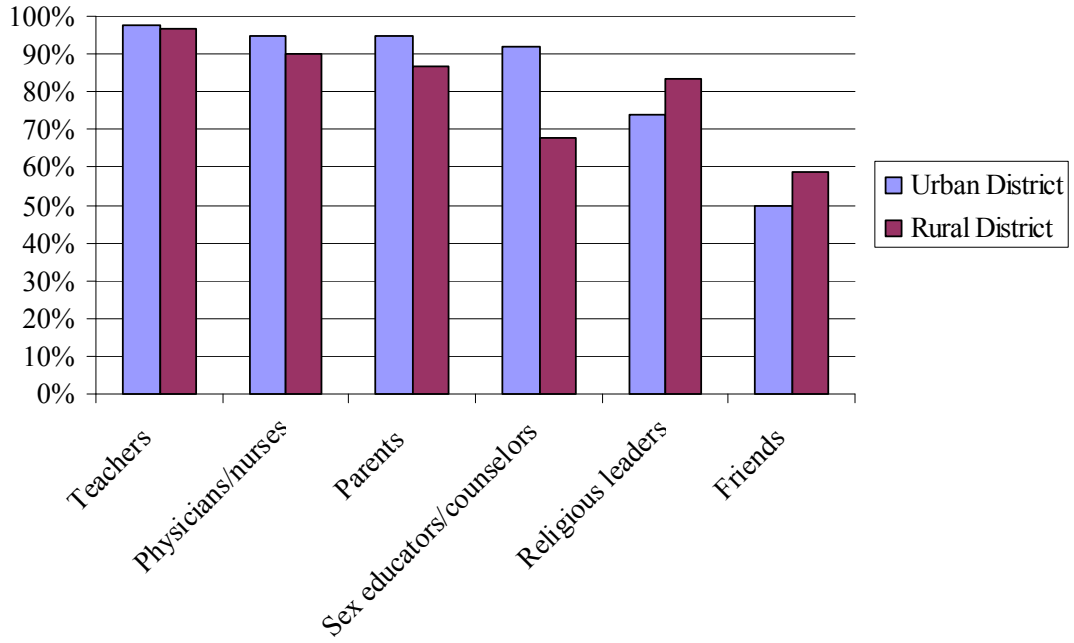

Figure 6.3. Percentage of teachers in the urban and rural districts indicating that various groups should be very much and much involved in the provision of SRE to young people

6.3.2 Effects of teachers' demographic characteristics on their attitudes towards school-based SRE

A logistic regression analysis was performed with *SRE should be provided in schools* as Dependent Variable (DV) and *sex, teaching subject, experience of training in SRE, location* and *religion* as Independent Variables (IVs). A total of 68 cases were

analysed, with the model accounting for between 28.3 % (Cox & Snell R Square=.096) and 21.7 % (Nagelkerke R Square=.217) of the variance. The Hosmer and Lemeshow test showed that the model was accurate in predicting the teachers' attitudes towards the provision of SRE in schools (Hosmer and Lemeshow test Chi-square=7.884, df=8, p=.445).

Table 6.2 presents coefficients and the Wald statistic and associated degrees of freedom and probability values for each of the predictor variables. The table shows that none of the teachers' demographic characteristics reliably predicted the teachers' attitudes towards school-based SRE. However, these results need to be interpreted with care given the small size of the sample (N=68) under investigation. According to Tabachnick and Fidel (2001), sometimes the failure of the logistic regression model is caused by too a small sample size relative to the number of predictors as was the case in this study. Pallant (2005) proposes this formula to determine the number of predictors to be entered into the logistic regression equation: $N>50+8m$, where m is the number of predictors. Thus, for a sample of 68 cases as was the case in this study, logistic regression model would work well for a maximum of only two predictor variables. However, in this case, even when only two predictors were considered at a time, none of them statistically significantly predicted teachers' attitudes towards school-based SRE.

Table 6.2

Variables Entered in the Logistic Regression Equation with the Resultant Coefficients

	Predictor variables	B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I.for EXP(B)	
		Lower	Upper	Lower	Upper	Lower	Upper	Lower	Upper
Step 1(a)	sex(1)	1.675	1.330	1.584	1	.208	5.336	.393	72.403
	Teaching subject(1)	1.160	1.175	.975	1	.323	3.191	.319	31.919
	Training in SRE(1)	-2.504	1.428	3.075	1	.079	.082	.005	1.343
	Location (1)	-.024	1.091	.000	1	.982	.976	.115	8.281
	Age(1)	-1.054	1.130	.870	1	.351	.349	.038	3.191
	Religion (1)	-1.093	1.431	.584	1	.445	.335	.020	5.537
	Constant	3.779	1.574	5.767	1	.016	43.780		

a Variable(s) entered on step 1: sex, Teaching subject, Training in SRE, Location, Age, Religion.

6.3.3 Teachers' views on the importance of topics to be included in the school-based SRE

Teachers were provided with a list of 44 SRE topics and were asked to rate the importance of each topic on a five-point scale ranging from *Not important at all* (1) to *Very important* (1). Table 6.3 summarises the mean and median response scores of the teachers' views about the importance of each of the 44 topics.

As can be seen from Table 6.3, teachers rated the majority of topics as *very important* or *important* (median score of 5 and 4 respectively). For example, teachers in the urban district rated 32 topics (72.7 percent of all topics) as *very important* (18 topics) or *important* (14 topics). Teachers in the rural district rated 33 topics (75 percent of all topics) as *very important* (19 topics) or *important* (14 topics).

Teachers in the urban district rated nine topics as *somehow important* (median score =3), whereas teachers in the rural district rated six topics as such. Only two topics were rated by teachers in both districts as *not important at all*, these were *homosexuality* and *pornography*. *Sex as part of a loving relationship* was rated by teachers in both districts as *not important* (median score= 2*)*. Additionally, teachers in the rural district rated five other topics as *not important* (median score=2); namely,

masturbation, appropriate/inappropriate touching, sexuality as a positive aspect of self, common myths about sexuality and *sexual feelings and expression*.

When the topics were classified into the three dimensions of SRE - cognitive, affective and behavioural dimensions- using the pattern obtained in the factor analysis presented in Table 5.6, it emerged that the affective dimension (encompassing topics on attitudes and values) was the least preferred by the majority of teachers in both districts. Whereas more than 90 percent of teachers in both districts rated cognitive (encompassing topics on facts and information) and behavioural (encompassing topics on skills and interpersonal relationships) dimensions as *very important* or *important*, less than 30 percent of teachers rated the affective dimension as such (see Figure 6.4).

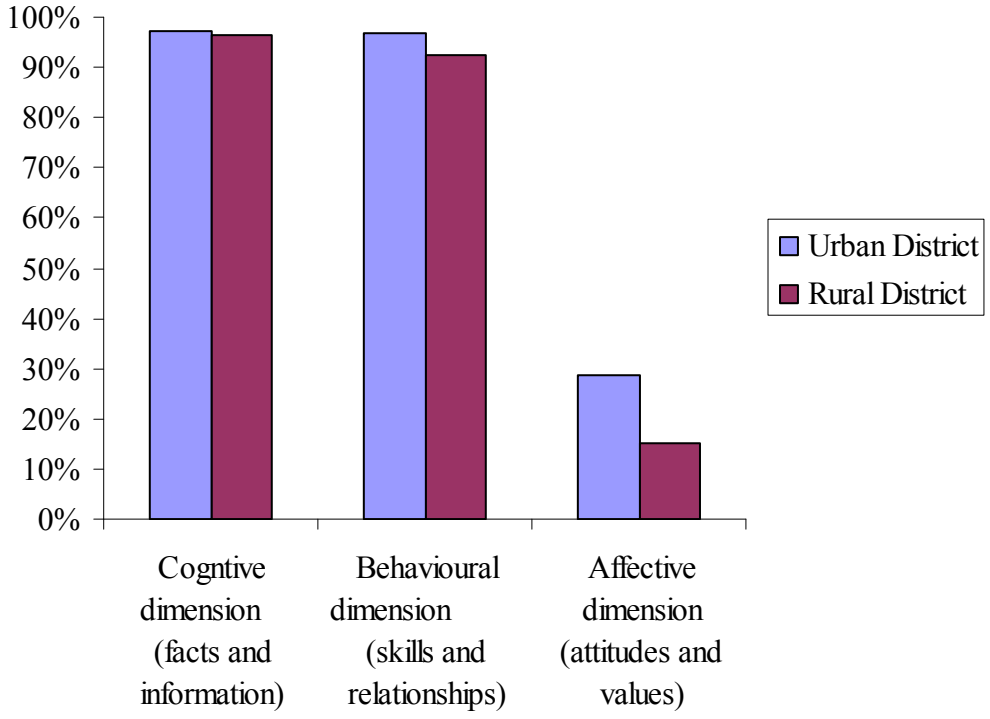

Figure 6.4. Percentage of teachers in the urban and rural districts indicating the importance of SRE dimensions

Table 6.3

Importance Teachers Assigned to Possible Topics to be Included in the SRE Curriculum by District

	Urban District (Kinondoni)			Rural District (Sengerema)		
	Mean	Median	Std Deviation	Mean	Median	Std Deviation
1. Correct names of genitalia	3.5	4	1.2	3.8	4	1.4
2. Body image	4.1	4	0.8	4.0	4	0.7
3. Puberty	4.5	5	0.8	4.5	5	0.6
4. Birth control	3.6	4	1.3	4.1	4	1.2
5. Menstruation	4.4	5	0.6	4.4	5	0.7
6. Pregnancy	3.9	4	1.0	4.5	5	0.8
7. Wet dreams	3.4	3	1.0	3.8	4	1.1
8. Personal safety	4.6	5	0.6	4.7	5	0.5
9. Health and wellness	4.6	5	0.7	4.6	5	0.6
10. The effects of drugs, alcohol and tobacco use	4.9	5	0.4	4.9	5	0.4
11. Sexually transmitted diseases (STDs) including HIV/AIDS	4.9	5	0.3	4.9	5	0.3
12. Body and diseases	4.6	5	0.7	4.6	5	0.6
13. Sexual problems and concerns	4.6	5	0.8	4.6	5	0.7
14. Masturbation	3.4	3	1.4	2.9	2	1.6
15. Friendships/social skills	4.3	5	0.9	3.9	4	1.1
16. Family types and roles	4.4	5	0.9	4.2	4	1.0
17. Dating and marriage	3.2	4	1.4	4.0	4	1.2
18. Parenting	4.3	5	0.9	4.5	5	0.6
19. Sexual behaviours	3.5	4	1.2	3.4	4	1.3
20. Attraction, love and intimacy	3.1	3	1.1	2.8	3	1.5
21. Sex as part of a loving relationship	2.1	2	1.2	2.4	2	1.5
22. Sexual orientation including homosexuality	2.2	1	1.5	1.8	1	1.2
23. Being comfortable with the other sex	3.6	4	1.2	3.8	4	1.2
24. Dealing with peer pressure to be sexually active	4.5	5	0.6	4.3	5	0.9
25. Sexual coercion and sexual assault	4.7	5	0.8	4.6	5	0.6
26. Sex in exchange of gifts and money	4.7	5	0.6	4.6	5	1.0
27. Sex in exchange of better examination grades at school	4.7	5	0.6	4.3	5	1.4
28. Communicating about sex	3.0	3	1.3	3.0	3	1.5
29. Pornography	1.9	1	1.4	1.8	1	1.2

	Urban District (Kinondoni)			Rural District (Sengerema)		
	Mean	Median	Std Deviation	Mean	Median	Std Deviation
30. Personal rights	4.3	4	0.9	4.6	5	0.5
31. Abstinence as an alternative to sexual intercourse	3.7	4	1.3	3.7	4	1.4
32. Masturbation as an alternative to sexual intercourse	2.7	3	1.5	2.2	2	1.3
33. Sexual behaviours other than intercourse	3.0	3	1.5	2.7	3	1.6
34. Appropriate/inappropriate touching	3.2	4	1.4	2.4	2	1.5
35. The effectiveness of different birth control methods	3.8	4	1.2	4.1	5	1.2
36. Decision making	4.4	5	0.8	4.5	5	1.1
37. Demonstrate use of condoms	2.9	3	1.3	3.4	4	1.5
38. Sexuality as a positive aspect of self	2.9	3	1.3	2.9	2	1.6
39. Common myths concerning sexuality	3.7	4	1.1	3.6	4	1.5
40. Sexual feelings and expression	3.0	3	1.4	2.7	2	1.6
41. Being responsible for your own behaviour	3.7	4	1.1	4.1	4	1.1
42. Reduction of fears and myths about sexuality matters	3.8	4	1.0	4.1	4	1.1
43. Saying 'no' to non-consensual sex	4.5	5	0.8	4.5	5	1.0
44. Saying 'no' to alcohol	4.9	5	0.4	4.8	5	0.6

Note: Response options: 1=Not at all important, 2=Not important, 3=Somehow important, 4=Important and 5= Very important.

6.3.4 Variation in the attitudes towards SRE between rural and urban teachers

An independent samples t-test was performed to investigate the variation in attitudes towards school- based SRE between rural and urban teachers, with *location* as independent variable and *SRE should be provided in schools* as dependent variable. There was no statistically significant difference in scores measuring the attitudes towards school- based SRE between rural teachers (M=4.43, SD= .86) and urban teachers (M= 4.32, SD= .93); t (66) = -.534, p=.59, with a very small magnitude of the difference in the means (eta squared = .004).

A one-way between groups MANOVA was performed to investigate variation in the perceived importance of the three mostly commonly identified controversial

topics in school-based SRE: *homosexuality*, *masturbation* and *condom use*. These are the topics that received the lowest rating, with clear percentage variation between urban and rural parents. Preliminary assumption testing using homogeneity of variance-covariance matrices revealed no serious violation of this assumption. There was no statistically significant difference between urban and rural based responding teachers on the combined dependent variables: F (3, 57) = 0.90, p= .442; Wilkis' Lambda=.95; partial eta squared = .05. Thus, despite the actual percentage variation, there was no statistically significant difference in attitudes towards these topics between urban and rural based teachers.

6.3.5 Teachers' preferred class levels to introduce SRE topics

Teachers were asked to indicate the class levels to introduce each of the 44 topics in the school-based SRE curriculum. There were five response options: Class 4 (age10), Class 5-7 (age 11-13), Form 1-2 (age 14-15), Form 3-4 (age 16-17) and Form 5-6 (age 18-20). In accordance with the education system in Tanzania, primary and secondary education levels roughly correspond to ages 7-13 and 14-17 respectively. In practice, however, a significant number of children complete primary education much later than age 13.

Tables 6.4 summarises the teachers' preference of school levels for introducing 12 SRE topics that have been considered as constituting the minimum package for a school- based SRE programme (Byers et al., 2003a; Lenderyou, 1993). The table shows that the majority of teachers wanted most of the topics to be introduced at some point during the children's primary education (ages 10-13). For example, in both districts, the overwhelming majority of the teachers wanted all but one topic (*homosexuality*) to be introduced during primary school between Classes 4 and 7 (ages 10 and 13). In both districts, the majority of teachers wanted *STDs/HIV/AIDS* to be introduced at a much earlier level than other topics; 55.3 percent of the teachers in the urban district and 43.3 percent of the teachers in the rural district indicated that this topic should be introduced at Class 4 (age 10).

Table 6.4

Percentage of Teachers Indicating the Class Levels for Introducing SRE Topics by District

	Percentage of teachers indicating each class level									
	Urban District (Kinondoni) N=25-38					Rural District (Sengerema) N=23-30				
Topics	Class 4	Class 5-7	Form 1-2	Form 3-4	Form 5-6	Class 4	Class 5-7	Form 1-2	Form 3-4	Form 5-6
1. Names of genitalia	20.6	50.0	14.7	8.8	5.9	10.7	71.4	14.3	0.0	3.6
2. Personal safety	43.2	43.2	2.7	5.4	5.4	26.7	66.7	6.7	0.0	0.0
3. Puberty	10.8	75.7	2.7	5.4	5.4	16.7	73.3	3.3	0.0	6.7
4. Reproduction and birth	8.8	58.8	14.7	11.8	5.9	17.2	62.1	17.2	3.4	0.0
5. Abstinence	7.7	50.0	26.9	11.5	3.8	0.0	43.5	34.8	21.7	0.0
6. Sexual pleasure	0.0	73.3	10.0	10.0	6.7	7.7	61.5	15.4	15.4	0.0
7. Decision making	0.0	56.0	16.0	24.0	4.0	3.8	69.2	19.2	7.7	0.0
8. Condom use	3.6	46.4	14.3	28.6	7.1	7.7	53.8	3.8	34.6	0.0
9. STDs and HIV/AIDS	55.3	28.9	7.9	0.0	0.0	43.3	40.0	10.0	6.7	0.0
10. Sexual coercion	29.7	56.8	2.7	2.7	8.1	30.0	70.0	0.0	0.0	0.0
11. Masturbation	10.3	51.7	10.3	20.7	6.9	0.0	54.2	25.0	20.8	0.0
12. Homosexuality	15.6	21.9	18.8	18.8	9.4	25.9	14.8	11.1	29.6	0.0

6.3.6 Teachers' views about the comfort of teaching various SRE topics

Teachers were asked to indicate the extent to which they would find it easy or difficulty to teach SRE topics in schools on a five response scale ranging from "*very difficult (1)* to *very easy (5)*". Table 6.5 summarises the teachers' responses regarding their views about the comfort in teaching each of the 12 basic SRE topics. As shown in the table, teachers were divided regarding their level of comfort in teaching SRE topics; in both districts, teachers expressed easiness in teaching some topics and difficulty in many others.

Only four topics were seen by teachers in the urban district (Kinondoni) as easy to teach, with more than 80 percent of the teachers indicating that these topics were either *very easy* or *easy* to teach. The topics and the percentage (in brackets) of teachers indicating that they would find them very easy and easy to teach are *personal safety* (88.9%), *puberty* (83.3%), *sexual decision making* (83.3%) and *sexual coercion and assault* (83.3%). Teachers in the rural district (Sengerema) indicated five topics as *very easy* or *easy* to teach; namely, *puberty* (96.6%), *reproduction and birth* (90.0%), *sexual decision making* (89.75), *STDs and HIV/AIDS* (96.6%) and *sexual coercion and assault* (82.1%).

Teachers in the urban district expressed difficult in teaching *correct names of genitalia, sexual pleasure and enjoyment, condom use, masturbation* and *homosexuality*, with less than 40% of them indicating that they would find it *very easy* or *easy* teaching these topics. Interestingly, teachers in the rural district indicated only two topics (*masturbation* and *homosexuality*) as being very difficult or difficult in teaching, with less than 40 percent of them indicating that they would find it very difficult or difficult in teaching these topics.

As would be expected, *homosexuality* was seen by teachers in both districts as the most difficult topic to teach, with 50 percent of the teachers in the urban district (Kinondoni) indicating that they would find it very difficult (36.1%) or difficult (13.9%) teaching this topic. In the rural district (Sengerema), 48.1 percent of the teachers indicated that they would find it very difficult (25.9%) or difficult (22.2%) teaching *homosexuality*.

Again, the one-way between groups MANOVA revealed no statistically significant difference between urban and rural based responding teachers in their

comfort about teaching the most three controversial SRE topics (*homosexuality*, *masturbation* and *condom use*): F (3, 55)= 1.473, p= .232; Wilkis' Lambda= .926.

Table 6.5

Percentage of Teachers Indicating the Extent to Which They Would Find it Easy or Difficult to Teach Various SRE Topics

	% Teachers Urban District (Kinondoni) N=					% Teachers Rural District (Sengerema) N=				
	Very difficult	Difficult	Neutral	Easy	Very easy	Very difficult	Difficult	Neutral	Easy	Very easy
1. Correct names of genitalia	25.0	11.1	30.6	22.2	11.1	13.8	17.2	10.3	41.4	17.2
2. Personal safety	0.0	2.8	8.3	38.9	50.0	0.0	3.4		58.6	37.9
3. Puberty	2.8	5.6	8.3	69.4	13.9	0.0	3.6	21.4	39.3	35.7
4. Reproduction and birth	11.8	11.8	26.5	26.5	23.5	0.0	10.0	0.0	40.0	50.0
5. Abstinence	13.9	11.1	16.7	33.3	25.0	19.2	7.7	26.9	26.9	19.2
6. Sexual pleasure and enjoyment	22.9	5.7	28.6	25.7	17.1	21.4	7.1	17.9	17.9	35.7
7. Sexual decision making	2.8	0.0	13.9	41.7	41.7	3.4	6.9	0.0	34.5	55.2
8. Condom use	36.1	16.7	19.4	19.4	8.3	24.1	13.8	10.3	20.7	31.0
9. STDs/HIV/AIDS	2.8	2.8	19.4	27.8	47.2	3.4	0.0	0.0	34.5	62.1
10. Sexual coercion and assault	0.0	0.0	16.7	38.9	44.4	3.6	7.1	7.1	32.1	50.0
11. Masturbation	25.7	17.1	25.7	22.9	8.6	32.1	7.1	25.0	21.4	14.3
12. Homosexuality	36.1	13.9	30.6	13.9	5.6	25.9	22.2	22.2	18.5	11.1

6.4 Results of the focus group study

Participants for the focus group study were recruited from schools in the two districts that took part in the survey. In each of the two participating districts, Kinondoni (urban) and Sengerema (rural), three schools were randomly selected from a list of the schools that participated in the survey study. From each of the selected schools, between four and nine teachers were invited to take part in the focus group discussions. In total, five focus groups were conducted, two in the urban district and three in the rural district, with each group comprising between four and nine members. Additionally, two focus groups, with each group comprising between five and nine members, were conducted with national school policy makers, with a view to understanding their views about the barriers to the teaching of SRE in schools in Tanzania.

The proceedings of the focus group discussions were recorded on a digital voice recorder; they were immediately transcribed verbatim and saved on a hard computer drive as well as on memory stick. The focus groups data were analysed using a thematic analysis approach, which has been described in Chapter 4 and summarised in Table 4.1. The transcripts were read and re-read several times until patterns and codes were identified. Possible themes were identified from the codes; these were subsequently named and used to develop and describe teachers, and policy makers' views and attitudes concerning the delivery of school-based SRE in Tanzania.

6.4.1 Teachers' views and attitudes towards the provision of SRE in schools

Five major issues emerged from the thematic analysis of teachers' focus group data representing their views and attitudes towards a wide range of issues concerning the provision of SRE in schools in Tanzania; these are highlighted and illustrated below.

6.4.1.1 Teachers' perspectives of the meaning and goals of SRE

Teachers had different views about the meaning and goals of teaching SRE in schools. However, a majority of them seemed to suggest that SRE concerns teaching young people about body changes and their associated consequences as children grow from one stage of the life span to another. The teachers' understanding of SRE

seemed to be limited to biological aspects as there was little mention of other aspects of SRE, such as psychological and social aspects.

In terms of the goals of SRE, a majority of teachers thought that SRE aimed to enable young people to grow and develop well and take care of themselves. They particularly underscored the need to equip young people with skills they need to protect themselves against teenage pregnancy and HIV infection as the main goals of SRE, as the following illustrations depict:

> *To me, when we talk of sex and relationships education we are essentially referring to issues concerning child development, ehee, something to do with growth or puberty, ehee. I think the main goal for teaching this education is to enable children and youth to grow well, ehee, to be able to take care of themselves. So when we teach them about sex and relationships, we teach them various things including the effects of early pregnancy, how to avoid HIV/AIDS, and we also teach them how to relate as friends as well as in sexual relationships (female teacher, rural district).*

> *To me, sex education is when we look at body changes as a person grows across different ages. This is the time when we start telling young people about the dangers facing them, especially with regard to sex, such as pregnancy and HIV/AIDS. This is the time when children undergo puberty and they develop sexual interests. So, if a young person does not receive sex education during this period, it means that he or she will end up into problems; if it is a girl she may get pregnancy and if it is a boy he may impregnate a girl. So, when we talk of sex education we mainly focus on body changes (male teacher, rural district).*

> *This [SRE] is the type of education provided in order to enable a young person to understand his or her body well. It is about body changes and how these affect young people in their relations between themselves and other adults in the society (female teacher, urban district).*

> *I think that sex education concerns teaching children about puberty, ehee, so you tell children how the body changes as they grow and what this means to their sexual life. It is about telling young people that now they are going to be adults and in the case of girls they will be attractive and people will follow them, you see. So it is education about life (male teacher, urban district).*

6.4.1.2 Views about the current state of SRE in schools

Teachers were asked to give their assessment of the current state of SRE in schools with respect to its quantity and quality. They were asked to mention the main SRE issues that are currently covered in the schools curriculum.

Almost all teachers were of the opinion that very little SRE was currently being provided in schools. The only issues that were frequently mentioned by teachers as being taught were some aspects of *reproduction* and *HIV/AIDS*. Generally, teachers expressed strong dissatisfaction with the current SRE practice in schools and called for the government to integrate more SRE issues in the school curriculum. Some of the teachers' views about the state of SRE in schools are illustrated below:

> *Well, I think that SRE is there in the syllabus, but I would say that it is very, very little indeed. It is only taught somewhere in standard 6 or 7; there is only one topic in science on reproduction (male teacher, rural district).*

> *I know there are some issues of SRE that are taught. For example, there is a topic on diseases; there is STDs and HIV/AIDS which are taught in standard 4 or 5. In standard 6 or 7, there is reproduction where we teach about reproductive organs a bit, then how a human being is developed, so in here we highlight the fusion of male and female gametes. And this is mainly taught in standard 7, so it means children do not learn about these things when they are in lower classes. That is why I insist that we should teach earlier beginning at least at standard 5. Another thing is that we need to include more topics, and this education should be made part and parcel of the curriculum, especially science syllabus (male teacher, rural district).*

What was also evident from teachers' views was that, even the little SRE that is currently being taught, it is not taught well. Additionally, as the quoted remark below demonstrates, teachers do not feel confident teaching some of the SRE topics such as mentioning the names of genitalia:

> *For now we teach human reproductive system. Under this topic we teach reproductive organs for both male and female, we tell kids this is a penis and this is a vagina, but not all teachers are courageous to do that. Most of us are very shy, we would rather not mention these things, or if we do then we hide our faces on the blackboard (laughs). It comes a time you just want to ask your fellow teacher to help you teach your class when it comes to teaching reproduction. So, yes, I would say we teach some aspects of SRE, especially reproduction, but how we teach is completely another story (male teacher, urban district).*

6.4.1.3 Attitudes towards the teaching of homosexuality and other 'hard to teach' SRE topics

The results of the survey study showed that a majority of teachers rated some of the topics unfavourably. This was particularly the case for homosexuality and masturbation, which are amongst the topics that have been described as hard to teach (SIECUS, 1998). During the focus groups, teachers had the opportunity to express

their views about the inclusion of homosexuality and masturbation in the school curriculum as well as their willingness and confidence to teach them.

For both homosexuality and masturbation, teachers expressed strong views about them as well as myths and misconceptions about their effects. Some of the views of teachers about these topics are highlighted and illustrated below.

Teachers' attitudes towards covering homosexuality in the SRE curriculum: it is not our nature!

