

**ROLE OF CULTURAL ORIENTATION TOWARDS RISK
SEXUAL BEHAVIOURS AMONG SCHOOL CHILDREN:
A CASE OF SELECTED SECONDARY SCHOOLS IN
MOROGORO URBAN**

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MOROGORO URBAN**

**By
Goodluck Patrice Nombo**

**A Dissertation Submitted In Partial Fulfilment of the Requirements
for Award of Master of Health System Management of Mzumbe
University**

2015

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled **“Role of Cultural Orientation Towards Risk Sexual Behaviours Among School Children: The Case of Selected Secondary Schools In Morogoro Urban”** in fulfilment of the requirements for awards of the degree of Master of Health System Management of Mzumbe University

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DEAN-SCHOOL OF PUBLIC ADMINISTRATION AND MANAGEMENT

DECLARATION

AND

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I, Goodluck Patrice Nombo, do hereby declare to the Senate of Mzumbe University that this dissertation is my own original work, and has not been submitted or simultaneously being submitted for any degree award in any other University.

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DEDICATION

I dedicate this dissertation to my beloved father Mr Patrice Nelson Nombo, for this is part of what he has lived to see his Son achieve. Your affectionate love, concern and support made me to say “you are the best daddy in the world”.

LIST OF ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome
CBO	-	Community Based Organisation
CSE	-	Comprehensive Sexual Education
ECD	-	Early Childhood Development
HIV	-	Human Immunodeficiency Virus
MDG	-	Millennium Development Goal
MDG	-	Millennium Development Goal
MOEVT	-	Ministry of Education and Vocational Training
MOH	-	Ministry of Health
MOHSW	-	Ministry of Health and Social Welfare
N=	-	Number of respondents
NGO	-	Non Governmental Organisation
NSGRP	-	National Strategy for Growth and Reduction of Poverty
SSA	-	Sub- Saharan Africa
STDs	-	Sexually Transmitted Diseases
WDEH	-	Women Dignity and Engender Health
WHO	-	World Health Organisation

ABSTRACT

The study was conducted in Morogoro urban in Tanzania to explore the relationship between the cultural orientation and students risky sexual behaviors and examine whether and how modern intervention including modern contraception influence these behaviors to secondary and primary schools students.

The main concern was to find out if traditional intervention through cultural orientation could be a proper strategy for risky sexual behaviors by determining the cultural orientation negative roles in students' sexual behaviors and also whether and how modern intervention programs for risky sexual behaviors had succeeded to reduce the problem.

The study employed cross-sectional design: structured and unstructured questionnaires were used to collect both primary and secondary data. It involved 300 respondents from five secondary schools that were purposively selected while convenience sampling was used in choosing 1 education officer, 1 health officer and 3 indigenous aged people.

Findings: 85% of students in secondary schools had sex before 19 years in which 68.33% of them did not use condoms completely as a result of cultural orientation factors; initiation ceremonies fostered the problem by 74.57% for males and 79.81% for females; having multiple sexual partners by 78.18% for males and 60.67% for females; Religion fostered the risky sexual behaviours by 61.42%; the orientation to use calendar or safe days method than modern contraceptives to females by 64.67%; social taboos caused 28% of males and 41.33% females not to use condoms. The parents' use of strokes to punish their children had led to the increase of risky behaviors among 19% of male students' while for females it decreased.

Cultural orientation factors had impact on failure or success of the modern strategies including contraceptives on controlling risky sexual behaviours, thus there was a call for improvement of sexual health education via reviewing the cultural orientation factors in efforts to combat them.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Risky sexual behaviors as viewed through unsafe premarital sexual activities are very common and reported to be on the rise in all parts of the world to the extent that is highly affecting youths' lives by increase of unplanned pregnancies, illegal abortion, and sexually transmitted diseases including HIV/AIDs. It has also impacted into girls school dropouts and short of skilled human resources due to high mortality of sexual transmitted diseases as for example in Tanzania in 2010, more than 8,000 girls dropped out of school due to pregnancy, including 1,760 girls in primary school and over 6,300 in secondary school (Songa, 2012). It is estimated that each year the rate of giving birth to adolescent girls aged 15 to 19 accounts for 16% of all births in sub-Saharan Africa. Condom use remains low and the area continues to have the highest rate of adolescent fertility in the world showing that there is almost no decline since 1990 to the extent that among the 14.31 million adolescent girls that gave birth in 2008, one of every three was from sub-Saharan Africa while the prevalence of HIV and other STDs among adolescents is higher in Sub-Saharan Africa than in other parts of the world (UNFPA, 2012).

Youths are facing various problems with regard to their sexuality and reproductive health needs including contraceptive use due to lack of information, misinformation and fear of social-cultural aspects. Tanzania Demographic and Health Survey (2010) found that 60.3% of the youths in Tanzania aged 15 and 19 which comprises the large group of students who are sexually active do not use modern or traditional contraceptives, while in Morogoro 53.3% of youth who are sexually active do not use any contraceptive (TDHS, 2010). The report shows that more than 50% of women and men had sexual intercourse before reaching 15 years. 1.9% of girls aged 15-19 years had two or more partners. Meanwhile, 6.8% of boys aged 15-19 years had more than two partners and only 34.2% of them were reported to be using condoms during sexual intercourse (TDHS, 2010)

Mtanzania news paper of September 3, 2014, published a report that 10% of the primary school students aged 12 to 14 years who were standard five and six in Tanzania had already had sexual intercourse, 6.3% were practicing homosexuality (both boys and girls). Moreover, 68% of all who were practicing sexual intercourse had never used condoms (Mtanzania, 2014). This persistence of unsafe sexual behaviors and practices has made early pregnancy become a leading cause of school drop out for girls both in primary and secondary levels (Mwateba, 1993). Moreover, more than 40.2% of secondary school students aged 13 to 19 years had experienced intercourse and 17.6% had multiple sexual partners while practicing unsafe sexual contacts (Laddunuri, 2013). Different perceptions have been generated regarding the sources for these behaviours and practices, including schools, education system, parents, and globalization which foster change of culture and society at large as there has been the increasing problems of early pregnancy, induced abortion and the rapid spread of sexually transmitted disease (STD) and HIV/AIDS among young people (Fuglesang, 1997).

In Tanzania and Africa initiation practices or puberty rite and ceremonies (including circumcision, jando and unyago) are some of cultural practices or social grounds which build the foundation for the problem. The practices are conducted soon after girls' first menstruation while to boys mostly at the age of puberty. The process of initiating girls is significant to the understanding of risky sexual behaviors in Tanzania respectively as it plays a crucial role in shaping girls' perception of sex since it involves teaching and demonstrating love making with emphasis on how to please a man in bed whenever he demanded and required to be pleased (Caplan 1976; Fundi 2010).

Social taboos, parental coercive care, religious influence, marriage systems, fertility, informal education system, women's decision making power and male preferences on other hand seem to have some roles to play on risky sexual behaviors. Even though there are strategies like sexual education programs and modern interventions, social taboos often prevent youths from getting the message. For example, in the conservative and predominantly Muslim society of Zanzibar, talking about the use of

condoms is forbidden and is blamed for promoting promiscuity (IRIN, 2007). Patriarchal system has impacted risky sexual behaviors and HIV/AIDS (UNAIDS 2006). The report found that girls in sub-Saharan Africa, three young women are infected for every young man. Young women tend to be less educated and poorer than young men thus making them less aware of the risks; unable to make decisions about their sexual health including contraception and dependency on men (UNAIDS 2006).

Cultural orientation have some roles in modeling the sexual behaviours of members of community including adolescents, as it shapes people's behaviours through traditional way of life, social norms, beliefs, religious influence, social dressing codes, communication, parental coercive care, education, advice, marriage systems, fertility, education and respected social taboos. Indeed scholars like Fuglesang (1997); Ersin and Bahar (2009); Mwateba (1993) have conducted serious research to determine the extent to which risky behaviors on schools prevail and how to combat them, determining the extent to which modern intervention have been established and implemented to control the problem and come out with results that the interventions are not satisfactorily able to control the problem which means that there is a gap left. Young students in Morogoro, like others in other parts of Tanzania are still facing this challenge. This study will reveal the risky sexual behaviors among school students as a result of cultural orientation thus getting towards the traditional intervention programs on the problem.

1.2 Problem statement

There have been different perceptions on what causes the school students' involvement in early sexual intercourse and risky behaviors. Scholars like Meekers and Calvès (1997) believe that in sub-Saharan countries poverty is a motive factor for female adolescents to engage in unsafe, early sexual inauguration and having multiple partners in terms of exchange of gifts and money. Hargreaves and Morison (2002) found that the main motivation for adolescent sex in Sub Saharan Africa is curiosity, experimentation or fun and drug abuse while Wellings et al (2006) revealed that urbanization, poverty, erosion of cultural values, openness and

acceptance of premarital life are encouraging premarital sexual activity amongst adolescents.

Various efforts have been made by the Tanzania government, NGOs and CBOs as mechanism to intervene to the risky sexual behaviours including establishing family planning facilities and enact reproductive health education for primary and secondary schools. Despite the efforts, early sexual behaviours are prevailing to and drastically affecting youths day by day. Since most of the students in Tanzania secondary schools range from 13 to 19, the group is highly at risk of diseases, early deaths or emotional and psychological problems (Ersin and Bahar 2009; Songa, 2012). The society has also lost trust on youths as they believe that nowadays youth generation have totally lost track on cultural upbringings, moral values and sexual behaviors control as for example a study conducted in Machame district -Tanzania, contends that there is a feeling among the residents that unsafe abortion rates are higher among secondary school students than other categories (Stambach, 1996).

While the government and private sectors rely on modern approach which encourages free access to sexual and reproductive health information for adolescents, there are cultural systems in coastal communities that give people power to diverge from the formal systems (Fundi 2010). This means that traditional teachings and initiation rituals which once functioned as systems of sex education have been widespread in East and Central Africa. Although some scholars believe that today such rituals of initiation have lost their meaning and function as a mode of initiation in most socio-cultural contexts (Caplan, 1976; Mbunda, 1991), in real, the practices still prevail and their effects are higher in the society (Fundi, 2010). In such cases, this study is aimed at exploring a single aspect of cultural orientation so as to understand the role it plays on propagating the risky sexual behaviors. As it has already been established, most of the intervention programs are modern while the problem seems to occur in cultural setting.

1.3 Research questions

This study aimed to explore the relationship between the cultural orientation and students risky sexual behaviours, another aim was to examine whether and how modern intervention including modern contraception have played an influential role for the risky sexual behaviours. The study main question was:

- What are the roles of cultural orientation towards risk sexual behaviours among school children?

1.3.1 Specific research questions

The study was guided by the following specific research questions

- What are the cultural orientation settings that may influence risky sexual behaviors?
- What are the relationships between cultural orientations and students risky sexual behaviors?
- Are the students' cultural practices, social norms, initiation systems and parents' coercive norms reduce the risky sexual behaviors or increase them?
- Are the modern strategies used by the government, NGOs, Religious groups and CBOs to strengthen pregnancy prevention among the adolescence effective?

1.4 Research Main Objective

- To explore the roles of cultural orientation towards risk sexual behaviours among school children.

1.4.1 Specific objectives

- To identify the cultural orientation settings that may influence risky sexual behaviors.
- To explore the relationship between cultural orientations and students risky sexual behaviors.

- To find out if the students' cultural practices, social norms, initiation systems and parents' coercive norms could reduce the risky sexual behaviors or increase them.
- To determine the effectiveness of modern strategies used by the government, NGOs, Religious groups and CBOs to strengthen pregnancy prevention among the adolescence.

1.6 Significance of the Study

The significance of this study include generation of further knowledge; creation of awareness on the problem to different health and education stakeholders that would finally help in establishing more realistic interventions to achieve number two and six of the Millennium Development Goals and chapter four cluster two of the National Strategy for Growth and Reduction of Poverty (NSGRP), that is improvement of quality of life and social wellbeing through goal one to three which involve ensuring equitable access to quality Early Childhood Development (ECD) programmes, primary and secondary education for all girls and boys, improving survival, health, nutrition wellbeing especially for children, women and vulnerable groups by 2025. It was important to conduct this study due to the limited community data on the cultural settings that fostered risky sexual acts among school children. Findings, data and information from this study will be used by policy makers, health program managers and education program managers in addressing the need for promoting community participation and review of cultural interventions strategies.

1.7 Scope of the study

This study was done to investigate contribution of cultural orientation towards risky sexual behaviours among secondary school students. It commenced in September, 2014 and ended in June 30, 2015. The study period covered introduction to the field station, analyzed different reports, writing research proposals, distribution of questionnaires, interview of respondents, and data collection by using instruments and report writing. The research involved different stakeholders and officials including education officers like teachers, medical officers, UMATI and students.

1.8 Limitation of the study

It took more than three weeks to get permission from Morogoro Urban Executive Director thus distorted researcher's planned time through daily permit request follow up. The college should make good contact in order to build strong relationship with the Municipal Council so as to allow students to access good services and cooperation from urban officers.

During the process of data collection some methods of data collection contradicted respondents for example in- depth, face to face interview which involved personal interaction and cooperation between interviewer and interviewee thus some respondents dropped out or were unable to share information that the interviewer hoped to access due to shyness and culture barriers. Moreover, Low support, lack of seriousness, cooperation from teachers, ignorance of the respondents especially students as they didn't know the purpose of the study, few mockery, and incomplete information which led to invalid data.

In order to overcome these limitations, respondents who had free will and those who voluntarily felt free to convey their information were encouraged and taken in; researcher took much time to educate them and promised to keep it confidential. Some of the students were afraid especially when questioned on matters pertaining sexual intercourse or about teacher's responses towards them because they thought that the information would leak to teachers. This forced the researcher to avoid some assistance from them on data collection thus making the job harder.

1.9 Definition of Key terms

1.9.1 Risk Sexual behaviours

Risky sexual behaviours is commonly defined as behaviours that increase one's risk of contracting sexually transmitted infections and experiencing unintended pregnancies (Centers for Disease Control and Prevention, 2010). In this study they include having sex at an early age at or below 18 years with the following characteristics: having multiple sexual partners, having sex under the influence of

alcohol or drugs, unprotected sexual behaviours as participating in group sex, having sex without using condoms or getting involved in oral sex.

1.9.2 Cultural orientation

Is an inclination to think, feel or act in a way that is culturally determined. Is the degree to which individuals are influenced by and actively engage in the traditions, norms and practices of a specific culture (Tsai and Dutton 1997). In this study, it involved being oriented through cultural settings and practices that promoted risk sexual behaviours of students living in the area.

1.9.3 Sexuality education

Sex education is a process whereby information is given or imparted to a group of young ones and which takes into account the development, growth, the anatomy and physiology of the human reproductive system and changes that occur from youth all through stages of adulthood (Maduakonam 2001). It consisted of instruction on the development of and understanding of the physical, mental, emotional, social, economic and psychological phases of human relations as they were affected by sex thus involved providing children with knowledge and concept that enabled them make informed and responsible decisions about sexual behaviours at all stages of their lives.

CHAPTER TWO

LITERATURE REVIEW

2.1 Theoretical literature review

This chapter explores the study objectives and their influence on risky sexual behaviours. The themes of the research were developed from the theoretical and empirical reviews that are relevant from the variables. It was structured into theoretical review and empirical framework which reviews on independent variables that facilitated the development of conceptual framework and research gap.

2.1.1 The concept of risk sexual behaviors.

Risky sexual behaviours can be defined as the increased risks of a negative outcome, which can take two ways: those which increase the chance of contacting or transmitting disease (physical health or psychological), or increase the chance of unwanted pregnancies among the students. It includes having more than one sexual partner, changing sexual partners frequently, having oral, vaginal, anal sexual contact without a condom, using unreliable methods of birth control, or using birth control inconsistently (CDCP, 2010). Different studies conducted among adolescents in the age group of 10 to 19 years in different countries revealed that the prevalence of sexual activity in South Africa was 46% (Palen, 2009), and 22% in Nigeria (Fatusi, 2008) on which the disparity was due to different sample characteristics, different socio-economic environment and different cultural background. It is revealed that Tanzania has one of the highest adolescent pregnancy and birth rates in the world (World Health Statistics, 2010).

In the world, youths are the most important category of people shaping the country's workforce and future power of the nation. Until 2011 Tanzania's adolescents aged between 10 and 19 years old comprised of about 9.9 million, representing almost 23% of the total population (that is 43,187,823 people) and most of them were either in primary or secondary schools during the time (UNICEF, 2011). Adolescents are particularly at high risk of becoming infected with HIV/AIDS because of the way in

which they live, learn, and the behaviours they adopt from different areas, which may be influenced by social, cultural and economic factors. Among the adolescents, the key drivers of the HIV epidemic in Tanzania include low and inconsistent use of condoms, multiple concurrent sexual relationships, transactional sex, and inter-generational sex (UNICEF (2011)).

2.1.2 First sexual intercourse

Age at first sex is the indicator to determine the average age at which young people become sexually active. It can also provide some insight into when most young people are exposed to risks related to pregnancy and sexually transmitted infections. About 60% of young women aged 18–24 had sex before the age of 18 in 2007/08 while about 9.4% of them and 12% of young men aged 15-24 had their first sexual intercourse before the age of 15. (Tanzania HIV and Malaria Indicator Survey 2007/08). It has been reported that adolescents rarely use protection when having sex for the first time and those who are young face a greater risk of acquiring sexually transmitted infections, including HIV/AIDS than older ones (UNFPA 2012). In addition, there are differences regarding young men and women's use of condoms. Overall, the rate of condom use is lower among women aged 15 to 24 than of men of the same age in all sub Saharan countries (UNFPA 2012).

