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Exploration of Sexual Health Communication between Parents and their Children in Ubungo Municipality, Dar es Salaam Tanzania

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Abstract

Purpose of the research was to investigate the communication and knowledge linkage between parents and adolescents on sexual health communication. The knowledge levels of sexual health of both parents and adolescents were assessed. Obstacles hindering this communication were explored. Talking cure linkage between parents and adolescents were carefully looked at who talks to who, when to communicate and where. 150 participants were selected at Ubungo Municipality in Dar es Salaam, using stratified sampling technique. A sample of randomly selected parents and their children aged 10-19. Parents were biological or guardians having experience of rearing the adolescents at a certain specific time and live with them. Data were collected by questionnaire technique, documentary reviews, interviews and focused group discussion. Few parents (34%) communicate sexual and reproductive health matters with their children. 59% of parents are not aware if their children have close friends of opposite sex and those who know 44% were told by other people, 15% catch SMSs/contraceptives/love letters, 10% just guess, 5% revealing themselves, 20% after dropping academically and 5% loose of respect. The study revealed some barriers hindering sexual health communication between parents and their children that, most parents escaping their role towards informing the adolescents' on sexual related matters. Special interventions therefore are needed at adoption and implementation levels which should involve changing policies. There should be kind of collaboration between researchers and programme developers on the one side and on the other side stakeholders, government officials and target groups (children as recipients and parents as deliverers).

Keywords: *Sexual Health Communication; Heterosexual; Sexual intercourse; Parents and Youth*

Introduction

Globally, 5.8% of adolescents living with HIV are in Tanzania; the new HIV infections among young people aged 15–24 years (2000–2019) over the last 20 years, young women continue to be twice as likely to get HIV compared to young men of the same age group (UNICEF, 2020). According to The

National AIDS Control Programme, 85 percent of HIV transmission in Tanzania occurs through heterosexual contact and the latest news reported that heterosexual sex remains the commonest (attributing up to 80%) route for HIV transmission in Tanzania Mainland (NACP, 2009 & 2022).

The number of people living with HIV in Tanzania increased from 1.3 million in 2010 to 1.7 million in 2019 (UNICEF, 2020). According to the Tanzania Commission for AIDS, TACAIDS (2010) between 10 and 11 percent of young women and men aged 15–24 in Tanzania had first sex before their 15th birthday and up to 43 percent of men and women in Tanzania had their first sexual intercourse before age 18. Research shows further that less than 30 percent of young people use a condom at their first sexual encounter.

This means that more attention needs to be paid to promoting young peoples' sexual health and in particular safer sex practices. Young people's engagement in risky sexual behaviour stems from, among other factors, lack of proper knowledge of sexual and reproductive health and poor skills to handle sexual relationships maturely.

The period of transition between childhood and adulthood is defined as Adolescence. Children entering adolescence they pass through many changes physically and mentally. Cleveland Clinic (2023) mentions some changes which include physical, psychological and sociological challenges, intellectual and the development of their own moral compass. It is said, these changes are rapid and often take place at different rates that can be an exciting, yet challenging time in the life of a teenager. During the adolescence time is when a child becomes more independent and begins to explore their identity.

Naturally, adolescence is viewed by many writers as a risk taking phenomenon with a multitude of consequences. Sexual risk taking behaviours are among the behaviours that have received considerable attention in research. These include, for example, early onset of sexual activities, multiple sexual partners and unsafe sexual practices.

Eliufoo, Mtoro, Godfrey, Bago, Kessy, Millanzi and Nyundo (2025) put out that, the prevalence of early sexual initiation among female youth in Tanzania was 17.4%. The analysis states more that,

Female youth with no formal education had higher odds of having early sexual initiation (aOR = 3.09, 95%CI: 2.06–4.57) compared to their counterparts who had attained secondary/higher education. Conversely, female youth who were working (aOR = 0.81, 95%CI: 0.62–0.97), having media exposure (aOR = 0.74, 95%CI: 0.58–0.96) and increased in age (aOR = 0.91, 95%CI: 0.87–0.96) were associated with lower odds of having early sexual initiation.

The consequences of risk taking sexual behaviour in young people are notable. According to TACAIDS (2010), 60 percent of new infections in Tanzania occur among adolescents aged 10 - 24. Furthermore, in recent years, teenage pregnancy has become one of the major reasons for school dropout among girls. For example, in the year 2010 alone, 816 girls left school due to pregnancy. Reports from the Ministry of Education and Vocational Training shows that while the dropout rate due to truancy decreased from 68.7 percent in 2008 to 36.2 percent in 2009, the dropout rate due to pregnancy increased tremendously from 10.3 percent to 20.4 percent (BEST, 2009).

Msoka, Mtesha, Masika, Swai, Maro and Emmanuel (2025) put out that, regardless of WHO recommendations on informing children aged 6 - 12 based on cognitive and emotional development yet disclosing HIV status to them is a challenge. Sexual health communication with parents is very important in preparing young people to be sexually responsible. Due to the decline or disappearance of traditional institutions like initiation rites, there is a big gap between adults and adolescents in educating them about sexual health.

At the very least, many analysts appear confident that adolescents who talk with their parents about sexual related issues will be "more responsible" in their sexual behaviour, meaning that they will be either less likely to engage in sexual relations or more likely to use contraceptives effectively. WHO (2024) recommends the comprehensive sexuality education should be given as a key to close gaps and empowering all young people to make informed decisions about sex at a particularly vulnerable moment in their lives, as they transition from adolescence to adulthood.

Sexual health communication aims to reduce the risks of potentially negative outcomes from sexual behaviour, such as unwanted or unplanned pregnancies and infection with sexually transmitted diseases including HIV. This kind of communication aims to contribute to young people's positive experience of their sexuality by enhancing the quality of their relationships and their ability to make informed decisions over their lifetime.

Statement of the Problem

Young people engage in risky sexual behaviour with negative sexual health consequences. Unprotected sexual activity can expose young women to the risk of unintended pregnancy, unwanted childbearing and abortion as well as HIV and other STIs. Condom use is still too low among the 15-24 age group, less than a third of young people using a condom when they first had sex. Some major challenges identified include problematic teacher-pupil relationships, lack of resources, stigma, cultural taboos and lack of culturally sensitive information.

Sexual health communication can help reduce sexual risks among young people and it is an essential part of good overall health and well-being. Investing early in a child's life will pay off. Good choices in life on sexual matters depend much on how parents and other caregivers discuss sexual health early. Early sexual health communication will enable young people to gain information and skills that are important in promoting sexual health and their ability to love and trust themselves and others and to develop healthy, respectful relationships (Kirby, Laris & Rolleri, 2005).

Many researchers discuss sexual health education for adolescents, some discuss generally parent-child communication, but few have researched the discussion of sexual health between parents and their children. None of the previous work explored in detail communication between parents and their children about sexual health at family level, by meeting parents and their children in their home and getting their views so that there was no doubt about the results. Using this technique this study is giving true and dependable results direct from the source thus avoiding untrue conclusions and the temptation to falsify information.

Objectives

The three specific objectives of this study were to assess knowledge levels of sexual health of both parents and adolescents; to examine the linkage between parents and adolescents communication on sexual health matters, in particular looking at who talks to whom, when communication takes place and where; lastly, to explore obstacles hindering communication between parents and their children concerning sexual and reproductive health matters.

Research Methodology

Study questions and data collection covered both qualitative and quantitative information. Through qualitative method, the researcher has been able to find answers as to why so many parents are not communicating with their children on sexual health. The quantitative approach has developed statistics, although the study was able to measure methodological statistics of the educational importance

of sexual health communication by measuring the outcome relationships of both approaches. The approach to qualitative is the one given a greater place in the study than the numerical approach where the author analysed the statistics in a phenomenal resilient manner (Joanne & Onwuegbuzie, 2013).

The target population included parents and/or guardians and their children between 10 and 19 years. A stratified simple random technique of sampling was used for obtaining a study sample of 150 participants. This method was used because the strata of parents and adolescents, coming from different environments was taken, i.e. level of economy (low income and high income earners), age groups (10-19, below 40, 40-50, above 50), different ethnicity (Zaramo and other ethnic groups), sex (gender balance considered males and females), education levels (primary, secondary, college and higher learning) and occupation (students, business and employed).