Teachers' opinions were divided regarding the inclusion of homosexuality in the SRE curriculum; there are those who strongly opposed the inclusion of this topic for various reasons, including traditional and cultural factors. Teachers also, as parents, expressed feared that teaching youngsters about homosexuality may sensitise them to wanting to become homosexuals. Some of the teachers' views are illustrated below:

> *For me, I think homosexuality should not be taught because of our traditional values. If you look at Tanzanian and African values, it doesn't make sense to talk about homosexuality. If you start teaching homosexuality in schools, you will be instilling in kids some interest about homosexuality; it is like you want them to try to become homosexuals (female teacher, rural district).*

> *Eheee eheeee! For me, ehee, this issue of homosexuality should never be taught to kids. I have three reasons why this topic should never be taught. First, it is unethical; you will be instructing the kids to break or violate the Tanzanian traditional values; this thing is not part of African culture, it is not ours. Second, the act itself, this homosexuality thing, is a very dirty thing, it is very bad. This is the last thing I would like my kid to hear about in this world. Third, if a child knows about this homosexuality and may be he or she tries to practice it, he or she will never know the other side, he or she will just be thinking about homosexuality, he or she will not know the other world, the normal world. So, I insist that this topic should never even be thought of in our curriculum, No way! (Male teacher, rural district)*

Despite the opposition to the inclusion of homosexuality in the SRE curriculum, there was a substantive number of members of the focus groups who supported its inclusion in the curriculum. However, as for parents, they supported it for rather negative reasons arguing that homosexuality should be taught so as to help youngsters avoid becoming gays or lesbians. Other members argued that it was important to teach homosexuality in schools so that children could be told about its

effects and how bad it was to be a homosexual. Some of the teachers' views in this direction are illustrated below:

> *People who oppose the teaching of homosexuality don't understand its aim well; they think that we will teach it as a normal subject like other subjects. But I don't think that is the case. I think that when we will be teaching this subject we will be teaching its negative consequences. I don't see anything else about this topic other than teaching how bad it is and how you can avoid becoming a homosexual (female teacher, rural district).*

> *I think that it is the attitude of our society; they think that if you teach children about homosexuality, they think they will go and practice it. So, they thought, well homosexuality, so you want our kids to become homosexuals, No way. But, when teaching homosexuality, I don't think that we are going to teach them to like homosexuality, No; we will teach its bad side, how bad it is to become a homosexual and how to avoid it. So, for me I would actually support that this topic be included because there are kids who become homosexuals without knowing, just because of bad mobs; we will help them [avoid] if we taught them this topic.(male teacher, rural district).*

> *For me I would strongly support that homosexuality should be taught in schools. Pupils should be told that being homosexual is going against the nature; ehee, it is not human nature to be homosexual. If it is taught along this direction it should be acceptable, but not otherwise (male teacher, urban district).*

> *I think we fear something that is part of our society. There are people who're already there, ehee, there are homosexuals in our society. So if we taught children about this topic it would help them to know its effects and we would be saving this nation. So I think that this topic should be included in the curriculum; not teaching it is trying to escape a problem which is part of us now (male teacher, urban district).*

> *For me I think that a person becomes homosexual for lack of proper education. So let homosexuality be taught in schools so that we can reduce the rate of homosexuality in our society (female teacher, urban district).*

6.4.2 Teachers' attitudes towards covering masturbation in the SRE curriculum

Masturbation was another topic that raised strong opinion from members of the focus groups. It was clear that myths about the negative effects of masturbation are wide spread among teachers. Teachers, for example, argued that masturbation reduces sexual power and has serious negative effects in the long run. Because of its perceived negative effects, teachers were of the opinion that there was no need to teach children about masturbation.

> *I don't agree with this topic, I strongly object to this topic, it should never be taught. We should look for other alternatives to help young people refrain from sex, but not this one. Because, the way I understand it, I think masturbation has very serious consequences, it has negative effects later. Many people who practice masturbation get psychological effects (female teacher, rural district).*

When prompted to explain the effects of masturbation, this respondent argued that:

> *For example, they loose sexual power; when they have sex with a woman they don't enjoy it; the only sexual pleasure they know is masturbation (laughs).*

Other members of the focus groups had similar views as quoted below:

> *I think there are several alternative ways to help young people refrain from sex, like sports. I think we should insist on sports. But now if we start telling them about masturbation and if they decide to start doing it at their age, don't you think by the time they become adults they will be exhausted sexually and they will never be normal? (Laughs). So, I think we should focus on sports (female teacher, rural district).*

> *For me I think that this topic [masturbation] should not be taught because it'll ruin children, especially boys. If they decide to masturbate they'll be addicted and they may not even want to marry (female teacher, urban district).*

> *I also don't support the idea of teaching masturbation and I wouldn't even want children to hear about this thing. This is because when you teach them about masturbation it is like you want them to try it, to masturbate, ehee. But we know masturbating looses a lot of energy; it is actually very dangerous, you may even die in the cause of doing it (laughs)! (Male teacher, rural district).*

However, a few teachers in the focus groups had positive views about masturbation. They systematically refuted the argument that masturbation is harmful. They even cited personal examples to show that masturbation was perfectly normal and even healthy. Teachers who had positive views about masturbation appeared to have benefited from some training on SRE, formal or informal. Some of the positive views about masturbation are illustrated below:

> *It is interesting to hear all these ideas [about masturbation]. This is why I said that our biggest problem with this education is lack of education. People may be surprised why I support all these things; it is because I have been trained, I got education on these things. Before I got a bit of education about sexual and reproductive health, I was like them. But I'm kind of now 'saved'. I clearly see the importance of teaching almost everything about sex in schools [including masturbation]. For example, our colleague there has talked about the negative effects of masturbation, now if you don't teach them where and how will they know that masturbation is a bad thing? So, I say that*

masturbation should be taught, it is better to teach it so that they know it. Even if there are side effects, let them be taught so that they know about them. But I don't believe that masturbation has any side effects (male teacher, rural district)

In my view I think this topic [masturbation] should be taught. When I try to think, I see that a majority of young people, especially boys, have done this, have practised masturbation. Even some of us know that we do sometimes masturbate and it is a good thing (laughs). When I was still young, a boy, I was very curious about masturbation. I talked to many young people older than me, including my brothers. I learnt that many young people went through this stage, they did masturbate. My brothers were doing it whilst in schools, but they stopped later when they got their girlfriends and when they got married. I have never heard them complaining that they can't perform sexually because they're masturbating when they're young, this is not true, it is just an excuse. If we say that we should not teach masturbation we're just cheating ourselves because these boys are already doing it; the bad thing is that they may be doing it in a wrong way and this is where our help is needed (male teacher, rural district).

6.4.3 Teachers' perspectives regarding barriers to teaching SRE in schools

Though teachers overwhelmingly and somehow enthusiastically supported the inclusion of SRE in the school curriculum, it would appear that very little SRE was actually being taught in schools. Thus one purpose of the focus group study was to examine the reasons that thwart the teaching of SRE in schools from the perspectives of teachers.

Teachers were divided on their views about the barriers to teaching SRE in schools. However, the major barrier, according to them, was the lack of SRE in the school curriculum. They asserted that they only teach subjects that are entailed in the syllabus; they cannot teach a subject that is not part of the curriculum. They insisted that if SRE were part of the school curriculum they would teach it without problem. Teachers' views on the barriers to teaching SRE in schools are illustrated below:

Our campus for teaching is the syllabus, so we have seen that sex and relationships education is not part of the curriculum, what can we do? So, it is not that we don't want to teach it, it is because it is not in the curriculum; we cannot teach anything that is not part of the prescribed curriculum (female teacher, rural district).

If you ask me why we are not teaching this education [SRE] my reason is simple, and this is that it is not in the syllabus. We don't teach things which are not in the syllabus. if they want us to teach it let them include the subject in the syllabus, we will teach it, it is our job (female teacher, urban district).

I think the biggest obstacle in teaching sex education in schools is the policy itself. The policy does not direct us to teach sex education. In actual fact in some instances the policy itself is an obstacle. For example, somewhere they say that condoms should not be given in schools, now how can we teach sex education in such situations? I think that policy makers need to change (male teacher, rural district).

Besides the absence of SRE in the school curriculum, teachers also cited fear for negative reaction from the society as another important factor that hinders the teaching of SRE schools. They asserted that teachers who volunteer to teach SRE are marked and sometimes ridiculed and shamed by some members of the society, as demonstrated by a remark of one member of the focus group:

I think one of the reasons is the lack of cooperation from the society. For example, here at our school we teach this Mema Kwa Vijana programme, when you go around the streets people say, this teacher is teaching our kids dirty things, he is teaching prostitution. I meet these things and I sometimes become very embarrassed. So, it is the attitude of our society; they think that if you teach their children these things, anything about sex, they think they will go and practice it (male teacher, rural district).

6.4.4 School policymakers' views and attitudes towards the provision of SRE in schools

The purpose of conducting focus groups with school policy makers was to get their views about what they thought about the provision of SRE in schools. The focus groups with school policy makers were particularly useful in understanding the policy makers' perspectives of barriers to teaching SRE in schools.

The thematic analysis of school policy makers' focus group data revealed three major issues reflecting their opinion about school-based SRE. The first issue concerned policy makers' views about the importance of school-based SRE. The second issue concerned the policy makers' views about the current state of SRE in schools. The third issue captured the policy makers' perspectives of the barriers to teaching SRE in schools. These issues are highlighted and illustrated below.

School policy makers' views about the importance of teaching SRE in schools

There was no much divergence in opinion regarding the importance of SRE in schools. There was a unanimous agreement among policy makers who took part in the focus group deliberations that SRE was a crucial avenue for preparing young people for responsible adult life. Policy makers especially underscored the importance of

SRE in preparing children to face the challenges brought about by pubertal changes. They also underscored the importance of SRE in protecting young people against HIV/AIDS and other sexual health problems. Some of the policy makers' views in this regard are demonstrated in their remarks quoted below:

> *In general this education [SRE] is very important especially that children these days reach puberty earlier than we did, at age 9, 10 or so. Now if they do not receive any education about their body changes they will get problems. They need this education so that they can understand what is happening in their bodies and what consequences they will face if they will engage into sexual intercourse at their age (female policy maker, Inspectorate Department, age 54).*

> *I wanted to add that apart from early maturation we see in our girls and boys nowadays, there is also the problem of HIV/AIDS. There is also the problem of rape; all these are problems that young people face today and they need sex education to protect themselves. Now I don't see any other place best suited to provide this education other than schools (male policy maker, Policy and Planning Department, age 48).*

> *Actually it is not just about HIV/AIDS or puberty or rape; this education is about everything in life. It is about life in totality, including puberty, life skills, physiological changes, psychological processes, social issues. So you will see that this education is very important if we are to secure the future of this nation (male policy maker, Secondary Education Department, age 44).*

6.4.5 School policy makers' views about the current state of SRE in schools

Policy makers' opinion about the current state of SRE in schools was sharply divided. Some thought that there was enough SRE already being taught in schools already, while others were of the view that there was very little SRE in schools. It was clear, however, from the discussions that SRE was not part of the school curriculum in the strict sense of it. This is because even those policy makers who said that SRE was being taught acknowledged that it was being taught by peer educators as an extracurricular subject rather than as an integral part of the school curriculum. Some of the policy makers' remarks are illustrated below.

As far as I am aware, sex education is currently taught in schools beginning standard 3. However, it is not called sex and relationships education as you call it; it is rather called HIV/AIDS education. This education is being delivered by peer educators as extra curriculum subject. We decided to use peer educators because teachers are not adequately trained to teach HIV/AIDS education. This is for primary school education. For secondary school, sex education appears in Biology, Home Economics, Geography and Civics. So some aspects of sex education are scattered

here and there across the school syllabus (male policy maker, Secondary Education Department, age 44).

Let's be realistic and honest; this education [SRE] is not there. If you went to schools and asked teachers if they're teaching this subject, they would categorically tell you that they're not. Even if you asked students they would tell you the same; that is they're not being taught this subject. May be it is true there are some aspects of sex education here and there, but this has just provided room for teachers to avoid teaching them. Therefore, even where various aspects of sex education appear in different subjects, they are not taught well or they are skipped all together because teachers feel uneasy teaching them. This is the reality; otherwise we are cheating ourselves when we say that this education is being taught in schools (Female policy maker, Policy and Planning Department, Age 44).

6.4.6 School policy makers' perspectives of the barriers to teaching SRE in schools

It was clear from the deliberations in the focus groups that the current SRE delivery in schools was inadequate, erratic and unhelpful to young people. To this effect, policy makers were prompted to discuss the factors that were constraining the effective delivery of SRE in schools. The researcher was particularly interested in understanding why policy makers have been hesitant to integrate SRE in the school curriculum.

The major barrier to the teaching of SRE in schools that emerged from the focus groups with policy makers was fear of reaction from the society. Policy makers, one after another, asserted that the Tanzanian community (especially parents) was strongly opposed to the teaching of SRE in schools, and as such, policy makers would not include in the curriculum issues that were not in line with the needs and wishes of the community. Part of the proceedings of the focus group discussions that demonstrate policy makers' perspectives of the barriers to include SRE in the school curriculum have been reproduced below:

> *Researcher:* Ok, we have seen that the current state of SRE delivery in schools is insufficient or rather ineffective. What do you think is constraining the effective provision of SRE in schools? In other words, why can't you make a policy for effective teaching of SRE in schools, what are the barriers here?
>
> *Respondent#1*: *The biggest stumbling block is the traditions of our country. Our traditions do not allow talking about sex issues openly. So, people do fear and are ashamed of talking about these things. Now, even us policy makers are part of the society; teachers are also part of the society. In the past sex education was provided by aunts, not by fathers or mothers. So, in the society*

it was very clear who was responsible for teaching young people about sexuality matters. Now this system is broken, no body is there to teach these things. Even if we want to teach sex education in schools, parents would say no, they don't want it. Now, the ministry cannot put things in the curriculum that are not wanted by the parents. There is too much resistance from society about teaching sex education in schools.

Researcher: So, what you are saying is that you fear resistance from the community, from parents, don't you?

All: ohoooo, very much (laughs), murmuring and laughs.

Respondent#2: *You know what, just as my colleagues said, policy makers are part of the society. The ministry cannot put things in the curriculum that will raise anxiety in the community. There is a very big resistance in the community. Parents believe that if we teach these things we will be teaching prostitution. In fact parents do not even hide their feelings, they have even sometimes written to the Minister*[9] *stating categorically that they don't want their children to be taught this education. They don't want to see anything about sex in their children's exercise books. So the problem is the community [not us policy makers].*

6.5 Discussion

The results of this study show that an overwhelming majority of the responding teachers in both rural and urban districts supported the provision of comprehensive school-based SRE. The results also show that the majority of teachers think that both parents and the school should share the responsibility to provide SRE to children. Furthermore, the results show that the majority of the teachers who took part in the study wanted SRE to begin early during primary education (ages 10-13) rather than during secondary education (ages 14 and above).

Again, teachers supported a wide range of SRE topics to be included in the school curriculum. This implies that teachers view school-based SRE not only as an important strategy for protecting young people from HIV/AIDS and other sexual health problems (diseases prevention model), but as an important strategy for promoting healthy adolescent sexual development.

The results of this study have also shown that though teachers may be committed to teaching SRE in schools, they are currently incapacitated to do so by the low status of SRE in the school curriculum. Nevertheless, this may not be the only

[9] When this respondent and other members of the focus group were asked if they could provide a copy of the minister's letter to the researcher they declined on ground of confidentiality.

factor behind the poor teaching of SRE in schools as teachers also showed considerable anxieties in teaching several topics. For example, when the teachers were presented with the same topics they had rated as important and asked to indicate their comfort about teaching them, a majority of the teachers expressed uneasiness in teaching many of the topics. The majority of teachers in the urban district, for example, expressed comfort in teaching only four topics; namely, *personal safety, puberty, decision making* and *sexual coercion and assault*. Teachers in the rural district expressed comfort in teaching only five topics: *puberty, reproduction and birth, decision making, STDs and HIV/AIDS* and *sexual coercion and assault*.

These results show that though teachers may support the teaching of SRE and the inclusion of a number of topics in the school curriculum, they may not be comfortable and capable of teaching all the key SRE topics. This was particularly the case with regard to *homosexuality* and other controversial topics. This implies that adequate preparation in a way of training is required for teachers if they are to handle SRE in the classroom situation effectively. Therefore declaration of positive attitudes towards school-based SRE as well as change in policy alone may not be enough; these need to go hand in hand with providing teachers with the knowledge, skills and confidence to teach the various SRE topics.

Chapter 7

Students' Perspectives, Needs and Preferences Regarding School-Based Sex and Relationships Education in Tanzania

7.1 Introduction

The involvement and participation of young people in the development and implementation of sex and relationships education (SRE) programmes has been acknowledged as an important factor for such programmes to be successful (Schaalma, Abraham, Gillmore & Kok, 2004). It is therefore imperative for SRE programme developers to elicit, understand and incorporate young people's views in the SRE development and implementation processes (Hilton, 2003).

There have been a number of studies, particularly in developed countries, that have assessed the views and attitudes of young people concerning the provision of SRE in schools; including, for example, Dailard (2001) in the USA, Reeves et al. (2006) in the UK and Byers, Sears, Voyer, Thurlow & Cohen (2003a) in Canada. These studies have demonstrated that students, at various levels of schooling (elementary, middle and high levels), consistently and overwhelmingly supported the provision of SRE in schools. Furthermore, in almost all countries where surveys have been conducted, young people have expressed a strong dissatisfaction with and criticised the current SRE provision in schools as being too little, too late and unhelpful (Frean, 2008; Reeves et al., 2006; Byers et al., 2003a; Hudson, 1999; Dailard, 2001).

Little is known about the views and attitudes of young people towards school-based SRE in sub-Saharan Africa due to a paucity of research in this area in the region (Amuyunzu-Nyamongo, Biddlecom, Ouedraogo & Woog, 2005; Kaaya, Mukoma, Flisher & Klepp, 2002; Kakavoulis & Forrest, 1999).

This chapter reports on a study that assessed the views and attitudes of students towards, and experiences with, the provision of SRE in schools in Tanzania. The study specifically investigated the students' attitudes in four main areas concerning SRE. First, the study investigated students' views and attitudes concerning the provision of SRE in schools and the sharing of this role (SRE provision) between the school and parents. Second, the study investigated the students' preferences of

specific SRE topics to be included in the school curriculum. Third, the study examined the influence that students' demographics had on their attitudes towards school-based SRE as well as on the perceived importance of the specific topics. Fourth, the study sought to identify young people's learning needs and priorities regarding sexual health.

7.2 Methods

Survey and focus groups were employed in the study. The survey method aimed to assess students' views and attitudes towards a wide range of issues concerning school-based SRE from a large and diverse sample of participants. The focus group method aimed to provide qualitative elaboration of the issues that emerged from the survey responses. This section describes the survey method; the description of the qualitative method is provided in the section reporting the results of the focus groups.

7.2.1 Participants

Surveys were completed by 715 students in two regions, Dar es Salaam and Mwanza; 351 (49.1%) students were attending primary schools in standards 5 to 7 and 364 (50.9%) students were attending secondary schools in Forms 2 to 6. The mean age for primary school students was 14 years with a standard deviation of 2, whereas the mean age of secondary school students was 17 with a standard deviation of 2.

Overall, more than half (52.3%) of the respondents were male; 53.4 percent of the primary school students and 51.3 percent of the secondary school students were male. A majority of the respondents were Protestants (38.9%), Moslems (25.0%) or Catholics (22.4%). More than 90 percent of the respondents reported that religion was very important in their life and they attended religious services regularly, that is, at least once a week. The demographic characteristics of responding students are summarised in Table 7.1.

Table 7.1
Demographic Characteristics of Responding Students

Demographic variables	% of Respondents	
	Primary School Students *N*= 351	Secondary School Students) *N*= 364
Age		
8-10	1.5	
11-13	43.0	N/A
14-16	38.3	
Over 16 years	17.3	
13-15		7.0
16-17	N/A	27.6
18-20		53.8
Over 20 years		11.5
Sex		
Male	47.5	51.3
Female	52.5	48.7
Religion		
Catholics	44.8	42.9
Protestant	27.6	33.2
Islam	25.6	22.4
Other	1.2	1.1
None	0.9	0.3
How many times do you attend religious services		
Everyday	33.1	20.7
At least once a week	54.0	71.7
At least once a month	6.7	6.1
At least once a year	3.3	1.1
Never attend	2.9	0.4
How important is religion in your life		
Very important	95.6	91.3
Important	3.2	5.7
Somehow important	-	1.5
Not important	1.2	1.5
Not important at all	-	-

7.2.2 Procedure and measure

The survey was conducted during the summers of 2006 and 2007 for primary and secondary schools respectively. Twelve primary schools in one urban district (Kinondoni, Dar es Salaam), eight primary schools in one rural district (Sengerema, Mwanza) and seven secondary schools (three schools in Dar es Salaam and four schools in Mwanza) were involved in the study. The schools were selected in such a

way as to ensure there were roughly an equal number of students from urban and rural areas. However, this was practically more feasible for primary schools than for secondary schools as a majority of secondary schools in Tanzania are located in urban areas.

The following procedures were followed in selecting students from the participating schools. The researcher sent a letter of introduction to the head teachers of each of the participating schools. An appointment was then made regarding a suitable time and place to administer the questionnaires. In each participating school, the head teacher appointed a teacher who assisted the researcher in the selection of the students and other logistic arrangements. For primary schools, a sample of 20 students was conveniently selected from amongst students attending standards 5, 6 and 7 (roughly aged between 11 and 15). For secondary schools, a sample of between 50 and 60 students was conveniently selected from amongst students attending Forms 2 to 6 (roughly aged between 15 and 19).

In each school, the selected students were assembled in one class to complete the surveys. For primary schools, each class had a maximum of 10 students whereas for secondary schools, each class had a maximum of 30 students. Prior to completing the questionnaires, students were briefed about the purpose of the study and filled out the consent forms. Respondents were informed that participation was voluntary and that they could skip any question they felt uncomfortable answering. Furthermore, respondents were informed that they were free to withdraw from the study any time.

The completion of the survey lasted between 30 and 45 minutes. Upon completion of the questionnaires, the researcher debriefed respondents on the objectives of the study and re-thanked them for agreeing to participate.

Respondents completed a five-part questionnaire on various aspects of school-based SRE (see Appendix 3). In the first part, respondents were asked to indicate the extent to which they agreed or disagreed with the view that *SRE should be provided in schools* and that *the school and parents should share the responsibility to provide this education*. In this same part, respondents were asked to indicate the level at which they thought SRE could begin to be taught in schools and to rate the quality of SRE they may have received at home and school.

In the second part of the questionnaire, respondents were provided with a list of 12 basic SRE topics and were asked to rate the importance of each topic on five response options ranging from *not at all important (1)* to *very important (5)*. In the

third part, respondents were asked to indicate the school level they thought each of the 12 topics could be introduced in the school curriculum. The fourth part of the questionnaire comprised demographics, including age, sex, religion and residential location (Dar es Salaam as urban or Mwanza as rural). In the last part of the questionnaire, students were asked to mention any two questions they had on sexual health.

Data analysis was carried out using SPSS statistical package version 15. Frequencies were used to describe students' responses to individual questions. Logistic regression analysis was run to examine the effect of students' demographics on their attitudes toward the provision of SRE in schools. Analyses of variance were used to examine the effect of each of the student demographics (age, residential location, studentship and religion) on the perceived importance of SRE topics.

Student responses' on the open question were analysed by content analysis. The researcher reviewed all the student responses and read them until patterns emerged that were classified into themes. These are reported in the section describing the results of the content analysis (section 7.5). A list of the questions that students asked is annexed to the thesis as Appendix 6.

7.3 Survey results

7.3.1 Students' attitudes towards school-based SRE

Students' responses regarding their views about the provision of SRE in schools are summarised in Figure 7.1, which shows that a majority of students in both levels supported the provision of SRE in schools, with 80.6 percent of primary school students either strongly agreeing (54.3%) or agreeing (26.3%) with the statement that *SRE should be provided in schools*. Similarly, almost all secondary school students supported the provision of SRE in schools, with 92.9 percent of them either strongly agreeing (62.6%) or agreeing (30.3%) with this statement.

An independent samples t-test was conducted to compare the scores measuring attitudes towards school- based SRE between primary and secondary school students. There was a statistically significant difference in the attitude scores, with secondary school students (M=4.48, SD=0.86) showing more favourable attitudes towards school- based SRE than primary school students (M=4.10, SD= 1.30): t (708) = -4.62, p<.0005. However, the effect size showed that the magnitude of the difference in the means was relatively small (eta squared= .03).

A paired samples t-test was conducted to explore the differences between students' attitudes towards the views that *SRE should be provided in schools* and that *school and parents should share the responsibility to provide SRE to young people*. There was a statistically significant difference between students' attitudes towards the two views: t (697) =5.88, p<.0005. Students were more likely to agree with the view that SRE should be provided in schools (M=4.31, SD=1.095*)* than with the view that it should be a shared responsibility between the school and parents (M=3.98, SD=1.35). However, despite reaching statistical significance level, and the notable difference in the mean scores in attitudes between the two views, the eta squared statistic (.05) indicated a small effect size implying that the magnitude of the differences in the means was actually quite small.

When they were asked to indicate the school level during which SRE should begin, a majority of students indicated that SRE should begin at primary school level (see Figure 7.2), with 76 percent of primary school students indicating that SRE should either begin at Class 4 (51.3%) or Class 5-7 (24.8%). Sixty six percent of the secondary school students indicated that SRE should begin either at Class 4 (14.9%) or at Class 5-7 (51.1%).

An independent samples t- test revealed a statistically significant difference in the preference of the level to introduce SRE in schools between primary (M=2.01, SD=1.35) and secondary (M=2.48, SD= 1.13) school students: t (703) = -4.93, p< .0005. However, the magnitude of the differences in the means was relatively small (eta squared = .03).

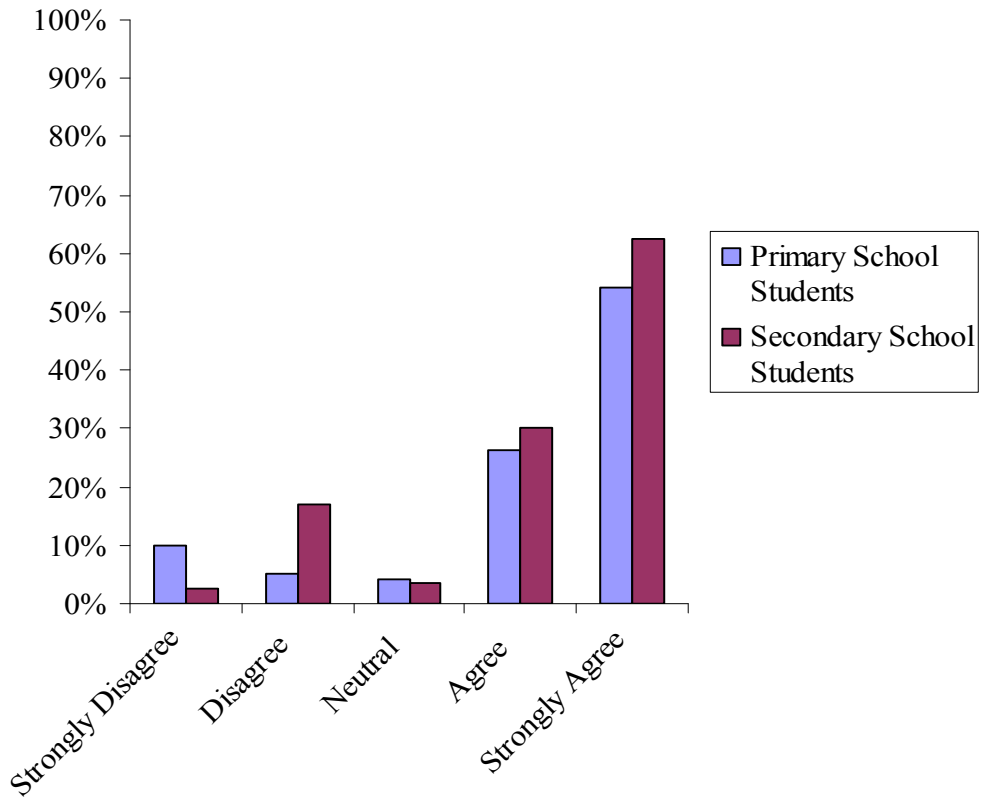

Figure 7.1. Percentage of primary and secondary school students agreeing/disagreeing with the statement that *SRE should be provided in schools*.