2.1.3 Initiatives against risk sexual behaviours and its impacts.

In the wake of the importance of the health and well being of youths, various initiatives have been established in the world and Tanzania to save youths' lives through Promoting Comprehensive Sexuality Education and Build Capacity for Sexual and Reproductive Health Service Delivery. In Tanzania, these strategies include 2002 Primary Education Development Plan (PEDP) launch with the need to ensure that all children get primary school education. Major educational issues for girls were late entry into primary school in grade one, early marriage, poor performance in the primary school leaving exams, and high rates of repeating classes. The abolition of mandatory contributions including school fees and relaxation of the uniform requirement were among the steps taken under the

education sector reform process, which aimed to have all primary school children in school by 2006 (UNICEF 2003). The National multi sectoral HIV prevention strategy 2009-2012 ‘towards achieving Tanzania without HIV’ was established and promoted, the National policy on HIV/AIDS was launched in 2001 with the objective number 5 prevention of HIV through sexual transmission for youth and institutions of higher learning and out of school youths.

Tanzania commission for AIDS (TACAIDS) was established, various efforts from governmental and non-governmental organizations (NGOs) such as UMATI, Engender–Health and Pathfinder have been initiated to facilitate the implementation of the family planning programs. NGOs were allowed and promoted to involve into action. Primary and secondary schools curricula were changed and enacted the anti HIV/AIDS subjects and programs so as to protect the children who were not sexually active before they were exposed to sexual practices so as to equip them with knowledge and skills to protect themselves from the disease and other sexually transmitted diseases (National Policy on HIV/AIDS - 2001). The Ministry of Health, local government affairs, NGOs and faith groups were incorporated together to develop participatory HIV/AIDS, sexual and reproductive health for the out of school youths National Policy on HIV/AIDS (2001).

Morogoro urban joined to launch anti HIV/AIDS and implement National policy on HIV AIDS Initiatives in all its health centres and educational centres including schools by equipping them with contraceptives, trained nurses, child health trained staff, other service deliverers, provision of books, magazines to regional library, prepare seminars to teachers so as to prepare them on the issue and the modernisation aspects, teach youths on sex matters, sexuality and family planning (MRSE,1997).

2.1.4 Sexuality Education and Life Skills.

Sex education refers to the teaching of information regarding sexual health, sexual behaviors and their effects and may be delivered in a school or community-based setting (Salkind, 2006). Sex education in Tanzania begins in schools at the early age

of seven (7) years old (standard 1) and continues for the rest of the school cycle. In most schools it covers important aspects of HIV/ AIDS and safe sex in the context of STIs but tends to leave out issues related to sexuality, sexual behaviours, cultural stand and human rights related to these issues thus lacks important character as effective sex education programs must have clear objectives, target multiple risk and protective factors, and provide instruction in a way that is appropriate to the culture, values, age, and sexual experience of participants (Kirby, Roller and Wilson 2007).

There is disagreement over STDs education on what to teach, by whom, to what extent should it be considered a taboo for teachers and parents to talk with children about sexual matters including sexually transmitted diseases (STDs) in schools and at home because of cultural and religious barriers (NACP 1994). Majority of the students in Tanzania hear about STDs or sexuality matters not through their parents or relatives, but through TV or radio even though most of the information offered through them is not detailed enough because of cultural and religious reasons as Okonkwo et al, (2002) found in his study. Respectively, UNESCO (2012) found that only 22% and 28% of schools cover sexual and reproductive health issues as part of life skill education and family planning thus led to the steady increase in HIV prevalence among the adolescents.

2.1.5 Sex Education Approaches:

2.1.5.1 Comprehensive Sexual Education.

Comprehensive Sexuality Education (CSE) emphasised a holistic approach to human development and sexuality. UNESCO identified the primary goal of sexual health education as that “children and young people become equipped with the knowledge, skills and values to make responsible choices about their sexual and social relationships in a world affected by HIV/AIDS (UNESCO 2009).” Moreover Ragab (2008) defines comprehensive approach to sexual health education, as an approach that explain to young people the potential benefits of delaying having sex until they are emotionally and physically ready and how to protect themselves from infections and pregnancy when they do decide to have sex. Both definitions view ‘sexuality’

within the context of emotional and social development, recognizing that the provision of information alone is not enough. Young people need to be given the opportunity to acquire essential life skills and develop positive attitudes and values.

CSE is an approach that recognizes and promotes: human rights; knowledge, values, skills necessary for HIV prevention, and gender equality. Evidence has shown that comprehensive sexual health education that is scientifically accurate, culturally, age-appropriate, gender-sensitive and life skilled based can provide young people with knowledge, skills and efficacy to make informed decisions about their sexuality and lifestyle. Scholarly research during the last two decades has shown that CSE can effectively delay sex among young people, even as it increases condom and overall contraceptive use among sexually active youths but also increase knowledge about sexual behaviours and their consequences thus reduce risk taking behaviours among those who are sexually active (UNESCO 2009).

2.1.5.2 An abstinence-based approach to sexual health education.

The primary objectives of “abstinence-only” programs are to encourage young people to not engage in sexual activity until they are married and to teach youth “...that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects...” (Title V, Section 510 of the U.S. Social Security Act cited in Trenholm, Forston, et al., 2007). It focuses on teaching young people that abstaining from sex until marriage is the best means of ensuring that they avoid infection with HIV, other sexually transmitted diseases and unwanted pregnancy (Ragab 2008). Abstinence programs purposefully do not teach young people the importance of consistent contraceptive use for unintended pregnancy prevention or condom use for STI/HIV infection prevention. Hauser (2004) concluded that, abstinence programs show little evidence of sustained (long-term) impact on attitudes and intentions. Worse, they show some negative impacts on youth’s willingness to use contraception, including condoms in order to prevent negative sexual health outcomes related to sexual intercourse. Current research suggests that abstinence-only approaches – those that focus only on abstinence and

do not teach about contraception – are by and largely not very effective (Kohler, Manhar, & Lafferty, 2008; Trenholm et al., 2007).

Both approaches seem to share the view that sexual health education is a key approach to tackle the HIV infection and both approaches emphasize on the potential benefits of delaying to have sexual intercourse that will help young people avoid HIV/AIDS, other STDs and unwanted pregnancies. In fact there are philosophical differences in the values and attitudes of supporters of both approaches. Several studies affirmed that comprehensive sexual health education on one hand can reduce behaviours that put young people at risk of HIV, STDs and unwanted pregnancy and on the other hand does not lead to the earlier onset of sexual activity among young people (Collins et al., 2002; Kirby et al., 1994).

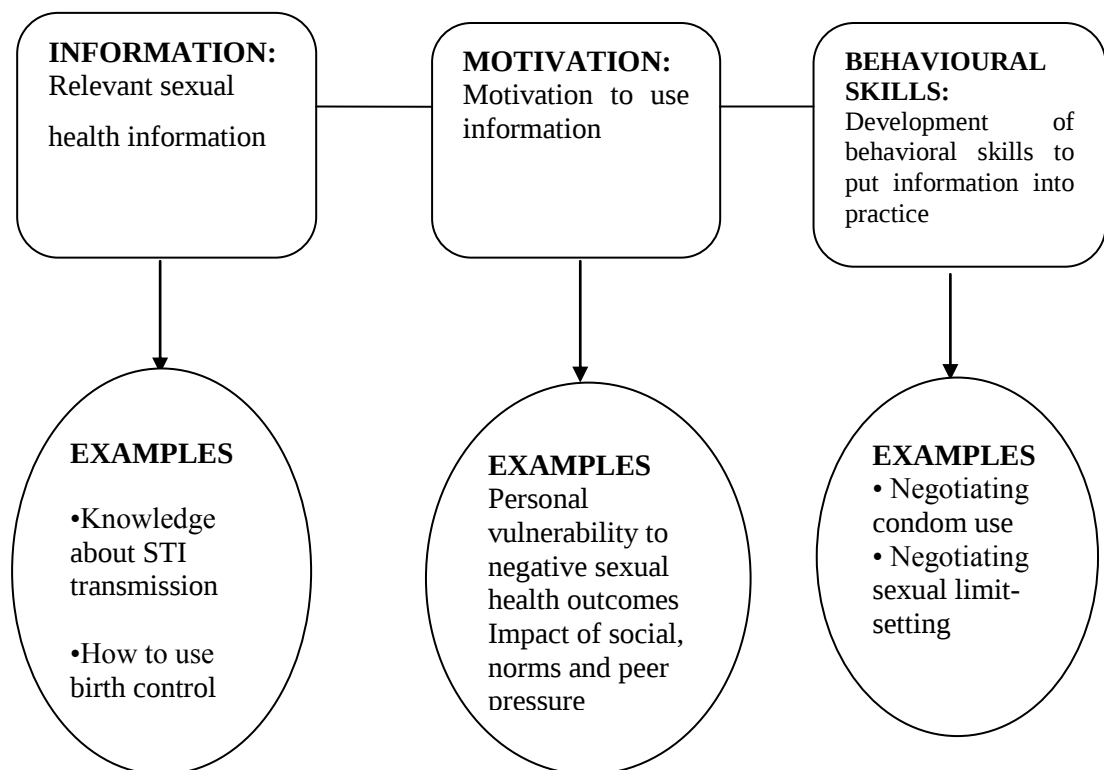
The comprehensive curriculum based on sexual health education approaches that encourage abstinence and also promote positive youth development which build knowledge and skills related to safe sexual behaviours. They have been found to prevent pregnancy and sexually transmitted infections among the youths by delaying sex in some cases and reducing sexual risk-taking behaviours in others (Kirby, 2007). Sex education should be presented by confident, well trained, knowledgeable and non-judgmental individuals who receive strong administrative support. In addition, it is clear that behavior effective programs are based and structured on theoretical models of behavioral change that enable educators to understand and influence sexual health behaviours (Public Health Agency of Canada, 2008).

2.1.5.3 Information Motivation-Behavioural Skills (IMB).

The Public Health Agency of Canada's (2008) on which Canadian guidelines of Sexual Health Education provide a framework for implementing effective programming based on the Information Motivation Behavioral Skills (IMB) model of sexual health enhancement and problem prevention (Albarracín, Gillette, Earl, et al., 2005; Fisher & Fisher, 1998). The IMB model specifies that in order for sexual health education to be effective it must provide information that is directly relevant to sexual health (e.g., information on effective forms of birth control and where to access them), address motivational factors that influence sexual health behaviours

(e.g., discussion of social pressures on youth to become sexually active and benefits of delaying first intercourse), and teach the specific behavioural skills that are needed to protect and enhance sexual health (e.g., learning to negotiate condom use and/or sexual limit setting).

Figure 2.1: The Information-Motivation-Behavioural Skills Model (IMB) for effective sexual health education



Source: Developed by The Public Health Agency of Canada's (2008)

When young people are equipped with accurate and relevant information, when they have developed skills in decision-making, negotiation, communication, critical thinking, have access to counseling, HIV services that are non-judgmental and affordable, they are better able to: take advantage of educational and other opportunities that will impact their lifelong well-being; Avoid unwanted pregnancies and unsafe abortions; improve their sexual and reproductive health and protect themselves against STIs including HIV; understand and question social norms and practices concerning sexuality, gender relationships and contribute positively to

society and be better equipped to face other challenges in life, especially during the transition period from childhood to adulthood (UNESCO 2009).

The key ingredients of behavioral effective sex education promotion programme

The Sex Information and Education Council of Canada (SIECAN 2010) developed a list of effective behavioral sex education promotion programme ingredients, thus provide a guideline for achievement of sex education.

1. A realistic and sufficient allocation of classroom time to achieve program objectives
2. Provide teachers/educators with the necessary training and administrative support to deliver the program effectively.
3. Employ sound teaching methods including the utilization of well-tested theoretical models to develop and implement programming (e.g., IMB Model, Social Cognitive Theory, Trans-theoretical Model, and Theory of Reasoned Action/Theory of Planned Behaviour).
4. Use elicitation research to identify student characteristics, needs, and optimal learning styles including tailoring instruction to student's ethno-cultural background, sexual orientation, and developmental stage
5. Specifically target the behaviours that lead to negative sexual health outcomes such as STI/HIV infection and unintended pregnancy.
6. Deliver and consistently reinforce prevention messages related to sexual limit-setting (e.g., delaying first intercourse; choosing not to have intercourse), consistent condom use and other forms of contraception.
7. Include program activities that address the individual's environment and social context including peer and partner pressures related to adolescent sexuality.
8. Incorporate the necessary information, motivation, and behavioral skills to effectively enact and maintain behaviours to promote sexual health.
9. Provide clear examples of and opportunities to practice (e.g., role plays) sexual limit setting, condom use negotiation, and other communication skills so that students are active participants in the program, not passive recipients.

10. Incorporate appropriate and effective evaluation tools to assess program strengths and weaknesses in order to improve subsequent programming

2.2. Empirical literature review

In the descriptive study done by Godeliver et al (2013) to assess knowledge and use of contraceptives among secondary school girls in Dar es Salaam region, it was found out that majority (97%) of the girls knew at least one contraception method but only (40%) used any. This means that there are some problems unsolved to make easy access and proper use of these contraceptives as the study revealed that knowledge is not a problem as 97% knew about the methods but their use was a major problem. Now this study is highly invested into researching and revealing some cultural settings that may have some impact into these risky behaviours that lead to unhealthy and unwanted pregnancies.

Again, Godeliver et al (2013) study found that the major source of information on contraceptives to the secondary school girls was from schools and media and called for further educational interventions in order to increase the use of contraceptives by adolescent school girls. The study found that 87% of students who participated were aware of unwanted pregnancies which prevailed among school girls and problems associated with them. Now with these findings, it was evident that the knowledge of unwanted pregnancies is not a problem anymore and leaves the question of why most of the school dropout cases are due to pregnancies. This study ought to reveal the parents measures or involvement in dealing with their children sexual behaviours to reduce the problem.

Adeyinka et al., 2009 conducted a study in Nigeria to determine the knowledge and source of information on contraceptive use among school adolescents and found that 65.1% of them had sexual intercourse; 90.2% of them had sex before the age of 19, while 31.8% had multiple sexual partners. It was found that all respondents were knowledgeable about HIV/AIDS but 30.2% of sexual active students took precautions where only 10.5% of them heard about contraception from their parents. Other studies have shown that parents did not communicate with their children about

reproductive health due to cultural barriers and lack of knowledge (Wamoyi et al., 2010; Tesso et al., 2012).

In the study on high-risk sexual behaviours among the Shambala youths and some other tribes in Tanga Region, Ikamba and Quedraogo (2003) found that adolescents were sexually active at an early age. Furthermore, 2.3% of the girls and 3.2% of the boys had their first sexual intercourse at about 9 years old, however the percentage rose up to 10 by the age of 13 years. The largest group (55% of the girls and 45% of the boys) had their first sexual intercourse between 14 and 17 years. This put the girls at more risk of becoming pregnant. Adolescent pregnancies cause adverse health, social and economic implications for the parents, mothers and their children and usually for their grandparents as well.

2.3 Impacts of the Increased Risk Behaviours

2.3.1 High Rates of Teen Pregnancy

About one in 20 girls in Tanzania begun child-bearing when they were only 15 years old, and this rises sharply to one in four among 17 year olds and more than one in three among 18 year olds (TDHS 2004/5: TDHS 2010): Girls in rural areas are almost twice likely as girls in urban areas to start childbearing before they reach 19 years. More than half of the girls with no education are mothers or pregnant before they reach 19 years, compared with about 25 per cent of those who completed primary school and less than five per cent of girls who attended secondary school (Tanzania HIV/AIDS and Malaria Survey 2011/12; the Violence against Children Survey (UNICEF, 2010).

2.3.2 Increased health risks

Sexually transmitted diseases and HIV/AIDS are among the diseases which causes infants' and adolescent mothers' deaths. Infants born to young mothers face greater survival risks as opposed to those born to older ones. Data show for every 1,000 live births born to mothers less than 20 years old, 41 infants die during the first month of their life. Worldwide, adolescent mothers face risks to their own health as

pregnancy is a leading cause of death for young women aged 15 to 19, accounting for at least 70,000 deaths each year. In Tanzania, the Ministry of Health reports that one-third of incomplete abortion cases that turn up in health facilities involve adolescents, and one in five of the girls involved are students. It is likely that illegal abortion is a significant cause of maternal death among adolescent girls (UNICEF, 2010).