There are several reasons why the study was done at Ubungo Municipality Dar es Salaam; the ethnic group of Dar es Salaam is Zaramo, but almost all Tanzanian ethnic groups nowadays live in Dar es Salaam, therefore different cultures are found in the area. The levels of interaction among various cultures contributed significantly to the emerging changes in social lifestyle. This in turn contributes to a more liberal attitude towards sexuality among adolescents.

Literature Review

This section describes and explains what is known and not known about communication between parents and their children regarding sexual health. It is concerned with identifying the gaps that may require further inquiry. The situation is examined carefully and analysed to determine how useful communication is between parents and their children. In different perspectives different researchers revealed the issue. The section comprises two parts, one being about the theoretical frame work whereby theoretical perspectives have been synthesized and the second being about the review of literature related to the study.

Theoretical Framework

This section review sexual health theories. It is worth considering how this might be achieved in practice. Three processes are suggested: the first is about promoting individual empowerment and autonomy; the second is providing the client with enough information to stimulate and motivate them to use self-protection measures and the third is encouraging clients to implement self-protection measures in practice centering on real life motivation. These indicate an approach that empowers, educates and changes behaviour. The question is how to fit these in to health promotion theory.

Individual Empowerment and Autonomy

Health Promotion Model

WHO (1948) in the Ottawa Charter define health promotion as the process by which people increase control over and improve their health. To make communication between parents/guardians and their children on sexual health successful then the behaviour change theories are useful and should be applied in finding the way out by guiding the stakeholders to the right track.

Protection Motivation Theory (PMT)

Conner and Norman (2005) show that, this is the theory developed by Rogers (1975, 1983 & 1985) which expanded the Health belief model theory. Originally, the PMT suggested that health-related

behaviour is a product of four components: severity, susceptibility, response effectiveness and self efficacy. These components predict behaviour.

Over the years, Rogers has added a fifth component to PMT namely, fear in response to education or information. According to PMT, severity, susceptibility and fear are related to threat appraisal (appraising outside threat), while response effectiveness and self efficacy are related to coping appraisal (appraising the individuals themselves). PMT describes two sources of information: environmental sources (i.e. verbal persuasion, observational learning) and intrapersonal sources (e.g. prior experience). These sources influence the five PMT components, which then elicit either: an adaptive coping response (i.e. Behavioural intention) or a maladaptive coping response (e.g. avoidance, denial).

They (*ibid*) clarify more saying that the Protection motivation theory is a more complex model containing several additional components to those mentioned above, namely intrinsic rewards (pleasure) and extrinsic reward (social approval). It also includes response efficacy (belief that the suggested behaviour will reduce the threat) and self-efficacy. Self efficacy is a person's belief that they can be successful in carrying out the suggested behaviour.

Health Belief Model (HBM)

In addition to the simplistic models of health promotion identified above (medical and behaviour–change models), various models incorporate several variables with identified pathways. One such model is the health belief model, which has been the subject of debate since the 1970s. It looks at how beliefs impact on behaviour (Conner & Norman 2005; Janz & Becker, 1984). This implies that whether an individual puts protection (contraception and/or condoms) into practice depends on their thoughts about: their susceptibility to pregnancy or STI infection; the anticipated severity of that occurrence; the benefits of implementing self-protection; and the barriers to implementation. When certain health beliefs are held, 'cues' (such as health education or perceived symptoms) can stimulate health behaviour (Abraham & Sheeran, 2005).

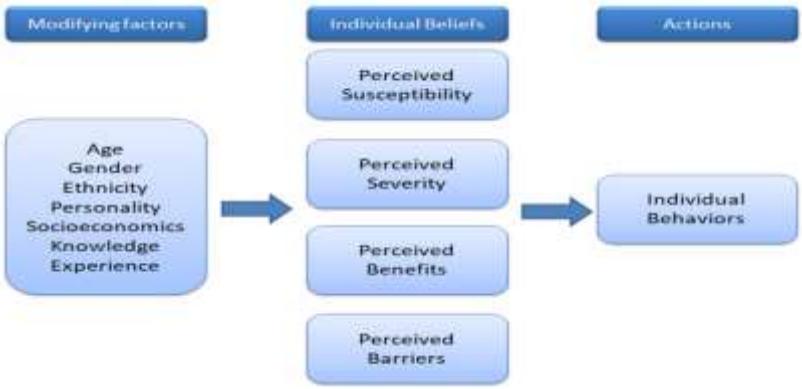

Figure 1: Health Belief Model

Theory of Planned Behaviour (TPB)

The argument of Conner and Norman (2005) is a complex theory. An individual's perceived behavioural control is the expectation that behaviour is within their control, therefore is linked to efficacy and autonomy. Within perceived behavioural control lie several factors, including information and skill.

Health promotion is an important aspect of service provision in sexual health care. It is important to use an approach that maximises impact with the clients. This could include encouraging client's participation using a bottom–up approach. Health promotion ultimately means motivating clients to use measures to improve and sustain their health. It is vital to recognize the value of the clients' potential to do this.

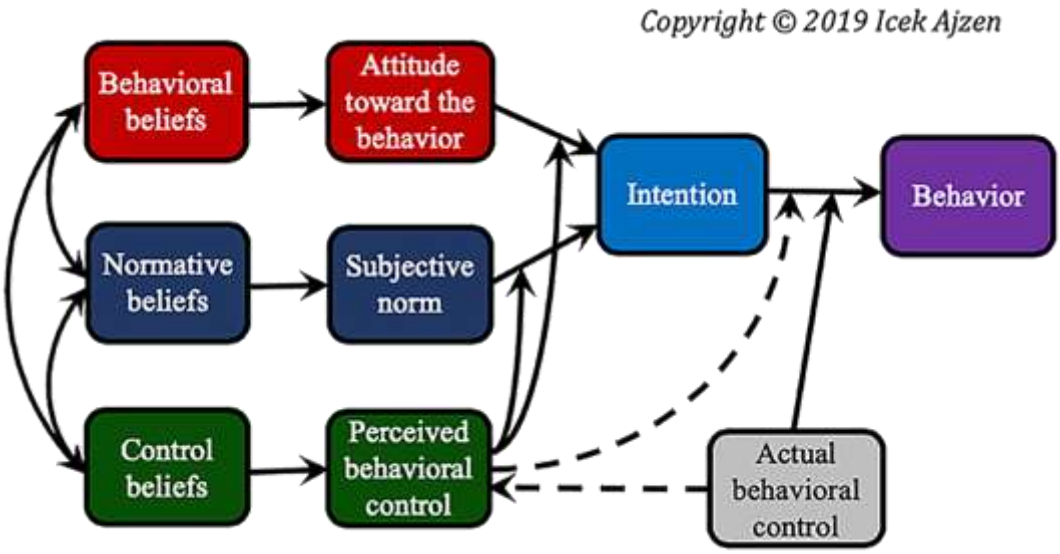

Figure 2: Theory of Planned Behaviour

Client with enough information

Persuasion Communication Model Theory (PCM)

In the process of reaching the goal, some theories can be helpful to guide the education provider. McGuire (1968) in his theory, persuasion communication model theory (PCM), distinguishes the seven stages of behaviour change as a result of communication. These are: the exposure to the message, attention to the message, comprehension of the arguments and conclusions, acceptance of the arguments, retention of the content resulting from information integration, change in attitude, self efficacy and behaviour. Educators and interventionists use PCM to describe an individual's progression from an initial response to an educational message, through intermediate processes, to change behaviour in the desired direction.

The first steps in PCM posit that successful communication should result in attention and comprehension by the receiver. The subsequent steps refer to the receiver's change in attitudes, social influences, self efficacy and behaviour. According to MacGuire, educational interventionists should match each step. Choices of the content of the message, the programme audience, the communication context and the message source should all match.

Protection Motivation Theory (PMT)

Brickman, Rabinowtz, Karuza, Coates, Cohn and Kidder (1982) define four orientations as follows: First, Moral model people; people are responsible for both creating and solving their problems.

Second, Medical model; people are responsible for neither creating their problems nor solving them. Third, Enlightenment model; people are responsible for creating their problems but not solving them. Fourth, Compensatory model; people are not responsible for creating their problems but are responsible for solving them.