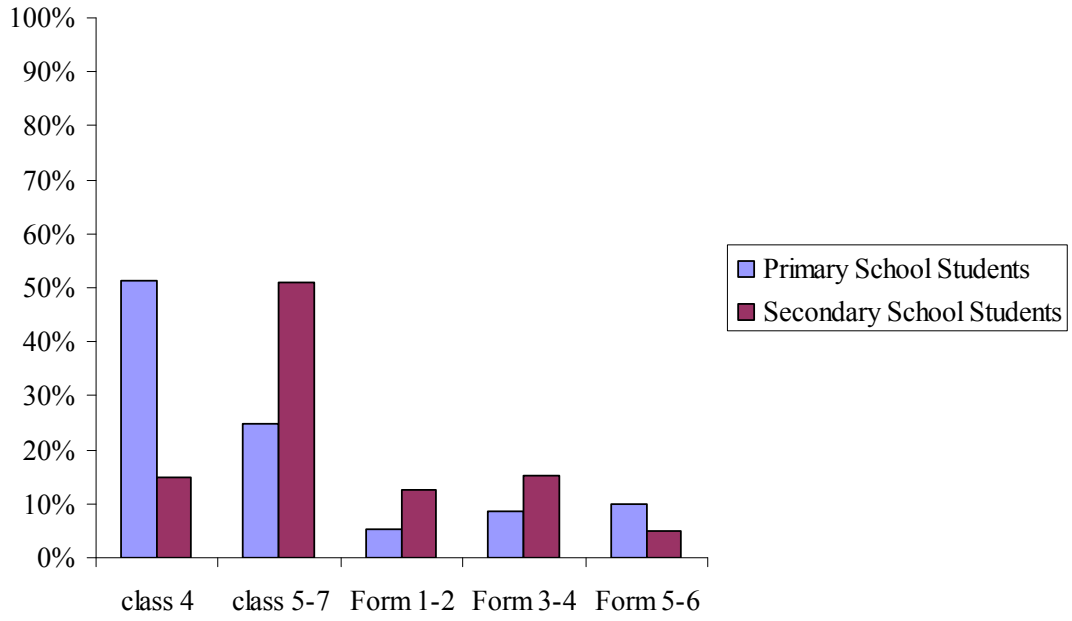

Figure 7.2. Percentage of primary and secondary school students indicating the school level at which SRE should begin

Respondents were also asked to rate the quality of SRE they might have received at home and school. Overall, students, at both primary and secondary school levels, reported higher levels of satisfaction about the quality of SRE they had received at school than at home. For example, as Figure 7.3 shows, 55.5 percent and 60.3 percent of primary and secondary school students respectively indicated that the quality of SRE they had received at school was good compared to 32. 9 percent of the primary school students and 56 percent of the secondary school students who reported that the quality of SRE they received at home was good.

A paired samples t-test was conducted to investigate the variation in the level of students' satisfaction of the quality of SRE received at home and school. There was a statistically significant difference in the level of satisfaction of the quality of SRE received at home (M= 3.62, SD= 1, 52) and at school (M=3.05, SD= 1.55): t (687) = 8.075, p<.005. The eta squared statistic (.09) indicated a relatively large effect size.

A one- way multivariate analysis of variance (MANOVA) was performed to investigate the difference in the level of satisfaction of the quality of SRE received at home and school between primary and secondary school students. Preliminary assumption testing using homogeneity of variance- covariance matrices revealed no serious violation of this assumption. There was a statistically significant difference

between primary and secondary school students on the combined dependent variables: F (2, 685) = 8.99, p<.0005; Wilkis' Lambda = .97; partial eta squared = .03.

However, when the results for the dependent variables were considered separately, the only difference to reach statistical significance was with respect to satisfaction about SRE received at home [F (1,686), = 11.67, p= .001; partial eta squared = .02] but not at school [F (1,686)= 1.91, p= .167; partial eta squared= .00]. An inspection of the mean scores indicated that primary school students (M= 3.82, SD= 1.35) reported a slightly higher level of satisfaction about SRE they received at home than secondary school students (M= 3.43m SD= 1.64).

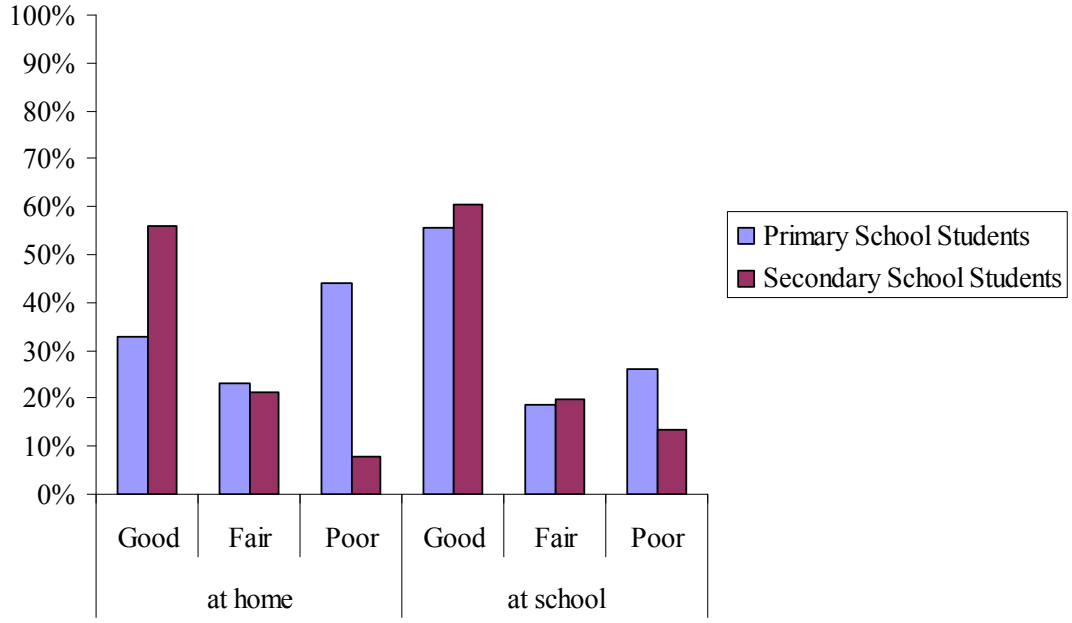

Figure 7.3. Percentage of primary and secondary school students indicating the quality of SRE they had received at home and school.

Note that the percentage for 'good' is a summation of the percentages for' excellent, very good and good'.

7.3.2 The effects of students' demographic factors on their attitudes towards school-based SRE

A logistic regression analysis was performed with *SRE should be provided in schools* as the DV and respondents' *religion, residential location, studentship* (primary or secondary school student) and *sex* as predictor values. Prior to running the

logistic regression analysis, scores for the DV were recoded into two values, *0 (No)* and *1(Yes).*

A total of 715 cases were analysed and the full model significantly predicted agreement with the provision of SRE in schools (Omnibus Chi-square=26.34, df=4, p<.0005). The model accounted for between 4.5% and 9.6% of the variance in agreement with school-based SRE.

Table 7.1 displays coefficients and the Wald Statistic and associated degrees of freedom and probability values for each of the predictor variable, showing that only *studentship* predicted the students' attitudes towards the school-based SRE provision. The values of the coefficients show that a change in the level of school from primary to secondary school was associated with a change in the attitude towards SRE by odd ratio of 0.23 (95% CI 0.12 and 0.42), implying that the likelihood of students supporting the provision of SRE in schools increased with increase in the level of education by a factor of .23.

Table 7.2
Variables Entered in the Logistic Regression Analysis Equation and their Associated Wald Statistic, Degrees of Freedom and Probability Values.

		B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I.for EXP(B)	
		Lower	Upper	Lower	Upper	Lower	Upper	Lower	Upper
Step 1(a)	religion(1)	.058	.312	.035	1	.852	1.060	.575	1.953
	location(1)	-.383	.312	1.505	1	.220	.682	.370	1.257
	Studentship(1)	-1.493	.322	21.499	1	.000	.225	.120	.422
	sex(1)	.390	.293	1.770	1	.183	1.477	.831	2.625
	Constant	3.085	.461	44.851	1	.000	21.857		

a Variable(s) entered on step 1: religion, location, studentship, sex.

A one-way between groups analysis of variance (ANOVA) was conducted to explore the impact of age on the attitude toward school-based SRE as measured by the level of agreement students indicated with the statement, *SRE should be provided in schools*. Participants were divided into four groups according to their age: Group 1: 10 or less; Group 2: 11-13; Group 3: 14-16 and Group 4: Above 16. There was a statistically significant difference at the $p<.05$ level for the four groups in the scores measuring the attitude towards school-based SRE: F (3,693) =4.84, p=.002. Despite reaching statistical significance level, the actual difference in mean scores between the four groups was small. The effect size, calculated using the eta squared, was only .02. Post-hoc comparisons (see Table 7.2) using Tukey HSD test indicated that the

mean score Group 2 (*M*=4.02, *SD*=1.33) was statistically significantly different from group 4 (*M*=4.42, *SD*=0.97). Group 1 (*M*=4.60, *SD*=0.55) and Group 3(*M*=4.29, *SD*=1.11) did not statistically significantly differ from either group 2 or 4.

Table 7.3

Post-hoc Comparisons for the Four Students Age Groups Using Tukey HSD Test

(I) Your age	(J) Your age	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
		Lower Bound	Upper Bound	Lower Bound	Upper Bound	Lower Bound
Below 10	11-13	.580	.496	.647	-.70	1.86
	14-16	.308	.495	.925	-.97	1.58
	Above 16	.181	.492	.983	-1.08	1.45
11-13	Below 10	-.580	.496	.647	-1.86	.70
	14-16	-.272	.121	.113	-.58	.04
	Above 16	-.399(*)	.106	.001	-.67	-.13
14-16	Below 10	-.308	.495	.925	-1.58	.97
	11-13	.272	.121	.113	-.04	.58
	Above 16	-.127	.100	.580	-.38	.13
Above 16	Below 10	-.181	.492	.983	-1.45	1.08
	11-13	.399(*)	.106	.001	.13	.67
	14-16	.127	.100	.580	-.13	.38

* The mean difference is significant at the .05 level.

7.3.3 Students' perceived importance of specific SRE topics

Table 7.3 summarises the results of student responses regarding the importance they assigned to specific SRE topics. The table shows that primary school students rated all but two topics either as very important, important or somewhat important. They rated *sexual pleasure and enjoyment* and *homosexuality* as not important. They rated three topics as very important: *reproduction and birth, STDs and HIV/AIDS* and *sexual coercion and assault*.

Secondary school students rated all topics as very important, important or somewhat important. They rated seven topics as very important; namely, *personal safety, puberty, reproduction and birth, abstinence, sexual decision making, condom use* and *STDs and HIV/AIDS*.

Table 7.4

Importance Primary and Secondary School Students Assigned to Specific SRE Topics

Topics		Primary School Students N=321-348			Secondary School Students N=344-358		
		Mean	Median	Std Deviation	Mean	Median	Std Deviation
1.	Correct names of genitalia	3.80	4	1.27	3.73	4	1.23
2.	Personal safety	4.10	4	1.15	4.74	5	0.53
3.	Puberty	4.02	4	1.24	4.61	5	0.71
4.	Reproduction and birth	4.23	5	1.09	4.60	5	0.70
5.	Abstinence	3.49	4	1.52	4.13	5	1.18
6.	Sexual pleasure	2.63	2	1.60	3.05	3	1.46
7.	Sexual decision making	3.85	4	1.31	4.23	5	1.11
8.	Condom use	3.15	3	1.59	4.13	5	1.25
9.	STDs/ HIV/AIDS	4.00	5	1.47	4.78	5	0.65
10.	Sexual coercion and assault	3.90	5	1.55	3.76	4	1.41
11.	Masturbation	3.41	3	1.16	2.90	3	1.50
12.	Homosexuality	2.70	2	1.51	3.07	3	1.67

Note: 1=not at all important, 2=not important, 3=somewhat important, 4=important and 5=very important.

7.3.4 Preferred school levels to introduce specific SRE topics

Table 7.4 summarises students' responses regarding their preference for introducing each of the 12 topics in the school curriculum. The table shows that a

majority of primary school students wanted most of the topics to be introduced during the secondary education level, especially between Form 1 and 2 (ages 14-15). However, they indicated that three topics, *STDs and HIV/AIDS*, *sexual coercion and sexual assault* and *masturbation*, should be introduced during the primary education level (age 10-13). It is rather surprising that primary school students wanted *masturbation* to be introduced early during the primary education level, while they rated it just *somewhat important* (see Table 7.3).

Conversely, the majority of secondary school students wanted half of all topics to be introduced during the primary education level and half of other topics to be introduced during the secondary education level. The topics that secondary school students wanted introduced during the primary education level were: *correct names of genitalia, personal safety, puberty, abstinence, STDs and HIV/AIDS* and *sexual coercion and assault*. The topics they wanted introduced during the secondary education level were: reproduction and birth, sexual pleasure and enjoyment, sexual decision making, condom use, masturbation and homosexuality.

Perhaps unsurprisingly, the majority of respondents wanted STDs and HIV/AIDS to be introduced early at the primary education level. In fact, a substantial percentage of primary school students (33.3%) and secondary school students (29.2%) wanted this topic to be introduced as early as Standard 4 (age 10). This is probably understandable given the seriousness of the HIV/AIDS problem in Tanzania and other sub-Saharan African countries, where more than 60 percent of new HIV infections are occurring among young people aged 15-24 (UNAIDS, 2006).

7.3.5 Variation in attitudes towards SRE topics by social demographics (sex, type of studentship, residential location and religion)

A two way-between groups MANOVAs were performed to investigate variations in the perceived importance of SRE topics, with sex and age and type of studentship and residential location as independent variables and the 12 SRE topics as the dependent variables. Furthermore, a one-way between groups MANOVA was performed to investigate the variation by religion in the attitudes towards controversial topics: *condom use*, *masturbation* and *homosexuality*. These topics were selected on the basis of their poor rating by students (see Table 7.3). The results are presented separately for each of the three groups of demographics.

7.3.5.1 Sex and age differences in attitudes towards SRE topics

A two-way between groups MANOVA was performed to investigate age and sex differences in the perceived importance of SRE topics. Preliminary assumption testing was conducted to check for the homogeneity of variance-covariance matrices, which revealed a number of variables with Levene's Test of Equality of Error Variances less than .05 indicating a serious violation of this assumption. Because of this violation, and in line with Tabachnick & Fidell's (2001) recommendation, a more conservative alpha level at .01 was set for determining significance for all the variables that had less than .05 significance value.

There was a statistically significant difference between age groups: F (36, 1655) =3.55, $p<.0005$; Wilk's Lambda=.80, partial eta squared=.07, as well as between males and females: F (12, 560) =3.33, $p<.0005$; Wilk's Lambda=.93, partial eta squared=.07 on the combined dependent variables. The interaction between the two variables (age and sex) was also statistically significant: F (12, 560) =2.23, $p=.01$; Wilk's Lambda=.95, partial eta squared=.05.

However, when an inspection of the mean scores was made, the actual age differences were statistically significantly notable for only three topics (see Table 7.5); namely, *personal safety* (students aged 10 and below rated this topics less favourably than students aged 11 and above), *abstinence* (students aged 10 and below and those aged above 16 rated this topic more favourably than those aged 11-13 and 14-16) and *condom use* (students aged above 16 years rated this topic more favourably than students of other age groups).

The sex differences were also statistically significantly notable for only three topics: *personal safety*, *sexual pleasure* and *enjoyment* and *sexual decision making*; boys rated these topics more favourably than girls (see Table 7.6)

7.3.5.2 Studentship and respondent residence variations in attitudes towards SRE topics

A two-way MANOVA was performed to investigate the studentship and residential location variations in the perceived importance of SRE topics using the 12 topics as dependent variables. An inspection of Box's Test of Equality of Covariance Matrices and Levene's test of Equality of Error Variances revealed a serious violation of this assumption; in order to address this violation in assumption, a more stringent

alpha level at .01 was set and used to determine the significance level reached in the MANOVA.

As shown in Table 7.6, the results of the MANOVA showed that there was a statistically significant variation by studentship in the perceived importance of SRE topics: F (12, 580) =21.362, p<.0005; Wilk's Lambda=.69, partial eta squared=.31, but not by respondent residence: F (12, 580) =1.37, p=.18; Wilk's Lambda=.97, partial eta squared=.03. However, an inspection of the mean score revealed that the actual variation in attitudes was statistically significant for only two topics: *abstinence* (whereas secondary school students rated this topic more favourably than primary school students) and *masturbation* (whereas primary school students rated this topic more favourably than secondary school students).

Table 7.5

Percentage of Primary and Secondary School Students Indicating the Class Levels for Introducing SRE in Schools

	% Primary School Students Indicating					%Secondary School Students Indicating				
	Class 4	Class 5-7	Form 1-2	Form 3-4	Form 5-6	Class 4	Class 5-7	Form 1-2	Form 3-4	Form 5-6
Correct names of genitalia	8.3	37.1	26.3	8.9	19.4	14.2	40.9	19.6	17.2	8.0
Personal safety	12.7	26.6	22.8	19.2	18.0	37.9	41.9	12.7	6.1	1.4
Puberty	8.2	26.9	42.3	14.2	8.5	16.4	61.9	14.6	6.0	1.2
Reproduction and birth	5.2	11.6	33.9	34.3	14.7	5.5	33.0	27.0	29.0	5.5
Abstinence	5.1	19.9	43.5	18.4	10.9	28.4	39.5	20.2	7.9	4.1
Sexual pleasure and enjoyment	5.8	14.3	39.5	31.0	9.4	5.2	12.5	19.5	27.4	35.4
Sexual decision making	3.1	9.4	14.4	20.4	52.7	6.3	23.3	22.2	27.7	20.5
Condom use	5.8	14.3	39.5	31.0	9.4	7.3	21.1	29.2	24.0	18.4

	% Primary School Students Indicating					%Secondary School Students Indicating				
	Class 4	Class 5-7	Form 1-2	Form 3-4	Form 5-6	Class 4	Class 5-7	Form 1-2	Form 3-4	Form 5-6
STDs and HIV/AIDS	33.7	29.2	18.2	16.7	1.8	29.2	48.1	16.3	4.6	1.7
Sexual coercion and sexual assault	33.7	29.2	18.2	16.7	1.8	22.7	37.9	21.5	12.5	5.4
Masturbation	25.4	29.8	22.4	20.4	1.5	8.6	24.2	34.3	19.0	14.1
Homosexuality	10.3	22.9	22.6	30.4	13.8	12.8	22.4	27.1	19.6	18.1

Table 7.6

Importance Students Assigned to Possible SRE Topics by Age

Dependent Variable	Age Group	Mean	Std. Error	95% Confidence Interval		F (3,576)	ή²
			Lower Bound	Upper Bound	Lower Bound	Upper Bound	
Correct names of genitalia	10<=	3.00	0.89	1.25	4.75	1.06	.01
	11-13	3.68	0.12	3.45	3.90		
	14-16	3.98	0.11	3.77	4.19		
	Above 16	3.71	0.07	3.58	3.85		
Personal safety	10<=	2.50	0.61	1.31	3.69	13.41	.07
	11-13	4.03	0.08	3.87	4.18		
	14-16	4.35	0.07	4.21	4.49		
	Above 16	4.68	0.05	4.59	4.78		
Puberty	10<=	5.00	0.69	3.64	6.36	5.26	.03
	11-13	3.97	0.09	3.80	4.15		
	14-16	4.18	0.08	4.02	4.34		
	Above 16	4.57	0.05	4.46	4.68		
Reproduction and birth	10<=	5.00	0.61	3.80	6.20	0.38	.00
	11-13	4.44	0.08	4.28	4.59		
	14-16	4.36	0.07	4.22	4.51		
	Above 16	4.54	0.05	4.44	4.63		

Dependent Variable	Age Group	Mean	Std. Error	95% Confidence Interval		F (3,576)	ή²
		Lower Bound	Upper Bound	Lower Bound	Upper Bound		
Abstinence	10 and below	5.00	0.95	3.14	6.86	5.34	.03
	11-13	3.38	0.12	3.14	3.63		
	14-16	3.84	0.11	3.61	4.06		
	Above 16	4.04	0.07	3.89	4.19		
Sexual pleasure	10<=	3.00	1.08	0.88	5.12	0.95	.01
	11-13	2.55	0.14	2.27	2.82		
	14-16	2.84	0.13	2.58	3.09		
	Above 16	3.07	0.08	2.90	3.23		
Sexual decision making	10 and below	3.50	0.84	1.85	5.15	1.67	.01
	11-13	3.83	0.11	3.61	4.04		
	14-16	3.96	0.10	3.76	4.15		
	Above 16	4.24	0.07	4.11	4.37		
Condom use	10<=	2.50	0.99	0.55	4.45	11.88	.06
	11-13	3.01	0.13	2.75	3.26		
	14-16	3.35	0.12	3.12	3.58		
	Above 16	4.12	0.08	3.97	4.27		
STDs and HIV/AIDS	10<=	5.00	0.74	3.55	6.45	6.89	.04
	11-13	4.03	0.10	3.84	4.22		
	14-16	4.24	0.09	4.06	4.41		
	Above 16	4.76	0.06	4.65	4.87		
Sexual coercion and assault	10<=	3.00	1.02	0.99	5.01	0.95	.01
	11-13	3.94	0.13	3.68	4.20		
	14-16	4.06	0.12	3.82	4.30		
	Above 16	3.83	0.08	3.67	3.98		
Masturbation	10<=	3.50	0.95	1.63	5.37	1.25	.01
	11-13	3.38	0.12	3.13	3.62		
	14-16	3.21	0.11	2.98	3.43		
	Above 16	3.01	0.07	2.86	3.15		
Homosexuality	10<=	2.50	1.14	0.27	4.73	2.68	.01
	11-13	2.48	0.15	2.19	2.77		
	14-16	3.09	0.14	2.83	3.36		
	Above 16	3.06	0.09	2.89	3.24		

Table 7.7

Variation in the Importance Students Assigned to Possible SRE Topics by Sex

Dependent Variable	Sex	Mean	Std. Error	95% Confidence Interval		F	ή²
		Lower Bound	Upper Bound	Lower Bound	Upper Bound		
Correct names of genitalia	male	3.87	0.15	3.57	4.18	0.162	
	female	3.57	0.23	3.12	4.02		0.00
Personal safety	male	4.69	0.10	4.49	4.89	2.671	
	female	3.88	0.15	3.58	4.18		0.01
Puberty	male	4.62	0.12	4.39	4.85	3.992	
	female	4.42	0.18	4.08	4.77		0.01
Reproduction and birth	male	4.62	0.11	4.41	4.83	3.229	
	female	4.56	0.16	4.26	4.87		0.01
Abstinence	male	4.23	0.16	3.91	4.55	2.696	
	female	4.06	0.24	3.59	4.54		0.01
Sexual pleasure	male	3.27	0.19	2.90	3.63	5.144	
	female	2.79	0.27	2.25	3.33		0.01
Sexual decision making	male	4.24	0.15	3.96	4.53	1.139	
	female	3.87	0.22	3.44	4.29		0.00
Condom use	male	3.92	0.17	3.58	4.25	2.632	
	female	3.18	0.25	2.69	3.68		0.01
STDs and HIV/AIDS	male	4.77	0.13	4.52	5.02	4.236	
	female	4.50	0.19	4.13	4.86		0.01
Sexual coercion and assault	male	3.62	0.17	3.28	3.96	6.516	
	female	3.79	0.26	3.29	4.30		0.01

Masturbation	male	3.04	0.16	2.72	3.37	0.168	
	female	3.28	0.24	2.80	3.76		0.00
Homosexuality	male	3.27	0.20	2.88	3.65	1.825	
	female	2.73	0.29	2.16	3.30		0.00

7.3.5.3 *Religious differences in attitudes towards SRE topics*

A one-way MANOVA was performed to examine the religious differences in attitudes towards 'controversial' or 'sensitive' topics; namely, masturbation, homosexuality and condom use, which were selected on the basis of their poor rating in the scale measuring the perceived importance of topics (see Table 7.3). Prior to running the MANOVA, an inspection of Box's Test of Equality of Covariance Matrices and Levene's test of Equality of Error Variances was done which revealed no serious violation of this assumption.

The results of the MANOVA showed that there was a statistically significant religious difference in the attitudes towards the above controversial topics: F (8, 1098) =5.587, p<.0005; Wilk's Lambda=.92, partial eta squared=.04. Catholics (M=3.08, SD=1.47) and Protestants (M=3.22, SD=1.37) rated *masturbation* more favourably than Moslems (M=2.97, SD=1.44). Similarly, and perhaps unsurprisingly, Catholics (M=3.37, SD=1.60) and Protestants (M=2.87, SD=1.64) rated *homosexuality* more favourably than Moslems (M=2.60, SD=1.54). Again, Catholics (M=4.30, SD=1.78) and Protestants (M=3.61, SD=1.51) rated *condom use* more favourably than Moslems (M=3.53, SD=1.49).

Thus, overall, respondents who reported belonging to Christianity (Catholics and Protestants) showed less negative attitudes towards controversial SRE topics than respondents who reported belonging to Islam.

7.4 Focus group study results

7.4.1 Introduction

The focus group study with students aimed to provide qualitative explanation for the survey responses. Participants for the focus groups were recruited from four primary schools and four secondary schools. In order to avoid intimidation of younger students from primary schools by older students from secondary schools, focus groups for primary and secondary school students were held separately. Thus a total of eight groups were held for students, with each group comprising between five and nine students.

The proceedings of the focus group discussions were recorded in a digital voice recorder and transcribed verbatim. The focus group data were analysed by thematic analysis following the Braun and Clarke's (2006) six steps as summarised in Table 4.1.

The thematic analysis of the students' focus group data revealed three major issues reflecting their views and attitudes towards the provision of SRE in schools; namely, the meaning, benefits and goals of SRE, the current status of SRE provision in schools and views and attitudes towards the inclusion of controversial topics in the school- based SRE curriculum: homosexuality, masturbation and condom use. These issues are highlighted and illustrated below.

7.4.2 Meaning, goals and benefits of SRE provision in schools

Students displayed a broad and diverse understanding of the meaning and goals of SRE in school- based SRE. Some students thought that SRE was concerned with teaching young people about the entire spectrum of important skills in life, such as safer sex, communication, relationships and family life. Others saw SRE as primarily concerned with the prevention of HIV/AIDS and other sexually transmitted diseases. In general, students seemed to have a fairly broad understanding of SRE beyond issues related to HIV/AIDS as demonstrated in the following quoted remarks.

> *This is [SRE] education about how to go about in life, how to protect yourself, how to move on in the world of sex (Secondary School Boy).*
>
> *[SRE] it is education given to youth to make them aware of life challenges; it aims to make them know that, yes there is sex and it is sweet, but there are*

also dangers. It is more than teaching young people about HIV/AIDS (Secondary School Girl).

When I hear about sex and relationships education, to me the first thing that comes to my mind is, wow, here is a relief. Someone is going to tell me something very important about me as a person. It is something that guides me in life. It is something that enlightens a person about sex life and how to fit well in the community (Secondary School Boy).

Let me start by saying that, many young people get into relationships without really knowing what they want, and at the end of the day, it is just stress. If this education was given, it would prepare young people well to face the relationship turbulence; we would be able to know and reflect what we really want in life. You see, when you have sex, whether you like it or not, you move to the next level. And if you expected a bunch of rose flowers and it turns out to be a bush of thorns, you end up in an emotional breakdown (laughs). So this SRE is very important and it should be given both at home and school (Secondary School Girl).

It was clear from the focus groups discussions that students viewed SRE as important not only for protecting themselves against HIV/AIDS and other sexual health problems, but also as a tool for preparing them for life in general and for promoting and protecting their sexual and emotional health in particular. However, to some students in the focus groups, still the emphasis remained very much within the realm of HIV/AIDS prevention. When discussing about the potential benefits of SRE, for example, some students emphasised its importance in protecting them against the HIV/AIDS epidemic. To this end, as illustrated in their remarks quoted below, students went as far as proclaiming that SRE was an important saviour of the nation from the "deadly AIDS".

I think if this education [SRE] were taught in schools it could save this country from the deadly AIDS and other sexually transmitted diseases. This is because, in schools, it is easier to get many young people at the same time (Secondary School Girl).

For me I think if sex education were provided it would save our nation greatly. For example, I have attended seminars at the Maisha College; I have seen the way we were taught about the importance of being principled in life. So, I think if this education were taught it would help us build a strong foundation in our life from the very beginning and, more importantly, defeat HIV/AIDS (Secondary School Boy).