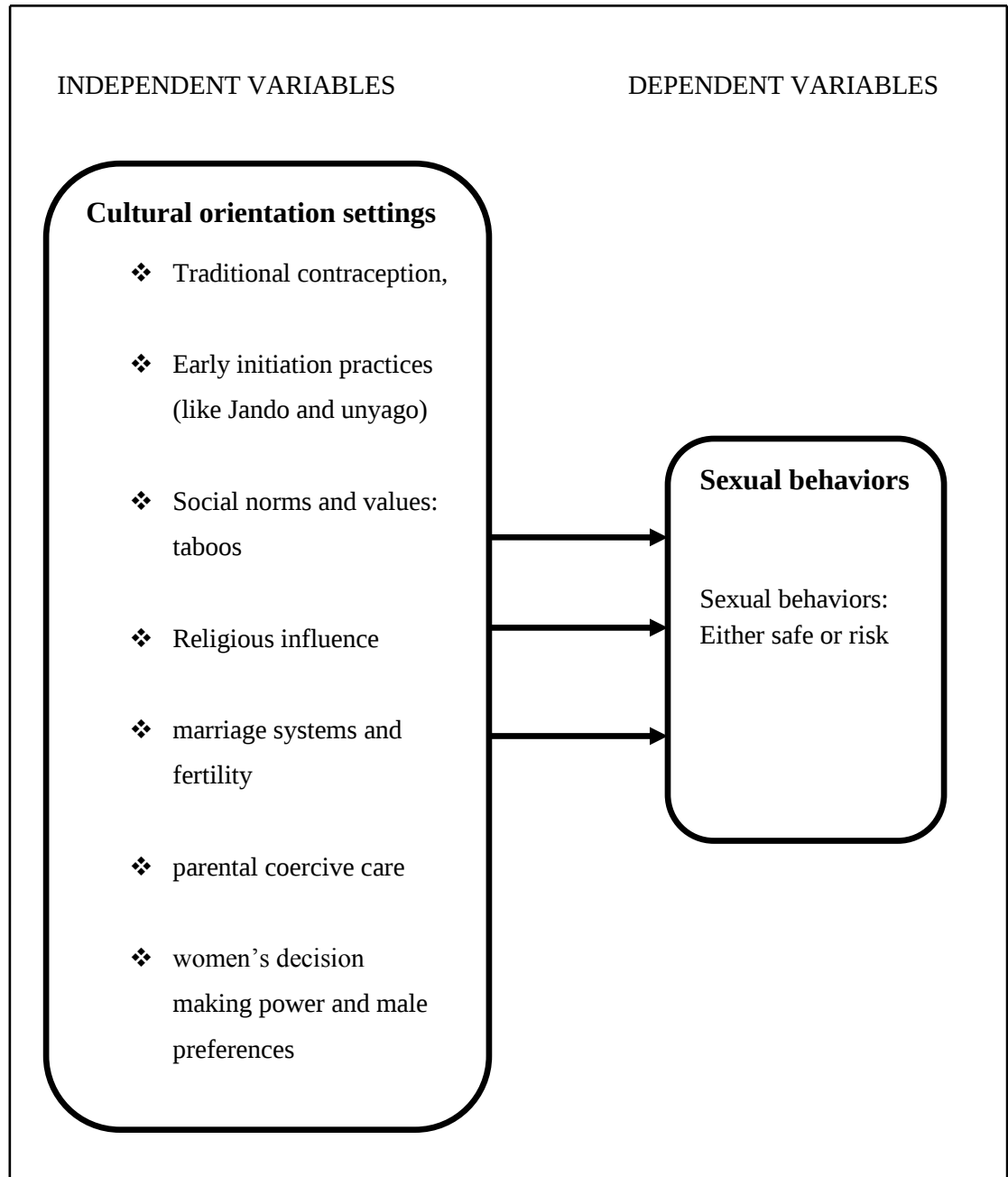
2.4 Research gap

Despite the fact that there are researches and different programs on diminishing the risk sexual behaviours to youths including the secondary school students, the level of decline is still low, indicating that efforts in this area are failing to make a significant impact in reducing the problem. This work will mainly focus on this gap left by examining the direct and indirect impact of cultural orientation factors towards risk sexual behaviours. Although Morogoro urban belongs to a developing country Tanzania, it may have different or more factors apart from those found in the areas in which different studies on risky sexual behaviours have been conducted. There is a need for further investigations on cultural orientation factors influencing those behaviours thus this study fills the gap.

2.5 Conceptual Framework

This study assumed that cultural orientation factors: traditional contraception, adulthood initiation (like Jando and unyago), social norms, values, taboos, religious influence, marriage systems, fertility, informal education system, parental coercive care, women's decision making power and male preferences (as most of the time male or boys are not considered as major causes of risky sexual behaviours rather than women or girls) as an important independent variable in considering whether a student would avoid premarital unsafe sexual activities or be able to practice safe sex. The conceptual framework proposed by this study is presented in Figure 2.2.

Figure 2.2: Conceptual Framework



Source: researcher's own formation.

2.6 Assumptions/Hypotheses

The major hypothesis in this study was to establish on fact that culture is the foundation and core of any social, behavioral and economic transformation in the perspective of sustainable and human development. As it regarded to risky sexual behaviours, reviewing cultural orientation factors meant that targeted population, cultural references and resources (ways of life, value systems, traditions beliefs, and the fundamental rights of persons) were considered key references in building a framework for health improvement, education strategies, policies and project planning, but also as resources and basis for building relevant and sustainable action against the risk sexual behaviours and their impacts.

- **Traditional contraception**

The assumptions for traditional contraception variable was that the initiation and use of them including natural methods, local or traditional medicines for family planning assumed to be positively related to the increase of risky sexual behaviours rather than controlling them.

- **Initiation ceremonies (like Jando and unyago),**

The assumption for adulthood initiation stated that ngoma, jando and unyago initiation practices and ceremonies were positively related to high risk sexual behaviours in villages and towns as they promoted sexual behaviours and early sex practises.

- **Social taboos and parental coercive care,**

The assumption for social taboos and parental coercive care was that forbidden words, forbidden behaviours of talking or discussing family planning issues, sexual matters and reproductive matters with youths assumed to be positively related to increase in risky sexual behaviours.

- **Religious influence,**

The assumption for religious influence was that being raised in a deep religious family which forbids the use of modern contraception methods like condom use led to the increase of risky sexual behaviours rather than controlling them.

- **Marriage systems and fertility,**

Marriage system and fertility variables which are polygamy, family size, and tradition of having many children had attributed positively towards risky sexual behaviours of school children.

- **informal education system,**

Informal education systems, local beliefs and local environment variables were positively related to the increase of risky sexual behaviours to the school students.

- **Parental coercive care**

Parental coercive care, their role of advising (counseling) students, limitation of their freedom outside home were contributing to the increase of risky sexual behaviours while the use of coercive method like punishing them using strokes was increasing the problem.

- **Women's decision making power and male preferences**

The assumption for women's decision making power and male preferences was that the denial of women's decision making power, male children preference than female, the belief on family generation and superiority (large number of children) were positively related to the risky sexual behaviours.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This part covered research methodology which was employed by denoting the research design, study area, study population and its characteristics, sample size, sampling procedure, types of data, methods of data collection, data processing, analysis section, ethical consideration, validity and reliability of research instruments.

3.2 Research Design

The study used both qualitative and quantitative and employed cross-sectional research design in which data were collected at one point in time or non-directional. The researcher used the design to make easy straight forward data portrayal, interpretation, and possibility of determining relationship among and between variables needed in the discussion. As the researcher was constrained by time and financial resource for data collection, the design was used to study multiple outcomes and exposures, facilitate good descriptive analyses and generate hypotheses.

3.3 Study Area

This study was conducted in Morogoro urban. The area is among Seven (7) administrative districts in the region, mainly consisting of small-scale peasants who are low-income earners, follow traditional customs and taboos. The inhabitants are Luguru, Ngulu, Kagulu, Sagala, Pogoro, Ndamba, Mbungu, kutu and Vidunda. According to Tanzania in 2013, the municipal had a population of 2,218,492 with a growth rate of 2.4. The area was selected because it was one among the most prominent districts in the country in terms of some cultural practices like unyago (Kayombo 2013).

3.4 Study Population

The population involved in the study were five selected Morogoro urban secondary school students both male and female aged 13-18 years of form one and three since the researcher believed that this age was relevant and accessible for this kind of study and they were found in the selected classes. An education officer operating as discipline and life skills teacher, one health officer from UMATI and three indigenous aged people were also involved in the study to provide additional information.

Table 3.1 Study population units

Study population	Unit/number	Sampling procedure applied
Students	300	Purposive sampling
Education Officer(teacher)	1	Convenience sampling
Indigenous aged people	3	Convenience & purposive sampling
Health officer from UMATI	1	Convenience sampling

Source: Field data 2014

3.4.1 Source of population

Inclusion criteria: The main inclusion criterion for a subject to be involved in the study was he/she had to in secondary school, also be boys and girls of age 13 to 18 years.

Exclusion criteria: all students less than 13 or more than 18 years of age were excluded from the study.

3.5 Sample Size

Sample size was 300 students studying form one to three aged 13-18 years that is 150 girls and 150 boys. They were obtained from five secondary schools namely Morogoro, Kingo, Kihonda, Kigurunyembe and Alfa James. One Education officer operating as discipline and life skills teacher, one health officer from UMATI and three indigenous aged people were also involved in the study.

3.6 Sampling Procedure

In this study, the purposive or judgemental and convenience-non probability samplings were employed. The researcher believed that these two techniques were the easiest, cheapest and less time consuming.

3.6.1 Purposive sampling

Students were purposively selected in their schools; with the aid of academic or discipline teacher, the researcher had to ask questions to students aged between 13-18 years of the selected classes who were willing to participate in the study. The researcher believed that they were of the appropriate age and easy to find. Drastically, more than 90% of the students of form one to three in government schools were appropriate for the study due to their age factor. Those who were willing to participate were kept in one large classroom in order to be given the questionnaires. In some schools, the number of students who were willing to participate were large than 60, here the researcher had to reduce them while considering their sexes.

3.6.2 Convenience sampling

One Education officer operating as discipline and life skills teacher, one health officer from UMATI and three indigenous aged people were also involved in the study to provide additional information. Unstructured questions (oral interviews) were used to collect data from them. The discipline and life skill teacher was selected from Morogoro secondary school because she was close to the students thus acquired a lot of information from them having a lot of experience over students' sexual problems and sexual activities. One Health officer from UMATI was selected because of his experience, skills over children, knowledge on sexual matters and the kind of job that she was doing pertaining on contraceptives use. The 3 indigenous aged people were selected from Kilakala ward as they were more experienced in cultural practices in the area.

Table 3.2 sample size

NAME OF SCHOOL	RESPONDENTS SEX	NUMBER OF RESPONDENTS	TOTAL
Morogoro Secondary School	Girls	30	60
	Boys	30	
Kihonda Secondary School	Girls	30	60
	Boys	30	
Kingo Secondary School	Girls	30	60
	Boys	30	
Kigurunyembe Secondary School	Girls	30	60
	Boys	30	
Alfa James Secondary School	Girls	30	60
	Boys	30	
Total			300

Source: Field data 2014

The sample size were calculated basing on the elevation and sampling factor elements whereby: N is an Elevation factor- the quotient between the population and sample size by dividing N to represent the number of elements which existed in the population for each element of the sample while η is sampling factor- the quotient between population and sample size by dividing η to N and the quotient multiplied by 100, to get the percentage of the population.

Table 3.3 Sample size factors

NAME OF SCHOOL	NUMBER OF STUDENTS AGED 13-18 YEARS FORM 1-3	SAMPLE SELECTED	ELEVATION FACTOR N	SAMPLING FACTOR η %
Kigurunyembe	301	60	5.017	19.93
Alfa James	505	60	8.417	11.88
Kingo	403	60	6.72	14.9
Morogoro	585	60	9.75	10.26
Kihonda	342	60	5.7	17.54
Total	2136	300	7.12	14.045

Source: Field data 2014

3.7 Types of data, sources, and methods of data collection

The study involved collecting qualitative and quantitative-primary data from students through face to face interviews using structured questionnaires as indicated in appendix 3. By using unstructured questions, secondary data were obtained from UMATI Morogoro on the number of students who attended their services; cultural

barriers to service provision, and other information were collected from 3 indigenous aged people in order to know other cultural practices and settings.

3.7.1 Questionnaires

There were one set of questionnaires prepared for students in schools as shown in appendix 3. They were written in English language and then translated into Swahili orally in order to be understood. They also went through pre-testing and were administered by the researcher and assistant researcher to Kingo secondary school. Most of close ended questionnaires were used compared to the open ended ones. In the closed ended questions, the respondents were offered a set of answers and were requested to choose one that most closely represented their views. However, the open ended questions were applied to clarify on all matters that needed in-depth analysis of different accounts of the study.

3.7.2 Unstructured or Semi-structured Interviews

Unstructured interviews were conducted to education officer, one health officer and 3 indigenous aged people. This helped the researcher to obtain different views direct from the respondents basically due to their work or life experiences on youths' risky sexual behaviours. The interview was conducted in Kiswahili language and was administered by the researcher himself.

3.8 Data Processing and Analysis

The organisation of data from students mainly comments, answers and description were collected and entered into the word processing program while data collected from unstructured questions were transcribed, scored, and recorded. Information was sorted according to age, religion, cultural practices, and the schools they went. Qualitative data were transformed into quantitative to prepare them for interpretation. Both of this data from the field survey were verified, coded, and summarised before being analysed using SPSS and Microsoft office computer software in order to have a picture based on the study sample.

3.9 Ethical consideration

The risky sexual behaviours which resulted into negative impacts such as HIV/AIDS are sensitive and confidential issues. The researcher had to request the teachers to ask for a free will of the students who had either disclosed or not participated in the study. Respondents were assured of confidentiality of the information they had provided and were assured that it was to be used for academic purposes only. Respondents were given free will to withdraw from the study at any time. Formal request from Morogoro urban Executive Director for conducting the research in the respective administrative area was done.

3.10 Validity and Reliability of Research Instruments

Data collection instruments were pre-tested in order to ensure their validity and consistency. So as to avoid non-answer error during data collection, questions were reviewed and filtered to prove if they were genuine, complete, consistence and precision. The identified potential problems enabled the review of logistics and modern methods of data collection before starting the actual fieldwork, as a result; validity and reliability of data, money and time were saved. The pre test helped the researcher to validate the appropriateness of the tools; whether the procedure was too long or not, difficult or easy to understand he checked the precision of the questionnaires, eliminated ambiguity, complicated words and intolerable questions.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Overview

This study was established to examine cultural orientation factors that influenced risky sexual behaviours among students in Morogoro urban. The study sought to establish the influence of traditional contraception, early initiation practices, social taboos, social norms and values, religion, marriage systems and fertility, parental coercive care, women's decision making power and male preferences towards risky sexual behaviours. It also intended to determine the impact of modern intervention factors to youth risky sexual behaviours. The presentation and analysis corresponded to specific objectives of the study as well as research questions which were used in collecting information in the study. The findings were based on data collection through questionnaires and interview methods.

4.2 Sample Size and Characteristics of the Sample

The study involved 300 students- form one to three aged 13-18 years from 5 secondary schools in Morogoro selected on equal sex category that is 150 girls and 150 boys. The respondents were obtained from five secondary schools namely Morogoro, Kingo, Kihonda, Kigurunyembe and Alfa James.

4.3 Results

Results were written using descriptive statistics namely, tabulated description that is tables, graphical description like graphs, charts and statistical commentary in discussion of the results. Percentages were also applied.

4.3.1 How Traditional contraception affected sexual behaviours

The first objective of this study was to determine whether traditional contraception (the use of traditional medicines and traditional or calendar method to students) influenced risky sexual behaviours. The hypothesis for the traditional contraception

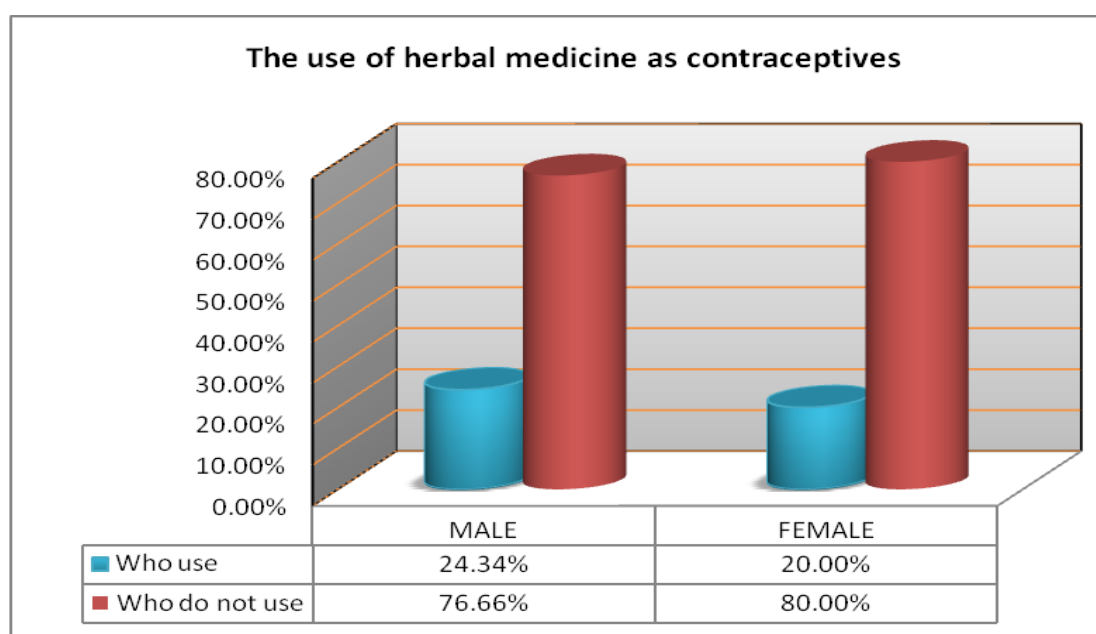
was that the initiation and use of herbal medicines, traditional or calendar method were positively related to risky sexual behaviours. The results are shown in categories.