It is true that the contemporary parents/guardians in one way or another contributed not only to create the more risky situation to their children by not defending good traditional values as part of the society by adopting everything brought by the meeting of new cultures due to globalization but also they do not find the alternative means of helping their children to get the knowledge about sexual health. They fall under, Moral model people. In this high time parents/guardians are supposed to look for permanent solution. Other parents/guardians may think that they are not responsible for creating problem but as far as Compensatory model is concerned they are responsible for solving them.

Self-protection Measures in Practice

Social Competition Enhancement Programmes (SCEP)

Santrock (2006) and some educational experts argue that coordinated school based planning, high quality curriculum and instruction and a supportive school environment might be needed to deal with students' problem behaviour. These types of programmes often try to improve the student's social competence by enhancing life skills, providing health education and developing socio-emotional skills.

Researchers have found that information programmes only or knowledge programmes only have minimal effects on decreasing students' problem behaviour; in contrast, programmes that teach broadly applicable personal and social competencies have been found to reduce students' aggressive behaviour and improve their adjustment. Such competence programmes deal with subjects such as self control, stress management, problem solving, decision making, communication, peer resistance and assertiveness.

Nice (2007) after recognising how complex the theories are, has come up with the recommendation that health care professionals (trained in sexual health) put the theories into practice in one-to-one structured discussions with clients because such theories need further study before being put into practice. The findings suggested that in order to promote sexual health behaviour, attention needs to be focused on the influence of perceptions of social pressure and behavioural control towards sexual health.

Reviews of Previous Studies

There are 1.2 billion young people aged 15 to 24 years, accounting for 16 per cent of the global population. By 2030 the number of youths is projected to have grown by 7 per cent, to nearly 1.3 (UN, 2022). Globally, about 25 percent of the population is under 15 years of age (Galan, 2025).

Knowledge Levels of Sexual Health of Parents

Many studies have been done to assess parents' knowledge of sexual and reproductive health issues (Population Council, 1993 & Amukena, 1997); however very few studies have been conducted on factors that are associated with parent-child communication regarding sexual health issues.

Bekele, Deksisa, Abera and Megersa (2022) argue that lack of parent-adolescent communication on sexual and reproductive health issues cause a serious problem resulted in teenage pregnancy, unsafe abortions, sexually transmitted infections, school problems and other sexual risk behaviours. From this study (*ibid*) which included a community-based cross-sectional study was conducted on 347 respondents

and shows that only 21.3% of the parents had communicated with their adolescents on sexual and reproductive health issues. The study concluded that there is a need of promoting parent-adolescent communication regarding to sexual and reproductive health issues, parents training and addressing the importance of parent to young people communication along with health care providers.

It seems there is a problem regarding the age at which sexual and reproductive health should begin. Mandona's study (1996) determines practices and attitudes of parents towards sex education with a study sample of 105 parents; she observed that parents who had received sex education in their adolescence support sex education as well. She also revealed that parents feel that the suitable age for giving children sex education lies in the range of 10 – 14 years, while 21% of the respondent parents suggested 15 – 19 years.

Knowledge Levels of Sexual Health of Adolescents

It is the right of our children to know about their body and the changes taking place especially at the age they reached now. Family conversations on sex and relationships offer one way to improve teen reproductive health by reducing teens' sexual risk behaviour; however, it is argued that teen-parent conversations about sex are only effective at reducing teens' risk behaviour when parents' match their messages about sex with their teen's developmental level and sexual experience (Grossman *et al.*, 2018).

Silverberg (2010) says that sexual health involves many things, including: knowing about your body and how it works; understanding the physical, social and emotional changes that come with puberty, pregnancy and ageing; keeping yourself and others safe; and finding information and support when things go wrong, such as an unplanned pregnancy or a sexually transmitted infection. These are the things that adolescent children need to know but they do not. It is a real challenge to parents that they have more time with their children than anybody else in this period through which children pass. On top of that these are their children, which means that they are responsible to make sure that they grow up safely.

Children pass through a series of universal psychosexual stages (Freud, 2004). In his theory (*ibid*) at each stage, sexual drives are focused on the stimulation of certain body areas and particular psychological issues can arouse anxiety.

…if the parents are not appropriately responsible to the child, helping him or her learn acceptable ways of satisfying and controlling drives and impulses, the child can become fixated at a stage, trapped in the concerns and issues of that stage, never successfully moving beyond that stage and through to the subsequent stage. At about the age of 12, children's sexual desires emerge again as they enter puberty and they enter the genital stage. If they have successfully resolved the phallic stage, their sexual interests turn to heterosexual relationships. They begin to pursue romantic alliances and learn to negotiate the world of dating and early sexual encounters with members of the opposite sex (pp. 47, 48 & 49).

Schnellansicht and Artikle (2010) comment that, taking care of your sexual health means more than being free from sexually transmissible infections (STIs) or not having to face an unplanned pregnancy. It means taking responsibility for your body, your health, your partner's health and your decisions about sex.

They (*ibid*) say that when one become a teenager, body changes and develops towards sexual maturity (basically, they go from being a child to an adult), this is called "puberty". There are visible changes to the body as well as changes inside. Girls start having periods every month and their breasts grow. For boys, erections become much more frequent and unused sperm is released in semen during a "wet dream" (usually at night during sleep). Being aware about these changes to their body and knowing they are a normal part of puberty is important. Talking about issues related to sex is also important for their mental health and well being.

Sdorow (1998) says that adolescence is a transition period between childhood and adulthood that begins with puberty. It is a time of identity formation. The adolescent is also increasingly influenced by peer values, especially with regard to fashion, sexuality and the use of drugs. So as to make adolescents know their worth they need people who are close to them to guide and shape them, through communication as early as possible to support what Sdorow describes as a '… time of identity formation.' Since adolescents can be influenced by many things such as those mentioned including sexuality, then it is the parents'/guardians' task to use the power they have to affect the way their children develop, behave and think without using direct force. Sexual health education is one of the important things for parents to invest in during this transition period.

Kosslyn and Rosenberg (2001) observed three basic problems adolescents' face of which the third is that adolescents are prone to taking risks. Among these is engaging in high-risk sexual behaviour which tends to peak in late adolescence. The present study is more valuable, in that it is there to find out if adolescent children are given the knowledge about sexual health or left to themselves and therefore exposed to risks.

In Norwich City where the study conducted by Schofield (1979) took place, it was revealed that children (47% of boys and 43% of girls) were dissatisfied with the amount of sex education they received from parents. In a different way this example serves as a reminder to question how much sexual health education the parents give their children.

Mbunda (1991) comments that the initiation ceremony for both sexes confer adult status. Since adolescence constitutes the developmental stages in which they have sexual debuts, they are clearly at high risk for reproductive health problems. One of the problems adolescents face in developing countries is limited literature and information about themselves and characteristics of the period.

Communication about sex as a means to promote safer sex is especially important for adolescents. Whitaker *et al.* (1999) in the research done in America show that by the age of 19, 86% of males and 75% of females have initiated intercourse, and about a quarter have had four or more sexual partners. However, only 57% of teenagers report having used condom during their most recent sexual intercourse. As a result, each year, about three million adolescents acquire a sexually transmitted disease (STDs), and 16% of women aged 15-19 become pregnant. Although America is not Tanzania, the adolescence period has the same characteristics and more attention must be given to them as a priority for parents/guardians with the aim of preventing them.

Obstacles Hindering Communication

The obstacle of traditional beliefs hinders the parents' desire to direct their children on sexual matters (Amukena, 1997). It is taboo to speak openly about sex to children in most ethnic groups in traditional society. Things related to sex and sexuality are taught traditionally where by adolescents are taken to special initiation camps (*Unyago* and *Jando*) in an isolated place for several weeks or months to be taught the traditional customs of their respective ethnic group with regard to sexual behaviour. Grandmothers or old women used to teach girls who cannot go to such camps. Many ethnic groups such as Gogo, Matengo, Zaramo, Pare and Yao people practiced this (Abdalah, 1991; Meyer, 1995 & Mwaruka, 1965).

In these days traditional systems are weak and in most cases they no longer exist. Modernisation like urban migration, schooling, less extended families where grandparents and other members of extended families are less available to provide sex education to adolescents, means that the traditional system is eroded.