Some students saw SRE as a great opportunity to enable them to avoid unwanted sexual intercourse; they mentioned, for example, that SRE would provide them with skills to delay sexual intercourse. This was a widely shared position in all

the focus groups in both sites. For example, a secondary school girl asserted in one of the focus groups that:

> *"If we were taught properly about sex, I am sure about seventy percent of young people will wait to have sex".*

7.4.3 Students' views about the current status of SRE provision in schools

The focus group discussions revealed that there was very little SRE being taught in schools in Tanzania. Students complained that they mainly relied on sources outside schools to get information about sex and relationships. It would appear that seminars were important sources of SRE for some students, especially those in secondary schools; however, they seemed unsatisfied with these sources and wished that SRE were provided in schools as demonstrated in the following quoted remarks:

> *I think that for now we just rely on seminars which come occasionally and very shallow. I think it should be made one of the subjects in the syllabus and, I tell you, it would be a very popular subject ((Secondary School Girl).*

> *As others have said, we just rely on seminars which come occasionally which we tend to forget after a while, because they come only once in a while; and they just teach a few things, only about HIV/AIDS, but I think there is something more in this education than HIV/AIDS, isn't it? (Secondary School Boy).*

It was evident, however, that some aspects of SRE were being taught in secondary schools, though students showed great dissatisfaction with the quality and quantity of the type of SRE currently being offered. It was also clear that the biological aspects of SRE, and particularly reproduction, take a great share of the current SRE offering in schools in Tanzania:

> *We have been taught about this education to some extent, but not much as such. The fact is when teachers teach about this education they don't go deep, especially when it comes to psychological issues. They just explain the negative consequences of sex, such as pregnancy and HIV/AIDS, but not the psychological issues regarding the act of sex (Secondary School Girl).*

> *In Tanzania, this topic is very rare, especially in schools. The way they teach, for example, in Biology, they just teach about the internal organs, menstruation and reproduction. They don't really engage us in discussing these things seriously (Secondary School Boy).*

When students were asked to comment as to why SRE was not being effectively taught in schools, they blamed teachers as being shy and somewhat incompetent as reflected in their following quoted remarks:

> *I think teachers are just shy; when they come to teach, say reproduction, they are too shallow and shy (Secondary School Girl).*
>
> *I remember our biology teacher when he was teaching reproduction he was using a very difficult language, and he was very shy, always looking down (Secondary School Girl).*
>
> *Most of the teachers are also parents. If a teacher can't talk about sex with his/her children, how can you expect him/her to teach it at school? They are just shy and may be they are not ready to teach this sort of education [SRE] (Secondary School Boy).*

Primary school students seemed more critical of the current status of SRE in schools than their counterparts in secondary schools. They complained that SRE was only taught in secondary schools. One student complained that the government did not care about the primary schools students because government officials think that primary school students were "kids" who did not deserve to learn about SRE as illustrated in the following quote:

> *For me, I believe that our government does not care about primary school students; they think that we don't deserve to have this education [SRE] because we are kids. But the truth is that we also need this education because we are doing all sorts of things that secondary schools students are doing (Primary School Girl).*

In general, many primary students seemed to agree that SRE was not part of the primary school curriculum. However, it would appear that some schools had arrangements for providing information on sexuality particularly for girls. These arrangements were done outside the normal school time table and did not include boys. This arrangement of 'discriminating' boys in the SRE sessions provided outside the school timetable was strongly disliked by boys as is demonstrated by their remarks below:

> *Let's be honest, we are not taught sex and relationships education in our school. There are times whereby teachers do volunteer to teach something about menstruation, but this is outside the class and it is only done for girls; I*

don't think that boys have ever been told about these things (Primary School Girl).

For me I say it is a big shame especially for us boys, girls are somehow told about menstruation; there is nothing for boys (Primary School Boy).

Sex and relationships education is not taught in the normal classes; teachers just volunteer their own time and they do it only for girls. They have never told us why we are not welcome to share with girls in their discussions and you cannot ask (Primary School Boy).

This habit of discriminating girls should be abolished; it is not fair, it doesn't even help girls because at the end of the day it us boys who convince them to have sex, so they should also involve us (Primary School Boy).

7.4.4 Students' views about the teaching of homosexuality and masturbation

Homosexuality and *masturbation* were among the topics that received the poorest rating in the students' survey responses regarding their perceived importance of SRE topics; a majority of students rated these topics as not important or just somewhat important (see Table 7.3). Besides their poor rating, these topics have also been regarded as controversial or sensitive topics as, more often than not, they tend to draw strong views from members of the public, including parents, teachers and students. Thus it was prudent to follow up the students' survey responses by a way of focus group discussions to seek explanation of the poor support for these topics.

During the focus groups discussions, as would be expected, students were divided on their views about the inclusion of homosexuality and masturbation as part of the school-based SRE curriculum. Some students supported the idea that these topics should be included, whilst others were strongly opposed to their inclusion in the SRE curriculum. Some of the students' views about these topics are highlighted and illustrated below.

7.4.4.1 Students' views about homosexuality

Some students expressed positive views about homosexuality whilst others had strong views about this topic. However, generally speaking, it was evident that almost all students in the focus groups had negative attitudes about homosexuality. This is because even those students who supported the inclusion of homosexuality in the school-based SRE curriculum thought that only negative aspects of homosexuality should be covered. By negative aspects they meant that students should be taught how

bad homosexuality was and the means and skills to avoid becoming a gay or lesbian. It was clear that students' views about homosexuality could be attributed to cultural influences of the society they came from, in which embracing homosexuality is largely seen as being against the spirit of the African culture and African way of life.

Other students categorically opposed the teaching of homosexuality saying that it was not important and not part of the problem that the society needs to address. Others rejected the teaching of homosexuality for the reason that it would 'sensitise' young people to like homosexuality and will make them want to practice being gays or lesbians.

Some of the students' remarks demonstrating their views about homosexuality are quoted below:

> *First of all, when you are told for the first time about homosexuality you are bound to react negatively, and this is expected in our society as no body wants to talk about homosexuality, leave alone teaching it in schools. But I think it should be taught, we should be taught about its meaning and its negative effects. So, people who opposed homosexuality didn't understand that they will teach about the negative effects of homosexuality; they thought may be children will be taught how to become homosexuals, something like that (Secondary School Boy).*

> *I think when people hear about homosexuality they just turn their faces away; it is a very difficult thing to talk about leave alone teaching it. But to me, I don't believe people are born homosexual. I believe homosexuality is caused by environment, which may result from people who you stay with. Or you just think may be girls are boring and may be you want to try a new thing because young people like adventures, and if you start you may be used to it and you may want to continue. It is a very confusing subject, the only thing I can say is that let it be taught, may be by telling young people how to avoid it, how not to become a gay or lesbian, this will be acceptable (Secondary School Girl).*

> *To many people being homosexual is abnormal; it is just unthinkable a man having an affair with a man. It is understandable why many respondents disapproved of this topic and I also do (Secondary School Girl).*

> *It is the question of priority; the normal Tanzanians don't understand issues of homosexuality, they can't talk about this thing. If they will at all talk about it, they will just talk about it negatively; it is something that is not acceptable. So, I think that teaching homosexuality is not a priority right now compared to HIV/AIDS, so I don't know why it should be taught in the first place (Secondary School Girl).*

> *I am one of those who would never support this topic. Actually, people are not even thinking about it, but if you introduce this knowledge they will know about it and even think of practising it. It is not in their mind in the first place,*

so parents know that their sons and daughters do not know about it, so they think if you tell them about it, they may start practising it (Secondary School Boy).

Despite the wide spread negative views about homosexuality demonstrated in the focus groups, a few students were somewhat courageously positive about teaching homosexuality. They said that students needed to be taught everything about sexuality, including homosexuality insisting that it was not helpful to hide young people from some sexuality issues because they get to know about them in the society, as one student remarked:

Most parents and teachers think that we don't know a lot of things about sex, but the fact is we know a lot about sex, including homosexuality. We know a lot about sex, we practice it. We tend to think that they don't exist, but they do, we live with them. Parents and children just play games, hiding from each other. We need to be taught everything about sexuality, including homosexuality; it is very important (Secondary School Girl).

A careful examination of the students' views about homosexuality shows that they were not very different from those of parents and teachers and largely reflected those of the Tanzanian community at large. Homosexuality is still viewed by the majority of people in Tanzania, and probably in other sub-Saharan African countries, as foreign, abnormal and an alien culture.

7.4.4.2 Students views about masturbation

A majority of students thought that masturbation was a healthy and an important part of young people's sexuality. Students seemed to agree that the majority of them were practising masturbation and thought of it as a good thing. They also saw masturbation as an important strategy for them to delay sex as well as avoiding HIV infection and unwanted pregnancy. Though some students displayed some serious misconceptions about masturbation, they were, however, generally positive about masturbation as an important aspect of their sexuality. Here are some of the remarks students made about masturbation:

We all know that religion disapproves sex before marriage, but young people have very strong sexual feelings, so they have to do masturbation. I believe masturbation is very safe and nice, but the society does not understand it, (laughs) [Secondary School Boy].

It is not that young people like masturbation, but they know the consequences of sex, diseases, etc. So the only thing is masturbation. And pornography is the

very thing that influences young people to masturbate, once you see a porno, you want to have sex but the quick option is masturbation and this is very important (Secondary School Boy).

For me I say a big yes to masturbation. You know what, if we can't do sex because of HIV, pregnancy, what should we do to get rid of sexual feelings? You know if you don't release your sexual feelings, you will become crazy, I tell you. So, guys, masturbation is very important if you don't want sex and if you want to be normal, help yourself with masturbation (laughs) [Secondary School Boy].

However, not all students thought that masturbation was a good thing. The reasons that students gave for disapproving of masturbation were clearly based on some common misconceptions about the adverse effects of masturbation, including addiction and a decrease in sexual prowess, as the following quoted remarks demonstrate:

For sure masturbation and pornography to me is a big no, because research shows that these things are addictive. People who do masturbate can even miss dinner for masturbation. There is a guy who has a wife, but he says the wife is not enough, he must masturbate, and the wife is not enough, I mean masturbation is dangerous! (Secondary School Girl).

Some girls were not sure whether masturbation was good or not and they seemed to suggest that it was only boys who do masturbation, as one of the girls remarked:

It is mainly boys who do it; and they do it when they can't get a girl. So, they have to do masturbation to get rid of their sexual urge, so may be it is good for them (Secondary School Girl).

7.5 Content analysis of students' responses to open question

The last question in the students' questionnaire asked respondents to mention any two questions about sex and relationships that they would like to learn about. The purpose of this section of the questionnaire was to provide an opportunity for students to identify their needs and preferences of issues to be covered in a school-based SRE programme. Respondents were given a choice of writing down their questions in English or in Swahili. Out of the 715 students who completed the questionnaire, 348 (48.7%) of them wrote at least one question; a total of 535 questions were asked.

The 535 questions were subjected to quantitative content analysis using the following procedures. First, all questions were typed and saved into computer. Second, questions written in Swahili were translated into English. Third, all the

questions were read and re-read to identify related and similar questions so that they could be grouped together. Though a total of 535 questions were asked, this step of analysis revealed that several students had actually asked the same questions, which were therefore grouped together. At the end of this step, a total of 168 questions remained; these were then subjected to the next step of the content analysis.

Consistent with Krippendorff's (1980) recommendation that the textual information generated by content analysis should be categorised according to a certain theoretical framework, in the fourth step, common themes were identified alongside the three dimensions of SRE curriculum; namely, facts and information (knowledge), attitudes and values and relationships and skills (see Figure 1.4). Each question was coded into one of the above dimensions. Questions falling on the facts and information dimension were coded as FI, those falling under the attitudes and values dimension as AV and questions that fell under the relationships and skills dimension were coded as RS. These codes formed the themes of the content analysis. Appendix 6 shows the list of questions for each of the three dimensions as well as a fourth dimension (theme), which is explained below.

While most of the questions could be categorised into one of the three themes (FI, AV and RS), some questions seemed to overlap between two or all the themes. These were categorised into a fourth category and coded as CCQ (Cross Cutting Questions). The cross cutting questions were the ones that fitted in more than one theme. The four themes are briefly highlighted and illustrated below.

7.5.1 Facts and information

There were a total of 65 questions that fell under the Facts and Information theme. The questions were diverse in nature covering different areas of sex and relationships, including condom use, masturbation, HIV/AIDS, puberty, menstruation, wet dreams, pregnancy, masturbation and orgasm. Questions on condom use were most frequently asked and clearly demonstrated that common misconceptions and myths about condom use are still pervasive among young people in Tanzania. For example, some students asked: "Is it good to use condom with your loved partner?" This question reveals that some young people in Tanzania still believe that condom use is only useful and meant for partners in a non-loving relationship; it also suggests that students may still associate condom use with prostitution.

Other questions on condom use revealed a prevalence of misconceptions and myths associating condom use and HIV transmission. For example, a couple of students asked: "I have heard that condoms do spread HIV, is this true?" Again, some students asked: "I have heard that condoms have pores that can easily allow HIV virus to pass through, is this true?" Yet some students believed that there were no condoms suitable for primary school children. For example, one primary school student asked: "When are they going to supply condoms suitable for primary school children?" Another student asked "How is a person infected with HIV?"

Some questions asked under this theme demonstrated a lack of knowledge on basic issues related to sexual health in general and HIV transmission and prevention modes in particular. For example, some students asked: "Can kissing transmit HIV?" Other students wanted to know: "why HIV cannot be transmitted by mosquito bite?" Other students asked: "can saliva transmit HIV?" A couple of students also asked: "what is the best way to protect against HIV infection?"

Apart from questions concerning HIV/AIDS, students were curious to know a wide rage of issues around sexuality. For example, some students wanted to know: "why do boys stimulate [get erection] when they are with girls but girls don't?" "Why only boys have wet dreams?" Why only girls undergo menstruation periods and not boys?" "Can a girl enjoy sex before reaching puberty?" "What is the role of pubic hair during sexual intercourse?" "Is first sexual intercourse necessarily painful?" And "why do boys reach orgasm earlier than girls?"

7.5.2 Attitudes and values

Thirty eight questions fell under the category of attitudes and values. Some of the most frequently asked questions were on homosexuality. Thus students, for example, asked: "Is it wrong to be homosexual?" "Why do some people decide to be homosexual?" And "why is anal sex considered a bad thing whilst there is more pleasure with it than with vaginal sexual intercourse?"

Some students wanted to know about the right time to start sexual intercourse. For example, one student asked: "what is the right time to start sexual intercourse?" Some students wanted to know about the experience of first sex; for example, one student asked "how does it feel to have sexual intercourse for the first time?"

A couple of students were curious to know why parents were reluctant to talk to their children about sex and relationships education. A couple of students asked, for example, “Why parents are not interested to talk to their children about sex?”

7.5.3 Relationships and skills

There were 43 questions on this theme. Most of the questions suggested that students wanted to learn about a wide range of practical skills in a number of areas concerning sex and relationships education and sexual health in general, including safer sex practices, sex techniques, sexual decision making and peer pressure management. For example, some students asked: “How can I reduce my sexual feelings without having sexual intercourse?” “What can I do during my first date?” “How can I stop a friend from convincing me to have sex like him?” “What should I do when am refused by a girl I love?” “How can I do masturbation?” “Who is supposed to put on a condom between a boy and a girl?” “How can I tell my boyfriend when I am not satisfied with his sexual performance?”

7.5.4 Cross-cutting questions

These are the questions that seemed to overlap, covering more than one category of the SRE dimensions. For example, students asked: “Are there any negative effects of having sex with more than one partner at a time?” “Who gets more pleasure between a male and a female during sexual intercourse?” “What will happen if I will be late in getting married?” “Why should people have sex?”

7.5.5 Summary

The content analysis showed that students’ questions were distributed around 10 topics; namely, puberty, reproduction and birth, STDs and HIV/AIDS, safe sex and condom use, masturbation, homosexuality, abstinence, sexual pleasure and enjoyment, relationships and sexual decision making. As shown in Figure 7.4, the most frequently asked questions were on sexual decision making (45 questions, 26.8%), sexual pleasure and enjoyment (34 questions, 20.2%), relationships (23 questions, 13.7%), safe sex and condom use (17 questions, 10.1%), STDs and HIV/AIDS (13 questions, 7.7%) and masturbation (11 questions, 6.5%).

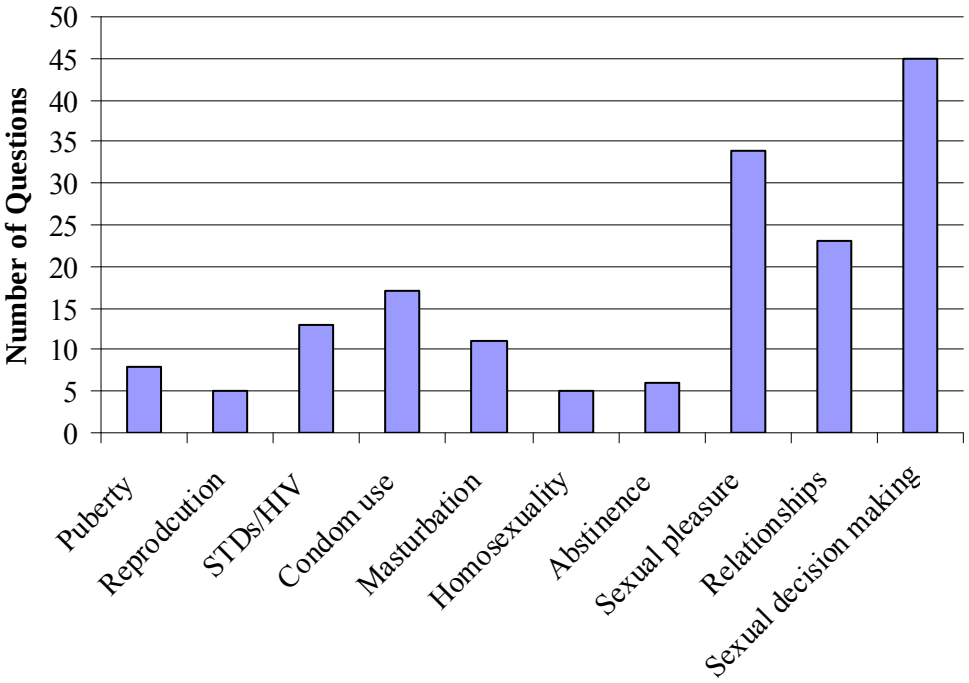

Figure 7.4. Number of questions students asked per topic.

7.6 Discussion

The results of this study have demonstrated that an overwhelming majority of primary and secondary school students in Tanzania support the provision of sex and relationships education (SRE) in schools. More than eighty percent of primary school students and almost all secondary school students who took part in the study strongly agreed or agreed that *SRE should be provided in schools*. Again, the majority of students, at both primary and secondary school levels, wanted SRE to begin at primary school level (age 10-14) rather than at secondary school level (age 15-18).

When asked to indicate the quality of SRE they may have received at home and school, the results show that the majority of students were unsatisfied. However, primary school students seemed to be more unsatisfied with the amount and quality of SRE they may have received both at home and at school than their counterparts in secondary schools. This suggests that parents may be more willing to talk to their older children about sexuality than their young children in primary schools. These results may also reflect the amount and quality of SRE offered at primary and secondary schools. The results suggest further that the amount and quality of SRE may be better at secondary school level than at primary school level. This was also corroborated by the findings of content analysis of the position of SRE in the national school curriculum, which is reported in Chapter 8.

Regarding the perceived importance of SRE topics, students supported a wide range of topics to be included in the SRE curriculum. However, unsurprisingly, they showed little support for topics that are normally regarded as controversial, including homosexuality and masturbation; students rated these topics as not important or just somewhat important. The focus group discussions showed that the poor support for these topics was mainly a result of misconceptions and myths about the negative effects of these topics. Students thought, for example, that teaching young people about homosexuality would 'sensitise' them to wanting to become homosexuals. Some students also rejected the teaching of masturbation for the reason that masturbation had negative consequences on the sexual prowess of those performing it.

The results of this study are, in many ways, strikingly consistent with the results of other similar studies conducted in developed countries, notably Byers et al. (2003a) and Byers et al. (2003b), which also demonstrated overwhelming student support for the provision of SRE in schools. These studies also showed that students

in New Brunswick, Canada, as for those covered in this study, were not satisfied with the quality of SRE they received at home and school. However, unlike the Tanzanian students who wanted SRE to begin at primary school level, the majority of students in Byers's et al. studies wanted SRE to begin in middle school, which is equivalent to ordinary secondary school in Tanzania.

The results of the content analysis of the student responses to open question in the questionnaire showed that students' needs and preferences for SRE are diverse and broad. The nature of the questions that students asked point to some serious inadequacies in the current SRE programmes in Tanzania, and probably other sub-Saharan African countries, regarding their efficacy in addressing young people's needs in sexual health. It is clear that most of the SRE programmes in Tanzania and the sub-Saharan African region in general have hitherto tended to have more inclination towards HIV/AIDS than other areas of sexual health. However, it is evident from the results of this study that young people's needs about sexual health are broader than HIV/AIDS. In fact, most students who asked the questions seemed to be interested in knowing about several issues around sexuality other than HIV/AIDS. For example, most of the student questions were centred round such topics as homosexuality, masturbation, sexual pleasure and enjoyment and even sexual techniques, which are seldom covered in the traditional SRE programmes in sub-Saharan Africa.

The results of the content analysis also reveal that there still are profound knowledge gaps in basic issues related to sexual health, including HIV/AIDS. It was rather surprising to note, for example, that some students were still uncertain of the ways through HIV is transmitted. Additionally, the results of the content analysis of student questions have revealed a prevalence of wide spread common misconceptions and myths about condom use. These results are consistent with the findings of the Joint United Nations Programmes on HIV/AIDS (UNAIDS), which show that only 44 percent of young women and 49 percent of young men aged 15-24 can correctly identify ways to prevent HIV/AIDS (UNAIDS, 2006).There is therefore need for continued concerted efforts in educating young people about basic information and facts about HIV/AIDS and other aspects of SRE, which are key to changing young people's attitudes and risky sexual behaviours associated with HIV transmission.

Chapter 8

The Status and Place of Sex and Relationships Education in the National School Policy and Curriculum in Tanzania

8.1 Introduction

One of the key tasks involved in the first step of the Intervention Mapping approach, situational analysis, is to identify the scope and nature of sex and relationships education (SRE) in a national school curriculum. This step aims to identify how much and where SRE is already being covered in schools in order to avoid duplication in the planning of future programmes.

Against the above background, this chapter examines the position of SRE in the Tanzanian national school policy and curriculum, with a view to identifying the scope and nature of SRE in the national school syllabi and the institutional barriers to, and facilitators of, the provision of SRE in schools in Tanzania.

The chapter is presented in the following five major sections*: introduction, an overview of the Tanzanian education system, school policies on SRE, the position of SRE in the national school curriculum* and *discussion*.

8.2 An overview of the Tanzanian education system

The formal education and training system in Tanzania is divided into three major levels. The first level is basic education consisting of two years of pre-primary education (approximately ages 5-6) and seven years of primary education (approximately ages 7-13). The second level is secondary education consisting of four years of ordinary level (approximately ages 14-17) and two years of advanced level (approximately ages 18-19). The third level is the technical and higher education level, which comprises 3+ years and is mainly involved in skills and/or academic training.

Due to limited opportunities for secondary and higher education, with the exception of the entry into primary education, progression from one level of education to another is not automatic or a function of age. It is a highly competitive process, whereby students have to pass a series of prescribed national examinations to be able to proceed into the next levels of education. For example, in order for primary school

students to get a chance of a secondary education level, they have to sit and pass a primary school leaving examination (PSLE). Similarly, for secondary school students to proceed to advanced secondary education, they have to sit and pass an even more competitive certificate of secondary education examination (CSEE) taken after seven years of primary education. An advanced certificate of secondary education examination (ACSEE) marks the completion of secondary education, and the results of this examination are used to select students for entry into higher education levels, including university education.

In the drive to achieve universal primary education (Millennium Development Goal#2), the Government has undertaken concerted efforts to ensure that all school age children are enrolled into and complete a full course of primary schooling; these efforts have resulted into some positive developments. For example, enrolment in primary schools has increased from almost 6 million students in 2002 to 8 million students in 2006, an increase of 33.1 percent (United Republic of Tanzania [URT], 2006).

While primary school enrolment has been increasing steadily over the years, secondary school enrolment has remained relatively stable at fewer than 10 percent for ordinary secondary school level and at lower than one percent for advanced level (Galabawa et al., 2001). Though in recent years the Government has taken several steps to expand the secondary education sector, it is still far too small to absorb all the primary school leavers. For example, Government statistics show that, while primary school enrolment was 85.3 percent of the primary school age (7-13) population by 2006, secondary school enrolment during this period was lower than 10 percent of the secondary school age (14-17) population (URT, 2006). This implies that, in terms of the school-based SRE provision, the primary school level presents the most reliable avenue for reaching a majority of young people.

The primary school curriculum consists of five compulsory subjects; namely, Swahili, English, Maths, Science and Social Studies. Similarly, the ordinary secondary school curriculum consists of five compulsory subjects: Swahili, English, Maths, Civics and Biology. In addition to these subjects, secondary students are also required to choose one subject from either the Arts stream (History or Geography) or the Science stream (Physics or Chemistry). In the advanced school level, students do a combination of at least three subjects in physical sciences or social sciences and arts.

8.3 School policies on SRE

Until recently, there was no clear policy related to the provision of SRE in schools in Tanzania. However, in 2004 the Ministry of Education developed a policy on HIV/AIDS education titled *Guidelines for Implementing HIV/AIDS and Life-Skills Education Programmes in Schools* (URT, 2004). The name assigned to these guidelines clearly indicates that school policy on SRE in Tanzania has been spurred by the advent of the AIDS epidemic whose impact in the country reached a significant toll in the early 1990s.

The objectives of the guidelines are two fold. Firstly, to mainstream the teaching of HIV/AIDS education in schools and other educational institutions. Secondly, to guide and control the amount and type of HIV/AIDS information and materials that should reach school premises and classrooms.

Through this policy, the Government of the United Republic of Tanzania has committed itself to ensuring that HIV/AIDS and STI preventive education is accessible to all schools and other educational institutions in the country. The guidelines envisage an interdisciplinary approach to providing SRE in schools. The guidelines stipulate that HIV/AIDS and STI preventive education should be integrated into the core curriculum through Science and Social Studies for primary schools, Biology and Civics for ordinary secondary school and General Studies and Biology for advanced secondary school.

According to the *Guidelines for Implementing HIV/AIDS and Life-Skills Education Programmes in Schools*, the content of HIV/AIDS, STI and Life skills education should reflect two major elements; namely, (a) providing basic information and facts about the transmission and prevention of HIV and STI and (b) promoting responsible sexual behaviours, including delaying sex and protected sex.

Paradoxically, though the guidelines acknowledge that some students may be already sexually active and provide for the teaching of condom use, they prohibit the distribution of condoms to students in schools and in teachers' colleges for the reason that such an act would compromise moral ethics about pre-marital sex. The guidelines state that:

> Education for proper use of condoms will be given in schools and teachers' colleges. However, the distribution of condoms in schools and teachers' colleges will not be permitted. It is important to underline the point that young people need to be exposed to correct and proper information and education

about protected sex (safer sex) and moral ethics related to pre-marital sex (URT, 2004, pp. 18-19).

It is, therefore, reasonable to assume and expect that some sort of SRE is covered and taught in both primary and secondary school syllabi. However, both the nature and the exact amount of SRE in these syllabi are unclear. The next sections, therefore, attempt to examine the status and place of SRE covered in the primary and secondary school curricula.

8.4 The position of SRE in the national school curriculum

As noted above, the *Guidelines for Implementing HIV/AIDS and Life Skills Education Programmes in Schools* state that HIV/AIDS and life skills education should be covered in Social Studies and Science subjects for primary schools and in Biology and Civics subjects for secondary schools. In light of these guidelines, quantitative content analysis was carried out on the Social Studies, Science, Biology and Civics syllabi (URT, 2005b, c, d & e) to determine the amount and nature of SRE covered in the primary and secondary school curricula.

The following procedures were followed in examining the position of SRE in the national school curriculum. First, all main topics and sub-topics in the Social Studies, Science, Biology and Civics syllabi were listed. Second, to ensure reliability of the rating regarding the relevance of the topics to SRE, the researcher read all sub-topics several times and at different intervals before the final rating into an SRE category was confirmed. Third, the relevance and relatedness of the sub-topics to SRE were assessed by the researcher on a five point scale ranging from "*Not at all related* (1) to *Strongly related*" (5).