4.3.1.1 The Use of Traditional Medicines

The assumption for the use of traditional medicine was that them being as contraceptives, they influenced early sexual behaviours because of their local status with no scientific proof and most of them had no role to play to avoid diseases like HIV/AIDS.

Data showed that 24.34% of the male students who knew and used traditional contraceptives, gained the information from their grandparents and few from their parents. 76.66% knew nothing about it, while for the female side 20% were aware and used them compared to 80% girls who knew nothing about them as shown in figure 4 down. As the assumption stated, the use of traditional contraception fostered the practice of unsafe sex because the students believed that they were out of danger by trusting these contraceptives.

Figure 4.1: The use of herbal medicine as contraceptives (N=300)



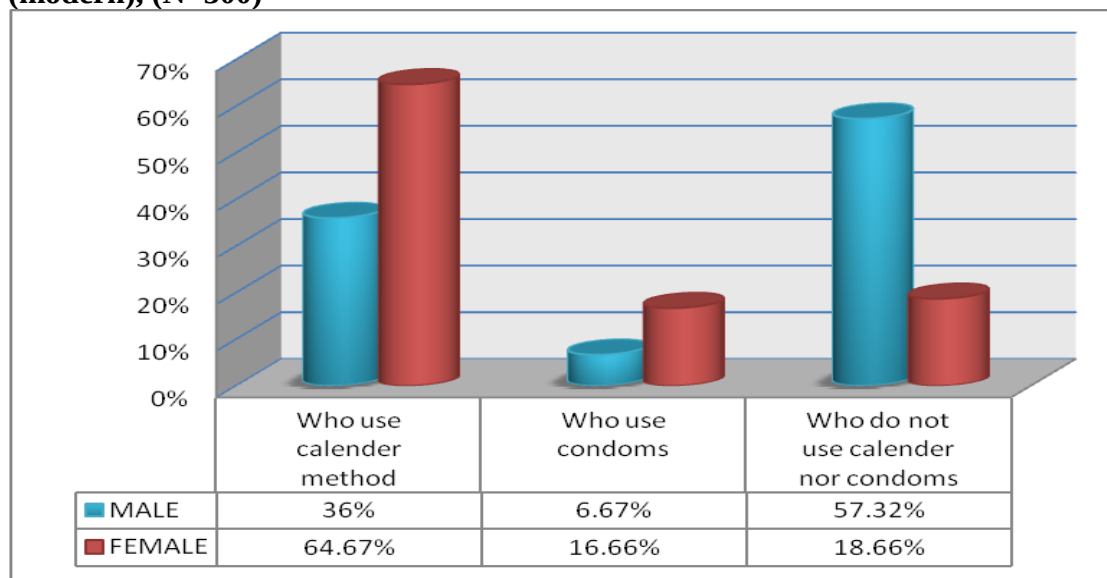
Source: Field data 2014

4.3.1.2 The Use of Traditional Calendar method

The study found that most of the girls preferred to use calendar method than modern contraceptives as most of them did not trust the cooperation from their partners on pregnancy prevention. In this area their tension was mostly relied on prevention from early pregnancies rather than sexually transmitted diseases.

Data from the field showed that among the students who had already had sex between the age of 13-18, 36% of them who were males knew and used traditional calendar method when they met with their sexual partners, 6.67% trusted on and used condoms, 57.32% did not use both methods, 64.67% of females used the calendar method, 16.66% trusted their partners and used condoms and the remaining 18.66% did not use both methods as explained in figure 4.2 below. The reasons for this high number of trust on calendar method are awareness, teachings from their parents, grandparents, initiation ceremonies or systems and few of them from friends. This is to say that the hypothesis was positive because the belief on traditional and calendar methods could not prevent pregnancies, sexually transmitted diseases and their impacts.

Figure 4.2: The use of calendar (tradition) method compared to condoms (modern), (N=300)



Source: Field data 2014

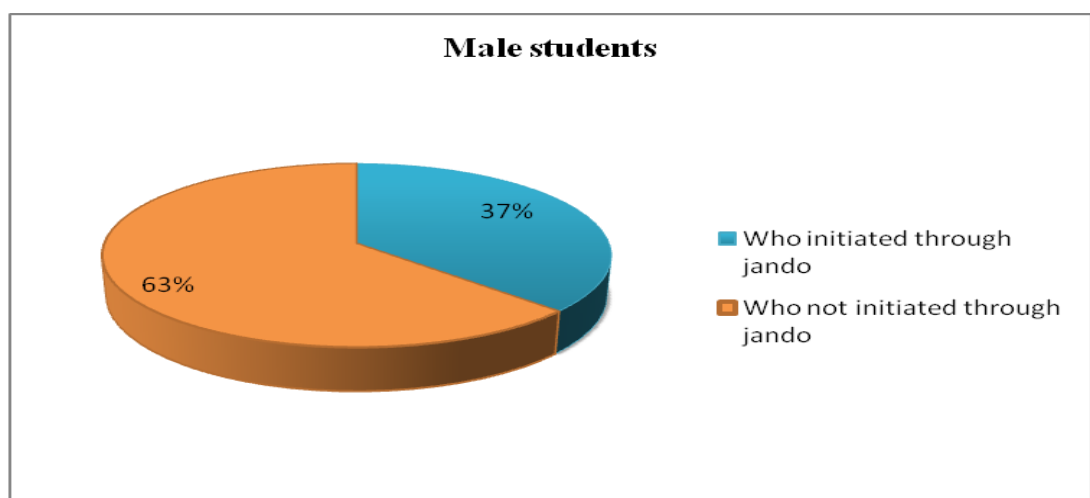
4.3.2 Early initiation practices (Jando and unyago)

The assumption for adulthood initiation was that ngoma, jando and unyago initiation practises and ceremonies were positively related to high risk sexual behaviours among students in Morogoro urban as they promoted risky sexual behaviors by perpetuating early sexual practices.

4.3.2.1 Jando

Jando the name for the boys' initiation ceremony is practicable in some communities in Morogoro as data from the field showed that 37% of male students went through jando system while 63% did not. The main reasons for not attending it were parents' education over hospital circumcision and religious family foundation. Boys who went for it believed that they were superior to those who did not, even their parents looked normal, friendly and courageous. The teachings they went through made them courageous and enabled them to control and fulfil women sexual desires as an experienced indigenous aged person notified that. "...*Ukitahiriwa na kupewa mafunzo na wazee unakuwa na adabu nzuri, unaweza kumudu kutunza familia yako, na mwanamke yeyote hawezi kukusumbua maana utammudu ...*" (if circumcised and initiated, a man become moral and disciplined, he can take care of his family and able to fulfil any woman sexual desire.)

Figure 4.3: Male involvement in Jando (N=150)



Source: Field data 2014

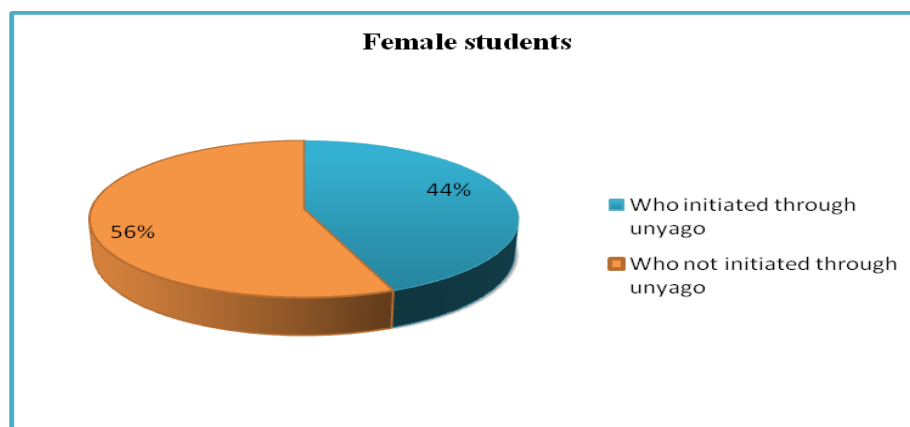
Data showed that among the male students who attended jando, 83.64% had sex before 19 years while 16.36% did not. As hypothesis stated, these initiation system enhanced risky sexual behaviours as the teachings made them believe that they were capable of managing and fulfilling multiple sexual partners while there was no emphasis on the proper use of condoms and contraceptives.

4.3.2.2 Unyago

Unyago simply denoted the initiation system for girls into adulthood. It always performed in the early years of adolescence and was known in Swahili language as “kuvunja ungo”. Most of the girls from 10 years of age attended this initiation as they were sent by their parents as traditional formal procedure.

Data from the field showed that 44% of girls in secondary schools in Morogoro went to what they call “Kunemwa or Mkoleni” and underwent this initiation while 56% did not attend as described in the figure 4.4 below. The reasons for those who attended it: more than 90% were parents’ commands and their own desire to be like other initiated girls: it was a sign of pride to them and their parents if they went through the procedure. The reasons for those who did not attend (31%) were parents’ education, 13% parents’ working stations (to change the family living location which fostered the adoption of new kind of living style and customs), religious matters 5% and other reasons 7%.

Figure 4.4: Female involvement in Unyago (N=150)

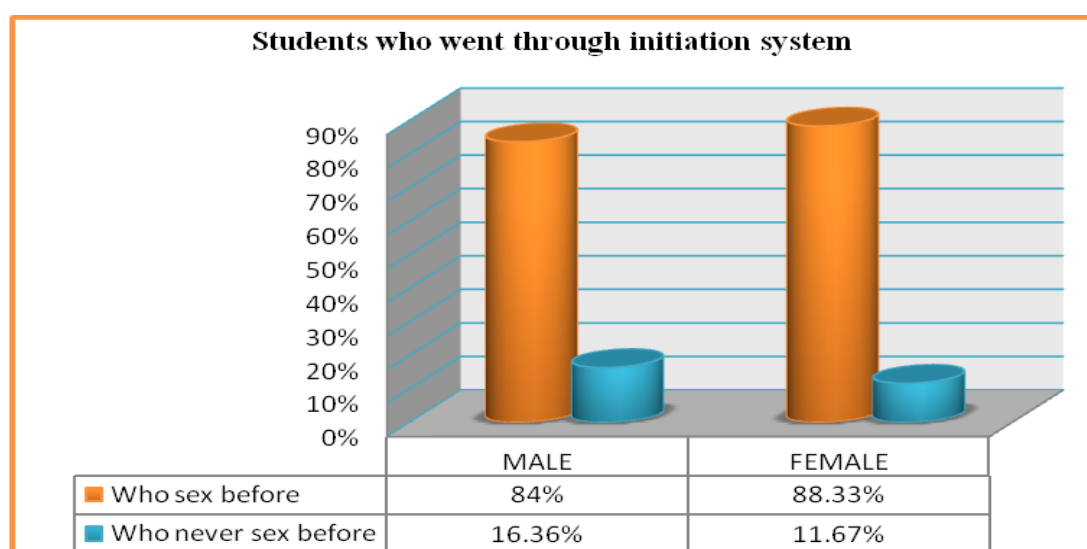


Source: Field data 2014

When the education officer was questioned about society's perception on initiation systems and its impact on students behaviours, it was found that parents liked and respected so much the initiation systems, though they were not aware of its negative impact towards their children "...Wazazi wengi wako tayari kuja shule kumuombea mtoto ruhusa aende kucheza ngoma, ukiwazuia unazua ugomvi nao...na watoto wakitoka huko wengi wao hubadilika sana kitabia na kuendekeza ngono, ila wazazi wanaipenda sana hiyo ngoma..."

Basing on their sex, these involvements in jando and unyago were then determined by the use of reliable birth control or contraceptives including condoms use when sex or having multiple partners in order to measure the rate of risky sexual behaviours among those who attended. It was found that among the female students who attended unyago, 88.33% had sex before 19 years while 11.67% never did.

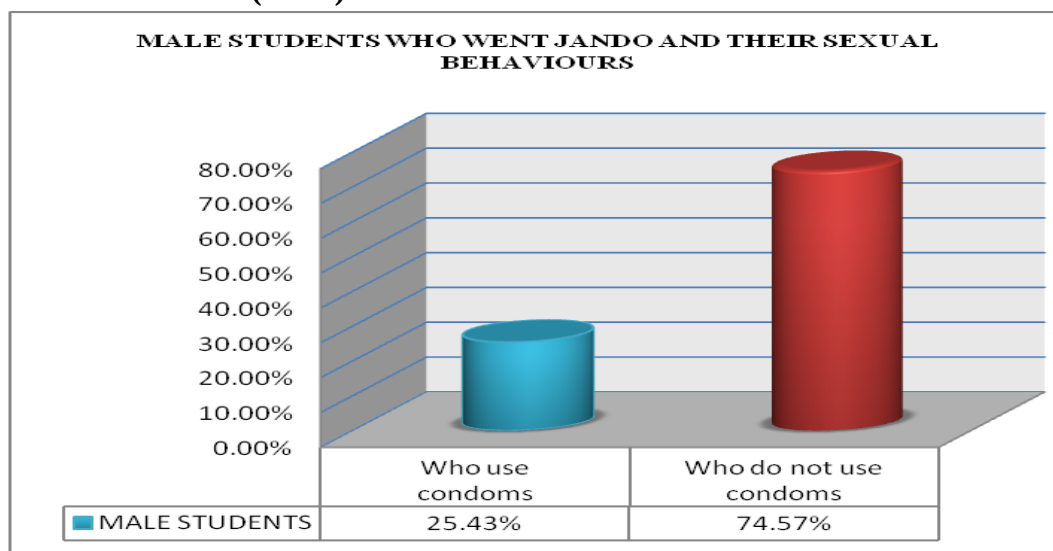
Figure 4.5: Sexual intercourse among initiated students (N=115)



Source: Field data 2014

The researcher then divided the initiated students who started having sexual intercourse into their sex category in order to attain their sexual behaviours and found that among 25.43% of initiated male students used condoms, 74.57% did not, and 20.19% of the girls also used condoms leaving 79.81% who did not. The figure below shows male initiated students' sexual behaviours.

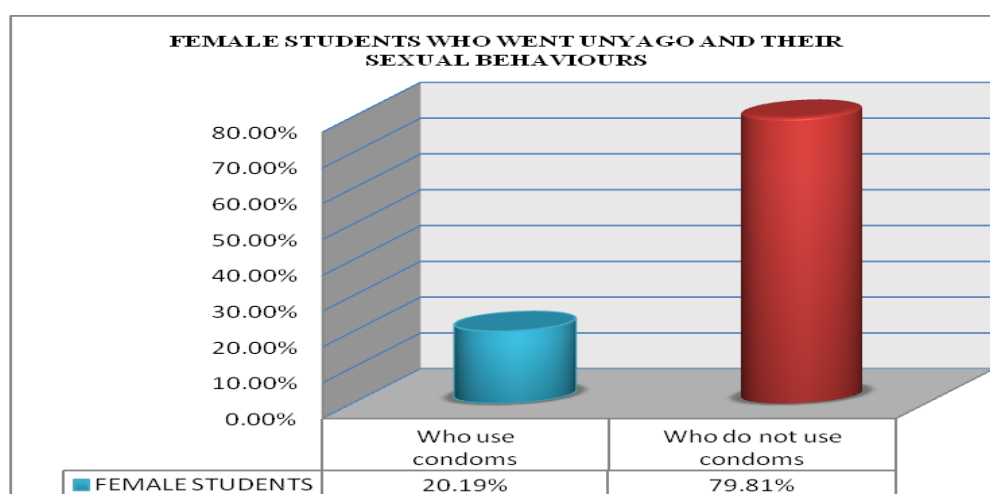
Figure 4.6: The risky sexual behaviours category 1 (condom use) among male initiated students.(N=46)



Source:Field data 2014

High number of girls did not use condoms because of their trust in the natural methods of birth control and fear of losing their lovers, because of this, boys in relationships had more power to decide on whether to use condoms or not.

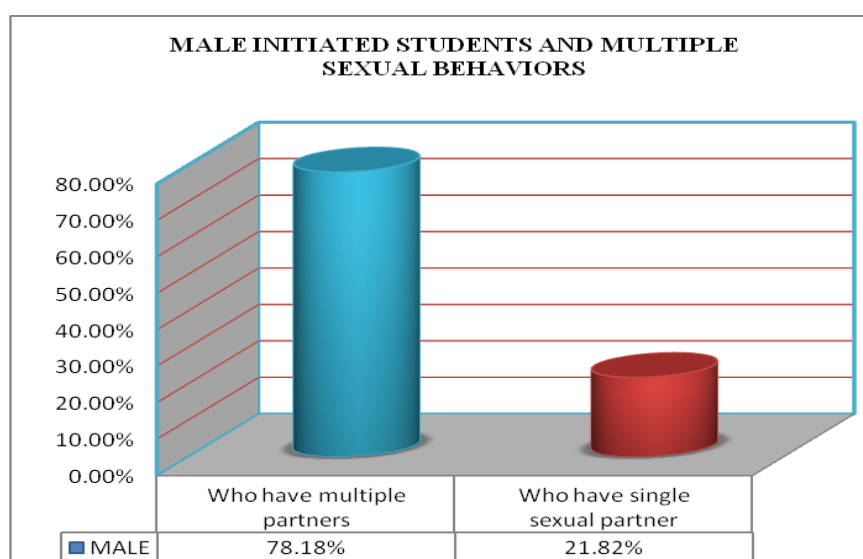
Figure 4.7: The risky sexual behaviours category 1 (condom use) among female initiated students.(N=53)



Source:Field data 2014

On the multiple or single partner category of risk sexual behaviours, Male initiated students with multiple sexual partners involved 78.18%, while with single sexual partners were 21.82% while 60.67% female students had multiple sexual partners and those with single were 38.33%.