It has been shown that a top-down communication style, which does not give adolescents the opportunity to discuss their own thoughts, cannot work, though it is what is done by most to impart information on sexuality to teens (Yowell, 1996). A national survey done by Kaiser (2002) in United States about sexual health communication between teens (15-17 years) and their parents, provides a snapshot of when teens indicate various reasons why they may not talk to their parents about sexual health issues;- 83% of teens worried about their parents' reaction, 80% of teens worried that their parents' would think they have had sex or are going to have sex, 78% named embarrassment as a main reason and 77% of teens said they did not know how to bring the subject up.

Lugoe and Rise (1996) show that young people are reluctant to use condoms, reasoning that condoms reduce sexual pleasure and sensation. There are some who regard condoms as a white man's conspiracy to get rid of black race (Sebastier, 1988 & Panos, 1988).

Whitaker, May and Levin (1999) say that parents have a tendency to give their children a lecture every time they see that a mistake is made. This gives them the impression that they are still being treated as little children. Try to reason with them instead, guide them to come up with rational explanations; refer to examples with which they can easily relate to, perhaps an experience of somebody dear to them and be careful to never undermine their opinions; in order to make communication successful, children should be treated as mature individuals.

Although talking about sex is important, it is not simple. Open discussions about the topic are made difficult by socio-cultural taboos and by the "secrecy" surrounding the subject. Norms that prohibit openness can hinder discussions about sexual behaviour and can be obstacles to sexual education and the dissemination of information about sex.

Linkage between Parents and Adolescents' Communication

Mmari (2002) studied the communication between mothers and daughters regarding sexual and reproductive health issues, and in one way that study integrates with this study by providing a certain picture of how important communication is between daughters and their female parents. While Mmari's work dealt with only one sex, this research combines both sons and daughters and their parents, both mothers and fathers, knowing that taking only to one gender cannot help the other group while the need is there for all. Leaving out one group means having an unsolved problem: that is why this work includes first of all parents/guardians and their children of both sexes, knowing that asking separately cannot give the solution to all the risks that adolescents face.

Gonzalez (2003) says that parents who act on the belief that young people have the right to accurate information on sexuality are parents whose teens will delay the initiation of intimacy and use contraceptives when they choose to be sexually active. He adds that parents need to start both listening and talking.

More than half of both mother and adolescent girls had negative perceptions of communication on sexual and reproductive health issues (Noe *et al.*, 2018). The study (*ibid*) shows more that it is only 2.7% of girls discussed sexual and reproductive health issues with their mothers. Factors found to create sexual and reproductive health communication barriers were as follow,

Higher family incomes (adjusted odd ration [AOR] 2.5, 95% confidence interval [CI] 1.0, 6.2), good knowledge of puberty (AOR 4.5, 95% CI 1.6, 12.5), good knowledge of sexual and reproductive health issues (AOR 4.5, 95% CI 1.8, 11.5), positive perception of communication (AOR 6.7, 95% CI 2.5, 17.9) among mothers and good knowledge of contraception (AOR 5.7, 95% CI 1.5, 21.4) and good knowledge of sexually transmitted infections (AOR 2.5, 95% CI 1.0, 6.4) among adolescent girls.

Whitaker *et al.* (1999) discovered that parents must be emphatic and understand their concerns. Parent-child communication should be in the form of a discussion. When children feel that what they have in mind is understood, they don't see a very huge gap between the level of understanding of child and parent. Try to make your children's logic and yours meet halfway. This can happen by opening up to your kids, by sharing with them your own experience. Tell them the wrong decisions you've made as well as the consequences. And then, tell them what judgment you will have now if you would be given the chance and why. At times, they might seem to ignore the logic you are trying to show, but do not underestimate the ability of your children to find the right reasons.

Newcomer and Udry (1985) comment that, a recurrent expectation in the family planning literature is that the better the sex education provided in the home, the less likely it is that teenagers will engage in sexual behaviour of which parents disapprove. At the very least, many analysts appear confident that adolescents who talk with their parents about sexually related issues will be "more responsible" in their sexual behaviour –meaning that they will be either less likely to engage in sexual relations or more likely to use contraceptives effectively. This is a very important thing to be understood by the parents/guardians and the objective of this work is to go further to the field and find out if at all the education is given, if yes, how and if not, why.

The finding shows that adolescents whose parents talk to them about sex tend to be less sexually active and more likely to use an effective means of contraception (National Library of Medicine, 1986). These results are from research done with children of 12-14 years and their parents completed sexual knowledge, sexual attitude, and contraceptive-choice questionnaires. Families were divided into high-communication and low-communication groups. Correlation between parents' and children's sexual attitudes in the high-communication group was significantly higher than that of the low-communication group. It seems likely that the similarity in sexual values was the result of parent-child discussion about sex.

The study done by Mvuoni (2006) on communication between parents and adolescents on sex education and the practice of safer sex discovered many fruitful things like the problems which hinder parents to discuss sexual related issues with adolescents. The difference between this research and that done by Mvuoni is clearly that this research dared to meet directly both biological parents, current guardians and their children who live together and not just picking any parent or any child available; it is a work with families who live together in one home. This is purposely done because both sides are aware that giving wrong information will be rejected by the other side. This sharing is two-way, involving a kind of reciprocity.

In concluding his empirical study, Shukia (2007) recommends that longitudinal study design would be necessary to demonstrate convincingly the cause-and-effect nature of the kind of relationships, he observed on the relationship between perceived self-esteem and the intention to use condoms among female adolescents in selected secondary schools in Dare es Salaam region. He (*ibid*) suggests that a future study should include male and female adolescents from various schools and locations across the country so as to be more representative of a diverse adolescent population.

Understanding both what parents discuss with their children and how they discuss it may lead to a greater understanding of teenagers' sexual behaviour (Whitaker *et al.*, 1999). This was the aim of this work - live exploration directly with the stakeholders, parents/guardians and their children.

Initiating conversations about the facts of life may be difficult for some parents because they did not grow up in an environment where the subject was discussed (Gonzalez, 2003). Some parents may be afraid that they do not know the right answers or may feel confused about the proper amount of information to offer.

There is some evidence that well-designed sexuality and HIV/AIDS education programmes have positive effects on reducing risky sexual behaviour among young people, including delaying the onset of sexual intercourse, reducing the frequency of sex, reducing the number of partners and increasing contraception and condom use (Kirby, Laris & Rolleri, 2005: Gallant & Maticka-Tyndale, 2004: Kaaya, Mukoma, Flisher & Klepp, 2002).

Findings and Discussions

This chapter presents the results of a study done in Ubungo District, Dar es Salaam Region. It is the chapter which aims to explore the communication and knowledge linkage between parents and adolescents on sexual health communication, knowing that many studies have been done in schools but not in the home situation. The total sample of 150 parents and guardians in one group and their children in another group were included: The number of parents/guardians who participated in this work was 100 of whom 95 responded and the number of children was 50 aged 10-19 of whom all 50 responded.

Socio-demographic Characteristics

Table1. Socio-demographic Characteristics of the Sample N = 145

Characteristic	**Parents & their Children**		**Percentage**	
Age (Years)	**145**		**100**	
10-19	50		34.5	
Below 40	3		2.1	
40-50	40		27.6	
Above 50	52		35.9	
Total	**145**		**100**	
Education	**Parents**	**Percentage**	**Children**	**Percentage**
Primary	20	21.1	8	16
Secondary education form 4	41	43.2	40	80
Secondary education form 6	17	17.9	2	4
College education	10	10.5	0	0
University	7	7.4	0	0
Total	**95**	**100**	**50**	**100**
Religion	**Parents**		**Percentage**	
Christians	49		51.6	
Moslem	46		48.4	
Total	**95**		**100**	
Occupation	**Parents & Children**		**Percentage**	
Students	50		34.5	
Business	41		28.3	
Employed	54		37.2	
Total	**145**		**100**	

Source: Study area

Table 1 shows that most parents are in the age range of above 50 years, and the score is 35.9% of all respondents. This means that many parents/guardians who responded were born during and a decade after Tanzania got her independence in 1961; therefore most respondents represent Tanzanian culture on sexual health issues because all of these respondents while they were children, lived as traditionalists keeping all the traditional ways of life.