The following sections present the results of the content analysis regarding the position of SRE in the national primary and secondary school syllabi.

8.4.1 The place of SRE in the national primary school curriculum

The primary school Social Studies and Science syllabi were subjected to quantitative content analysis to determine the scope and nature of SRE in these subjects. The analysis was done at two levels. First, all SRE related topics were identified and listed down. Second, the SRE related topics were classified within the

three SRE dimensions: knowledge, skills and relationships and attitudes and values. The results are presented below.

8.4.1.1 The place of SRE in the primary school General Studies syllabus

The General Studies subject begins to be taught in Standard III and continues up to Standard VII. A total of 24 main topics, 40 sub- topics and 604 periods[10] are covered in the General Studies syllabus.

As Appendix 7.1 shows, of the 18 sub-topics and 108 periods that are covered in Standard III, only three (16.7%) sub - topics can be said to be somewhat related or relevant to SRE, which are allotted six periods(5.6%). These topics are *the concept of family* and *family relationships*. In Standard IV, a total of 20 sub-topics and 92 periods are covered. Of these four (20%) sub-topics can be said to be somewhat related to SRE, with only 18 periods (19.6%) allotted to them. These sub- topics are: *the concept of social norms, features of good social norms and values, benefits of social norms and values* and *the effects of bad social norms and values*.

In Standard V, there are eight main topics and 21 sub- topics covered in 135 periods, with four somewhat SRE related sub- topics (19%) covered in 10 periods (7.5%). In Standards VI and VII, there are 13 sub- topics in each class; none of these is related to SRE.

8.4.1.2 The place of SRE in the primary school Science syllabus

Science is taught in all the seven classes (Standard I-VII) in the primary school curriculum. Appendix 7.2 summarises the composition of the Science syllabus and the position of SRE in it. In Standard I, there are eight main topics and 20 sub-topics covered in 102 periods. Of these, five (25%) sub - topics (three are somewhat related and two topics are strongly related to SRE) sub - topics are related to SRE. The SRE related topics are covered in 25 periods, which is 24.5 percent of the total number of periods covered in Standard I. The topics that are somewhat related to SRE are *the human body, body cleanliness and tidiness* and *body health*; the topics that are strongly related to SRE are *the meaning of HIV and AIDS* and *HIV transmission and prevention modes*.

[10] A period means one class session which runs for 30 minutes for Standard I and II and 40 minutes for Standard III-VII and ordinary secondary school classes.

There are eight main topics and 21 sub- topics covered in 80 periods in Standard II. Two sub - topics, *the human body* and *body cleanliness and tidiness*, are somewhat related to SRE, whereas two sub - topics, *the meaning of HIV and AIDS* and *HIV transmission and prevention modes* are strongly related to SRE.

Twenty two sub - topics and 148 periods are covered in Standard III. Four (18.2%) sub- topics can be said to be related to SRE, with two sub- topics, *the human body* and *body cleanliness and tidiness,* being somewhat related to SRE and two sub-topics, *the meaning of HIV and AIDS* and *HIV transmission and prevention modes,* being strongly related to SRE. The SRE related sub- topics are covered in 15 periods, which is equivalent to 10.1 percent of the total periods covered in Standard III.

In Standard IV, there are seven main topics and 26 sub- topics covered in 160 periods. Of these, six (23.1%) sub- topics are either somewhat related to SRE (*principles of good health, body health* and *preventing infectious diseases*) or strongly related to SRE (*the importance of body immunity in preventing HIV infection and AIDS, the effects of low body immunity and its relationships with AIDS* and *food types that can enhance body immunity to fight with AIDS disease).* Twelve (7.5%) periods are allotted for SRE related sub- topics.

Seven main topics and 23 sub - topics are covered in Standard V, in which four (17.4%) sub- topics are strongly related to SRE; namely, *the differences between HIV and AIDS, HIV transmission modes, effects of HIV/AIDS* and *ways of protecting against HIV infection*. A total of 160 periods are covered in Standard V, of which 10 (6.3%) periods are allotted for SRE related sub- topics.

In Standard VI, eight main topics, 22 sub- topics and 147 periods are covered; of these, two (9.1%) sub- topics are strongly related to SRE topics; namely, *the reproductive system and HIV* and *STI infection*; 17 (11.6%) periods are allotted for SRE related topics. None of topics covered in Standard VII is related to SRE.

In summary, as shown in Table 8.1, there are 85 sub- topics covered in 604 periods in the General Studies primary school syllabus. Of these, only 11 (12.9%) sub- topics, covered in 34 (5.6%) periods, can be said to be related to SRE. In the Science syllabus, there are 149 sub- topics covered in 957 periods, of which 24 (16.1%) [10 or 7% are somewhat related and 14 or 9.1% are strongly related to SRE]

Overall, there are 234 sub- topics and 1561 periods in both the Social Studies and Science primary school syllabi. In these, SRE related topics appear in 35 (15%) sub- topics and 131 (8.4%) periods.

Table 8.1

Summary of the Position of SRE in General Studies and Science Primary School Syllabi

Subject	**General Studies**							**Science**						
Standard	# Sub-topics	# Periods	# SRE related topics		# periods for SRE	% SRE related topics	% SRE periods	# Sub-topics	# Periods	# SRE related topics		# periods for SRE	% SRE related topics	% SRE periods
			somewhat related	*strongly related*						*somewhat related*	*strongly related*			
I								20	102	3	2	25	25.0	24.5
II								21	80	2	1	18	14.3	22.5
III	18	108	3	0	6	16.7	5.6	22	148	2	2	15	18.2	10.1
IV	20	92	4	0	18	20.0	19.6	26	160	3	3	12	23.1	7.5
V	21	134	4	0	10	19.0	7.5	23	160	0	4	10	17.4	6.3
VI	13	135	0	0	0	0.0	0.0	22	147	0	2	17	9.1	11.6
VII	13	135	0	0	0	0.0	0.0	15	160	0	0	0	0.0	0.0
Totals:	***85***	***604***	***11***	***0***	***34***	***12.9***	***6.5***	***149***	***957***	***10***	***14***	***97***	***16.1***	***10.1***

8.4.2 The place of SRE in the national secondary school curriculum

According to the *Guidelines for Implementing HIV/AIDS and Life-Skills Education Programme in Schools* (URT, 2004), the delivery of SRE in secondary schools is envisaged through Civics and Biology subjects. Thus, in order to examine the status and place of SRE in the secondary school curriculum, quantitative content analysis was carried out on the Civics and Biology secondary school syllabi. The results regarding the amount and nature of SRE in the subjects are presented below.

8.4.2.1 The place of SRE in the secondary school Civics syllabus

In order to determine the place and amount of SRE covered in the Civics secondary school syllabus, all main topics, sub-topics and periods covered for each class were listed. The extent to which the sub-topics were relevant or related to SRE was assessed on a five point scale ranging from "*Not at all related*" (1) to "*Strongly related*" (5).

As shown in Appendix 7.3, some sub-topics covered in the secondary school Civics syllabus clearly appear to be related to SRE. For example, of the 20 sub- topics and 159 periods covered in Form I, eight (40%) sub-topics and 64 (40.3%) periods appear to be somewhat related to SRE. Again, of the 11 sub- topics and 154 periods covered in Form II, two (18.2%) sub- topics and 28 (18.2%) periods are somewhat related to SRE. In Form IV, eight sub-topics and 160 periods are covered, of which three (37.5%) sub- topics and 80 (50%) periods are related to SRE.

The SRE related sub- topics in Form I include *meaning and types of life skills, importance of life skills, courtship and marriage, the concept of family, rights and obligations of family members, meaning and types of behaviour, elements of proper behaviour* and *responsible decision making*. In Form II, the SRE related sub-topics are *the concept of gender* and *issues that hinder equal opportunities between men and women*. In Form IV, the SRE related sub- topics are: *aspects and elements of culture, positive and negative aspects of culture, customs that lead to the spread of HIV/AIDS and STIs* and *promotion of Tanzanian cultural values*.

8.4.2.2 The place of SRE in the secondary school Biology syllabus

As done in the case of the Civics syllabus, in order to determine the place and amount of SRE covered in the Biology syllabus, all topics, sub-topics and periods covered there were listed in a tabular form. The relevance and relatedness of the sub-topics to SRE were assessed on a five point scale as explained above. The results of this process are summarised in Appendix 7.4.

SRE related topics appear in Form I, III and IV syllabi. In Form I, as Appendix 7.4 shows, the Biology syllabus consists of six main topics and 19 sub-topics, which are covered in 120 periods. Of these seven (36.8%) sub- topics, covered in 44 (36.7%) periods, can be said to be somewhat or strongly related to SRE. The sub-topics that are somewhat related are: *the concept of health and community and infections* and *diseases*. The sub-topics that can be regarded as strongly related to SRE are: *personal hygiene and good manners, meaning of HIV, AIDS, STIs and STDs, management and control of STIs and HIV/IDS and care* and *support for people living with HIV/AIDS*.

In Form III, six main topics and 22 sub-topics are covered in 120 periods. Of these, three (18.2%) sub-topics can be said to be either somewhat related or strongly related to SRE, which are covered in 22 (18%) periods. The somewhat SRE related sub-topic is *the concept of reproduction*, and those that can be regarded as strongly related to SRE are *reproduction in mammals (in humans), sexuality, sexual health and responsible sexual behaviour, family planning, maternal and child care* and *prevention of mother to child HIV infection.*

Five main topics and 23 sub-topics are covered in Form IV in 108 periods. Of these, five (21.7%) sub- topics covered in 23 (21.3%) periods are either somewhat or strongly related to SRE. The somewhat SRE related sub- topic is *the concept of growth*, and the sub-topics that can be considered as strongly related to SRE are *growth and developmental stages in human, relationship between HIV and AIDS, management and control of HIV/AIDS and STIs* and *HIV counselling and testing*.

In summary, as shown in Table 8.2, 15 main topics and 51 sub-topics are covered in the Civics secondary school syllabus and delivered in 539 periods. Of these, 13 (25.5%) sub-topics and 172 (31.9%) are allotted for SRE. In the science syllabus, 22 main topics and 82 sub- topics are covered, which are delivered in 470 periods. Of these, 16 (19.5%) sub-topics and 89 (18.9%) periods are allotted for SRE.

Table 8.2

Summary of the Position of SRE in the Civics and Biology Secondary School Syllabi

	Civics							**Biology**						
Form	# Sub-topics	# Periods	Number of SRE related topics		# periods for SRE	% SRE related topics	% SRE periods	# Sub-topics	# Periods	Number of SRE related topics		# periods for SRE	% SRE related topics	% SRE periods
			somewhat related	*strongly related*						*somewhat related*	*strongly related*			
I	20	159	2	6	64	40.0	40.3	19	120	2	5	44	36.8	36.7
II	11	154	1	1	28	18.2	18.2	18	120	0	0	0	0.0	0.0
III	12	66	0	0	0	0.0	0.0	22	122	1	3	22	18.2	18.0
IV	8	160	2	1	80	37.5	50.0	23	108	1	4	23	21.7	21.3
Totals:	***51***	***539***	***5***	***8***	***172***	***25.5***	***31.9***	***82***	***470***	***4***	***12***	***89***	***19.5***	***18.9***

8.4.3 Classification of SRE related topics into SRE dimensions

The content of each of the SRE related topics in the national school curriculum was examined to determine their relevance and relatedness to the three SRE dimensions: knowledge, skills and relationships and attitudes and values. The classification of the SRE related topics into the SRE dimensions followed the pattern of the results of the rotated matrix of factor analysis of school-based SRE topics as rated by parents (see Table 5.6).

As can be seen in Table 8.3, almost all SRE related sub-topics in the school curriculum were found to be mainly focused on knowledge and only a few of them focused on skills and relationships and attitudes and values. Table 8.3 shows that, of the 32 sub-topics identified as related to SRE, 31 sub-topics are exclusively focused on knowledge and only five are considerably focused on the other two dimensions.

Table 8.3

Classification of SRE Topics Appearing in the School Curriculum by SRE Dimensions

Sub- topic	Level covered	Subject in which it is covered	SRE Dimension		
			Knowledge	*Skills and relationships*	*Attitudes and values*
1. The concept of family	PIII; S1	Social Studies/Civics	√		
2. Family relationships	PIII	Social Studies	√	√	
3. The human body	PI	Science	√		
4. Body cleanliness	PI and PII	Science	√		
5. The meaning of HIV and AIDS	PI, PII and PIII	Science	√		
6. Ways of preventing HIV transmission	PI, PII and PIII	Science	√	√	
7. The differences between HIV and AIDS	PV	Science	√		
8. Effects of HIV/AIDS	PV	Science	√		
9. The reproductive system	PVI	Science	√		
10. The relationship between HIV and STI infection	PVI	Science	√		
11. Meaning and types of life skills	S1	Civics	√	√	
12. Importance of life	S1	Civics	√		

Sub- topic	Level covered	Subject in which it is covered	SRE Dimension		
			Knowledge	*Skills and relationships*	*Attitudes and values*
skills					
13. Courtship and marriage	S1	Civics	√		√
14. Rights and obligations of family members	S1	Civics	√		√
15. Meaning and types of proper behaviour	S1	Civics	√		
16. Decision making	S1	Civics	√		
17. The concept of gender	S2	Civics	√		
18. Differences between men and women	S2	Civics	√		
19. Customs that lead to the spread of HIV/AIDS and STIs	S4	Civics	√		√
20. The concept of health and community	S1	Biology	√		
21. Personal hygiene and good manners	S1	Biology	√		
22. Diseases and infections	S1	Biology	√		
23. Meaning of HIV, STI, AIDS and STDs	S1	Biology	√		
24. Modes of HIV and STI transmission	S1	Biology	√		
25. Management and control of STIs and HIV/AIDS	S1 and S4	Biology	√		
26. Care and support for people living with HIV/AIDS	S1 and S4	Biology	√		√
27. Family planning			√		
28. Sexuality, sexual health and responsible sexual behaviour	S4	Biology	√		√
29. Maternal and child care	S4	Biology	√		
30. Prevention of mother to child HIV transmission	S4	Biology	√		
31. Growth and developmental stages in human beings	S4	Biology	√		
32. HIV counselling and testing	S4	Biology		√	
		Totals	31	5	5

Note that "P" stands for primary school and "S" stands for secondary school.

8.5 Discussion

This chapter has examined the position of SRE in the Tanzanian national school policy and curriculum. The analysis of school policy was done with respect to the *Guidelines for Implementing HIV/AIDS and Life-Skills Programme in Schools* (URT, 2004), whereas the analysis of school curriculum involved the Social Studies and Science primary school syllabi as well as the secondary school Civics and Biology syllabi.

Several issues have emerged from the analysis of the school policy on SRE. Firstly, the promulgation of the guidelines on HIV/AIDS education was mainly prompted by the advent of the AIDS epidemic and the need to protect young people from HIV infection. Secondly, in view of the above factor, HIV/AIDS education features more prominently in the policy than other aspects of SRE. Thirdly, though the guidelines acknowledge that about 50 percent of young people below the age of 15, most of whom are still in schools, are already sexually active, they seem to put more focus and emphasis on the promotion of abstinence than condom use. This is confirmed by the fact that the guidelines, despite providing for the teaching of condom use, prohibit the availability of condoms in schools. Additionally, there is no reference to contraception in the guidelines. Because of the prohibition of condom availability in schools, alongside the active promotion of abstinence in the guidelines, though it is not explicitly stated in the policy and curriculum frameworks, it seems reasonable to suggest that the abstinence-only approach is much more favoured and promoted in the current SRE offering in schools in Tanzania than the comprehensive approach.

However, the prohibition of condom availability in schools is arguably counterproductive and inconsistent with the Tanzanian Government's efforts to protect young people against HIV infection. This is because it has been demonstrated that teaching the use of condoms without demonstrating their proper use and making them available does not increase the prevalence of effective condom use in young people (Holmes, Levine & Weaver, 2004).

Indeed, several studies have demonstrated that condom education and availability are essential elements to successful HIV/AIDS prevention efforts (Guttmacher et al., 1997; Furstenberg, Geitz, Teitler & Weiss, 1997; Kirby & Brown, 1996; American Academy of Pediatrics, Committee on Adolescence, 1995). For

example, a study in New York revealed that making condoms available in schools increases the prevalence of condom use, which is ultimately associated with reduced incidence of STIs among sexually active young people (Guttmacher et al., 1997).

The analysis of the school curriculum has shown that some aspects of SRE are covered both at primary and secondary school levels. The SRE related topics appear in the Social Studies and Science primary school syllabi and Civics and Biology secondary school syllabi.

However, a careful analysis of the topics covered in the school curriculum shows that very few of them would qualify to be categorised as related to SRE in the strict sense of the name and meaning. For example, of the total 22 main topics, only two main topics in the Social Studies primary school syllabus can be said to be related to SRE; these are *family types and roles* and *social norms and values*, which are allotted 34 periods out of the 640 periods delivered in the entire Social Studies syllabus. In the Science primary school syllabus, of the total 49 main topics covered, only one topic can be considered to be related to SRE; namely, *HIV/AIDS*. Again, of the total 957 periods delivered in the Science primary school syllabus, only 45 (or 4.7%) are allotted to the SRE related topic (HIV/AIDS).

A relatively much higher proportion of SRE related topics is covered in the secondary school than in the primary school curriculum. For example, overall, three SRE related topics are covered in the primary school curriculum, which are *family types and roles, social norms and values* and *HIV/AIDS,* compared to six topics covered in the secondary school curriculum; namely, *life skills, gender, responsible decision making, personal hygiene, HIV/AIDS and STDs* and *reproduction*. This means that only 4.1 percent of the total 73 main topics covered in the primary school curriculum are related to SRE. In contrast, 17.9 percent of the total 39 main topics covered in the secondary school curriculum are related to SRE.

One of the important sub-topics covered under reproduction in the Biology secondary school syllabus is *family planning*. Interestingly, however, there is no reference to contraception and, instead, only the meaning and importance of family planning are referred to. Again, this is inconsistent with the Government efforts to address the problem of the increasing rates of teenage pregnancy among school girls.

In conclusion, this review has revealed that only a small proportion of possible SRE related topics is covered in the Tanzanian national school curriculum. Besides being too few, the SRE related topics in the national school curriculum appear to be

somewhat disorganised and scattered across four subjects to the extent that they can hardly be said to constitute a meaningful SRE programme.

The analysis of the national school curriculum has also shown that a great deal of the SRE related topics are covered during secondary education. This is arguably ineffective and somewhat unhelpful given that, as demonstrated in section 8.2 above, only a small proportion of primary school leavers get the opportunity to attend secondary education in Tanzania. This means that, by providing SRE during secondary education instead of primary education, only a small proportion (less than 10 percent) of students are reached. Additionally, providing SRE at secondary education level is probably too late as it has been argued that SRE works effectively if, among other factors, it is provided early, before young people reach puberty (Grunseit et al., 1997). In Tanzania, it has been observed that a majority of young people reach puberty before age 15, and while still attending primary education (Omari & Mkumbo, 2006).

Chapter 9
Summary, Conclusions and Recommendations

9.1 Introduction

The main aim of the research described in this thesis was to explore the potential for the development and implementation of school-based sex and relationships education (SRE) in Tanzania. In an attempt to achieve this aim, the research assessed the level of support for the provision of SRE in schools among key stakeholders in the education sector in Tanzania; namely, parents, teachers, students and national school policy makers. The assessment of support for the provision of SRE in schools was important because, as argued by Wells (1992), SRE works best if supported by the community and that community opposition can stop SRE programmes from being effective or indeed, being implemented at all.

The research has also examined the status and place of SRE in the national school policy and curriculum. This involved analysing school policies related to SRE as well as national school curriculum materials with a view to determining the nature and scope of SRE currently being offered in schools.

This chapter synthesises the issues emerging from the research in a way to help to provide answers to the research questions raised in Chapter 1. The chapter also presents the major contributions of the research and advances recommendations for future research directions and policy actions regarding school- based SRE in Tanzania.

9.2 Summary

9.2.1 A comparison of parents', teachers' and students' attitudes towards school-based SRE

The support for school-based SRE was examined with respect to parents', teachers' and students' attitudes towards the provision of SRE in schools. Both quantitative and qualitative research approaches were used in which surveys and focus groups were employed as methods of data collection respectively. Respondents were drawn from one urban district (Kinondoni) and one rural district (Sengerema).

This section presents a comparative analysis of parents', teachers' and students' attitudes towards school-based SRE. The comparative analysis was made

with respect to responses to four questionnaire items: (i) SRE should be provided in schools, (ii) timing of SRE provision in schools (iii) preference of SRE providers and (iv) the perceived importance of SRE topics.

9.2.1.1 Should SRE be provided in schools?

A comparative analysis was carried out to examine the variation in attitudes towards the statement *SRE should be provided in schools in Tanzania* among parents (*N*=287), teachers (*N*=68) and primary school students (*N*=351). The results showed that teachers reported more favourable attitudes towards the provision of SRE in schools than did parents and students (see Figure 9.1). Almost all teachers (91.2%) strongly agreed (54.4%) or agreed (36.8%) with the statement that SRE should be provided in schools compared to 80.6 percent of the students and 74.2 percent of the parents who did so.

A two-way between groups analysis of variance (ANOVA) was conducted to explore the variation in attitudes towards school-based SRE by *respondent location* and *category* (parents, teachers and students). There was a statistically significant difference in the attitudes towards the statement: *SRE should be provided in schools,* by *respondent category*: [F (2, 682) =6.452, *p*=.002]; however, the effect size was quite small (partial eta squared =.02).

Post- hoc comparisons using the Tukey HSD test indicated that the mean score for parents (*M*=3.71, *SD*=1.39) was statistically significantly different from teachers (*M*=4.32, *SD*=0.93) and students (*M*=4.01, *SD*=1, 34). However, as Table 9.1 shows, there was no statistically significant difference in the attitudes towards school-based SRE between teachers and students.

There was no statistically significant variation in the attitudes towards school-based SRE by *respondent location* [*F* (1, 682) =1.783, *p*=.182] and the interaction effect [*F* (2, 682] =0.041, *p*=.960] was far from reaching statistical significance.

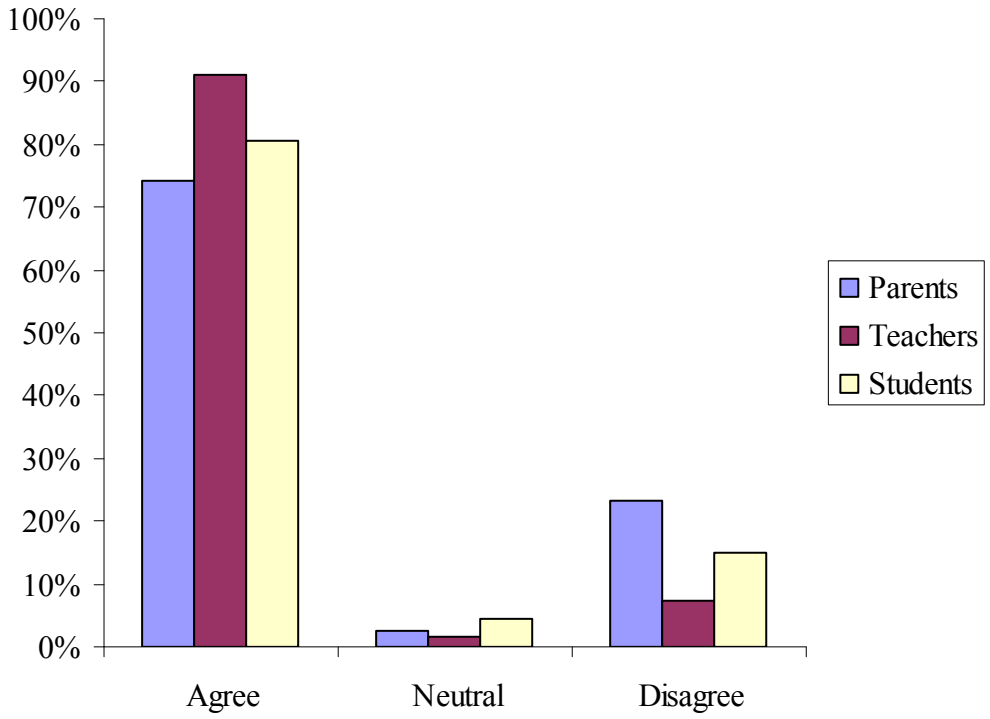

Figure 9.1 Percentage of parents, teachers and students agreeing and disagreeing with the statement: *SRE should be provided in schools*

Note: The percentage of *agree* is a summation of the percentages of *agree* and *strongly agree* while the percentage of *disagree* is the summation of the percentages of *disagree* and *strongly disagree*.

Table 9.1

Multiple Comparisons Using the Tukey HSD Test with the Dependent Variable: SRE Should be Provided in Schools

(I) Respondent category	(J) Respondent category	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
		Lower Bound	Upper Bound	Lower Bound	Upper Bound	Lower Bound
Parents	Teachers	-.60(*)	.177	.002	-1.02	-.19
	Students	-.34(*)	.106	.004	-.59	-.09
Teachers	Parents	.60(*)	.177	.002	.19	1.02
	Students	.27	.173	.274	-.14	.67
Students	Parents	.34(*)	.106	.004	.09	.59
	Teachers	-.27	.173	.274	-.67	.14

* Based on observed means.

* The mean difference is significant at the .05 level.

9.2.1.2 Preference of SRE providers

Figure 9.2 summarises the parents', teachers' and students' preferences for SRE providers among the six possible groups: *teachers, physicians or nurses, parents, professional sex educators or counsellors, religious leaders* and *friends*.

As can be seen in Figure 9.2, for parents, *professional sex educators or counsellors* were the most preferred SRE deliverers, with 86.9 percent of the parents indicating that this group should either be involved (23.3%) or very much involved (63.6%) in educating young people about SRE. Closely following were *teachers*, with 86.4 percent of the parents indicating that this groups should either be involved (30.6%) or very much involved (55.8%) in the SRE delivery. *Friends* were the least preferred group by parents, with only 55.9 percent of the parents wanting this group to be involved in the SRE delivery for young people.

Teachers ranked themselves (*teachers*) highly as the most preferred SRE providers, with 97.1 percent of them indicating that *teachers* should either be involved (29.4%) or very much involved (67.6%) in educating young people about SRE. Other groups that were highly ranked by teachers as preferred SRE deliverers were

physicians or nurses, professional sex educators or counsellors and *parents,* with more than 90 percent of teachers indicating that these groups should be involved or very much involved in educating young people about SRE. Again, *friends* were the least preferred SRE deliverers by teachers, with only 53.8 percent of them indicating that this group should be involved (26.9%) or very much involved (26.9%) in the SRE delivery.

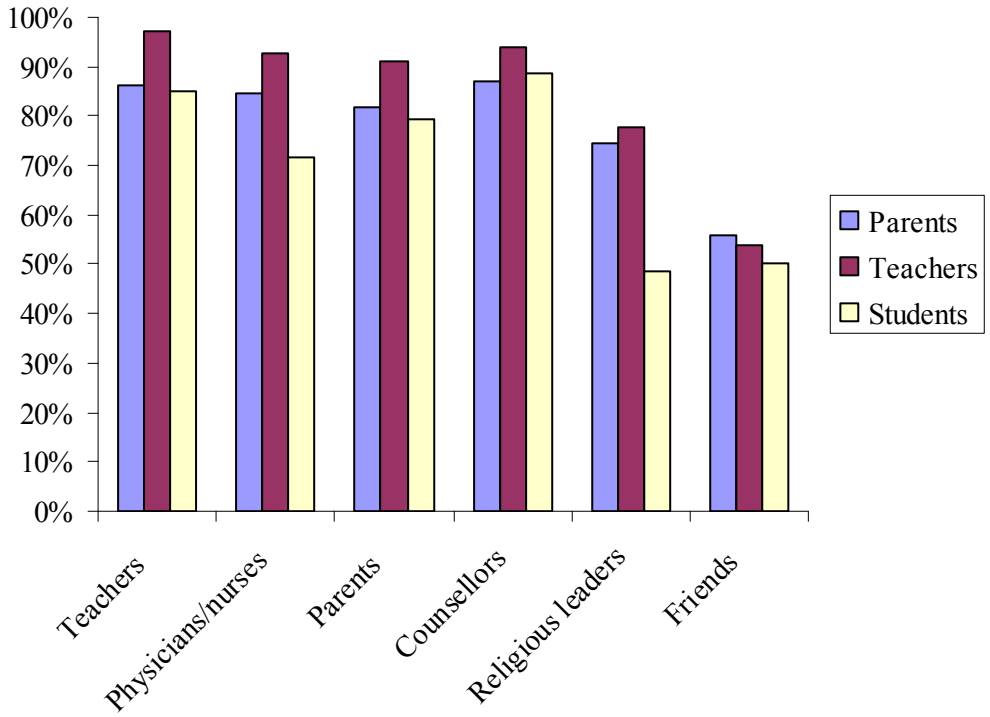

Figure 9.2 Percentage of parents, teachers and students indicating their preference of SRE deliverers in schools

For students, *professional sex educators or counsellors* were the most preferred SRE deliverers followed by *teachers*. Almost 89 percent of students wanted *professional sex educators or counsellors* to be involved (21.8%) or very much involved (67.2%) in the SRE delivery. Eighty five percent of students wanted *teachers* to be involved (30 %) or very much involved (55 %) in educating young people about SRE. *Religious leaders* and *friends* were the least preferred SRE providers by students, with just 50 percent of students indicating that these groups should be involved in the SRE delivery in schools.