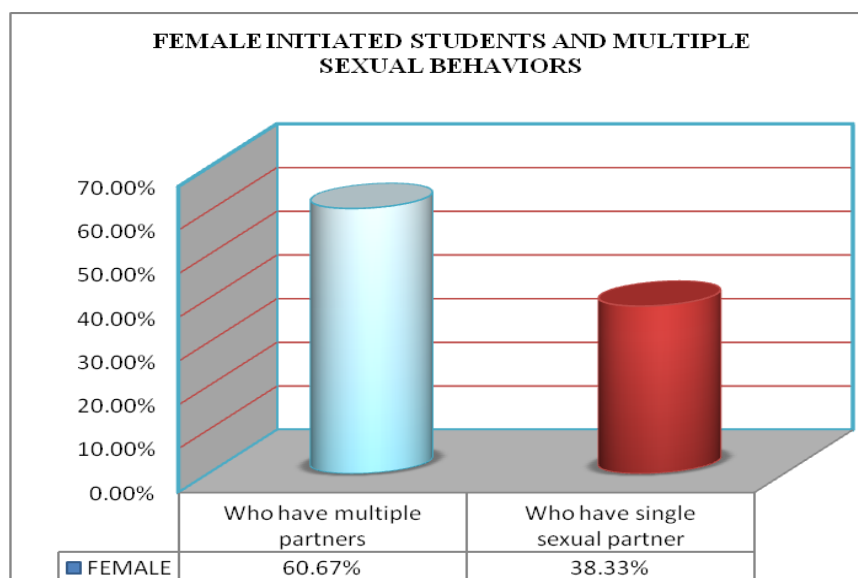
Figure 4.8: The risky sexual behaviours category 2 (multiple sexual partners) among male initiated students. (N=55)



Source: Field data 2014

The male students' higher percentage of multiple partners was explained as due to them being overconfident as a result of tradition or initiation systems. The training they had gone through had some aspects which were good towards morals as it shaped them to become respectful and able to take care of their family responsibilities, but their confidence towards sexual intercourse control (ability to fulfil or control any woman sexual desire) could result into multiple sexual partners as one aged respondent argued that "...Ukitahiriwa na kupewa mafunzo na wazee unakuwa na adabu nzuri, unaweza kumudu kutunza na kuwajibika kwa familia yako, na mwanamke yeyote hawezi kukusumbua maana utammudu..."

Figure 4.9: The risky sexual behaviours category 2 (multiple sexual partners) among female initiated students. (N=60)



Source: Field data 2014

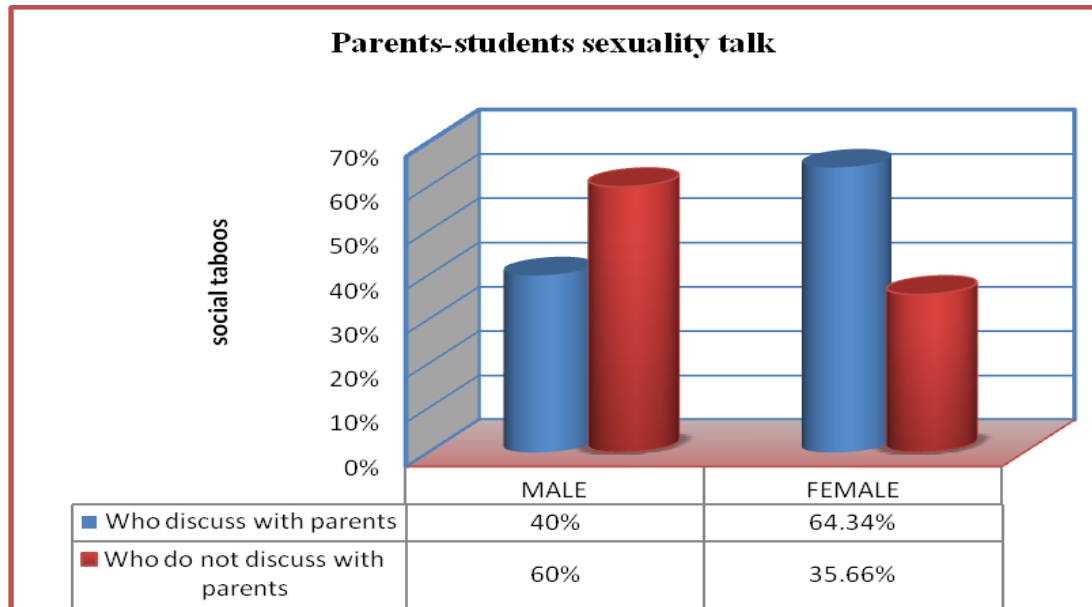
4.3.3 Social Taboos

The assumption for social taboos was that forbidden words, talking, discussing family planning issues, sexual matters and reproductive matters with youths assumed to be positively related to increase in the risky sexual behaviours among students as they hindered free conveyance of health education information.

4.3.3.1 The way social taboos affected parents counseling role to their children by prohibiting sexuality matters discussion.

The question asked to the students was, did their parents have a tendency of talking to them about sexual matters. Data from the field indicated that there were forbidden words and discussions over sex and family matters inside and out of the school (inside homes) thus affecting youth's lives by hindering free conveyance of sexual information. Only 40% of male students got the chance to talk to their parents about sex, 60% did not, 64.34% of the girls always had a chance to discuss it, living 36.66% without.

Figure 4.10: Social taboos affecting parents counseling role to their children by prohibiting sexuality matters discussion (N=300)

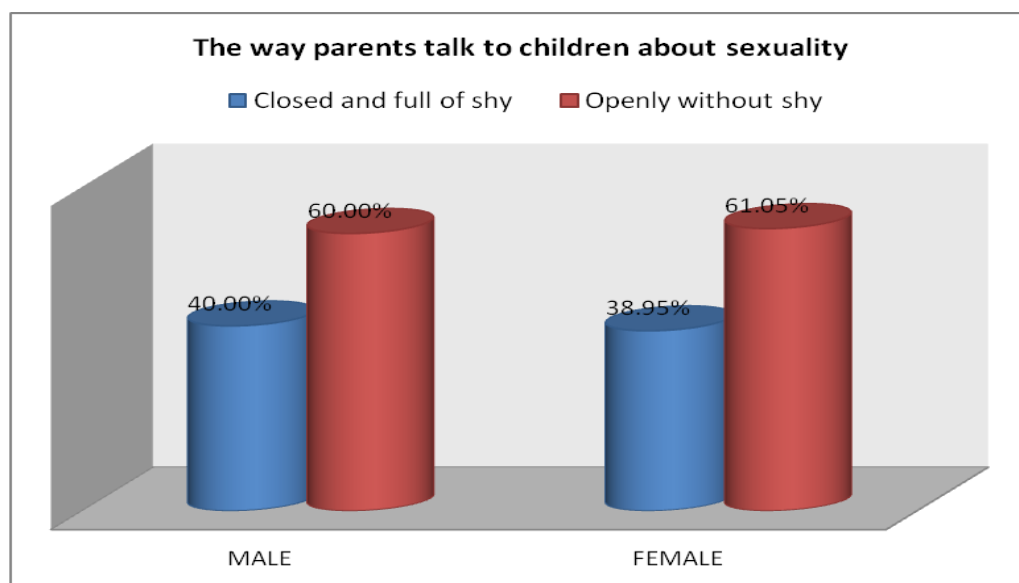


Source: Field data 2014

4.3.3.1.1 The mode of parent and child when talking about sexual matters

Emphasis of the researcher was to determine the clarity of the (40%) male and (63.34%) female students who answered that their parents always talked to them about sex by asking the mode of conversation between them. Among the male students, it was found that 60% had a chance to talk freely, 40% had very few conversations which were as a result of their parents being shy, 61.05% of the female also did and 38.95% had very few chances.

Figure 4.11: The way social taboos prohibited parents’ free and proper counseling to their children. (N=155)



Source:Field data 2014

When the parents were questioned about this issue, they responded by saying that they talked to their children about HIV/AIDS, but the actual data from field indicated different results as their talk was highly affected by cultural barriers “...Mimi sioni shida kuongea na mwanangu kuhusu kujilinda na ngono, ila asiponisikila ni hasara kwake...”

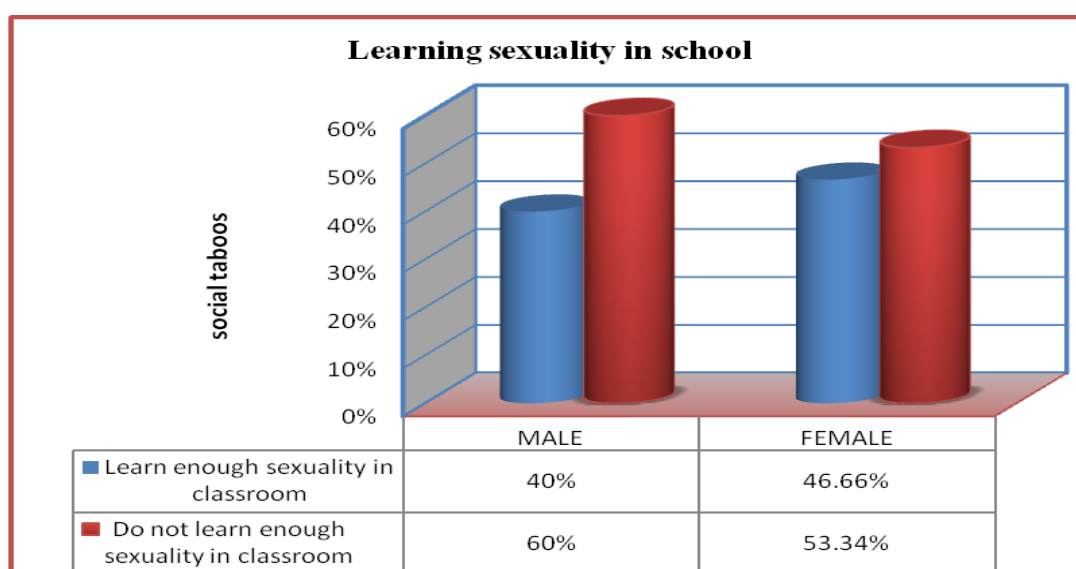
4.3.3.2 Teachers’ freedom to cover sex education in schools as opposed to culture

Respondents were questioned to get data on teachers’ freedom of explanation to students, counseling and teaching them on sexuality matters. The assumption was that social taboos through prohibited words and shyness hindered the proper conveyance of education to these students by their teachers.

Inside schools, teachers taught sexual health education and civilization through provided curriculum which had made remarkable margins on what was taught. However, the study found that there was no clear emphasis on sexual health education or proper counseling to those who were affected by risky sexual

behaviours due to social taboos. The initiatives were mostly propounded to form four students who mostly ranged between 17 to 20 years because they believed that they were mature enough living those of 13 to 16 years. 60% of male students argued that teachers did not teach them enough to cover all areas concerning sex due to shyness, while 40% of said that they did, 53.34% of the female students said they did not, while 46.66% of them said they did.

Figure 4.12: Teachers freedom to cover sex education to students as limited by social taboos (N=300)



Source:Field data 2014

4.3.4 Religious influence

The assumption here was that being raised in a deep religious family which forbids the use of modern contraception methods including condoms led to the increase of risky sexual behaviours rather than controlling them because religion shapes moral values of an individual or society.

In the field, respondents were from Muslim and Christian religions. Data indicated that 15.87% of the male Christians used condom when they had sex, 63.49% of them did not use, 20.63% reported to have never had sex and this was compared to

17.24% of male Muslims who had used condoms during sexual intercourse with their partners, 70.11% who did not and 12.64% who had never had sex.

Table 4.1: The way religion affected the use of condoms among males (total N=150)

	MALE CHRISTIANS			MALE MUSLIM		
	Using condoms	Do not use condoms	Never sex before	Using condoms	Do not use condoms	Never sex before
Frequency	10	40	13	15	61	11
Percentage	15.87%	63.49%	20.63%	17.24%	70.11%	12.64%
Total Number	63			87		

Source: Field data 2014

Respectively, it was found that among 17.81% of the female Christians students, used condoms when they had sexual intercourse, 67.12% of them did not while 15.07% reported they never had sex. Among 15.58% of female Muslims were found to have used condoms, 71.43% did not always use them while 12.99% had never had sex before.

Table 4.2: The way religion affected the use of condoms among female (total N=150)

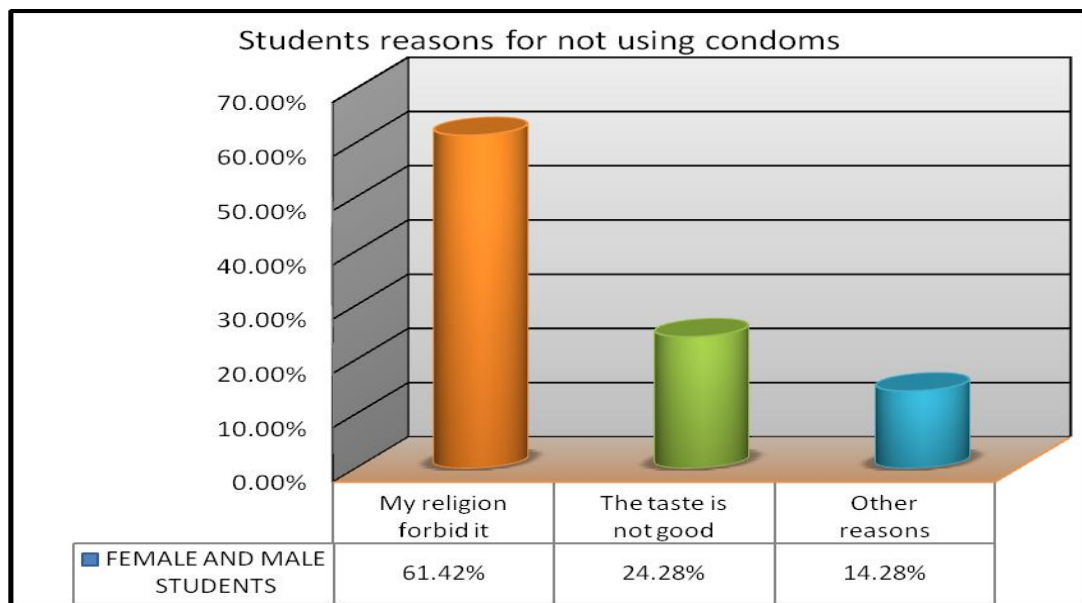
DESCRIPTION	FEMALE CHRISTIANS			FEMALE MUSLIM		
	Using condoms	Do not use condoms	Never sex before	Using condoms	Do not use condoms	Never sex before
Frequency	13	49	11	12	55	10
Percentage	17.81%	67.12%	15.07%	15.58%	71.43%	12.99%
Total Number	73			77		

Source: Field data 201

Provided reasons for not using condoms

Those who did not use condoms were then questioned on why they did not. It was found that religion influenced risky sexual behaviours by 61.42% as both students of both religion answered that their religion forbid it, 24.28% answered they did not feel good when they used them and 14.28% provided other reasons. This proved that majority of adolescent's feared religious teachings from padres, bishops, pastors and sheikhs who most of the times prohibited the use of condoms by condemning it as being the same as abortion or murdering.

Figure 4.13: Students reasons for not using condoms



Source: Field data 2014

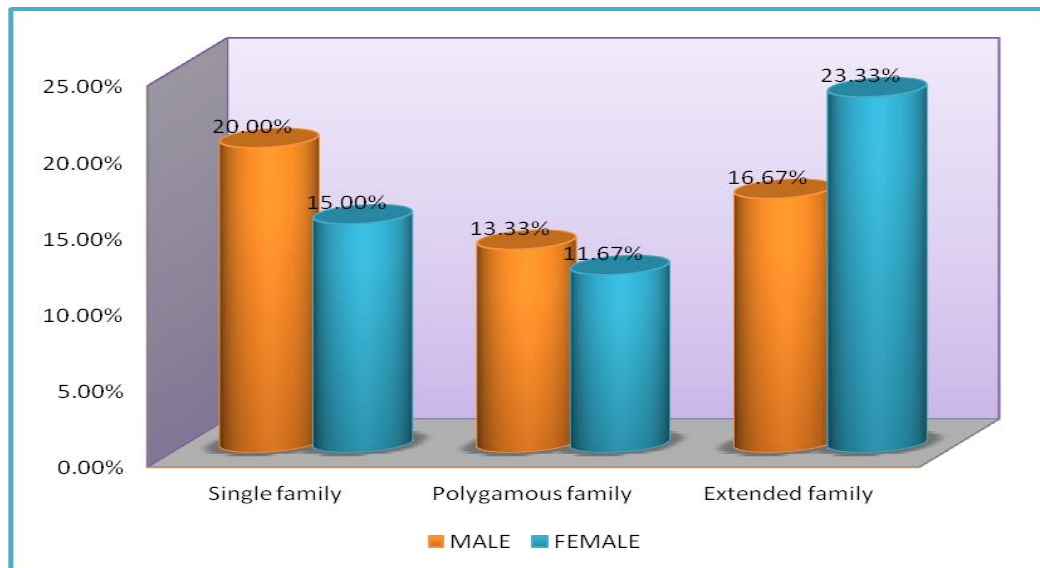
4. 3. 5 Marriage systems and fertility

The assumption for marriage system and fertility was belonging to polygamy families, large family size and tradition of having many children attributed positively towards risky sexual behaviours of school children.