Parents/guardians (in marriage) in total scored 62.1% while widowed scored 3.4%. Among the respondents (on the side of parents/guardians) 62.1% were male and 37.9% female. Because of the culture, males were given first priority by their wives to respond on their behalf; although females show more cooperation and finished early all the questions asked compared to men, most of whom required a longer time to facilitate the research.

The majority of parents/guardians were married - 94.7% - while widowed are 5.3%. Female children scored 58% and male children 42%. Parents having primary education are 21.05%, having Ordinary secondary education (Form 4) 43.15%, Advanced secondary education (Form 6) 17.89%, College education 10.52% and those with University education are 7.36%. So in the group of parents/guardians, most of the respondents are form four leavers and four out of five adolescents who responded (80%) achieved the same level.

In Tanzania due to government rules, children are expected to start primary education when they are 7 years old although at a time of this study they begin at 6 years; if seven years of primary education plus four years of ordinary secondary education (to form four) are added, the age is 17 years. A very few began primary level at 6 years instead of 7 years as per the government rule, and a very few skipped some other classes in between and managed to finish form 6 by the age of 19 years.

On the side of parents/guardians, businessmen/women scored 43.15% of the respondents while the employed parents/guardians scored 59.84%. All children respondents were students. The employed exceed both the number of businessmen/women, and students.

Parents' Attitude

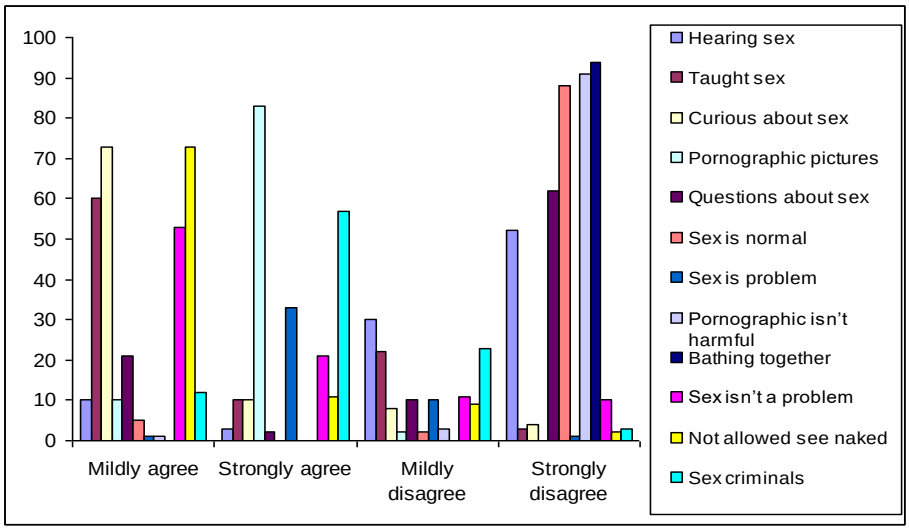

Figure 3: Parental Attitude toward Sexual Health Education
Source: Study area

The disagreement record is leading to the three attitudes parents have about the kind of sexual health topics they do not accept to reach their children. Three score higher than all other topics in this part which are indicated by 94 respondents leaving only one who did not respond. They say they do not accept the notion that there is nothing wrong with bathing boys and girls in the same bathtub. This is followed by a majority of 91 out of 95 who say that pornography is harmful to young children and therefore there is a need to be concerned about their coming into contact with it. The third highest score is 88 respondents who strongly disagree that sex play is a normal thing in children.

This is followed by the fourth in the strongly agree section where 83 respondents agree strongly that young children should be prevented from contact with pornographic pictures. The fifth score (73 respondents) is shared by two, of which both are in the mildly agree group as per the chart; one is that children are normally curious about sex and the second is that it is very important that young boys and girls are not allowed to see each other completely undressed.

Almost all parents/guardians say that sharing bathing between boys and girls in the same bathtub is wrong and most respondents stress that it is very important that young boys and girls are not allowed to see each other completely undressed.

The observation here is that respondents know the danger of putting together male and female adolescents or exposing them to a dangerous situation. This result is supported by Freud (2004) who argues that, "…if the parents are not appropriately responsible to the child, helping him or her learn acceptable ways of satisfying and controlling drives and impulses, the child can become fixated at a stage, trapped in the concerns and issues of that stage, never successfully moving beyond that stage and through to the subsequent stage. At about the age of 12, children's sexual desires emerge again as they enter puberty and they enter the genital stage. If they have successfully resolved the phallic stage, their sexual interests turn to heterosexual relationships. They begin to pursue romantic alliances and learn to negotiate the world of dating and early sexual encounters with members of the opposite sex."

The second score in the graph shows that most respondents (98.9%) say that pornography is harmful to young children and there is a need to be concerned about their coming into contact with it. Ninety four point seven percent (94.7%) of parents/guardians say that sex play is not a normal thing in children and the majority accepts the point that sex is one of the greatest problems to be contended within children.

Eighty six point three percent (86.3%) of parents/guardians accept the point that a child should not be protected from hearing about sex and among them fifty four percent (54.7%) strongly support this idea that they should not be protected: Some parents (13.7%) are against the idea saying that the young child should be protected from hearing about sex. Those who are against the idea, just look at the present and are not focusing ahead; the respondents who say children should not be protected for the unavoidable challenges facing them are supported by Luther King (2004) who argues that, "The ultimate measure of a man is not where he stands in moments of comfort and convenience, but where he stands at times of challenge and controversy." Hearing about sex will therefore give them knowledge about the issue. Gonzalez (2003) argues that parents who act on the belief that young people have the right to accurate information on sexuality are parents whose teens will delay the initiation of intimacy and use contraceptives when they choose to be sexually active. The majority accept that children should be taught about sex as soon as possible. The research shows that the feeling of parents/guardians is in support of sexual health education for adolescents.

The majority agree that children are normally curious about sex, although many parents/guardians want to maintain morals, by saying that young children should be prevented from contact with pornographic pictures, leaving the minority who are against it below 25%. The research shows that in determining risky sexual behaviour among young people in Tanzania, early sexual debut, for instance, has been attributed to adolescents' curiosity and implementation with behaviour, Mkumbo *et al.* (2009).

Most of the respondents say they do not see any problem with a child who asks a lot of questions about sex. Gonzalez (2004) comments that parents need to start listening and talking so that they answer and clear away their children's doubts.

Most of the respondents applied their experience to respond to the following statement in this way, all children who take part in sex play become sex offenders when they grow up. One respondent

comments, “Playing is not speaking, you can play and speak, but in a play there are some physical actions taking place and those can make one to awake and become sexual active.” They say the habit will grow and become a normal thing. However, one can challenge this statement of the respondent, as it cannot be taken for granted that all who take part in sex play will be sex offenders without having convincing data to verify the argument.

Sexual Health Education, Parents/Guardians

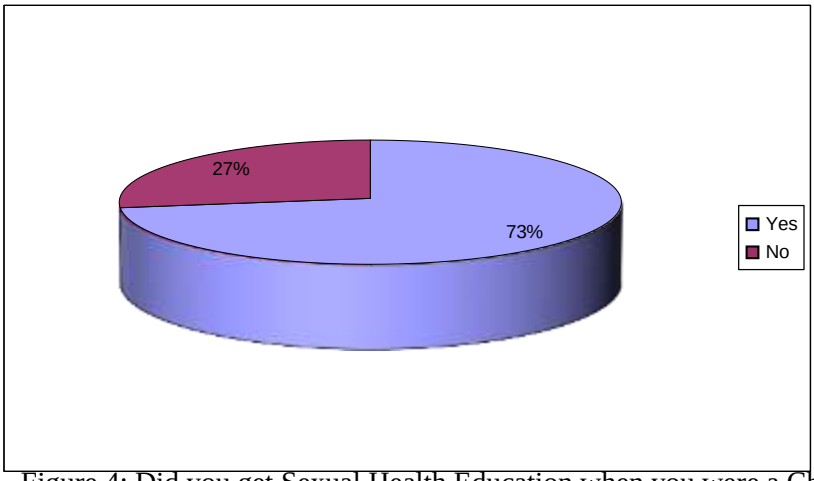

Figure 4: Did you get Sexual Health Education when you were a Child?
Source: Study area

It is only a minority of 27% among the respondents (parents/guardians) who did not get sexual health education when they were children. These results indicate that many respondents had the knowledge, but what sort of education is the biggest issue. There are some obstacles hindering communication between parents and their children concerning sexual health matters. One of the things that make it difficult for the respondents to communicate about sexual health with their children is their background of the source of knowledge they themselves got. Although the data indicate that it is only 27% among the parents who did not get sexual health education when they were children, yet the interviews showed that quite a large number of these were not competent in any area of sexual health except in a few topics and that the culture of a lack of openness between parents and their children is why they carry forward what they have inherited.