Overall, teachers were the most preferred SRE providers by all the three groups of respondents (parents, teachers and students). This provides yet again another ground to argue for schools as the most suitable and appropriate place for providing SRE to young people.

9.2.1.3 Perceived importance of SRE topics

The comparative analysis of the respondents' attitudes towards specific topics was carried out on 12 topics; namely, *correct names of genitalia, puberty, personal safety, STDs and HIV/AIDS, masturbation, homosexuality, sexual coercion and assault, abstinence, decision making, birth control, condom use* and *sexual pleasure*. These have been identified as the most basic SRE topics constituting a minimum package for SRE programme at elementary level such as primary school (Lenderyou, 1993). The results of respondents' perceived importance of each of these topics are summarised in Table 9.2.

As can be seen in Table 9.2, *puberty, personal safety, STDs and HIV/AIDS, sexual coercion and sexual assault, birth control* and *decision making* were rated as very important or important by all the three groups of respondents. For example, more than 90 percent of teachers rated these topics as important or very important. Indeed, all teachers (100%) indicated that *STDs and HIV/AIDS* was important (10.3%) or very important (89.7%), and more than 70 percent of parents and students rated these topics as important or very important. However, a comparatively lower proportion of students (64.1%) than parents and teachers rated *STDs and HIV/AIDS* as important or very important.

Condom use, sexual pleasure and *masturbation* were seen as relatively less important than other topics, with just about 40 percent of teachers and less than 40 percent of students rating these topics as important or very important. Nevertheless, condom use was relatively regarded as more important by parents than by teachers and students, with 51.2 percent of the parents rating it as important (25.4%) or very important (25.8%). A one-way between groups ANOVA, however, revealed no statistically significant difference in the perceived importance of covering condom use among parents, teachers and students [F (2, 666) =0.038, p=.962].

Homosexuality was the least preferred topic amongst all the three groups of respondents. For example, 55 percent of the parents indicated that homosexuality was either *not important at all* (38.5%) or *not important* (16.5%). Similarly, 69.7 percent

of the teachers indicated that covering homosexuality was either *not important at all* (56.1%) or *not important* (13.6%), with more than 60 percent of students indicating that covering homosexuality was either *not important at all* (45.5%) or *not important* (16.1%).

A one-way between groups ANOVA was carried out to examine the variation in attitudes towards the teaching of homosexuality among parents, teachers and students. Homosexuality was particularly selected because it received the poorest rating compared to other controversial topics (masturbation and condom use). There was a statistically significant difference at the $p<.05$ level in the score measuring the perceived importance of homosexuality: [F (2, 666] =4.706, p=.009]. However, despite reaching statistical significance, the actual difference in mean scores between parents and teachers and between parents and students was quite small. The effect size, calculated using eta squared, was only .01. This means that the attitudes towards homosexuality among the three groups were fairly similar.

When multiple comparisons were examined, it emerged that the statistically significant differences in attitudes towards the teaching of homosexuality were only between parents and teachers, but not between parents and students or between teachers and students (see Table 9.3). Post- hoc comparisons using the Tukey HSD test indicated that the mean score for parents (M=2.59, SD=1.570) was statistically significantly different from that for teachers (M=2.03, SD=1.40) but not from that for students (M=2.31, SD=1.47).

Table 9.2

Percentages of Parents, Teachers and Students Indicating the Importance of SRE Topics

	Parents %			**Teachers %**			**Students %**		
	Important	***Neutral***	***Not important***	***Important***	***Neutral***	***Not important***	***Important***	***Neutral***	***Not important***
1. Correct names of genitalia	55.9	17.3	26.8	53.7	20.9	25.4	51.7	18.0	30.2
2. Puberty	86.1	7.3	6.6	94.1	2.9	2.9	75.8	13.7	10.5
3. Personal safety	87.7	6.7	5.6	97.0	3.0	0.0	80.7	10.9	8.3
4. STDs and HIV/AIDS	79.8	5.4	14.8	100.0	0.0	0.0	64.1	2.9	33.0
5. Masturbation	44.4	12.0	43.6	43.8	18.8	37.5	32.5	16.0	51.5
6. Homosexuality	32.8	12.2	55.0	18.2	12.1	69.7	24.6	13.8	61.6
7. Sexual coercion	76.6	9.1	14.0	93.8	4.7	1.6	74.6	5.2	20.1
8. Abstinence	56.5	11.9	31.6	69.7	12.1	18.2	56.7	12.0	31.1
9. Decision making	77.8	11.1	11.1	92.4	0.0	7.6	72.4	12.3	15.2
10. Birth control	68.1	11.1	20.8	77.2	14.9	17.9	74.1	12.8	13.0
11. Condom use	51.2	13.5	35.4	41.5	26.2	32.3	49.1	14.0	36.8
12. Sexual pleasure	43.5	15.0	25.4	34.9	22.2	42.9	34.5	11.6	53.9

Table 9.3

Multiple Comparisons Using the Tukey HSD Test with the Dependent Variable: Homosexuality

(I) Respondent category	(J) Respondent category	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
		Lower Bound	Upper Bound	Lower Bound	Upper Bound	Lower Bound
Parents	Teachers	.561(*)	.207	.019	.07	1.05
	Students	.281	.124	.061	-.01	.57
Teachers	Parents	-.561(*)	.207	.019	-1.05	-.07
	Students	-.281	.202	.349	-.76	.19
Students	Parents	-.281	.124	.061	-.57	.01
	Teachers	.281	.202	.349	-.19	.76

* The mean difference is significant at the .05 level.

The survey results of parents', teachers' and students' attitudes towards homosexuality were corroborated by the findings of the focus group research, which also demonstrated a clear opposition to the teaching of homosexuality in schools. During the focus group discussions, some respondents appeared to support the teaching of homosexuality; however, they supported its teaching in the context that students were only taught the 'unnaturalness' and 'uncleanness' of homosexuality. But teaching students this kind of SRE is unhelpful and it is not the role of the school in the first place. It has been argued that the role of the school regarding the teaching of such controversial subjects as homosexuality, should be to facilitate students to clarify their values and promote tolerance and respect for diversity in beliefs and values as well as individual choices, including sexual orientation (Harrison, 2000).

The resistance to the teaching of homosexuality, as demonstrated by the results of this research, can partly be linked to respondents' traditional and religious beliefs about homosexuality, which are generally reflective of those of the Tanzanian society at large. Homosexuality in Tanzania is largely seen as an aberration or illness and, from a religious point of view, blasphemous and heretic. The results should also be seen in the context of child rearing practices in Tanzania. As observed by Omari

and Mkumbo (2006), childhood in Tanzania is perceived by a majority of parents as innocence worthy of protection from being 'spoiled and polluted by world sins'. As such, teaching homosexuality would be seen as spoiling the innocence of school children.

Clearly, therefore, the line between the respect for individual choices and freedoms and the desire to conform and be part of the larger societal values is quite thin particularly in collective societies such as Tanzania. As such, teaching of homosexuality in societies that actively promote collective values, such as Tanzania, and as long as religion continues to exert significant influence in people's lives, will continue to be a hotly debatable and contentious issue. The question, as far as Tanzania is concerned and as the results of this research show, is not, therefore, so much about whether or not homosexuality should be included in the school SRE curriculum; rather, is it possible to rescue SRE from being rejected by excluding some of the seemly contentious topics such as homosexuality? And what will be the effect of excluding such topics on the comprehensiveness of SRE programmes?

Answers to the above questions and others would confirm the observation made earlier in this thesis that the nature and goals and, therefore, the content of SRE programmes are dependent upon the social-cultural contexts in which they are implemented. It is clear from the results of this research that excluding homosexuality, until such a time that the general society's attitude towards this subject is fairly permissive, is an important strategy for attracting the support of key stakeholders for the provision of SRE in schools in Tanzania. This is important because, as observed by Meredith (1989), for school-based SRE to be effective, among other things, it should be morally permissible and acceptable.

9.2.2 The place of SRE in the school policy and curricula

One policy document and four subject syllabi were identified as having relevance and bearing to SRE. The policy document is *Guidelines for Implementing HIV/AIDS and Life-Skills Education Programme in Schools* (URT, 2004), and the four subject syllabi are Social Studies primary school syllabus, Science primary school syllabus, Civics secondary school syllabus and Biology secondary school syllabus. These were subjected to content analysis to determine the scope and nature of SRE in them.

The analysis of the above cited school policy document shows that it promotes the inclusion and teaching of some aspects of SRE in the school curricula. It is, however, clear that the promulgation of this policy was mainly spurred by the need to equip school children with information and skills they need for HIV/AIDS prevention rather than the promotion and protection of their sexual health in general.

The analysis of the guidelines also revealed a provision that, rather disturbingly, limits the opportunities for young people to protect themselves against HIV/AIDS, viz. the prohibition of condom availability in schools. One implication of this provision is that the Government seems keener to promote abstinence than protection as an effective strategy for protecting young people against HIV infection. This tacit adoption of the abstinence-only approach to HIV/AIDS education clearly contradicts the Government's own observation and the available scientific evidence that a majority of young people in schools in Tanzania are already sexually active and they therefore need to use condoms to protect themselves against HIV infection as well as unwanted pregnancy.

As stated in the guidelines on HIV/AIDS, the analysis of the school curriculum showed that some aspects of SRE are covered both at primary and secondary school levels. The SRE related topics are integrated in the Social Studies and Science primary school syllabi and Civics and Biology secondary school syllabi. The analysis identified four main topics in the school curriculum that are particularly related or somewhat related to SRE; namely, *STDs and HIV/AIDS, decision making, health and growth* and *development in humans*.

The scope and weight of SRE in the school curriculum was measured by calculating the proportion of the SRE related sub-topics and the amount of time (measured by number of periods) allocated for their teaching relative to the total number of sub-topics and the number of periods allocated in the entire curricula.

The analysis of the subject syllabi in which SRE is said to be integrated revealed that only 35 (15.6%) sub-topics of the total 224 sub-topics covered in the primary school curriculum can be said to be related to SRE. In the secondary school syllabi, of the total 133 sub-topics covered, only 29 (21.8%) sub-topics are related to SRE.

Overall, of the total 357 sub-topics covered in the national school curriculum, the proportion of the SRE related topics is only 17.9 percent (64 sub-topics). The

proportion of time allotted for SRE related sub-topics is 14.7 percent (392 periods) out of the total 2,670 periods covered in the entire national school curriculum.

In assessing the relevance of the content of the SRE related topics with respect to the three dimensions of SRE (see Figure 1.4), the analysis showed that the coverage of SRE in the school curriculum has more focus and emphasis on knowledge aspects of SRE but very little attention is paid to skills and attitudes and values.

The analysis showed further that, of the 11 basic SRE topics (see Table 9.2), only three (27.3%) appear in the primary and secondary school curricula. These are *STDs and HIV/AIDS, Reproduction and birth* and *Decision making*. Therefore, from the point of view of the number of topics, it can be said that 27.3 percent of the national school curriculum is devoted to SRE. However, this could give a rather misleading picture due to the fact that these topics are spread across four subjects covered in a period of almost more than 10 years of schooling. Having said this, it is evidently rather difficult to come up with a candid measure and therefore an acceptable proportion of SRE in the Tanzanian school curriculum. Hence the proportion of SRE as reported in this thesis should be considered as an indicative but not a conclusive picture of SRE in the national school curriculum in Tanzania.

Having said all this, it should be noted that the status of SRE in the national school curriculum established in this thesis was wholly based on the analysis of the SRE related topics as they appear in the subject syllabi. This analysis does not indicate the extent to which these topics are covered in the actual teaching process. Neither does it indicate the methods and resources used in teaching the SRE related topics in the classroom context. As such, while the analysis has established the quantity SRE in the current national school syllabi, it does not reveal the quality of SRE offered in the Tanzanian schools.

9.3 Conclusions

The research described in this thesis has examined the potential for the development and implementation of school-based sex and relationships education (SRE) in Tanzania and the factors that may affect this. The research attempted to address five specific research questions (see Chapter 1, Section 1.3): (1) what are the attitudes of Tanzanian parents, teachers and students towards the provision of SRE in schools? (2) Is there a significant difference in the attitudes towards school-based SRE between parents, teachers and students in rural and urban settings? (3) How are social demographic factors such as age, sex and religion associated with attitudes towards school-based SRE? (4) What is the status and place of SRE in the Tanzanian national school policy and curriculum? and (5) what are the needs and preferences of young people regarding sexual health that should be reflected and included in a school-based SRE programme?

In the search for answers to the above questions, two major research tasks were undertaken. In the first task, employing quantitative (survey) and qualitative (focus groups) research methods, the research assessed the views and attitudes of parents, teachers and students regarding the provision of SRE in schools. In the second task, using quantitative content analysis, the research examined the position of SRE in the school policy and curriculum, with a view to examining the potential institutional barriers to the provision of SRE in schools on the one hand and, on the other, to determining the scope and nature of the current SRE provision in schools. Content analysis was also employed in examining the students' responses to the open ended questionnaire questions in an attempt to determine their needs and preferences for school-based SRE.

This section attempts to synthesise and put together answers to the above research questions.

9.3.1 What are the attitudes of the Tanzanian parents, teachers and students towards the provision of SRE in schools?

The results of survey and focus groups revealed that, firstly, the majority of parents, teachers and students support the teaching of SRE in schools, and the inclusion of a wide range of topics in a possible SRE curriculum. Secondly, the majority of respondents wanted SRE to be introduced early during primary education

(age 10-14) rather than during secondary education (age 15-18). Thirdly, despite supporting the inclusion of a wide range of topics in the SRE curriculum, respondents, particularly in the urban district, showed a strong resistance to the inclusion of some topics that are usually regarded in the SRE field as controversial, including homosexuality, masturbation and, to some extent, condom use.

Clearly, therefore, the theoretical framework for the development of SRE programmes as presented in Figure 1.4 (page 16) was not wholly applicable to the context investigated in this research. In this research, participants were more supportive to the SRE components that are related and relevant to the avoidance of sexual health problems than those related to sexual health promotion in general. This implies that the disease prevention approach to SRE may be more acceptable than the health approach to developing countries such as Tanzania, and this needs to be taken into account in the planning and development of SRE programmes.

It is interesting to note, however, that, though a significant proportion of respondents (parents, teachers and students), particularly in the urban district, objected to the inclusion of condom use in the school- based SRE curriculum, an overwhelming majority of them supported the inclusion of birth control. For example, as Table 9.2 shows, 68.1 percent of parents, 77.2 percent of teachers and 74.1 percent of students indicated that birth control was either very important or important. It is therefore clear that, though parents, teachers and students may have difficulties accepting the teaching of condom use in schools, the results of this research suggest that they would want SRE programmes in schools which both encourage young people to wait until they are cognitively and emotionally ready to have sex and also to teach them about birth control. It is thus reasonable to argue that the results for this research suggest that parents, teachers and students may be willing to support a comprehensive approach to SRE as opposed to the abstinence- only approach.

In general, respondents' attitudes were more favourable, perhaps understandably so given the magnitude of the AIDS crisis in Tanzania and other sub-Saharan African countries, towards SRE topics that have a direct relation to, and a bearing on, HIV/AIDS prevention. This has the implication that respondents perceived SRE more as a tool for enabling young people to avoid diseases related to sexual behaviour (diseases prevention perspective) than as a vehicle for promoting young people's sexual health in general (sexual health promotion perspective).

9.3.2 Are there significant differences in the attitudes towards school-based SRE between parents, teachers and students in rural and urban settings?

The results of a two-way ANOVA, exploring the variation in attitudes towards school-based SRE between rural and urban based respondents, revealed no statistically significant difference in attitudes towards the provision of SRE in schools between respondents (parents, teachers and students) in the rural (Sengerema) and urban (Kinondoni) districts. The MANOVA also revealed no statistically significant variation in the perceived importance of SRE topics among parents, teachers and students in the two districts. However, there was a statistically significant variation in the attitudes towards controversial topics such as homosexuality, masturbation and condom use between respondents in the urban and rural districts. Respondents in the rural district generally showed more favourable attitudes towards these topics than their counterparts in the urban district.

9.3.3 How are social demographic factors such as age, sex and religion associated with attitudes towards school-based SRE?

The logistic regression analyses examining the influence of respondents' social demographic factors on their attitudes towards school-based SRE showed that, apart from the age of parents, none of the social demographic factors (location, sex, religion, number of children and educational level) showed a statistically significant impact on the respondents' attitudes towards the provision of SRE in schools or on the perceived importance of SRE topics. Younger (age 25-35) and middle aged (36-45) parents reported statistically significantly more favourable attitudes towards school-based SRE than older parents (aged 45 and above).

9.3.4 What is the status and place of SRE in the Tanzanian national school policy and curriculum?

The content analysis of the national school policy and curriculum demonstrated that the current SRE provision in schools in Tanzania is limited in scope covering little more than the biology of HIV/AIDS prevention. Indeed, it would be more appropriate to refer to what appears in the school curriculum as HIV/AIDS education rather than SRE. However, even when described as such, it would still fall short of HIV/AIDS education in its strict sense due to limited scope and a disorderly arrangement of the HIV/AIDS topics in the school curriculum.

It is also clear that, though not specifically stated in the school policy documents, the abstinence-only approach is more actively promoted both in the school policy and curriculum than the comprehensive approach to HIV/AIDS education. The abstinence-only orientation in the school curriculum is evidenced by the prohibition of condom availability in schools and a lack of reference to contraception in the school policy document and curricula materials. The results of the focus group discussions with national school policy makers showed that the prohibition of condom availability in schools was mainly prompted by the fear of the opposition from parents and community and religious leaders. The results of the survey of parents' attitudes towards school-based SRE did not, however, support such fears.

9.3.5 What are the needs and preferences of young people regarding sexual health that should be reflected and included in a school-based SRE programme?

The content analysis of the students' responses to the open ended question in the questionnaire revealed a wide range of young people's needs and preferences about sexual health. Students' questions covered a diverse and broad range of issues beyond but including HIV/AIDS and traversed across all the three dimensions of SRE: knowledge, skills and relationships and attitudes and values. Indeed, students seemed even more interested in SRE topics that they rated relatively unfavourably while completing the questionnaire and that are seldom covered in most SRE programmes in sub-Saharan African countries, including homosexuality, masturbation, sexual pleasure and enjoyment and condom use.

A good number of students' questions centred on the common myths and misconceptions about such basic issues as ways in which HIV is transmitted and the effectiveness of condom use in protecting against HIV infection and pregnancy. This shows that, despite many years of concerted HIV/AIDS education efforts in Tanzania, young people's knowledge about basic issues such as HIV/AIDS prevention is still limited.

To sum up, in view of the results of this research, three major conclusions can be drawn. Firstly, the results of this research have demonstrated an overwhelming support for the provision of SRE in schools among parents, teachers and students. One caveat, though, is the respondents' resistance to some of the topics that have for long been regarded as controversial, including homosexuality, condom use and

masturbation. The resistance was notably stronger for the inclusion of homosexuality in the SRE curriculum than other controversial topics. However, the resistance to homosexuality should be seen a challenge rather than a barrier to the development and delivery of school- based SRE.

It should also be noted here that, apart from the age of parents, none of the demographic factors was statistically significantly associated with the attitudes of respondents towards the provision of SRE in schools. It is particularly imperative to note that, though a majority of respondents reported religion as being very important in their lives and attended religious services quite frequently (at least once a week), religion did not have a statistically significant influence on their attitudes towards school-based SRE. This is an important aspect of the results of this research worth noting and further researching because previous research suggested that people who attend religious services less often and view religion as not being very important in their lives tend to be more likely to support SRE than those who attend regularly and view religion as being very important in their lives (Hardinge, 2004).

It is, therefore, clear that, contrary to school policy makers' belief that parents are opposed to the provision of SRE in schools, it is not the opposition itself but the unfounded fear of the opposition that has prevented the development and delivery of wider scale SRE in schools in Tanzania.

Further, though the research did not aim to explore the effectiveness of SRE teaching in schools, it is clear from the students' views, as gathered in the focus groups, that the current SRE in schools is not only limited in scope, but also, in the words of one student participant, 'badly taught'. This was further confirmed and corroborated by the results of the content analysis of school policy and curriculum, which showed that only a few aspects of SRE, especially those relevant to HIV/AIDS prevention, are included in the school syllabi.

The content analysis of the curricula materials also revealed that the SRE related topics in the syllabi are not only too few, they are also too scattered to constitute a meaningful SRE programme worthy of the name. Additionally, the content analysis of the students' responses to the open ended questionnaire question demonstrated that young people's SRE needs are far broader than those currently addressed in the Tanzanian national school curriculum.

9.4 Recommendations

9.4.1 For future research directions

This research has established the extent of community support for the provision of SRE in schools in Tanzania, which is an important consideration to be taken into account when planning school-based SRE programmes. The research has also established the scope and nature of SRE in the current national school curriculum as well as the institutional support in the school policy framework.

Two fundamental limitations are evident from this research. First, the survey of parents', teachers' and students' attitudes towards the provision of SRE in schools was limited to two districts only; namely, Kinondoni (urban) District in Dar es Salaam and Sengerema (rural) District in Mwanza. It follows that, though the results of this survey have provided an informative picture about the extent of support for the provision of SRE in schools among parents, teachers and students, they do not provide a definitive picture of the community support for the school-based SRE in Tanzania. Second, the research has only reported the 'quantity' of SRE in the current national school curriculum, but not the quality of its delivery. In this case, only theoretical barriers to the SRE delivery in the curriculum have been identified but not the impediments in practice. Additionally, the research did not examine the infrastructure for the teaching of SRE in schools, such as teachers' competence with respect to knowledge about sexual health and skills for teaching SRE as well as teaching and learning facilities.

In the light of the above research limitations, the following recommendations are made to guide future research in the field of SRE in Tanzania.

i) Given the diverse nature of the Tanzania community spanning across more than 100 districts and 120 tribes, in order to enhance the representativeness and transferability of the results, it is recommended that a more comprehensive survey of the attitudes of parents, teachers and students regarding school-based SRE be extended to other districts. It is also recommended that future surveys on this area should involve other stakeholders, such as religious and community leaders as well as young people out of school settings. Further, since the current research has only explored the attitudes of teachers and other experts in the education sector, and because SRE overlaps between education and health domains, it would be useful and appropriate for future surveys to recruit participants from the health sector,

such as medical doctors and nurses as well as policy makers in the Ministry of Health.

ii) As observed earlier, this research only established the scope and nature of SRE in the school syllabi, but did not explore the infrastructure for its teaching. Thus future research should explore, in much more detail, the infrastructural framework for teaching SRE in schools in Tanzania. More specifically, future research regarding SRE should attempt to answer the following questions:

   a. What training and external support have teachers received for teaching SRE?
   b. What resources (e.g., books and teaching aids) are being used in teaching about SRE?
   c. What methods are teachers using in teaching about SRE and how effective these methods are?
   d. How is the teaching of SRE being evaluated by teachers and students and externally?

Two further issues emerged from this research that need further follow up by a way of research. First, due to limitations of time and financial resources, only the first step, situational analysis, of the Intervention Mapping model was effectively employed in guiding the formulation of objectives and questions for this research. Second, the content analysis of the students' responses on the open ended questionnaire question pointed out a number of young people's sexual health needs, which hitherto have not been addressed in Tanzania. However, this was only a small section of a bigger questionnaire and was not a major part of the research. It should also be noted that no major study has been undertaken in Tanzania systematically and comprehensively to assess young people's sexual behaviours and sexual health needs. Thus there is a lack of a good and up-to-date published database on the sexual behaviours and sexual health needs of young people that could guide the planning of important health interventions such as SRE. In the light of these two issues emerging from this research, two additional recommendations are made as follows:

iii) Future research should explore the feasibility and applicability of the other five steps of the Intervention Mapping model, which has hitherto been mainly employed in designing health intervention programmes in developed

countries, in the development, implementation and evaluation of school-based SRE programmes in a developing country context such as Tanzania.

iv) There is need to conduct a wide scale survey of young people's sexual behaviours and needs in Tanzania to inform future SRE programme development, implementation and evaluation.

9.4.2 For future policy actions

This research has revealed several issues that have clear policy implications about the provision of SRE in schools in Tanzania. First of all, it is clear that there is a lack of a concrete and clear policy to guide the development and delivery of SRE in schools. The current policy, *Guidelines for Implementing HIV/AIDS and Life-Skills Education Programmes in Schools*, is limited in scope and mandate to enforce an effective development and delivery of comprehensive SRE in schools. It is clear that these guidelines were developed in response to the AIDS crisis and mainly aim at promoting the integration of HIV/AIDS education in the school curriculum rather than comprehensive SRE. It is therefore reasonable to state that, whereas currently there is a school policy on HIV/AIDS education, there is no such a policy on SRE.

Second, this research has clearly demonstrated strong support for the provision of SRE in schools in Tanzania among parents, teachers and students. Though the results cannot be claimed to be representative of the views and attitudes of the wider Tanzanian community, they have, however, provided a clear indication that a large section of the Tanzanian community has acknowledged the value of SRE in addressing some of their critical and pressing health concerns such as HIV/AIDS and may be ready to welcome its provision in schools. Third, and perhaps most important, the results of this research have effectively dispelled the seemingly common belief among school policy makers that parents are opposed to the provision of SRE in schools. On the contrary, the results of this research have shown that, though parents may be opposed to some aspects of SRE such as homosexuality, they overwhelmingly support the provision of SRE in schools.

On the basis of the above observations, the following policy recommendations are made:

v) There is need for the Government to develop a clear policy that will guide the development and teaching of SRE in schools.

vi) The Government should expeditiously introduce SRE in schools as a strategy to promote and protect young people's sexual health. However, there are several issues that need to be addressed in order to get comprehensive SRE into the school classrooms in Tanzania. These include:

a. As noted above, as much as a majority of respondents endorsed the provision of SRE in schools, there was a lack of consensus on what should actually constitute a school-based SRE programme. There were particularly divergent and contentious opinions when it came to discussing, in the focus groups, the introduction of controversial and sensitive SRE topics such as homosexuality, masturbation, condom use and sexual pleasure. There is therefore need to establish a structure for consultation and decision making in deciding the SRE curriculum content in the context of the divergent and varied social cultural backgrounds of the Tanzanian culture, and the high levels of religiosity of the majority of the population. There is especially a need for clear guidelines on the teaching of homosexuality, the recognition of sexual diversity and the promotion and protection of sexual health rights.

b. The current SRE in schools is integrated in four subjects and its provision spans across primary and secondary schools. This could lead to duplication and inconsistency in the SRE topics covered in the school curriculum. Indeed, it is difficult to assess the effectiveness of the current SRE practice in schools due to its disorganised structure. There is therefore a need to decide on how best SRE should be taught in schools, including deciding whether it should be taught as compulsory or an optional subject and whether it should be integrated in other subjects or it should stand alone as an independent subject.

c. Alongside introducing it in primary and secondary schools, SRE should be introduced in teacher colleges and integrated in the university teacher preparatory courses so as to equip would be teachers with the requisite knowledge, skills and confidence to teach SRE in schools.