4.3.5.1 Polygamous families

The assumption was that belonging to polygamous families attributed to increase in risky sexual behaviours to students, the underlying assumption was that members from this kind of family lack proper care, support and education from both parents thus affecting their lives negatively. From the field, respondents' family distribution was as shown in the figure:

Figure 4.14: Number and types of families of respondents (N=300)



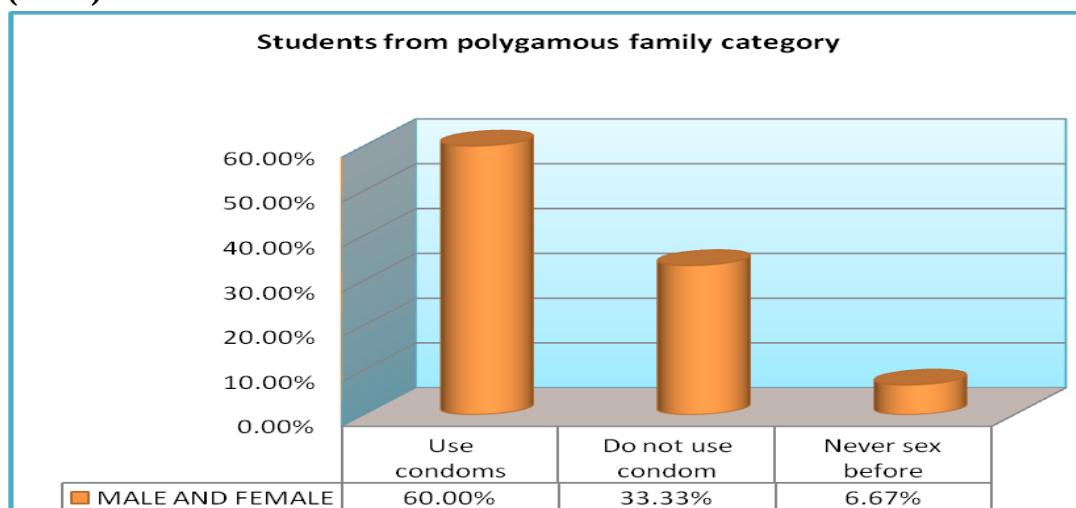
Source: Field data 2014

However, data show some significant changes as these types of families portrayed different results. Students' results were categorized according to their families especially in this part, then their results on risky sexual behaviours specifically on the use of condoms and other contraceptives to keep themselves safe from unwanted pregnancies and STDs. Data here were represented based on the family type;

(a) Sexual behaviours of students belonging to Polygamous families category

Data showed that male and female students who used condoms were 60%, those who did not use condoms were 33.33%, and those who never had sex before were 6.67%. However from this study, it was found that more than 90% of students who came from polygamous families had already started having sex (either safe or unsafe) before the age of 18 years but 33.33% fell under the risky category due to the tendency of not using condoms during sexual intercourse as shown in the figure below:

Figure 4.15: Students from Polygamous families and risky sexual behaviours (N=75)

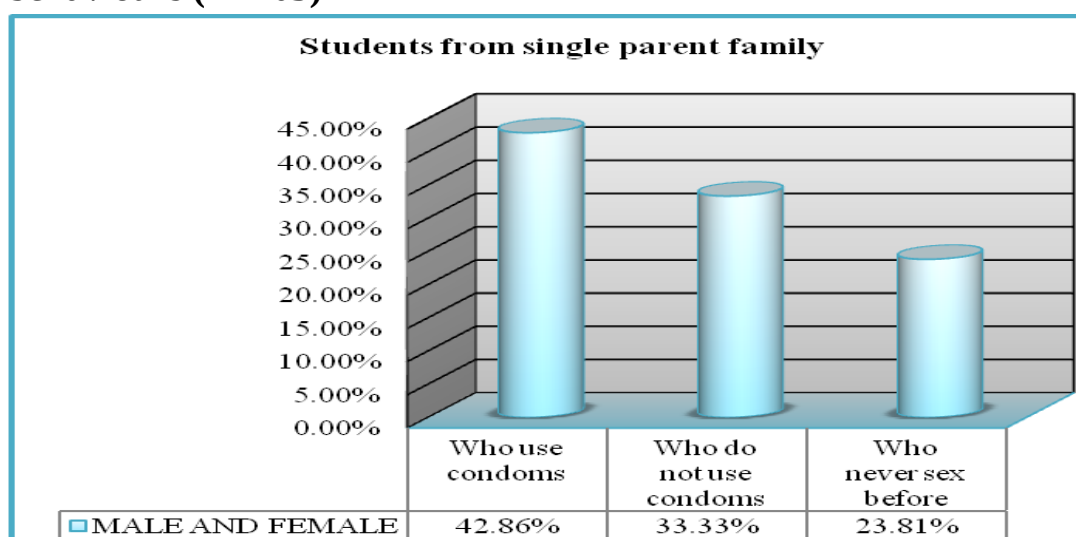


Source: Field data 2014

(b) Sexual behaviours of students belonging to single parent families category

Compared to the students from the above family groups, data from the field showed that in the single parent families category, male and female students who used condoms were 42.86%, who did not were 33.33% and those who never had sex before were 23.81% as shown in the figure below.

Figure 4.16: Students from single parent families and risky sexual behaviours (N=105)



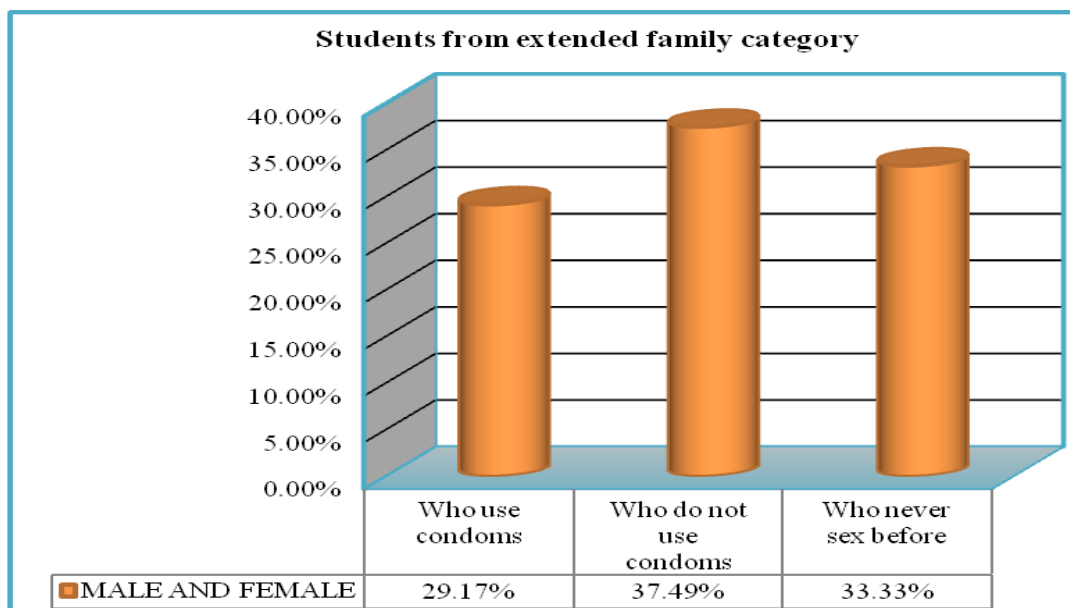
Source:Field data 2014

It was found that more than 75% of students from single parent families, had already sex before the age of 19 years while 33.33% among them had the tendency of not using condoms during sexual intercourse.

(c) Sexual behaviours of students belonging to Extended family

The last family type to be assessed was extended family so as to get the real picture and data about type of families including polygamous and their impact to student's risky sexual behaviours. Data showed from the extended family category that male and female students who used condoms were 29.17%, who did not were 37.49% and those who never had sex before were 33.33%.

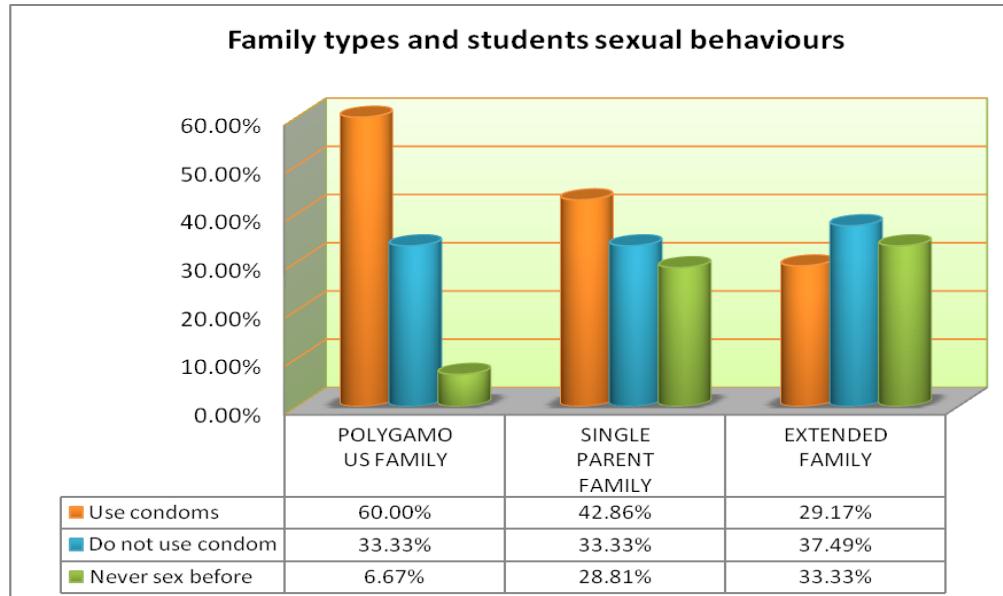
Fig 4.17: Students from extended family and risk sexual behaviours (N=120)



Source: Field data 2014

This was astonishing because students from extended families showed greater number of risky sexual behaviours compared to all the above family types. This suggested that not only polygamy, but any kind of family can be a cause to the risky sexual behaviors. Strong measures to provide education, advice, counseling, care and healthy medical treatment to these students belonging to these families could not be administered properly. The researcher compiled all these families' data together in order to have a clear report as shown in figure below;

Figure 4.17: Family types and risk sexual behaviours (N=300)



Source: Field data 2014

Data showed that students from polygamous families were leading when it came to the use of condoms during sex, single parent followed then extended by 29.17%. On the other side, students from extended families led by doing sexual intercourse without using condoms by 37.49% while single parent and polygamous families both followed by having 33.33%.

4.3.5.2 Tradition of having many children

The assumption was that the traditional belief of having many children attributed positively towards risky sexual behaviours of school children due to the inability to take care of them, and when these children belonged to polygamous families, the problem became worse. Data from field were collected on types of families and number of children available, the specific number of children was:

- (a) Families who had more than three children= many children
- (b) Families who had less than three children= few children.

(a) Number of children from polygamous families

33.33% male students were from single parent families having many children (more than three), 20% of them were from single parent families having few children (less than three) while Female students 33.33% were from single parent families having many children (more than three), and 13.33% were from single parent families having few children (less than three).

Table 4.3: showing number of children in polygamous families (N=75)

NUMBER OF CHILDREN	MALE	PERCENT	FEMALE	PERCENT
MORE THAN 3	25	33.33%	25	33.33%
LESS THAN 3	15	20%	10	13.33%

Source: Field data 2014

(b) Number of children from single parent families

38.09% male students were from single parent families having many children (more than three), 19.05% of them were from single parent families having few children (less than three) while 14.29% female students were from single parent families having many children (more than three), and 28.57% were from single parent families having few children (less than three).

Table 4.4: Number of children in single parent families (N=105)

NUMBER OF CHILDREN	MALE	PERCENT	FEMALE	PERCENT
MORE THAN 3	40	38.09%	15	14.29%
LESS THAN 3	20	19.05%	30	28.57%

Source: Field data 2014

(c) Number of children from extended families

20.83% male students were from single parent families having many children (more than three), 20.83% male students were from single parent families having few children (less than three) while Female students 37.5% were from single parent

families having many children (more than three), and 20.83% were from single parent families having few children (less than three).

Table 4.5: Number of children in extended families (N=120)

NUMBER OF CHILDREN	MALE	PERCENT	FEMALE	PERCENT
MORE THAN 3	25	20.83%	45	37.5%
LESS THAN 3	25	20.83%	25	20.83%

Source: Field data 2014

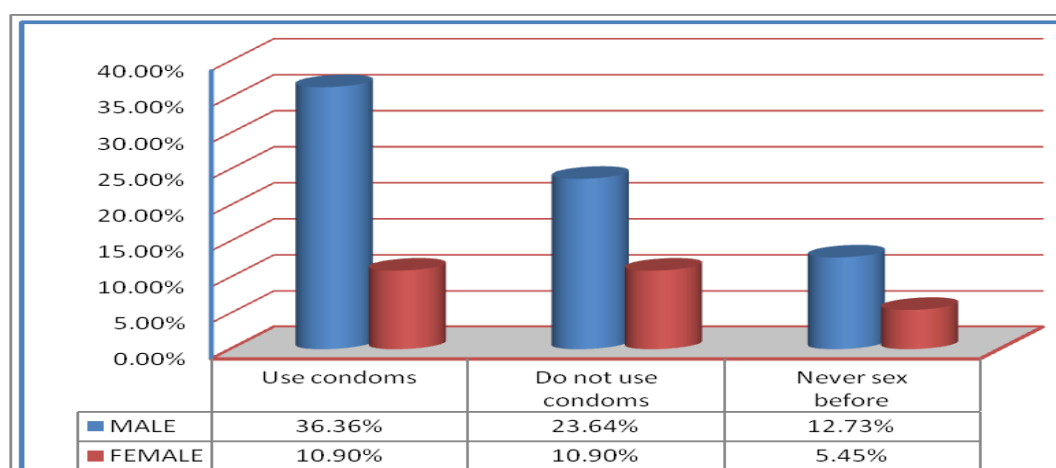
Results: Students' condom use basing on family and number of children

Information was then collected to determine the risky sexual behaviours of students from the two families: with many children with those having few children regardless of the family type. From each polygamous, single parent and extended families, two groups were determined, that is students from families with many children and those from families with few children.

(a) In single parent families-having more than three children (many children)

From these families male students were 40: on which 36.36% used condom consistently, 23.64% did not while 12.73% had never had sex before. Female were 15: on which 10.9% of the female students used condoms consistently, 10.9 % did not, while 5.45% had never had sex before.

Figure 4.18: Sexual behaviours among students from single parent families- More than three children (N=55)

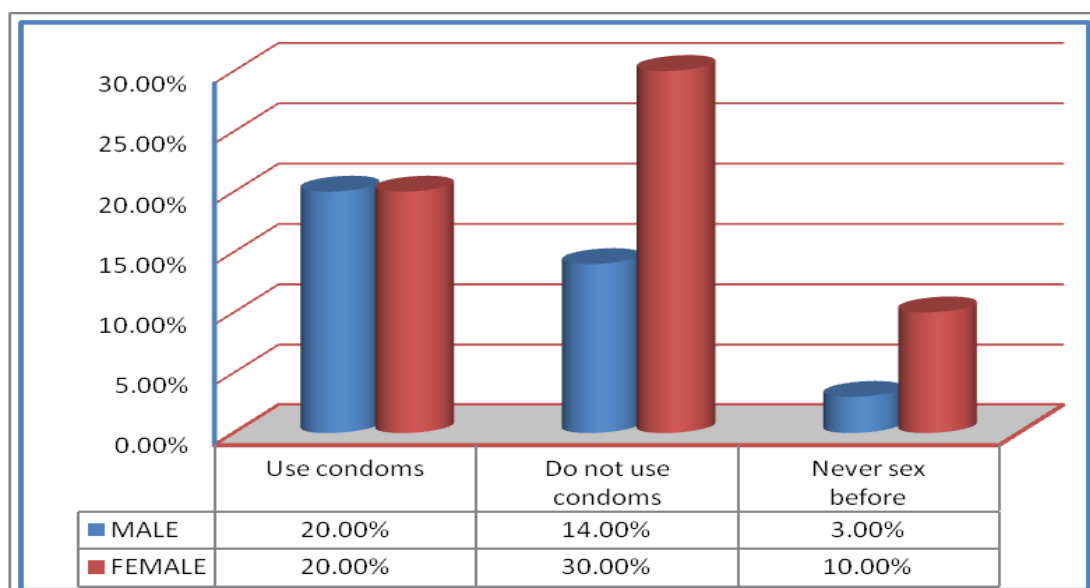


Source: Field data 2014

(b) In single parent families-Less than three children (few)

From these families male students were 20: on which 20% used condom consistently, 14% did not, and 6% had never had sex before. Female students were 30: on which 20% used condoms consistently, 30% did not while 10% had never had sex before.