Table 2. Sexual Health Education

	Character	Score	Percentage
Who offered you sexual health education when you were a child?	Friends	32	33.7
	Parents	11	11.6
	Elderly people	8	8.4
	Elder sibling	8	8.4
	Initiation rites	33	34.7
	Doctors	3	3.2

Source: Study area

According to the above scores, the results give a picture that sexual health education for most of the respondents (parents/guardians) was offered to them through traditional ways popularly known as initiation rites. Friends score second, but parents scored third with a very low percentage of 11.6%.

The observation here is that culturally related things overshadow other means and explains the total of 57% (49 respondents out of 95) respondents offering sexual health education in traditional ways.

At the time the respondents (parents/guardians) were adolescents, medical specialists were very few and were not dependable by society then, since the parents/guardians of the respondents (grandparents of the vulnerable group) were satisfied with the traditional ways. That is why the score shows health specialists is the last at 3.2%.

Awareness of Sexual Behaviour

Children with Close Friends of the Opposite Sex

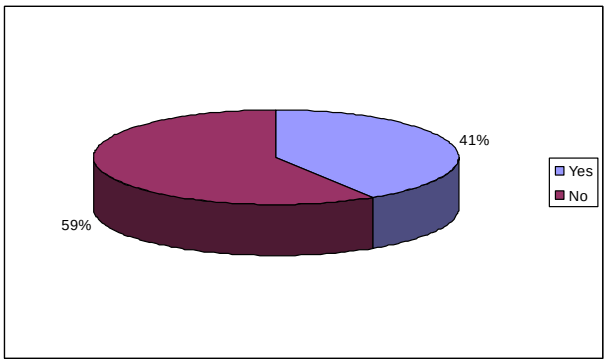

Figure 5: Parents Awareness on their Children have close Friends of Opposite Sex

Source: Study area

More than half of the respondents (59%) did not know whether or not their children had close friends of opposite sex.

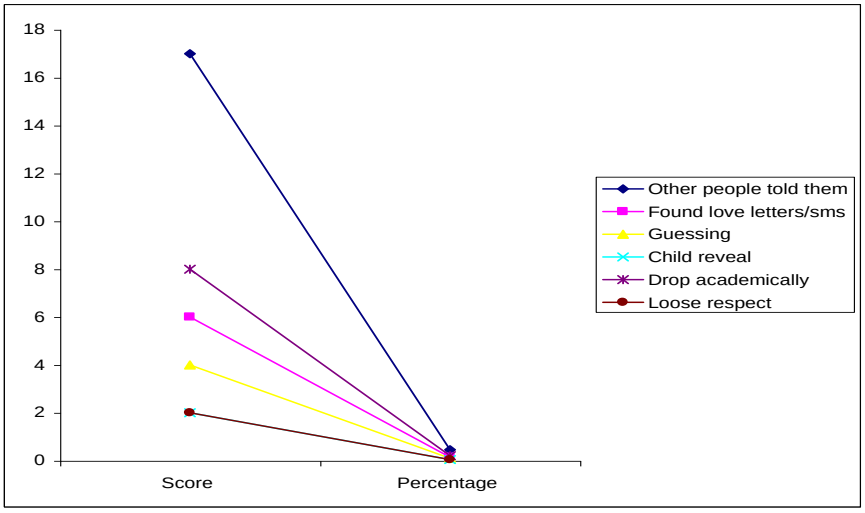

Figure 6: How Parents/Guardians Know if Children have Friends of Opposite Sex

Source: Study area

On the question of, how parents/guardians know if their children have friends of opposite sex, Seventeen respondents (equal to 44%) of these said that other people told them, 6 (equal to 15%) by seeing love letters/SMS/contraceptives, 4 (equal to 10%) by guessing, 2 (equal to 5%) by children revealing willingly, 8 (equal to 20%) by dropping academically and 2 (equal to 5%) by losing respect.

Only 2 out of all 95 respondents said that their children revealed honestly to them that they had friends of the opposite sex and sometimes they welcome their friends to their home. One parent said,

> "It was one weekend when I was out with my daughter to look for her school uniform and other school requirements including stationery and text books, when in town, moving from one shop to another, she just told me openly that she had a boyfriend who promised to be married by her and they agreed that they will do so only after they finish university.

Actually she assured me that she will not have any sexual intercourse following my tireless advice to her that marriage is everybody's right but so as to enjoy and succeed in life she has to wait till at least reaching a certain level, and I advised her that the minimum level was after she is reaching college education level!"

The percentage of parents and guardians who make kind of this communication is very small and therefore that gives a picture that there is no good communication between parents/guardians and their children, and that is why, for many, communication only starts after the event.

Most parents/guardians (17.9%) knew it as a secret thing through other people who told them. One female parent says,

> "It is my neighbour who told me that my son has an affair with her daughter and she requested me to stop my son's behaviour." It is very costly if no communication exists between parents/guardians on sexual health. This respondent said, "From the day her neighbour reported this sexual relationship, the neighbourly relations worsened and there were no greetings like we used to. Even her daughter does not give my respect *'shikamoo'* as usual, and when she sees that I am coming she changes direction."

About six percent (6.3%) of the respondents knew that their children had close friends of the opposite sex only after they caught their children with love messages through a mobile phone, contraceptive tablets, condoms, or love letters.

> "One day message entered my home mobile phone which is used in the home to communicate with me while at work; when I read it I found a lovely message from a boy requesting to meet my daughter the following day at Mlimani city, and it pained me unexplainably; then I pretended that I was my daughter and replied positively showing that I really loved this unknown guy. That was the day when I caught my daughter's boy friend."

The other group (4.2%) knew that their children had a close friend of opposite sex just by guessing. One responded says,

> "This is a normal thing, I know my child; if your child changes behaviour then you have to research what is going on? It is difficult for the 'dot com generation' to reveal willingly in front of their parents if they commit sexual sin."

Through interviews, the researcher found that other respondents were guessing that their children had a close friend of the opposite sex, but the factors guiding them were:- loss of respect, dropping academically, through STIs and behavioural change. When these things happened, some of the respondents said they applied the observation method and others said they just leave it and pray for their children so that God the almighty intervenes. Minorities dare to call their children for discussion and a further minority say that they will punish them till they reveal everything.

Some respondents claim that they succeed by applying the above mentioned ways to catch their children who have this kind of relationship, but almost all respondents admit that they are too late for

prevention and therefore the majority are convinced of the need for the government or any organisation to quickly find the solution as soon as possible before their children get lost, so that their children can be educated early and therefore be prevented from negative impacts of lacking knowledge of sexual health.

The data collected show that more than half (56) of all respondents equal to 58.9% of the parents/guardians who responded to the researcher do not know if their children have close friend of opposite sex. While the data collected from the children's side show 76% of these children who filled the same questionnaires confirmed that they have friends of opposite sex, on top of that more than a half of these children (42%) who have friends of opposite sex declare that they have sexual relationships. The findings justify the available gap in communication between parents and their children on this burning issue. This therefore is very discouraging and sets back all the efforts which have been taken seriously by the Government, non-governmental organisations, international agencies, etc. to reduce young peoples' vulnerability and susceptibility to sexual risks.