9.4.3 General recommendations

In the search for literature about SRE and interacting with stakeholders in the field of SRE in Tanzania, including researchers, policy makers and practitioners, the

researcher observed a clear confusion and a lack of consensus about the name used to describe the education about sex and relationships in Tanzania, whereby different stakeholders used different names. Some of the names that were used included, for example, Family life education, Life skills education, HIV/AIDS education, Sexuality education and Life skills and HIV/AIDS education. There is, therefore, a need for various stakeholders in Tanzania to come together to chart out and agree about the name to use for this education (SRE) for the whole country. As a starting point, Tanzania could adopt the name 'sexuality education' which has been used by the Africa Regional Sexuality Resource Centre (ARSRC) [Maticka- Tyndale, Tiemoko & Makinwa- Adebusoye, 2007], and was recently endorsed by the delegates of the 3rd Africa Conference on Sexual Health and Rights held on 4-7 February 2008 in Abuja, Nigeria.

Additionally, though the benefits of school-based SRE in promoting and protecting young people's sexual health have been documented widely, some parents, teachers, students and school policy makers who participated in the focus group discussions seemed oblivious to and clearly doubted such benefits. There is therefore need for public awareness and enlightenment about the importance of school-based SRE through media and other campaigns. Such campaigns would also provide an opportunity for researchers to bring to the forefront key research findings as well as providing an opportunity for people to debate various aspects of school-based SRE such as content, teaching methods and timing for its introduction in schools.

Lastly, cultural norms were cited by many participants in the focus groups as one of the major barriers constraining the introduction of SRE in schools. However, this research did not examine in detail the specific cultural norms that could be taken into account in the development and delivery of school-based SRE programmes. Future research therefore needs to closely examine and identify positive cultural norms that could be incorporated in school-based SRE programmes. Identifying, recognising and incorporating positive cultural norms in the SRE programmes will not only make such programmes relevant to social-cultural contexts in which they will be implemented, but will also facilitate the acceptability of these programmes to local communities.

9.5 Major contributions of this research

This is so far the first study that has attempted systematically to explore the level of support for the provision of SRE in schools in Tanzania. It is also the first research to quantify the amount of SRE in Tanzanian national school policy and the formally published curriculum. Thus one key contribution of this research has been to create a database on the prevalence of community support for school-based SRE in Tanzania, which is, as observed earlier, one of the important factors to consider when designing school- based SRE programmes. The results of the research have also provided a useful database on the scope and nature of SRE in the Tanzanian national school curriculum. As such, the results of this research have provided important baseline data for future policy and research initiatives regarding school-based SRE and sexual health in general.

Additionally, this research has assessed the level of support for school-based SRE, apart from the general aspects and specific SRE topics, with respect to, first, the three dimensions of SRE (knowledge, skills and relationships and attitudes and values) and, second, to the two major goals of SRE: diseases prevention and sexual health promotion. Previous research only assessed the level of support with respect to general aspects of, and specific, SRE topics. Using this approach to assess the level of support for school-based SRE, the research has shown that the attitudes of a majority of parents, teachers and students were more favourable towards the knowledge and skills dimensions than towards the attitudes and values SRE dimensions. Similarly, the results have shown that parents', teachers' and students' attitudes were more favourable towards the diseases prevention SRE related topics than those related to sexual health promotion in general.

It should be noted, however, that this research was limited to only two districts that were selected purposively rather than randomly. Additionally, though the schools that participated in the research were selected randomly, participants were selected conveniently by volunteering to complete the questionnaire study. As such, due to volunteer bias, the generalisability of the results of this research cannot be guaranteed and should be made with care and caution.

Appendices

Appendix 1
Parents' questionnaire

Parents' views and attitudes towards school- based sex and relationships education in Tanzania

Dear respondent,

- Thank you for agreeing to take part in this study.
- Please ensure that you have read the information sheet and signed the consent form before you start to answer the questions in this questionnaire.
- The person who gave you this booklet will collect it after you have finished answering the questions.

Instructions for completing the questionnaire

1. Please answer the questions in the order they appear in the booklet.
2. There are no right or wrong answers. Please be as honest and truthful as you can.
3. Your answers will be **COMPLETELY CONFIDENTIAL**. No one but the researchers on this study will ever see your answers.
4. You have the right to skip any question that you do not want to answer.
5. You can stop filling out the questionnaire at any time you wish.
6. We do not ask for your name, so your answers are anonymous.

Section I: General views on the provision of school-based sex and relationships education

For each of the following statements, please tick the ONE response that best describes your opinion.

1. Sex and relationships education should be provided in schools in Tanzania
   O Strongly Disagree
   O Disagree
   O Not Sure/Neutral
   O Agree
   O Strongly Agree
2. The school and parents should share the responsibility for providing children with sex and relationships education
   O Strongly Disagree
   O Disagree
   O Not Sure/Neutral
   O Agree
   O Strongly Agree

3. Sex and relationships education in schools should begin at:
   - O Class 4
   - O Class 5-7
   - O Form 1-2
   - O Form 3-4
   - O Form 5-6

The following is a list of group of people who can provide sex and relationships education to young people. Please indicate the level of involvement that you think each group should have in educating young people about sex and relationships. Please circle the one most appropriate number using the following criteria:

Not involved at all (1) Not involved (2) Somehow involved (3) Involved (4) Very much involved (5)

4. Teachers	1 2 3 4 5
5. Physicians or nurses	1 2 3 4 5
6. Parents	1 2 3 4 5
7. Professional sex educators or counselors	1 2 3 4 5
8. Religious leaders (priests and sheikhs)	1 2 3 4 5
9. Friends	1 2 3 4 5

10. Please mention any other group of people that you think should be involved in educating young people about sex and relationships:
    _____
    _____

Section II: Views about topics to be covered in school based sex and relationships education

The following is a list of possible topics to be covered in a school- based sex and relationships education curriculum. Please indicate the level of importance you attach to each topic by circling one response that best represents your feeling using the following criteria:

Not important at all (1) Not important (2) Neutral/Not sure (3) Important (4) Very important (5)

11. Correct names of genitalia	1 2 3 4 5
12. Body image	1 2 3 4 5
13. Puberty	1 2 3 4 5
14. Birth control	1 2 3 4 5
15. Menstruation	1 2 3 4 5
16. Pregnancy	1 2 3 4 5
17. Wet dreams	1 2 3 4 5
18. Personal safety	1 2 3 4 5
19. Health and wellness	1 2 3 4 5
20. The effects of drugs, alcohol and tobacco use	1 2 3 4 5

21. Sexually transmitted diseases (STDs) and HIV/AIDS	1 2 3 4 5
22. Body and diseases	1 2 3 4 5
23. Sexual problems and concerns	1 2 3 4 5
24. Masturbation	1 2 3 4 5
25. Friendships/social skills	1 2 3 4 5
26. Family types and roles	1 2 3 4 5
27. Dating and marriage	1 2 3 4 5
28. Parenting	1 2 3 4 5
29. Sexual behaviours	1 2 3 4 5
30. Attraction, love and intimacy	1 2 3 4 5
31. Sex as part of a loving relationship	1 2 3 4 5
32. Sexual orientation including homosexuality	1 2 3 4 5
33. Being comfortable with the other sex	1 2 3 4 5
34. Dealing with peer pressure to be sexually active	1 2 3 4 5
35. Sexual coercion and sexual assault	1 2 3 4 5
36. Sex in exchange of gifts and money	1 2 3 4 5
37. Sex in exchange of better examination grades at school	1 2 3 4 5
38. Communicating about sex	1 2 3 4 5
39. Pornography	1 2 3 4 5
40. Personal rights	1 2 3 4 5
41. Abstinence as an alternative to sexual intercourse	1 2 3 4 5
42. Masturbation as an alternative to sexual intercourse	1 2 3 4 5
43. Sexual behaviours other than intercourse	1 2 3 4 5
44. Appropriate/inappropriate touching	1 2 3 4 5
45. The effectiveness of different birth control methods	1 2 3 4 5
46. Decision making	1 2 3 4 5
47. Demonstrate use of condoms	1 2 3 4 5
48. Sexuality as a positive aspect of self	1 2 3 4 5
49. Common myths concerning sexuality	1 2 3 4 5
50. Sexual feelings and expression	1 2 3 4 5
51. Being responsible for their own behaviours	1 2 3 4 5
52. Reduction of fears and myths about sexuality matters	1 2 3 4 5
53. Saying ‘no’ to non-consensual sex	1 2 3 4 5
54. Saying ‘no’ to alcohol and drug use	1 2 3 4 5

55. Please mention any other topics that you think are important and should be included in sex and relationships education:

_____

Section III: Levels at which specific topics should be introduced

What is the earliest level at which the following topics should be taught in schools?

Please indicate your response to this question by ticking an appropriate box that indicates the school level of your preference. Please tick one option only.

S/N	TOPIC	LEVEL							
		Primary school level (class)				***Secondary school level (Form)***			
		4	**5**	**6**	**7**	**1**	**2**	**3**	**4**
56.	Correct names of genitalia								
57.	Body image								
58.	Puberty								
59.	Birth control								
60.	Menstruation								
61.	Pregnancy								
62.	Wet dreams								
63.	Personal safety								
64.	Health and wellness								
65.	The effects of drugs, alcohol and tobacco use								
66.	Transmitted diseases (STDs) and HIV/AIDS								
67.	Body and diseases								
68.	Sexual problems and concerns								
69.	Masturbation								
70.	Sexual feelings and expression								
71.	Friendships/social skills								
72.	Family types and roles								
73.	Dating and marriage								
74.	Parenting								
75.	Sexual behaviours (touching, kissing, sexual intercourse)								
76.	Attraction, love and intimacy								
77.	Sex as part of a loving relationship								
78.	Being comfortable with the other sex								
79.	Dealing with peer pressure to be sexually active								
80.	Sexual coercion and sexual assault								
81.	Sex in exchange of gifts and money								
82.	Sex in exchange of better examination grades at school								
83.	Communicating about sex								
84.	Pornography								
85.	Personal rights								
86.	Abstinence as an alternative to sexual intercourse								

S/N	TOPIC	LEVEL							
		Primary school level (class)				***Secondary school level (Form)***			
87.	Masturbation as an alternative to sexual intercourse								
88.	Sexual behaviours other than intercourse								
89.	Appropriate/inappropriate touching								
90.	The effectiveness of different birth control methods								
91.	Decision making								
92.	Demonstrate use of condoms								
93.	Sexuality as a positive aspect of self								
94.	Common myths concerning sexuality								
95.	Sexual feelings								
96.	Sexual orientation including homosexuality								
97.	Being responsible for their own behaviours								
98.	Reduction of fears and myths about sexuality matters								
99	Saying 'no' to nonconsensual sex								
100.	Saying 'no' to alcohol and drug use								

Section V: Social and demographic characteristics

To enable a better understanding of the results of this survey, please tell us about your personal information as follows:

154. Your age (please mention): _____ years
155. Your gender (please circle whichever is relevant):
    a. Male
    b. Female
156. Your relationship status (please circle the relevant response to you):
    a. Single
    b. Married
    c. Cohabiting
    d. Separated/divorced
157. How many children do you have?
    a. 1-2
    b. 3-5
    c. More than 5
    d. No children
158. Your educational background (please circle one letter that identifies your highest level of education):
    a. No formal education
    b. Primary
    c. Secondary
    d. Tertiary/college education
    e. University degree or above

159. What is your occupation? (Please circle one letter that represents your occupation)
    a. Full time employment
    b. Self employed
    c. Farmer/peasant
    d. Other (please mention) _____
160. What is your religion? (Please circle)
    a. None
    b. Catholic
    c. Protestant
    d. Muslim
    e. Other (please mention) _____
161. How many times do you attend religious services (Please circle one letter that represents your response)
    a. Every day
    b. At least once a week
    c. At least once a month
    d. At least once a year
    e. Less than once a year
    f. Never attend
162. How important is religion in your life? (Please circle)
    a. Very important
    b. Important
    c. Somehow important
    d. Not important
    e. Not important at all

THANK YOU VERY MUCH FOR TAKING PART IN THIS STUDY..

Appendix 2
Teachers' questionnaire

Survey on Teachers' attitudes and comfort about teaching sex and relationships education in schools.

Dear Teacher,

My name is Kitila Mkumbo. I am conducting a study on teachers' views and attitudes towards school-based sex and relationships education as part of PhD research. To assist me, I request you to take a few minutes to fill out a questionnaire. It is important that you answer each question honestly. All the information you provide is confidential and anonymous, so please DO NOT put your name on the questionnaire.

I appreciate your participation. If you have any questions about the study, please contact me at any time on 0754 301 908 or kakm@soton.ac.uk.

Thank you for your assistance.

Please read and sign the consent form below before completing the questionnaire.

Statement of Consent:

I have read the above information about the study. I understand that I may withdraw my consent and discontinue participation at any time without penalty. I understand that data collected in this research will be treated in confidence and that the publication of results of the study will maintain anonymity.

I give consent to participate in the study (**Circle Yes or No**): Yes No

Signature: _____ Date:_____.

I understand that if I have questions about my rights as a participant in this research, or if I feel that I have been placed at risk, I can contact the Chair of the Research and Publication Committee of the University of Dar es Salaam, P.O. Box 35091, Dar es Salaam. Phone: 022 2410700; or the Chair of the Ethics Committee, School of Psychology, University of Southampton, Southampton, UK, SO17 1BJ. Phone: +44 (0) 23 8059 3995.

<u>Part A</u>. For each of the following statements, please tick the ONE response that best describes your opinion.

1. Sex and relationships education should be provided in the schools
   - O Strongly Disagree
   - O Disagree
   - O Not Sure/Neutral
   - O Agree
   - O Strongly Agree
2. The school and parents should share the responsibility for providing children with sex and relationships education
   - O Strongly Disagree
   - O Disagree
   - O Not Sure/Neutral
   - O Agree
   - O Strongly Agree
3. Sex and relationships education in schools should begin at:
   - O Class 4
   - O Class 5-7
   - O Form 1-2
   - O Form 3-4
   - O Form 5-6
4. Overall, please rate the quality of sex and relationships education you may have received at **home**:
   - O Excellent
   - O Very Good
   - O Good
   - O Fair
   - O Poor
   - O I have not received any sex and relationships education at **home**
5. Overall, please rate the quality of sex and relationships education you may have received at **school/college**:
   - O Excellent
   - O Very Good
   - O Good
   - O Fair
   - O Poor

<u>Part B</u>: There are many topics that could be covered in the school-based sex and relationships education curriculum. We would like to know how important you feel it is for each of the following topics to be included in the sex and relationships education curriculum. For each topic, please tick the option that best represents your opinion.

	Not at all important	Not important	Somewhat important	Important	Very Important
6. Correct names of genitalia	O	O	O	O	O
7. Personal safety	O	O	O	O	O
8. Puberty	O	O	O	O	O
9. Reproduction and birth	O	O	O	O	O
10. Abstinence	O	O	O	O	O
11. Sexual pleasure and enjoyment	O	O	O	O	O
12. Sexual decision-making in dating relationships	O	O	O	O	O
13. Safer sex practices including condom use	O	O	O	O	O
14. Sexually transmitted diseases and HIV/AIDS	O	O	O	O	O
15. Sexual coercion and assault	O	O	O	O	O
16. Masturbation	O	O	O	O	O
17. Homosexuality	O	O	O	O	O

<u>Part C</u>: We are interesting in your views about the class level at which you think would be appropriate for students to learn various topics related to sex and relationships. Please tick the class level which you would like children to begin learning about each of the following topics related to sexual health.

	Class 4	Class 5-7	Form 1-2	Form 3-4	Form 5-6
18. Correct names of genitalia	O	O	O	O	O
19. Personal safety	O	O	O	O	O
20. Puberty	O	O	O	O	O
21. Reproduction and birth	O	O	O	O	O
22. Abstinence	O	O	O	O	O
23. Sexual pleasure and enjoyment	O	O	O	O	O
24. Sexual decision-making in dating relationships	O	O	O	O	O
25. Safer sex practices including condom use	O	O	O	O	O
26. Sexually transmitted diseases and HIV/AIDS	O	O	O	O	O
27. Sexual coercion and assault	O	O	O	O	O
28. Masturbation	O	O	O	O	O
29. Homosexuality	O	O	O	O	O

<u>Part D</u>: Please indicate the extent to which you feel that it would be easy or difficult for you to teach each of the following topics related to sex and relationships. Please tick the option that best represents your opinion.

	Very difficult	**Difficult**	**Neutral**	**Easy**	**Very Easy**
30. Correct names of genitalia	O	O	O	O	O
31. Personal safety	O	O	O	O	O
32. Puberty	O	O	O	O	O
33. Reproduction and birth	O	O	O	O	O
34. Abstinence	O	O	O	O	O
35. Sexual pleasure and enjoyment	O	O	O	O	O
36. Sexual decision-making in dating relationships	O	O	O	O	O
37. Safer sex practices including condom use	O	O	O	O	O
38. Sexually transmitted diseases and HIV/AIDS	O	O	O	O	O
39. Sexual coercion and assault	O	O	O	O	O
40. Masturbation	O	O	O	O	O
41. Homosexuality	O	O	O	O	O

<u>Part E</u>: In order to enable us to better understand the results of this survey, it is important to know some of the characteristics of the people who complete this questionnaire. Please tell your personal information as follows:

42. Your age is (please mention): _____years
43. Are your male or female?
    O male
    O female
44. What classes do you teach (Please mention) _____.
45. Which subjects do you teach? Please mention: ----------
    ----
46. Have your ever attended any training course about teaching sexual health to young people?
    O Yes (if your answer is yes, please answer Question No. 59)'
    O No (If your answer is NO, please proceed to Question No. 60)
47. How would you rate the training you received?
    O Poor
    O Fair
    O Good
    O Very good
    O Extremely good
48. How much experience do you have in teaching sexual health related subjects?
    O None
    O Some
    O Moderate
    O Considerate
    O Extensive

THANK YOU VERY MUCH FOR TAKING PART IN THIS STUDY..

Appendix 3
Students' questionnaire

Survey on young people's attitudes towards school-based sex and relationships education

Dear Student,

My name is Kitila Mkumbo. I am conducting a study on young people's views and attitudes towards school-based sex and relationships education as part of PhD research. To assist me, I request you to take a few minutes to fill out a questionnaire. It is important that you answer each question honestly. All the information you provide is confidential and anonymous, so please DO NOT put your name on the questionnaire.

I appreciate your participation. If you have any questions about the study, please contact me at any time on 0754 301 908 or kakm@soton.ac.uk.

Thank you for your assistance.

Please read and sign the consent form below before completing the questionnaire.

Statement of Consent:
I have read the above information about the study. I understand that I may withdraw my consent and discontinue participation at any time without penalty. I understand that data collected in this research will be treated in confidence and that the publication of results of the study will maintain anonymity.

I give consent to participate in the study (**Circle Yes or No**): Yes No

Signature: _____ Date:_____.

I understand that if I have questions about my rights as a participant in this research, or if I feel that I have been placed at risk, I can contact the Chair of the Research and Publication Committee of the University of Dar es Salaam, P.O. Box 35091, Dar es Salaam. Phone: 022 2410700; or the Chair of the Ethics Committee, School of Psychology, University of Southampton, Southampton, UK, SO17 1BJ. Phone: +44 (0) 23 8059 3995.

Part A. For each of the following statements, please mark the ONE response that best describes your opinion.

1. Sex and relationships education should be provided in the schools
   - O Strongly Disagree
   - O Disagree
   - O Not Sure/Neutral
   - O Agree
   - O Strongly Agree
2. The school and parents should share the responsibility for providing children with sex and relationships education

O Strongly Disagree
O Disagree
O Not Sure/Neutral
O Agree
O Strongly Agree

3. Sex and relationships education in schools should begin at:
   O Class 4
   O Class 5-7
   O Form 1-2
   O Form 3-4
   O Form 5-6
   O There should be no sex and relationships education in schools
4. Overall, please rate the quality of sex and relationships education you may have received at **home**:
   O Excellent
   O Very Good
   O Good
   O Fair
   O Poor
   O I have not received any sex and relationships education at **home**
5. Overall, please rate the quality of sex and relationships education you may have received at **school/college**:
   O Excellent
   O Very Good
   O Good
   O Fair
   O Poor
   O I have not received any sex and relationships education at **school/college**

<u>Part B</u>: There are many topics that could be covered in the school-based sex and relationships education curriculum. We would like to know how important you feel it is for each of the following topics to be included in the sex and relationships education curriculum. For each topic, please tick the option that best represents your opinion.

	Not at all important	Not important	Somewhat important	Important	Very Important
6. Correct names of genitalia	O	O	O	O	O
7. Personal safety	O	O	O	O	O
8. Puberty	O	O	O	O	O
9. Reproduction and birth	O	O	O	O	O
10. Abstinence	O	O	O	O	O
11. Sexual pleasure and enjoyment	O	O	O	O	O
12. Sexual decision-making in dating relationships	O	O	O	O	O
13. Safer sex practices including condom use	O	O	O	O	O
14. Sexually transmitted diseases and HIV/AIDS	O	O	O	O	O

	Not at all important	Not important	Somewhat important	Important	Very Important
15. Sexual coercion and assault	O	O	O	O	O
16. Masturbation	O	O	O	O	O
17. Homosexuality	O	O	O	O	O

<u>Part C</u>: We are interesting in your views about the class level at which you think would be appropriate for students to learn various topics related to sexual health. Please indicate the class level at which you would like to learn about each of the following topics related to sexual health. For each topic, please tick the option that best represents your opinion.

	Class 4	**Class 5-7**	**Form 1-2**	**Form 3-4**	**Form 5-6**
18. Correct names of genitalia	O	O	O	O	O
19. Personal safety	O	O	O	O	O
20. Puberty	O	O	O	O	O
21. Reproduction and birth	O	O	O	O	O
22. Abstinence	O	O	O	O	O
23. Sexual pleasure and enjoyment	O	O	O	O	O
24. Sexual decision-making in dating relationships	O	O	O	O	O
25. Safer sex practices including condom use	O	O	O	O	O
26. Sexually transmitted diseases and HIV/AIDS	O	O	O	O	O
27. Sexual coercion and assault	O	O	O	O	O
28. Masturbation	O	O	O	O	O
29. Homosexuality	O	O	O	O	O

<u>Part D</u>: In order to enable us to better understand the results of this survey, it is important to know some of the characteristics of the people who complete this questionnaire. Please tell your personal information as follows:

30. Your age is (please mention): _____years
31. Are your male or female?
    - O male
    - O female
32. What class are you?
    - O O' level (Form 1-4)
    - O A' level (Form 5-6)
33. What is your religion?
    - O Catholic
    - O Protestant
    - O Islam
    - O None
    - O Other (please mention): _____
34. What is the level of education of your parents/carers?
    - O Less than primary school
    - O Primary school
    - O Secondary school
    - O High school
    - O University (undergraduate degree)
    - O University (Graduate degree)

35. Please mention any two questions you may have concerning sex and relationships

_____

THANK YOU VERY MUCH FOR TAKING PART IN THIS STUDY.

Appendix 4

Topic guides for focus group discussions with parents, teachers, students and school policy makers

A. Students

Topic focus	Core questions	Prompts & probes
1. Sources of information about sexual health Most frequently used and most important sources	• How do young people of your age usually find out information about sexual health? • Whom or what do young people rely on for information about sex and related matters? • Do young people of your age talk openly to other people about sex and related issues? • Is there any one/group that young people don't talk to? Don't like talking to? • Whom or what are the most important sources of information about sex and related matters to young people? • Do the sources of information vary for young men and women?	• How do young people learn about body changes, menstruation, wet dreams, reproductive organs, HIV/AIDS, STIs, etc. • Role of Parents, teachers, friends, religious leaders • Role of the media-newspapers, magazines, TV, videos, etc.

2. General views about sex and relationships education in schools	• What do you understand by the term "sex and relationships education"?
	• What do you think about teaching sex and relationships education in schools?
	• Would teaching SRE in schools be useful to young people?
	• What do you think would be the benefits of providing sex education in schools?
	• Would both young men and women find sex education useful?
	• How do you think it should be provided?
	  o single sex education
	  o co-education
	• Who do you think should be responsible in teaching young people about sex and relationships education?
		• Reasons for providing sex education in schools
		• Reasons for objections
		• Should SRE be integrated in other subjects or offered as a separate subject, etc
		• Methods of teaching
		• Teachers, health professionals, friends (peer educators), etc

3. Views about specific topics	• The survey results conducted in summer 2006 show the majority of parents, teachers and students object the inclusion of some topics in the SRE curriculum. Why do you think they object the teaching of: o homosexuality o condom use o pornography o abortion o love, intimacy and sex • Who do you think should be responsible for teaching these topics?	• Why do you think some people think that some topics such as homosexuality, condom use, abortion, contraception, pornography, love, should be excluded?
4. Experience of sex and relationships education at home and school	• Do you discuss sex related matters with your parents or carers at home? • What specific issues do you discuss with your parents or carers at home? • Are you satisfied with the kind of sex and relationships education you have received at home? • Have you been taught about sex and relationships education at school? • What specific topics about sexual health have you been taught at school? • How useful do you think is the sex and relationships education you received at school?	
Sexual activity	• What is sex and what is not? • What proportion of young people of your age do you think have had sex? • At what age would you say young people start having sex? • Is it generally acceptable for young people to have sexual relations before they are married? • How do people react if a young woman becomes pregnant or a young man becomes a father? • Is abstinence actively promoted?	

	• Do young people of your age actively abstain from having sex? • Do young people have alternative techniques of obtaining satisfaction whilst maintaining abstinence?	

Reasons for having sex
 	
Pressure for sex
	• Why do you think young men and women of your age have sex?
	  o what do you think they get out of it?
	  o what do you think young people feel after sex?
	• To what extent do you think that young people of your age are pressured into sex?
	• To what extent do you think that young people of your age are pressured into sex by their friends?
	• Are there differences in the pressure experienced by young men and women?
	• To what extent do you think that some women of your age are pressured about sex by men?
	• To what extent do you think that some men of your age are pressured about sex by women?
	• Do you think young men and women are able to avoid pressures?
		Explore about:
		• Gender differences
		• Sources of pressure
		• Media influences
		• Financial pressures/gains from sex
		• Nature of sexual consent
		• Ways of avoidance

Risk perception	• To what extent do you think that people of your age take risks of any sort during sex? • Do men and women take the same or different risks? • To what extent do you think that people of your age are aware of the risks? Why do they take these risks? • To what extent do you think HIV/AIDS is a risk to young people of your age? • Are young people more worried/concerned about pregnancy or HIV/AIDS and other STIs? • Do you think young people take sexual risks seriously?	

B. Parents

Topic focus	Core questions	Prompts & probes
1. Views about sex and relationships education in schools	• What do we mean by sex and relationships education? • Should SRE be provided in schools? • What worries do you have about the idea of teaching SRE in schools? • How much do you feel you know about sex and relationships education taught in your child's school? • Are you satisfied with the kind of sex and relationships education your child has received at school?	Awareness on the existence of sex and relationships education in schools
2. Views about specific topics	• What would you like to see covered in a SRE programme? • What specific traditional/community values should be included in the school-based SRE curriculum? • Which topics should not be included and why?	• Why do you think some topics such as homosexuality, condom use, abortion, contraception, pornography, love, should be excluded? • Who do you think should be responsible for teaching these issues?
3. Communication about sex related matters at home	• To what extent do you discuss sex related matters with your children? • Which sex related issues do you discuss with your male and female children? • In which time and context do you discuss sex matters with your children?	• Which topics are normally discussed at home? • Why other topics are avoided/not discussed? • When do they have these discussions: after school, evenings, during meals • Where do they conduct these discussions: Kitchen, sitting room

C. Teachers and policy makers

Topic focus	Core questions	Prompts & expansion material
1. Views about sex education in schools	• What do you think about teaching sex and relationships education in schools? • What do you think would be the benefits of providing sex and relationships education in schools? • What do you think would be the disadvantages of providing sex and relationships education in schools? • At which age and class levels do you think would be appropriate to introduce sex and relationships education in schools? • How much sex and relationships education do you think is provided in schools today?	Awareness on the existence of sex and relationships education in schools
2. Views about specific topics	• Which topics do you think should be included? • Which topics should not be included?	Check for: Homosexuality, condom use, abortion, contraception, pornography, love,
3. Challenges and constraints	• What do you think are the main challenges and constraints for teaching SRE in schools in Tanzania? • What can be done to ensure that sex and relationships education starts to be taught in schools?	Check for: policies, shortage of time for teachers, lack of space in the curriculum, lack of skills to teach, etc.