Figure 4.19: Sexual behaviours among students from single parent families-Less than three children (N=55)

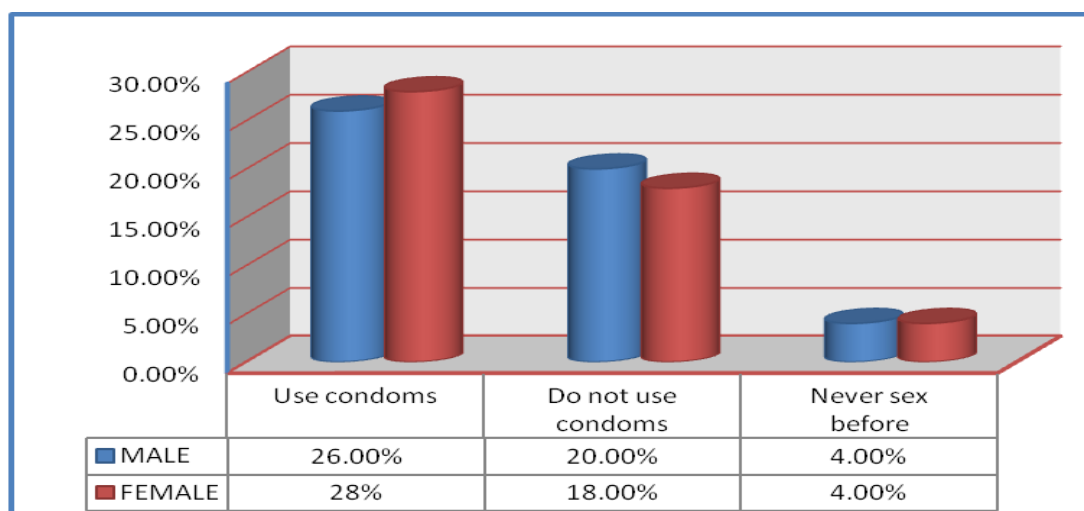


Source:Field data 2014

(c) In Polygamous families-More than three children (many children)

From these families male students were 25: on which 26% used condoms consistently, 20% used no condoms and 4% had never had sex before. Female students were 25: on which 28% used condoms consistently, 18% did not, while 4% had never had sex before.

Figure 4.20: Sexual behaviours among students from Polygamous families-more than three children (N=50)

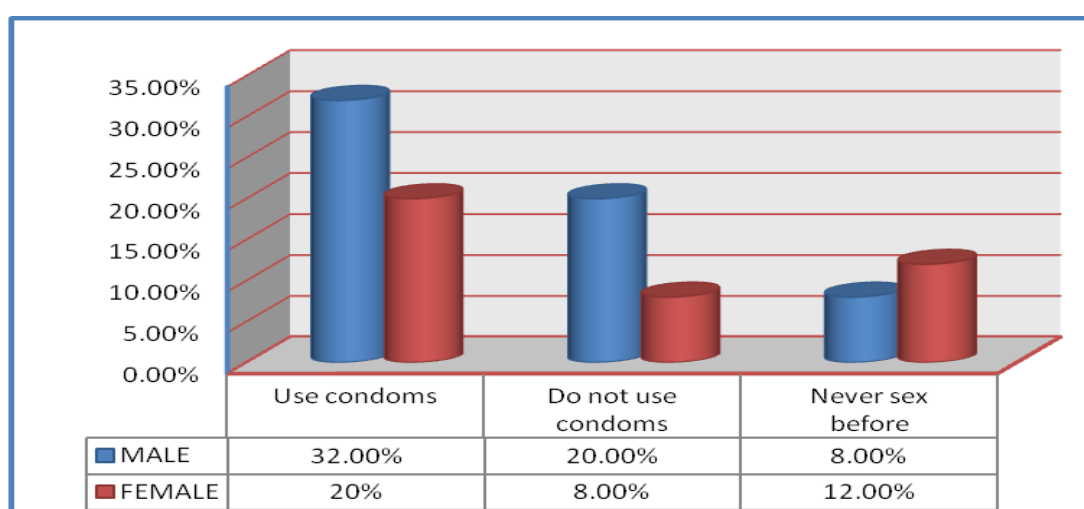


Source: Field data 2014

(d) In Polygamous families-Less than three children (many)

From these families male students were 15: on which 32% used condoms consistently, 20% did not and 8% had never had sex before. Female respondents were 10: on which 20% of them used condoms consistently, 8% used no condoms while 12% had never had sex before.

Figure 4.21: Sexual behaviours among students from Polygamous families-Less than three children (N=25)

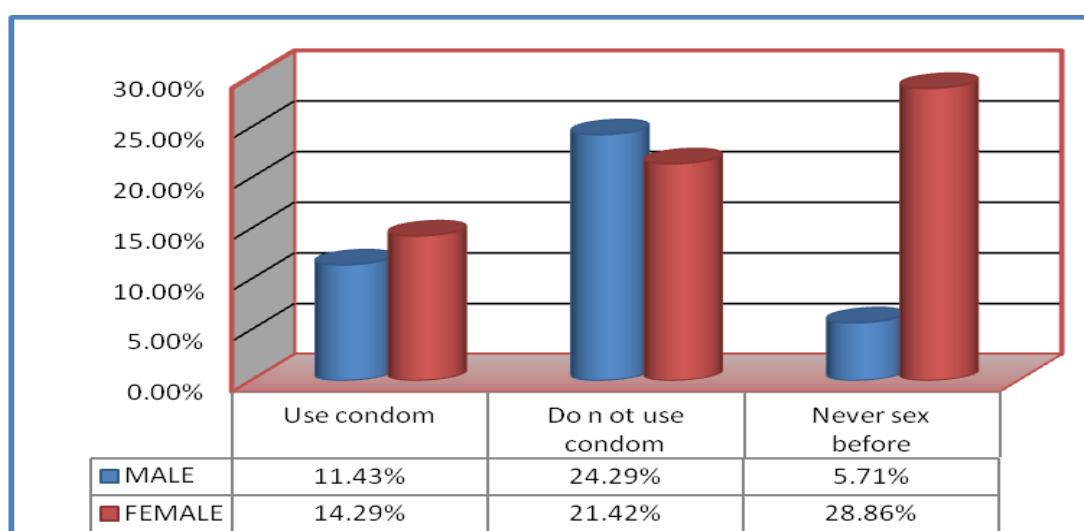


Source: Field data 2014

(e) In Extended family-More than three children (many)

From these families male students were 70: on which 11.43% used condoms consistently, 24.28% did not while 5.71% had never had sex before, among the female students 14.28% used condoms consistently, and 21.42% did not, while 28.85% had never had sex before. The figure below explain this.

Figure 4.22: Sexual behaviours among students from Extended families-More than three children (N=70)

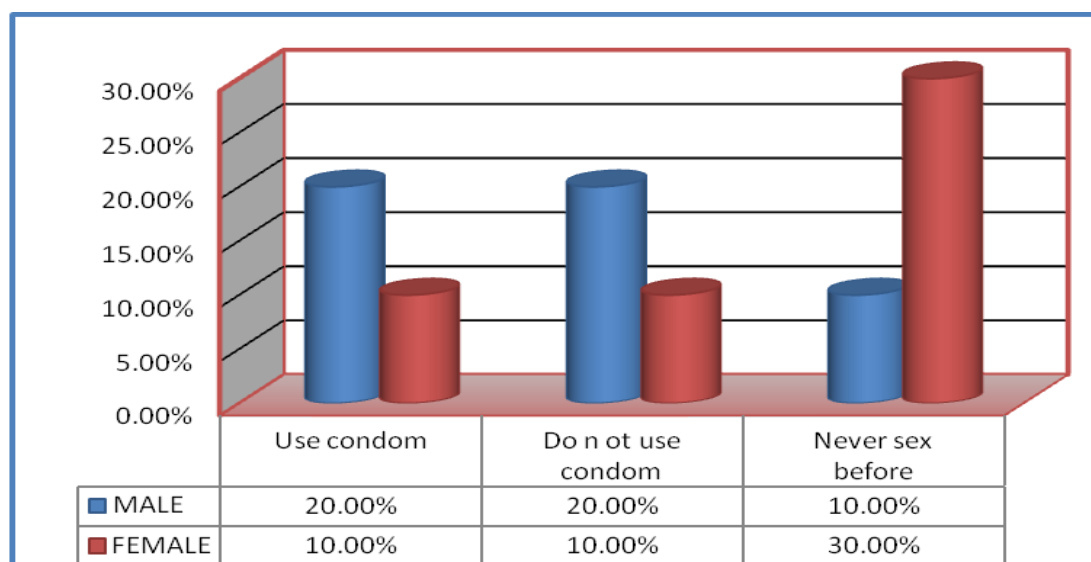


Source:Field data 2014

(f) In Extended families-Less than three children (few children)

From these families male students were 25: on which 20% used condoms consistently, 20% did not, 10% had never had sex before. Female students were 25: on which 10% used condoms consistently, 10% used none while 30% had never had sex before.

Figure 4.23: Sexual behaviours among students from Extended family-Less than three children (N=50)

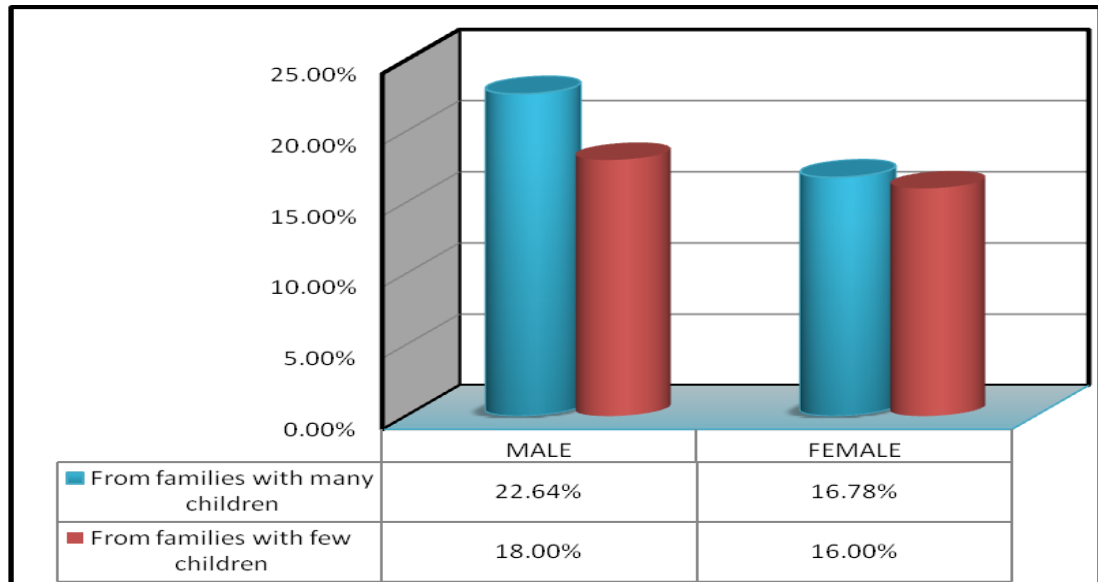


Source: Field data 2014

Final result on number of children and risk sexual behaviours

The risk behaviours percentages were then added together and divided by number of groups (3 types of families) to find the level of risk within the two categories. It was found that among male students from families with many children there was significant risky sexual behaviours by 22.64% compared to 18% from families with few children. Among female students coming from families with many children there was a significant risky sexual behaviours by 16.78% compared to the 16% from families with few children. Having many children is still detrimental. Health officer's response to this was most of the time origin of Morogoro inhabitants whose low income earned and no power to hold greater influence over children prevailed, so having large number of children increased the burden and resulted to low ability to control them, providing adequate care to them, financial support emotional counseling and health analysis or even sending them to school thus resulting to greater number of risky sexual behaviours.

Figure 4.24: Students at risk (never used condoms) from many or few children families (N=300)



Source: Field Data 2014

4.3.6 Parental coercive care

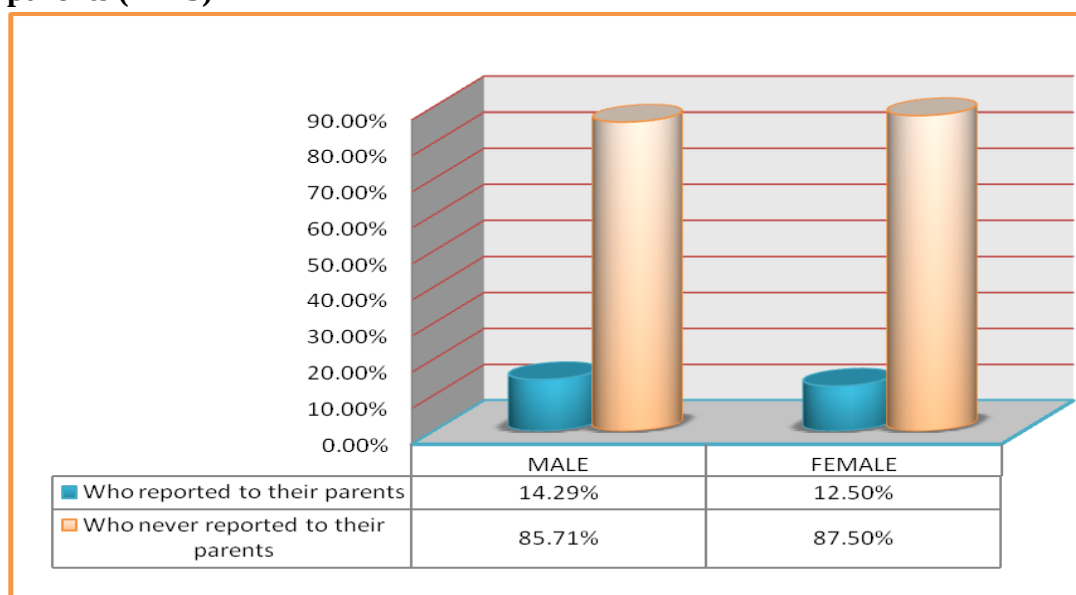
The assumption for parental coercive care was because of parent's role on taking proper measures over rising sexual problems facing their children, and limitation of freedom outside home decrease the risk sexual behaviours to youths while the use of coercive measures like strokes were positively related to the increase of the problem. The researcher went through analyzing the three important aspects on this: whether parents had a tendency of talking with their children about sex (as it was observed above that some of the social taboos or moral values prohibited it), whether and how parents took strong measures to deal with sexual problems when they arose, and last whether they used strokes to provide better solution or increased the problem.

4.3.6.1 Parents' proper measures over arising sexuality problems

The assumption here was that the parents' roles on dealing with already existing sexual problems like rape, breast pain, diseases and unhealthy menstrual cycle to their children resulted to reduction of the risky sexual behaviours.

Data from the field showed that 11.67% of the male students encountered some sexual problems while 13.33% of female students had serious sexual problems including rape, breast pain or diseases and unhealthy menstrual cycle. Going further the researcher questioned the students who had encountered some sexual problems before if they had ever reported them to their parents, and if they did, what measures had been taken. Astonishingly, only 14.29% of the male students did, while 85.71% hid their problems. 12.5% of the female students' had told their parents while 87.5% never said anything. The information is better portrayed in the figure 4.26 below.

Figure 4.25: Students who encountered sexual problems and their trust in parents (N=75)



Source: Field data 2014

When asked why most of them did not report to their parents or elsewhere, it was found that they were shy and the society including their own parents perceived sexual issues as more confidential. The unreported sexual problems had result to risk sexual acts as shown in the table 4.6 were obtained.

Table 4.6: Effects of unreported sexual problems as a result of social norms (shyness) and low parental care (N=75)

MALE				FEMALE			
Who reported their sexual problems		Who never reported their sexual problems		Who reported their sexual problems		Who never reported their sexual problems	
Using condoms	Do not use condoms	Using condoms	Do not use condoms	Using condoms	Do not use condoms	Using condoms	Do not use condoms
5.33%	1.33%	12%	28%	6.67%	0.00%	5.33%	41.33%

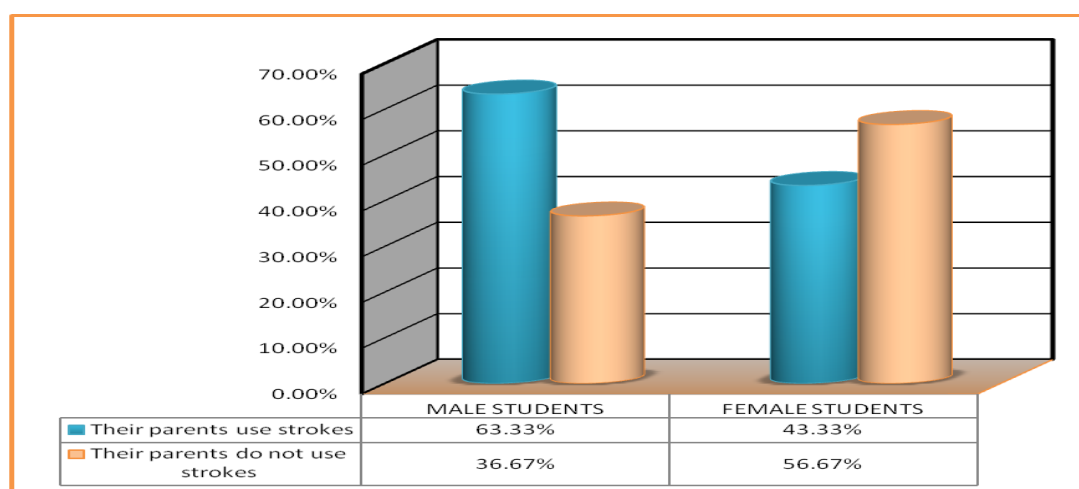
Source: Field data 2014

4.3.6.2 Parents' use of strokes for punishing misbehaved children

The assumption was the use of coercive measures like strokes was positively related to the increase of the problem. It is a traditional aspect that most of the time when children misbehave, most of their parents use strokes as a way of leading them back to the track, but this seemed to increase the risk sexual behaviours to most students.