Discussions about Sexual Health

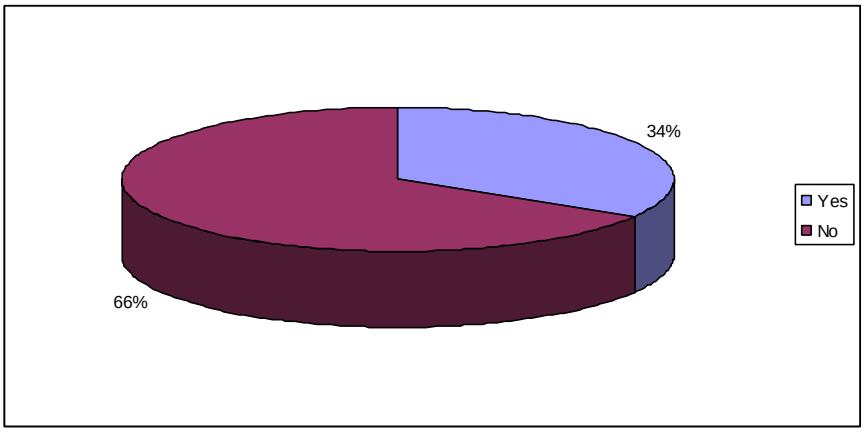

Figure 7: Discussions of Sexual Health between Parents with their Child/Children
Source: Study area

The research also shows that parents/guardians do not know the danger their children face through the result that parents/guardians who normally discuss with their children on sexual health number 32 (33.7%), while those who do not number 63 (66.3%). Studies by Kiwara (2001) alert parents/guardians by showing that a large proportion of adolescents indulge in unprotected sex and most of them are ignorant about the consequences of their behaviour.

From the above data it can be seen that one third (1/3) of the parents and guardians equal to 33.7%, dare to have discussions with their children on the matter, i.e. discussion between parents/guardians and their children is very rare. Table 3 shows that even the frequency of the discussion of the one third who do discuss, the highest level is once in a month score 22.1%, and this shows there is no seriousness, and the issue is not a priority for many respondents, and if this is the case so far, extra emergency measures should be taken by the authorities since the ruination of these children would be a calamity for the nation at large. As recommended by the study done by Mkumbo *et al.* (2009) that special intervention is needed, researchers and programme developers on the one hand, and stakeholders (parents and government officials) on the other hand, together with target groups (students as recipients and teachers as deliverers) should associate to plan for the success of such an intervention.

Table 3. Parent and Child Discussion about Sexual Health

No.	Time	Score	Percentage
i	Everyday	None	0
ii	Once per week	4	4.2
iii	Once in a month	21	22.1
iv	During religious ceremony	Non	0
v	During public holidays	Non	0
vi	Others (i.e. when feel, bad things happen, committed mistake etc.)	7	7.4

Source: Study area

Among the 95 respondents, only 32 discussed with their children; 7 of those who do discuss reported that they discuss when they feel like it but not because it is an important issue. They discuss only if bad things happen so that they get a reference of where to begin the discussion, or when their children make a mistake and things of the kind. The outcome shows how parents/guardians devalue the importance of sexual health which is the central to the life of everybody.

Even those who answer that the discussion they have is at least once in every week, and once in a month, are not necessarily being honest but may just say that so the researcher gets what he wanted. This was observed when the researcher asked the majority of the respondents to clarify when and how exactly they meet with their children for discussion or if there is any permanent timetable, most of them just say they estimate and give an average. There is a real work to be done to educate parents and guardians on the importance of sexual health to the adolescents and the importance of their position as parents and guardians.

Table 4. Why not Discussing Sexual Health – Parents' Views

No	Reasons	Score	Percentage
i	Culture taboo	22	35
ii	Sexually active	21	33
iii	Lose respect	5	8
iv	Very young, Not comfortable, Time will tell, School	15	24

Source: Study area

The research confirms the hypothesis that most parents are escaping their role towards informing adolescents' on sexually related matters. The research discovered that very few parents in Tanzania communicate on sexual and reproductive health matters with their children for many reasons. On top of that there is a problem even with the minority of parents and guardians who do dare to communicate.

Thirty four point nine percent (35%) of parents/guardians said that among the four important reasons why they do not discuss with their children about sexual health, the main reason was cultural taboo. The research showed that premarital sexuality is taboo in our Tanzanian context and that parents are not discussing it with their children; for many there is no involvement and no talking together, and if any discussion is made, usually parents dominate the discussion.

Some parents still maintain this taboo and actually remain silent by not discussing the subject with their children for this reason. However, sexual health communication is very important in addressing these risks. Mvuoni (2006) argues that due to cultural taboos, adolescents in many developing countries rarely discuss sexual matters explicitly with their parents. He (*ibid*) points out that they gain information among themselves and their patchy knowledge often comes from peers of the same sex who themselves may be uninformed or incorrectly informed.

The fear that children will be active sexually if at all they are exposed to sexual health education, was the second obstacle to the question asked, and it scored 33.3%, only one point behind taboo. This means that most parents are not sure if the communication will give positive results and therefore they decide to remain on the thought of the negative results.

One of the important things that parents want, and they deserve as far as the culture is concerned, is respect; the fear of losing respect scored 7.9%. One parent said, "There are things that I do hide although I know for sure that children either know or will know, for the purpose of keeping my respect before my children!" This parent mentions two things he hides as an example; first he hides the sexual intercourse between him and his wife that no child knows, and second is that no one among his children knows at what time he goes to the toilet to remove waste products. Another said they keep their dignity before their children by saying, "Who taught you on how to suck your mommy's breast? These sexual health things are automatic things which are not necessary that you need to be taught so early!"

Parents/guardians are not aware that 98% of their children have already some knowledge about sexual intercourse; the data show they are made aware through discussion with their peers and most of these are of the same sex, and if this is the case then parents/guardians do not know what kind of teaching their children have on the issue! The kind of education they have is not complete enough to be used; it might be good in some parts but bad in others.

A few parents made some comments, "As my children go further they will be taught"; another say, "time itself will tell."; one committed Christian believer, a born again Christian quoted the Bible in Song of Songs Chapter 8:4 & 6, "…Not to awaken love until the time is right. …; For love is as strong as death." This Christian believer forgets or he is shallow in his understanding that even in his Bible there are many teachings concerning sexuality and this holy book is free and suitable for everybody to read, even children below the mentioned age in this work, and that they have the right to read. The researcher discovered this short sentence when he was in the process of checking the given one, "So do not deprive each other of sexual relations. …" (1 Corinthians 7:5). Teaching like this from First Corinthians needs clarification otherwise children with their young minds can pick up anything without knowing the after effects and that is why communication with them is needed.

Who Is Supposed to Give Sexual Education?

Education about sexuality must go beyond just providing information, young people need safe spaces to discuss issues like consent, intimate relationships, gender identity and sexual orientation; the governments, health and education authorities and civil society organisations – should help them develop crucial life skills including transparent, non-judgmental communication and decision-making (WHO, 2024).

Table 5. Educating Adolescents about Sexual Health – Parents' Views

No	Group	N = 95	% age
i.	Parents	58	61.1
ii.	Grandparents	12	12.6
iii.	Uncles/aunts	7	7.4
iv.	Elderly respect people	6	6.3
v.	Rites	4	4.2
vi.	Others (teachers, doctors etc)	8	8.4
	Total	**95**	**100**

Source: Study area

Most parents/guardians (Table 5) aired their views of who was supposed to give sexual health education to adolescents by saying that parents are the right group to do so (score 61.1%). However, the data show that the percentage of those who do educate adolescents is below this figure - only 33.7%!

The reality is that parents can do so, but they lack confidence due to their background and the fact that some were not educated about this in their time. Funnily enough, when these parents/guardians asked who, in their view, was supposed to give this education to adolescents, more than a half - the majority as the data shows above - strongly said parents! It seem that parents rely on theory but not practice, and they sing communism but they dance capitalism by only speaking but not acting on the matter of educating their children. This, one can say, it is a betrayal of responsibility.