Appendix 5:
Materials for Chapter 5

Factor analysis rotated component matrix based on the parents' scores of the perceived importance of SRE topics

	Component								
	1	2	3	4	5	6	7	8	9
Communicating about sex	.746								
Attraction, love and intimacy	.743								
Sex as part of a loving relationship	.732								
Sexual behaviours	.722								
Sexual orientation including homosexuality	.685	.379							
Pornography	.595	.362							
Being comfortable with the other sex	.442	.399							
Masturbation	.385	.380	.384	.358					
Sexual behaviours other than intercourse		.750							
Masturbation as an alternative to sexual intercourse		.740							
Appropriate/inappropriate touching		.657			.321				
Common myths concerning sexuality	.362	.496						.372	

	Component								
	1	2	3	4	5	6	7	8	9
Abstinence as an alternative to sexual intercourse		.444							
Reduction of fears and myths about sexuality matters		.415					.363	.329	
Sexual feelings and expression	.391	.403						.338	.335
Menstruation			.728						
Puberty			.700						
Body image			.665						
Pregnancy			.654						
Correct names of genitalia			.650						-.338
Wet dreams			.535						
Sexually transmitted diseases (STDs) including HIV/AIDS				.850					
Body and diseases				.800					
The effects of drugs, alcohol and tobacco use				.756	.331				
Sexual problems and concerns				.753					
Sexual coercion and sexual assault					.795				
Sex in exchange of gifts and money					.784				
Sex in exchange of better examination grades at school					.742				

	Component								
	1	2	3	4	5	6	7	8	9
Dealing with peer pressure to be sexually active					.565				
Personal safety						.772			
Health and wellness						.757			
Family types and roles						.611			
Friendships/social skills	.312					.564			
Personal rights						.545	.349		
The effectiveness of different birth control methods							.700		
Dating and marriage	.335						.684		
Parenting							.677		-.315
Birth control			.493				.553		
Decision making					.327	.369	.401		
Saying 'no' to alcohol								.749	
Saying 'no' to nonconsensual sex					.335			.648	
Being responsible for your own behaviour		.340						.441	
Sexuality as a positive aspect of self	.354	.363							.609
Demonstrate use of condoms	.345						.401		.435

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.
a Rotation converged in 9 iterations.

Appendix 6
List of questions students asked about sex and relationships education

Questions on Facts and Information (FI) [Cognitive Dimension]	Questions on Attitudes and Values (AV) [Affective/Emotional Dimension]	Questions on Relationships and Skills (RS) [Behavioural Dimension]	Questions Falling on more than one theme (FAR)
1. Do condoms really prevent HIV infection?	1. Why do people have sexual intercourse?	1. How can I reduce my sexual feelings without having sexual intercourse?	1. Are there any negative effects for abstaining from sex? (FI and AV)
2. Is it possible to have a boyfriend and not have sex?	2. Why do people marry? Is it really for love?	2. What can I do during my first date?	2. Is there any negative effect of having sex with more than one person at a time? (FI and AV)
3. Are condoms 100% safe?	3. Is having sex with a fellow female as pleasant as having it with a male?	3. I have tried to participate in sports to calm down my sexual feeling but it hasn't helped, what should I do?	3. Is it true that it is bad to combine sex/love learning? (AV and RS)
4. Are there schools in Tanzania that teach sex and relationships education as part of their curriculum?	4. Is it necessary to have a boy friend or a girl friend at any age? Should we do sex?	4. I am having a girlfriend and we have been together for a while without having sex, but now I am feeling something different, it is like she wants to move to the next level [have sex] and I don't want, what should I do?	4. Who gets more sexual enjoyment between male and female during sexual intercourse? (FI, AV & RS)
5. Is it true that mouth to mouth kiss (tongue kiss) can transmit HIV?	5. Why do parents tell their children not to have boyfriends or girlfriends?		5. Why do boys like to have sex more than girls? (FAR)
6. Why do boys stimulate (erect) when they are with girls but girls don't?	6. What actions are taken to adults who coerce students to have sex with them?		6. Why do boys loose interest with girls after having sex with them?
7. Why only boys have wet dreams and not girls?	7. Is it ok to have sex at age 14 and above? if not, why?		7. What do you think are the reasons that propel young people to have sex? (FAR)
8. Why can't girls get pregnancy during their menstruation period?	8. What makes girls have sex while they are still students; is it for money or love?		8. Why can't boys stay as long as girls without sex? (FAR)
9. Is it safe to use sex machines and toys for sexual satisfaction?	9. Why parents are not open about discussing sex and relationships with their children?	5. What should I do to maintain my abstinence?	9. Between a boy and girl, who should thank the other after sexual intercourse? (AV &RS)
10. What effects can one get for having sex during pregnancy?	10. Why do some people decide to be homosexuals?	6. Why is it that many people tell young people to use condoms but they don't teach how to use them properly?	10. What will happen if I will be
11. Why only girls experience menstruation period and not boys?	11. Is it necessary to have sex before marriage with your boyfriend and why?	7. Is it possible for a girl who has reached puberty to abstain from sex?	
12. Is it true that masturbation in boys can lead to loss of sexual power?	12. Is it necessary to have a girlfriend at my age?	8. Is it possible to be in a love	
13. Is it true that inserting a finger in a girl's vagina may transmit HIV?			
14. Is it good to use condom to your loved partner?			

Questions on Facts and Information (FI) [Cognitive Dimension]	Questions on Attitudes and Values (AV) [Affective/Emotional Dimension]	Questions on Relationships and Skills (RS) [Behavioural Dimension]	Questions Falling on more than one theme (FAR)
15. Is it possible not to use contraceptives and avoid getting HIV?	13. Can having a girlfriend make me fail in my exams?	relationship without having sex?	late in getting married? (FI &AV)
16. Is it true that having sex too frequently can have negative healthy consequences even if you are using protection?	14. I have a girlfriend who doesn't want to have sex and I really want it, what should I do?	9. Is there any problem if I have sex while am still a student?	11. What is the effect of not having sex in a lifetime? (FI &AV)
17. Are there any medicines that help to reduce sexual urge?	15. What is the right time to start sexual intercourse?	10. How can I avoid my boyfriend who wants to have sex? Do you think it is possible? Do you think I can?	12. Why do girls like to make themselves attractive before boys? (FI &RS)
18. Is it true that masturbation can help to prevent HIV transmission?	16. Why some men prefer to have masturbation to sexual intercourse?	11. How can I know that my boyfriend is having an affair outside our relationship?	13. Why boys get tired earlier during sexual intercourse than girls? (FI &RS)
19. What is the best way to protect against HIV infection?	17. Why nowadays is so difficult to wait to have sex until marriage?	12. Why some men prefer to have masturbation to sexual intercourse?	14. Why should people have sex? (FI &AV)
20. I want to have sex, but I don't trust that condoms can be protective, what should I do?	18. How can I tell that my boyfriend truly loves me?	13. What is virgin? Does it mean from the time a girl was born to the time she begins menstruation or from the time she begins menstruation?	15. What makes sexual intercourse more pleasurable and enjoyable? (FAR)
21. I have heard that condoms do spread HIV, is this true?	19. Is it necessary to have sex with my boyfriend before marriage?	14. How can I tell that my boyfriend truly loves me?	16. What are the things that make a girl love a boy? (FAR)
22. I have heard that masturbation affects sperm production at a later age, is this true?	20. Why people are not faithful in their relationships?	15. What sort of behaviours to consider in choosing a partner?	17. Why is it that a boy gets sexually aroused when he sees girls' thighs and breasts? How can I avoid this? (FI &RS)
23. Can saliva transmit HIV?	21. How long should one stay in a relationship before getting married?	16. Why nowadays many people say that they can't perform sexual intercourse properly?	18. How can I tell my parents about my relationship with a boy? (AV &RS)
24. Why is it that some condoms are more expensive than others?	22. Why should we use condom whilst it is forbidden by religion?	17. Why are boys so persistent in pursuing a sexual relationship even when they	19. Is it right to have sex with a boyfriend to prove that I love him?
25. Why is it that poor countries are more affected by HIV/AIDS than developed countries while people in the latter are even more promiscuous than in the former?	23. Why boys are always the first to approach girls and not otherwise?		20. Is it true that having anal sex even once has negative effects or it is only if you do
26. Are condoms more effective for pregnancy prevention than for preventing HIV transmission?	24. Why many boys prefer sexual relationship to normal relationship?		
27. Why is it that HIV transmission rate	25. Why is it that the society disapproves more of women having many partners than men?		
	26. Why girls don't ask boys to have sexual relationship even when they want to?		
	27. Why is anal sex considered a bad thing whilst there is more pleasure to		

Questions on Facts and Information (FI) [Cognitive Dimension]	Questions on Attitudes and Values (AV) [Affective/Emotional Dimension]	Questions on Relationships and Skills (RS) [Behavioural Dimension]	Questions Falling on more than one theme (FAR)
is increasing while condom use has also increased? 28. How could the government reduce the transmission of HIV without the promotion of condoms? 29. How reliable and safe are the condoms in preventing the transmission of HIV? 30. Is it true that contraceptives have side effects? 31. Is it true that pregnant mothers are not supposed to drink cold water? 32. Can a girl enjoy sex before reaching puberty? 33. Is it true that teaching young people about sex and relationships education hastens them to start sex at an early age? 34. Why is it that in Tanzania the rate of HIV transmission is higher among married couples than in unmarried ones? 35. I have heard that condoms have pores that can easily allow HIV virus to pass through, is this true? 36. Is there any problem for staying without having sex for a long time? 37. Can a boy/man discover if a girl is virgin by looking on her palms or face? 38. What is virgin? Does it mean from the time a girl was born to the time she begins menstruation or from the	it than to vagina sexual intercourse? 28. Is it possible to have a girlfriend without having sexual intercourse? 29. Is it wrong to be homosexual? 30. What are the effects of men having sex with men? 31. Will I get all the sexual enjoyment if I will accept to have sex with a fellow man? 32. How many times should married couple have sex in a week? 33. Is it true that women like sex more than men? 34. How does it feel to have sexual intercourse for the first time? 35. Is first sex based on love or just lust? 36. Is it ok to tell my parents that I have a boyfriend? 37. Am I missing anything now for not doing sex? 38. Is it bad for girls to masturbate?	have been rejected? 18. Why many boys can't abstain? How can they be helped? 19. What should I do when I want to have sex with my girlfriend when she is in her period? 20. What can I do to make my girl friend really love me? 21. How can I stop a friend from convincing me to have sex like him? 22. How can I avoid a girl who always gives me gifts so I can have sex with her? 23. How can I control my sexual feelings? 24. What can I do so that at the end of my studies I will be able to get a good wife? 25. What should I do when am refused by a girl I love? 26. How can I abstain from sex? 27. How can I do masturbation? 28. How can you help a person who is used to masturbation to stop it? 29. What to do with a boy who loves you but you don't love him? 30. How can I initiate a return of a broken relationship?	it more than once? (FI &AV) 21. How many rounds of orgasm are healthy during sexual intercourse? (FI &AV) 22. I always date for a few days and have love feeling only occasionally, does it mean that I have never really fallen in love? (FAR) 23. Why nowadays is so difficult to wait to have sex until marriage? (AV &RS)

Questions on Facts and Information (FI) [Cognitive Dimension]	Questions on Attitudes and Values (AV) [Affective/Emotional Dimension]	Questions on Relationships and Skills (RS) [Behavioural Dimension]	Questions Falling on more than one theme (FAR)
time she begins menstruation? 39. Do boys/men also have virgin as girls/women? 40. Why sometimes a virgin girl does not bleed when she has sex for the first time? 41. Does condom use cause cancer? 42. Can kissing transmit HIV? 43. What is the role of pubic hair during sexual intercourse? 44. Why nowadays young people are much more interested in sex than in previous generations? 45. Why HIV cannot be transmitted by mosquito bite? 46. I have heard that masturbation leads to facial pimples, is this true? 47. What is the difference in sexual enjoyment between having sex with a circumcised girl and an uncircumcised girl? 48. How effective are condoms in preventing HIV transmission? 49. Who enjoys more between a boy and a girl during sexual intercourse? 50. How many times should a boy ejaculate without having effects on his health? 51. When can a girl get pregnant when he meets with a boy sexually? 52. Is it true that using condom during sexual intercourse reduces sexual pleasure?		31. Should I always agree to my boyfriend whenever he wants me to have sex with him? 32. Is possible that after having sex with your boyfriend for the first time he will throw me like garbage? 33. How can I show my boyfriend that I love him without having sex? 34. Why is it that after dating a boy for a while he ends up asking for sex? 35. Is true that if you don't satisfy your boyfriend sexually, he may break up the relationship? 36. How can I know that my boyfriend truly loves me? 37. I would like to stop masturbating, but all the time I think about HIV, I get scared of having sex, should I continue doing masturbation? 38. I can't stop having sex, it is too pleasurable and enjoyable, what can I do so as to avoid negative consequences in future? 39. How can you prepare your lover for pleasurable sex?	

Questions on Facts and Information (FI) [Cognitive Dimension]	Questions on Attitudes and Values (AV) [Affective/Emotional Dimension]	Questions on Relationships and Skills (RS) [Behavioural Dimension]	Questions Falling on more than one theme (FAR)
53. How is a person infected with HIV? 54. What are the effects of sexual enhancing drugs [like Viagra]? 55. What part of the vagina has the highest pleasure? 56. What are the effects of oral sex? 57. Does excessive alcohol drinking cause sexual dysfunction? 58. Is first sexual intercourse necessarily painful? What about the second one? 59. Is it true that heavy work and riding bicycle can remove virginity? 60. Is it true that sex at young age is more pleasurable than at an old age? 61. Is there a chance of avoiding HIV infection if you have sex with a person who is infected? 62. Can a person get diseases by licking sperms? 63. Why is it not advisable to have sex with a woman in her periods? 64. Why do boys reach orgasm earlier than girls? 65. When are they going to supply condoms that are suitable for primary school children?		40. Which is better between oral and real sex at this time while I am still a school girl? 41. Who is supposed to put on a condom during sexual intercourse between a boy and a girl? 42. How can I tell my boyfriend when I am not satisfied with his sexual performance 43. I have been approached by a boy, and of course I like him, but I am not interested to be with him. He has true love with me, but I just don't trust him. What should I do?	

Note: FI=Facts and Information; AV=Attitudes and Values; RS=Relationships and Skills and FAR=Fits in two or all three themes.

Appendix 7
Materials for Chapter 8: Finding out What, Where and How much SRE is being Covered in the national school curriculum

Appendix 7.1: Finding out What, Where and How much SRE is being Covered in the Primary School Social Studies Syllabus

Standard	Main Topics Covered	Sub- topics Covered	Number of periods	How is the sub-topic related and relevant to SRE topic? (on a scale of 1 to 5)[11]
III	1. The source of family	The concept of family	24	3
		Family needs		3
		Family relationships		3
		Clan relationships		1
	2. Leadership in the family and school	2.1 The concept of leadership	18	1
		2.2 Leadership in a family		1
		2.3 Leadership in schools		1
	3. Environmental protection	5 sub- topics	30	1
	4. Map reading	6 sub- topics	36	1
Totals	***4***	***18***	***108***	
IV	1.Social development before colonialism	3 sub- topics	22	1
	2. Social norms and values		18	
		1.1 The concept of social norms and values		3
		1.2 Features of good social norms and values		3
		1.3 Benefits of social norms and values		3
		1.4 The effects of bad social norms and		3

[11] Note that 1=Not at all related; 2= Not related; 3=Somewhat related; 4= Related and 5= strongly related to SRE.

Standard	Main Topics Covered	Sub- topics Covered	Number of periods	How is the sub-topic related and relevant to SRE topic? (on a scale of 1 to 5)[11]
		values		
	2. Leadership and Government	4 sub- topics	20	1
	3. Work and careers	4 sub- topics	14	1
	4. Map reading	5 sub- topics	18	1
Total	***4***	***7***	***92***	
V	1. Leadership and Government	2 sub- topics	20	1
	2. Relationships between Tanzania and other countries	2 sub- topics	20	1
	3. The slave trade and its impact	2 sub- topics	10	1
	4. The Tanzanian culture		10	
		4.1 The meaning of culture		3
		4.2 What makes a culture?		3
		4.3 The importance of culture		3
		4.4 Behaviours and habits that destroy the Tanzanian national culture		3
	5. The formation and management of governments	4 sub- topics	22	1
	6. Environmental protection	3 sub- topics	33	1
	7. Human rights	7.1 The concept of human rights	9	1
		7.2 The role of government in enforcing human rights		1
	8. Map reading	2 sub- topics	10	1
Totals	***8***	***21***	***134***	
VI	1. A short history of Tanganyika and Zanzibar during colonialism	4 sub- topics	41	1
	2. Political, social and economic changes in Tanzania	1 sub- topic	18	1

Standard	Main Topics Covered	Sub- topics Covered	Number of periods	How is the sub-topic related and relevant to SRE topic? (on a scale of 1 to 5)[11]
	after independence			
	3. Environmental protection	4 sub- topics	25	1
	4. Map reading	4 sub- topics	51	1
Totals	***4***	***13***	***135***	
VII	1. Participation in social and economic development activities		25	1
	2. Democratic governance		20	1
	3. Development efforts in Africa		40	1
	4. Climate and impacts of climate change		50	1
Totals	***4***	***13***	***135***	

Appendix 7.2: Finding out What, Where and How much SRE is being Covered in the Primary School Science Syllabus

Standard	Main Topics Covered	Sub- topics Covered	Number of periods	How is the sub- topic related and relevant to SRE? (in a scale of 1 to 5)
I	1. Health and the ways to protect against diseases		36	
		1.1 The human body		3
		1.2 Dress and body cleanliness and tidiness		1
		1.3 Food hygiene		1
		1.4 Body health		3
	2 HIV and AIDS		4	
		2.1 The meaning of HIV and AIDS		5
		2.2 HIV transmission and prevention modes		5
	3. Environmental protection	3 sub- topics	14	1
	4. First Aid	1 sub- topic	2	1
	5. Scientific techniques and procedures	2 sub- topics	6	1
	6. Living organisms	1 sub- topic	4	1
	7. Climate change and its effects	2 sub- topics	4	1
	8. Energy	4 sub- topic	32	1
Totals	***8***	***19***	***102***	
II	1. Health and ways of protecting against diseases		32	
		1.1 The human body		3
		1.2 Body cleanliness and tidiness		3
		1.3 Food hygiene		1
		1.4 Water cleanliness and safety		1
		1.5 Air cleanliness and safety		1
		1.6 Environmental cleanliness and safety		1

Standard	Main Topics Covered	Sub- topics Covered	Number of periods	How is the sub- topic related and relevant to SRE? (in a scale of 1 to 5)
	2. HIV and AIDS		8	
		2.1 The meaning of HIV and AIDS		5
		2.2 HIV transmission and prevention modes		5
	3. Environmental protection	4 sub- topics	12	1
	4. Scientific techniques and procedures	2 sub- topics	5	1
	5. Living organisms	2 sub- topics	6	1
	6. Energy	5 sub- topics	17	1
Total	***6***	***21***	***80***	
III	1. Health and ways of protecting against diseases		44	
		1.1 Body cleanliness and tidiness		3
		1.2 Dress cleanliness and tidiness		1
		1.3 Food hygiene		1
		1.4 Dental health		1
		1.5 Water cleanliness and safety		1
		1.6 Air cleanliness and safety		1
	2. HIV and AIDS		8	
		1.1 The meaning of HIV and AIDS		5
		1.2 HIV transmission and prevention modes		5
	3. Environmental protection	1 sub- topic	8	1
	4. First Aid	1 sub- topic	11	1
	5. Scientific techniques and procedures	3 sub- topics	14	1
	6. Living organisms	2 sub- topics	9	1
	7. Climate change and its impact	2 sub- topics	14	1
	8. Energy	5 sub- topics	40	1
Totals	***8***	***22***	***148***	
IV	1. Health and ways of protecting against diseases		36	

Standard	Main Topics Covered	Sub- topics Covered	Number of periods	How is the sub- topic related and relevant to SRE? (in a scale of 1 to 5)
		1.1 Principles of good health		3
		1.2 Body health		3
		1.3 Dress cleanliness		1
		1.4 Food hygiene		1
		1.5 Environmental health and cleanliness		1
		1.6 Preventing infectious diseases		3
	2. HIV/AIDS and body immunity		10	
		2.1 The meaning of body immunity		1
		2.2 the importance of body immunity in preventing AIDS		5
		2.3 the effects of low body immunity and its relationship with AIDS		5
		2.4 Symptoms of poor body immunity		1
		2.5 Food types that can enhance body immunity to fight against AIDS		5
	3. First aid	1 sub- topic	10	1
	4. Scientific techniques and procedures	2 sub- topics	10	1
	5. Living organisms	4 sub- topics	20	1
	6. Climate change and its impact	2 sub- topics	18	1
	7. Energy	6 subtopics	56	1
Totals	***7***	***26***	***160***	
V	1. Health and ways of protecting against diseases		50	
		1.1 The system of living organisms		1
		1.2 The digestive system		1
		1.3 The blood circulation system		1
	2. HIV and AIDS		10	
		2.1 The differences between HIV and AIDS		5
		2.2 HIV transmission modes		5
		2.3 Effects of HIV/AIDS		5

Standard	Main Topics Covered	Sub- topics Covered	Number of periods	How is the sub- topic related and relevant to SRE? (in a scale of 1 to 5)
		2.4 Ways of protecting against HIV infection		5
	3. Health needs		16	
		Body cleanliness and safety		1
		Food hygiene		1
	4. First aid	1 sub- topic	2	1
	5. Scientific techniques and procedures	2 sub- topics	7	1
	6. Climate change and its impact	4 sub- topics	35	1
	7. Energy	7 subtopics	40	1
Totals	***7***	***23***	***160***	
VI	1. Health and ways of protecting against diseases		50	
		1.1 The respiratory system		1
		1.2 The excretory system		1
		1.3 Hormonal system		1
		1.4 The reproductive system		5
	2. HIV and AIDS		5	
		2.1 HIV and STI infection		5
		2.2 Food hygiene		1
	3. Health services for special groups such as PLWA and pregnant mothers	1 sub- topic	5	1
	4. First Aid	1 sub- topic	5	1
	5. Scientific techniques and procedures	2 sub- topics	12	
	6. Climate change and its impact	2 sub- topics	12	1
	7. Reproduction in plants	6 sub- topics	30	1
	8. Energy	4 subtopics	27	1
Totals	***8***	***22***	***146***	
VII	1. Health and ways of protecting against diseases		38	
		1.1 Sensory system		1
		1.2 Skeletal system		1
	2. Health services		30	
		2.1 Ways of protection against diseases		2

Standard	Main Topics Covered	Sub- topics Covered	Number of periods	How is the sub- topic related and relevant to SRE? (in a scale of 1 to 5)
		2.2 Infectious diseases		2
		2.3 Non infectious diseases		1
		2.4 Inheritable and non-inheritable diseases		1
	3. Scientific techniques and procedures	2 sub- topics	16	
	4. Living organisms	2 sub- topics	26	
	5. Energy	5 sub- topics	50	1
Totals	***5***	***15***	***160***	

Appendix 7.3 Finding out What, Where and How Much SRE is Covered in the Civics Secondary School Syllabus

Form	Main Topics	Sub- topics	Number of Periods	How is the sub-topic related to SRE in a five point scale (1-5)?
I	1. Our nation	2 sub- topics	14	1
	2. Promotion of life skills		39	
		1.1 Meaning and types		5
		1.2 Importance of life skills		5
	3. Human rights	3 sub- topics	17	1
	4. Responsible citizenship	3 sub- topics	31	1
	5. Family life		14	
		5.1 Courtship and marriage		5
		5.2 The concept of family		5
		5.3 Rights and obligations of family members		5
	6. Proper behaviour and responsible decision making		22	
		6.1 Meaning and types of behaviour		3
		6.2 Elements of proper behaviour		3
		6.3 Responsible decision making		5
	7. Road safety	4 sub- topics	22	1
Totals	***7***	***20***	***159***	
II	1. Promotion of life skills	1.1 Social problem solving techniques	39	1
	2. Government of Tanzania	5 sub- topics	54	1
	3. Democracy	2 sub- topics	35	1
	4. Gender		26	
		4.1 The concept of gender		5
		4.2 Gender concepts		2
		4.3 Issues that hinder equal opportunities between men and women		5
Totals	***4***	***11***	***154***	
III	1. Economic and social development	9 sub- topics	45	1
	2. Poverty	3 sub- topics	21	1
Totals	***2***	***12***	***66***	
IV	1. Culture		135	
		1.1 Aspects and elements of culture		3
		1.2 Positive and negative aspects of culture		3
		1.3 Customs that lead to the		5

Form	Main Topics	Sub- topics	Number of Periods	How is the sub-topic related to SRE in a five point scale (1-5)?
		spread of HIV/AIDS and STIs		
		1.4 Promotion of Tanzanian worth cultural values		3
		1.5 Preventive care and maintenance of personal and public property		1
	2. Globalisation	3 sub- topics	25	1
Totals	***2***	***8***	***160***	

Appendix 7.4: Finding out What, Where and How Much SRE is Covered in the Biology Secondary School Syllabus

Form	Main Topics	Sub- topics	Number of Periods	How is the sub-topic related to SRE in a five point scale (1-5)?
I	1. Introduction to Biology	4 sub- topics	28	1
	2. Safety in our environment	3 sub- topics	34	1
	3. Health and community		10	
		3.1 The concept of health and community		3
		3.2 Personal hygiene and good manners		5
		3.3 Infections and diseases		3
	4. HIV, AIDS, STIs and STDs		18	
		4.1 Meaning of HIV, AIDS, STIs and STDs		5
		4.2 Causes and modes of transmission of HIV and STIs		5
		4.3 Management and control of STIs and HIV/AIDS		5
		4.4 Care and support for people living with HIV/AIDS		5
	5. Cell structure and organisation	2 sub- topics	4	1
	6. Classification of living things	3 sub- topics	26	1
Total	***6***	***19***	***120***	
II	1. Classification of living things	2 sub- topics	10	1
	2. Nutrition	5 sub- topics	40	1
	3. Balance of nature	3 sub- topics	22	1
	4. Transport of materials in living things	4 sub- topics	42	1
	5. Gaseous exchange and respiration	4 sub- topics	32	1
Total	***5***	***18***	***146***	
III	1. Classification of living things	2 sub- topics	8	1
	2. Movement	3 sub- topics	16	1
	3. Coordination	5 sub- topics	32	1
	4. Excretion	2 sub- topics	10	1
	5. Regulation	2 sub- topics	16	1
	6. Reproduction		40	
		6.1 Concept of		3

			reproduction		
			6.2 Meiosis and reproduction		2
			6.3 Reproduction in flowering plants		1
			6.4 Reproduction in mammals		4
			6.5 Sexuality and sexual health and responsible sexual behaviour		5
			6.6 Family planning		5
			6.7 Maternal and child care		4
			6.8 Prevention of mother to child HIV infection		4
Totals	***6***		***22***	***122***	
IV	1.	Growth		22	
			1.1 Concept of growth		3
			1.2 Mitosis and growth		2
			1.3 Growth and developmental stages in human		4
			1.4 Growth in flowering plants		1
	2.	Genetics	7 sub- topics	40	1
	3.	Classification of living things	5 sub- topics	16	1
	4.	Evolution	4 sub- topics	18	1
	5.	HIV and AIDS		12	
			5.1 Relationship between HIV and AIDS		5
			5.2 Management and control of HIV/AIDS and STIs		5
			5.3 HIV Counselling and Testing		5
Totals	***5***		***23***	***108***	

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