Data from the field indicated that 63.33% of the male students had been punished by their parents using strokes when they did something wrong, 36.67% of the parents did not use strokes while 43.33% of the female students were always punished using strokes and 56.67% of the parents used other means to warn their children rather than strokes.

Figure 4.26: Parents tendency of using strokes to punish students over sexual behaviours (N=300)



Source: Field data 2014

By then, researcher evaluated the impact of this traditional means as a way of educating children the reality by comparing the two groups on the use of condoms as illustrated on the table 4.7.

Table 4.7: Use of strokes as tools for punishing students and their impacts to their sexual behaviours (N=300)

MALE STUDENTS				FEMALE STUDENTS			
Whose parents use strokes		Whose parents do not use strokes		Whose parents use strokes		Whose parents do not use strokes	
Using condoms	Not use condoms	Using condoms	Not use condoms	Using condoms	Not use condoms	Using condoms	Not using condoms
12.67%	19%	7%	11.33%	15.33%	6.33%	14.33%	15%

Source: Field data 2014

This study found that the use of strokes had some impact on the increase or decrease of risky sexual behaviours as it showed that among the parents who used strokes, 19% of their male children were at risk, while among the females the use of strokes increased the rate of using condoms. Aged people believed that using strokes was a better way of controlling sexual behaviours among teenagers and without using them their bad behaviors worsen “...Mtoto kama hachapwi fimbo atakuletea wanaume hadi ndani kwako...fimbo inamnyoosha kabisa...” (Meaning if a child could not get strokes, she would bring her sexual partners even in her father’s own house...strokes could discipline her completely)

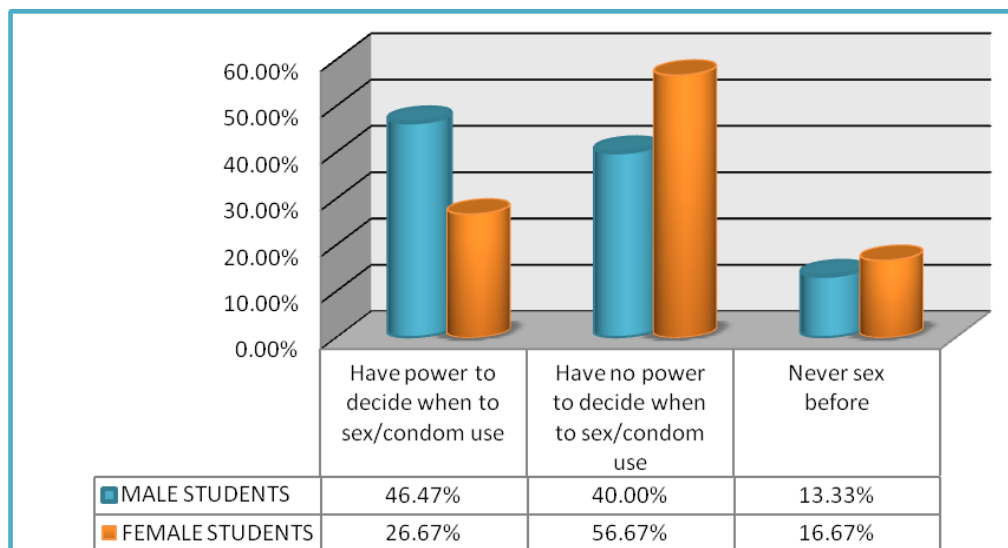
4.3.7 Women’s decision making power and male preferences

The assumption for women’s decision making power and male preferences was that denial of women’s decision making power, male children preference than females, the belief on family generation and superiority (large number of children) were positively related to the risky sexual behaviours.

Data from the field showed that 85% of all students had already started having sexual intercourse living only 15% with the following description: 46.67% of the male students had power to decide and control (not to have sex or use condoms) when their sexual partners wants to do so, 40% had no power and 13.33% had never

had sex before while 26.67% of the female students had power to decide and control (not to have sex or use condoms) when their sexual partners were in need of it, 56.67% had no power and 16.67% had never had sex before.

Figure 4.27: Women’s decision making power and male preferences (N=300)



Source: Field data 2014

It was found that women were mostly affected by lack of decision power, systems created by the traditions as male were considered superior than them when it came to decision making including sexual affairs. This is to say that most of the time, the use of condoms among women depended much on men’s decision rather than their own.

CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND POLICY IMPLICATIONS

5.1 Summary

This study examined cultural orientation factors which influenced risky sexual behaviours on school children in Morogoro urban aiming to find out if the traditional intervention through cultural orientation could be a proper intervention strategy for those behaviours among secondary and primary schools students. Specifically in the first place, the study determined the influence of traditional contraception, adulthood initiation (like Jando and unyago), social norms, values, taboos, religious influence, marriage systems, fertility, parental coercive care, women's decision making power and male preferences to identify the cultural orientation settings that may have influenced risky sexual behaviours, explored the relationship between cultural orientations, determined if students' value to their cultural practices, social norms, and initiation systems, parents' coercive norms could reduce risky sexual behaviours or increase them and lastly determine the effectiveness of modern strategies used by the government, NGOs, Religious groups and CBOs to strengthen pregnancy prevention among the adolescence.

5.2 Conclusion

The research objectives had been used as headings or subsections to provide greater understanding of the conclusion part.

5.2.1 To identify the cultural orientation settings that may have influenced risky sexual behaviors.

It was found that traditional medicines, initiation practices, some social norms and values (taboos), religious settings, family settings (parental coercive care), women's decision making power and male preferences influenced the problem while family types seemed not to hold this influence.

Basing on these findings, it could be concluded that except for polygamous families, all other variables that influence traditional contraception, adulthood initiation, social norms, values including taboos, religious influence, marriage systems, fertility, parental coercive care, women's decision making power and male preferences influenced risky sexual behaviours. Belonging to polygamous families did not influence risky sexual behaviours most likely because large numbers of data showed that students who belonged to extended families were highly affected by the sexual behaviours than those from polygamous.

5.2.2 To explore the relationship between cultural orientation and students risky sexual behaviors.

All variables were found to have a relationship with risky sexual behaviours except one subpart (polygamous families). Cultural orientation factors were found to have an impact on failure or success of strategies and modern contraceptives established by the government, CBO and NGOs to control sexual behaviours and their impact since cultural grounds were the most important areas to consider in many community awareness strategies.

5.2.3 To find out if the students' value to their cultural practices, social norms, including initiation systems norms could reduce the risky sexual behaviours or increase them.

With regard to factors that influenced risky sexual behaviours, early initiation ceremonies including jando and unyago seemed to lead, such that it resulted into higher percentage of students who had sex before, unsafe sex and multiple sexual partners. Although valued their culture, 84% of male and 88% female who underwent the initiation procedure had sex before 18 years. Unsafe sex among male initiated include 30.43% and 69.81% of female while 61.82% of male and 40% of female had multiple sexual partners. This means value to some practices could increase the problem rather than reducing it.

Additionally, findings showed that low parents measures over children's arising sexual problems, lack of women's decision making power, male preference, having large number of children, religion, unfit curriculum in schools, teachers cultural background, social norms and values including taboos influenced risky sexual behaviours.

5.2.4 Determine the effectiveness of modern strategies used by the government, NGOs, Religious groups and CBOs to strengthen pregnancy prevention among the adolescence.

The effectiveness of modern strategies depended much on the cultural orientation settings in reducing the problem; condom use education in schools is mainly prohibited by cultural orientation as 61.42% of the respondents argued that some religions forbid using them. The preference of traditional contraception and calendar method as examples of cultural orientation factors hamper the effectiveness of modern strategies. There is need to review the cultural orientation factors and integrate them into the health education curriculum as most of the time modern interventions are hindered by these cultural systems as reported.

5.3 Policy Implications and Recommendations

Though the government through NSGRP have strategies to reduce unwanted pregnancies, HIV/AIDS and school dropouts, most of these strategies do not involve cultural orientation factors. This study has implications towards the review of health education curriculum in Ministry of Health and Social Welfare (MOHSW) and Ministry of Education and Vocational Training (MOEVT) in achieving the NSGRP strategies. The following recommendations have to be considered: As was found that 64.67% of the females trusted and used calendar method than condoms while 24.34% of male students and 20% of females preferred using traditional contraception while rejecting condoms, the sexuality education should insist on the use of condoms, and mobilising society to change from their tradition view.

There should be emphasis on Comprehensive Sex Education rather than Abstinence based approach education, this should be reviewed and changes should be implemented by establishing and promoting the CSE system since it enhance the potential benefits of delaying having sex until youths are emotionally and physically ready and how to protect themselves from infections and pregnancy when they do decide to have sex (Ragab 2008). The approaches do emphasis on the use of condoms when someone seems not to have the abstaining power, thus call for provision of condoms to individuals. CSE can effectively delay sex among young people, increase condoms together with overall contraceptives use among sexually active youth, increase knowledge about sexual behaviours and their consequences thus reduce risky sexual behaviours among those who are sexually active (UNESCO 2009).

However, there is a need for improvement of life skills and health-education syllabuses and national education curriculum by reviewing and involving the cultural orientation factors in efforts to combat them, improve health awareness strategies and provision of modern contraceptives including condoms in schools. Teachers should be equipped with IMB model skills for it specifies that in order for sex education to be effective it must provide information that is directly relevant to sexual health (e.g., information on effective forms of birth control and where to access them), address motivational factors that influence sexual health behaviours (e.g., discussion of social pressures of youth becoming sexually active and benefits of delaying first intercourse), teach the specific behavioural skills that are needed to protect and enhance sexual health (e.g., learning to negotiate condom use and/or limit sexual settings) The Public Health Agency of Canada's (2008).

The initiation systems should be reviewed by involving local leaders and elders into insisting prevention of early sexual contacts by establishing social taboos that prohibit the practice rather than encourage it, involving parents, local leaders to review tradition, social norms and values that prohibit the fight against HIV/AIDS free conveyance of education. Involving religious leaders into sexual health

education is another success step towards HIV/AIDS and unwanted pregnancies prevention as religion was found to foster risky sexual behaviours by 61.42%.

However, sexual and reproductive services for adolescents are still surrounded by stigma, especially among parents, community leaders, religious leaders, service providers and even programs for adolescent care. Existing services are not teenagers' friendly in terms of type and quality of services offered, time of service, location and affordability. Society perceived that students knew nothing about sex as contraceptive services were hidden from them and those who tried to seek for them were perceived as prostitutes, therefore, strong emphasis and proper education on the use of contraceptives should be provided to parents on determining the role of family type and fertility.. In short, teenagers have not benefited in spite of favorable policies and guidelines. At the same time, if these services could benefit teenage girls, then they could complete school, get jobs, raise their own family's and the country's economic status (RCHS 2004).

Expertise is lacking in schools. As it was found that there were number of unreported sexual problems that emanated due to shyness and social norms in schools and this fostered risky sexual behaviours among 60% of the male students and 53.34% on the females. Retaining more and distributing 'psychology' teachers in schools rather than depending on the science subject teachers to deal with those behaviours and often providing voluntary health checkup facilities could provide a solution. Last, more efforts on empowering women to have power on decisions making should be invested including putting more emphasis on the use of female condoms as most of the times males seem to be the controller and decision makers on whether to use condoms or not during sexual intercourse.

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APPENDICES

APPENDIX 1: INTERVIEW GUIDE

Location/school.....

Region.....

District.....

Date of interview.....

Introduction

You have been selected for an interview so as to enable me get to data that will help know the determinants of risky sexual behaviours by determining whether cultural orientation lead to more of those behaviours despite all the government interventions. All the information you provide is for academic purpose, promotion of health services and education curricula at our area and nation and will be confidential. Therefore, I kindly request your true and faithful response to the following questions by filling them or fill the gaps provided using either English or Swahili language. Thank you.

1. How old are you?

Between 13 and 18 years = 1 () 18 to 19 years = 2 ()

2. Sex/gender

Male = 1 () Female = 2 ()

3. Religion

Muslim=1 (), Christian=2 () Other=3.....

4. In which type of family do you belong?

Single family = 1 () Extended family = 2 () Polygamous family=3 ()

5. How many children are there in your family?

Exceeding 3 =1 () less than 3 = 2 ()

6. Have you acquired sexual health education?

Yes = 1 () No = 2 ()

7. Do you know anything about Ngoma za jadi?

Yes = 1 () No = 2 ()

8. If yes, how did you come across with them?

School= 1 () Parents= 2 () Ngoma in an area of living=3 ()

9. Do you know anything about traditional contraception?

Yes = 1 () No = 2 ()

10. If Yes, How did you get information about it?

Parents=1 () School=2 () Hospital=3 ()

Other.....

11. Have you ever had sex before?

Yes=1 () No=2 ()

12. If yes, do you always use condoms or any other contraception method?

Yes=1 () No=2 ()

13. If no, what makes you not to?

I don't know how to use them=1 () My Religion forbid it=2 () I do not enjoy
=3 ()

Other reason if you have.....

14. Do you have power to decide when your boyfriend/ girlfriend want to have sex with you?

Yes = 1 () No = 2 ()

15. If no, what do you always do in response?

.....

16. Do your parents have a tendency of talking to you about sex?

Yes = 1 () No = 2 ()

17. If yes, How?

Openly = 1 () Not openly= 2 ()

18. Have you ever faced any problems due to Sexual intercourse?

Yes = 1 () No = 2 ()

19. If yes, mention them

.....

20. How often have you told your parents?

None=1 (), Several times =2 ()

22. If no, why you did you not tell them?

I was shy=1 (), Moral values and taboos forbid it=2 (),

Other=3.....

23. Do you know anything about HIV/AIDS and sexual transmitted diseases (STDs)?

Yes = 1() No =2 ()

24. If yes, where did you hear it from?

Through Parents= 1 () from teachers in school=2 () Friends =3 ()

25. Have you ever known your parent outside sexual partner?

Yes = 1 () No = ()

26. Do you have traditional customs in your culture that inquire youths to have sex at an early age?

Yes= 1 () No = 2 ()

27. If yes, mention them

i..... ii.....

28. Did you apply any traditional practise during your first sexual intercourse act?

Yes = 1 () No = 2 ()

29. If yes, mention them

i..... ii.....

30. Do your tradition customs allow you to have sex at any age?

Yes = 1 () No = 2 ()

31. If no, at which age does it allow it?

.....

32. Have you ever attended UMATI or family planning services?

Yes = 1 () No = 2 ()

33. If no, give reasons why

.....

34. If yes, what was the reaction of the nurses and other people in the health centre when you went to receive the contraceptive services?

Normal = 1 () Bad = 2 (), Good=3 ()

35. Have ever you gone through any initiation system or ceremonies?

Yes = 1 () No= 2 ()

If yes, name them.....

36. If no, how do your friends and society perceive you?

Normal = 1 () against the society = 2 () Rebellious=3 ()

37. If yes, what was the reaction of your parents?

Bad =1 () Irritated =2 () Normal =3 ()

38. Are your parents very coercive to the extent that they use strokes to punish you?

Yes = 1 () No = 2 ()

39. Do teachers here in school teach sex education freely?

Yes = 1 () No = 2 ()

40. If no, why do you think so?

.....

APPENDIX 2-RESEARCHER’S INTERVIEW GUIDE

**A GUIDE TO LEAD RESEARCHER ON INTERVIEWING 1 HEALTH, 1
EDUCATION SERVICE PERSONNEL AND 3 INDIGENOUS AGED
PEOPLE**

This is only a guideline, it helped the researcher to question the respondents in order to arrive at secondary information and it was administered orally in Swahili language by researcher himself

1. What do you know about initiation system in Morogoro and its advantage or disadvantages on youths’ lives? How does the society perceive it?
2. As teachers, health personnel or parents, why do you use strokes as a tool for disciplining the children to avoid risky sexual behaviours?
3. Do you think parents at home and teachers at school do freely talk with the children about unsafe sex, multiple sexual partners, and group sex also insist on condoms use?
4. What do you think are most reasons for secondary schools risky sexual behaviours?
5. What is your suggest or perceive when students use family planning methods or contraceptives in order to avoid unwanted pregnancies and diseases?

Appendix 3: Work plan

WORK PLAN											
TASK TO BE PERFORMED	2014				2015						
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July
Proposal writing											
Proposal presentation and approval											
Preparation of units of study											
Pilot testing of data collection tools											
Revision of study methodology											
Hiring and training of data personnel											
Actual field work											
Data collection											
Transformation of data into software											
Preparation for analysis											
Data cleaning											
Data recoding											
Processing and analysis											
Report writing											
Report submission											
Report presentation											

Appendix 4: Proposed budget

The estimated cost for enhancing the execution of this study:

COST CATEGORIES (IN TANZANIA SHILLINGS)	INITIAL PHASE	FINAL PHASE
Stationeries costs: photocopy, Internet surfing, flash disk, papers and binding cost.	250,000/=	250,000/=
Payment of supporting staff.	200,000/=	200,000/=
Emergence Costs.	150,000/=	150,000/=
Data entry, Analysis, and Interpretation, Report writing and Presentations, Dissemination of data.	200,000/=	200,000/=
Travel and Transport Cost.	200,000/=	200,000/=
Accommodation and Meals.	250,000/=	250,000/=
Sub Total Cost	1,250,000/=	1,250,000/=
Grand Total	2,500,000/=	