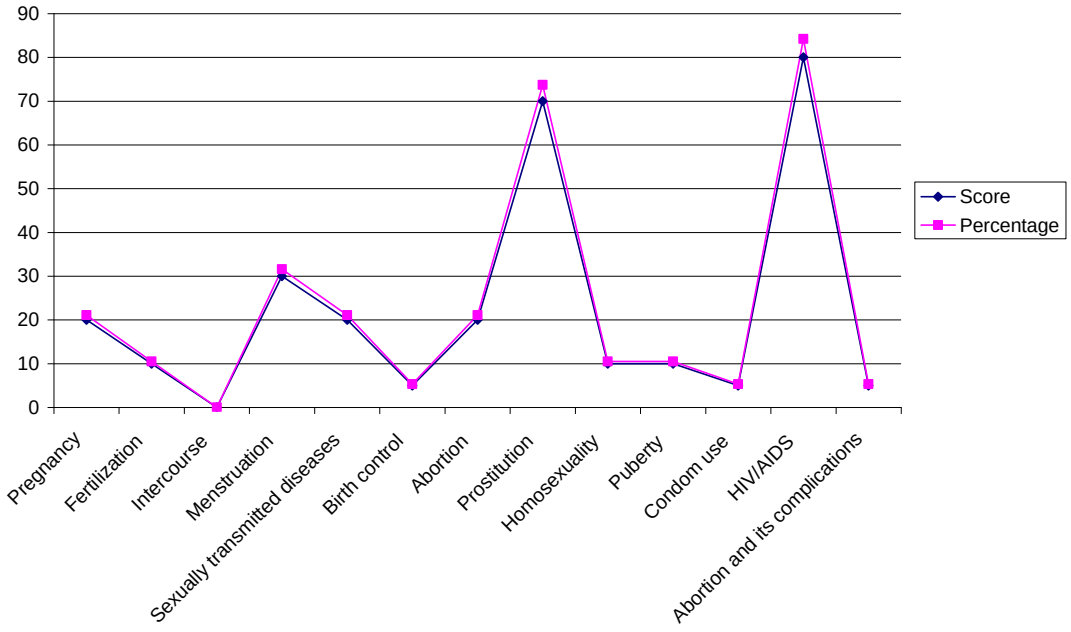

Figure 8: Discussions Parents/Guardians have had with their Children on Topics.
Source: Study area.

As per the above data, a lot of parents prefer to discuss with their children about HIV/AIDS which scored 84.2% while prostitution got the second score of 73.7%. The reason why HIV/AIDS and prostitution score a lot are as follow; most respondents were scared of AIDS as a killing disease, so they give it priority. But they forget that it is not only AIDS which kills and AIDS is the outcome only - they forget that the source of AIDS is more dangerous and what is lacking is the knowledge of sexual health! No parents/guardians had discussions with their child about sexual intercourse - the score reads none (0%), the reason given is taboo. Very few discuss about birth control (the score is 5.3%) and condom use scored 5.3%, because they believe that having such a kind of discussion would give a green light to their children to test and become familiar with it.

Very few respondents discussed with their children about fertilization, homosexuality and the issue of puberty, each of which scored 10.5%. A minority of 21.1% discussed pregnancy, abortion and sexually transmitted disease. At least some (31.6%) discussed menstruation with their children. From the interviews the researcher carried out it was observed that female parents/guardians were willing to communicate and most communicated with their adolescent females about puberty and menstruation. At the same time, male parents were willing to communicate with their male adolescents on condom use, HIV/AIDS and sexually transmitted (venereal) disease.

Male parents are an information source for a very small proportion compared to females, 62% to 38% respectively. In responding to the question asked about how much discussion parents have had with their children on the important topics of sexual health, parents varied in their score and some parents did not answer; although it should not be taken for granted that all who did not answer did not do so because of the fact that they do not know.

One of the parents who dared to reveal this secret said, "I escape this business because I am not a health professional." Another parent said, "Since our childhood this was the responsibility of our grandparents, it is therefore very embarrassing and not acceptable to talk openly with your daughter on things associated with the secret parts of her body, to me it is like an abuse!" Another parent said, "I am not blind to all health topics, but other topics need extra attention; one must be very knowledgeable about those sensitive things which you cannot talk to your child about by just relying on your own experience."

"We used to send our children to traditional initiation rites; the problem we face in this century is, in town we do not have this kind of teachings, even in our villages nowadays the teachings are devalued and slowly disappear."

Children's Knowledge of Sexual Health

Do Children Have Knowledge of Sexual Health?

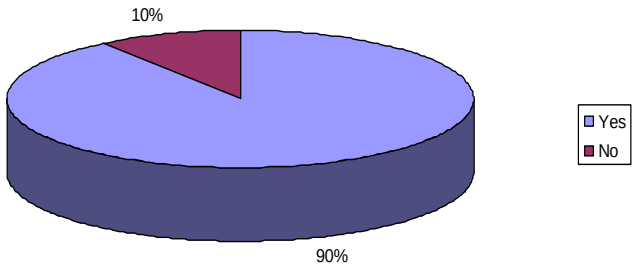

Figure 9: Do Children have Sexual Health Education?
Source: Study area

Pie chart (Figure 9) shows that 90% of children have sexual health education and only 10% of them do not. It is encouraging to hear this, but the question comes from which sources were they educated? Is that kind of education reliable? The question remains, who offered our children sexual health education to this large percentage?

Although 90% of children said they have knowledge of sexual health, yet there is a doubt about which kind of knowledge they have! This doubt is directed to the source where children got the knowledge and if those sources are correct and reliable enough to depend on them.

Children's Sexual Health Education

ASHA (2025) argues that being sexually healthy it means to understanding that sexuality is a natural part of life and involves more than sexual behaviour; to recognising and respecting the sexual rights we all share; to have access of sexual health information, education and care; to make effort preventing unintended pregnancies, STIs and seek care and treatment when needed; being able to

experience sexual pleasure, satisfaction and intimacy when desired; and being able to communicate about sexual health with others including sexual partners and health care providers.

Table 6. *Sexual Health Education for Children*

Character	N=45	% age
Who offered you Sexual Health Education? Friends	27	60
Parents	3	6.6
Elderly people	1	2.2
Rites	1	2.2
Elder sibling	2	4.4
Doctors	2	4.4
School	4	8.8
Others	2	4.4
Total	**45**	**100**

Source: Study area

In answering the question, who offered you sexual health education, children responded mostly by their friends (60%). By very far, school scored second at 8.8%.

The others are parents (6.6%) scoring third and the fourth source which scored 4.4% was elderly sibling; this score matches two other source percentage wise, namely health specialists (4.4%) and neighbours (4.4%). The last group is elderly people which score 2.2% and coincides with initiation rites at the same percentage, 2.2%.

Friends therefore are the leading source, they take over the parents/guardians' important responsibility or the health professional's chance and they become the advisers of their fellows on the sensitive issues of sexual health; but do respondents know where these friends got their knowledge? Are they sure of the materials on which their children feed?

One parent respondent said, "Frankly speaking my child is grown up, I know he must know something about sexual health, but I did not dare ask who taught him or what did he know?" This respondent represented the majority. The respondent gives the reason why he do not communicate with his child on sexual health matters that, "I cannot even explain the reason why I do not communicate" Then unknowingly he give out some suggestions, "I need assistance or external force or a catalyst to make me do so!" WHO (2025) reports that, sexual health is essential to the complete health and well-being of persons, couples, families and to the economic and social development of communities and countries. Sexual health-related issues are wide-ranging, encompass sexual orientation, gender identity, sexual expression, relationships and pleasure.

It is very interesting to hear this, he 'needs external force'… It means he cannot by himself! Now the question is which external force, which is the right force from the right source? The stakeholders know! "The government must intervene." one respondent commented. Another respondent suggested, "Teachers are the right, correct and reliable source and if syllabuses for the sexual health are there they can do it."

Another thing observed here is that most parents were educated traditionally through initiation rites as we have seen above; initiation rites used to be the leading way to educate the parents/guardians (33.7% by then), while now society is changing and parents or let us say society, does not organise the same traditional teachings as it was in those days. This is proved by the results which show that initiation rites score only 2.2% from the adolescents who got the sexual education through that source.

Table 6 shows that 60% of children received sexual health education through their friends and this score leads, with the last group showing two kinds of educators who each scored the same percentage (2.2%), namely rites and elderly people. This outcome gives the picture that two periods interfere with each other, the period where traditional culture dominated and the contemporary period where we see cultures are shaped by other cultures due to the globalization, and this is more powerful. Still the majority of the respondents want to enter the new era with all the old values and qualities without accepting the reality that each era comes with unavoidable changes.

Some of the respondents commented that old teachings to adolescents on sexual health must be replaced scientifically. “This is a century of science and technology; everything should fit in this time otherwise it won’t survive.” That is why you see no more rites even in the villages; our children today cannot accept being educated by the elderly people, the way they perceive them is that old people are outdated and I support this!”

Regarding the 4.4% who received sexual health education from health specialists, some say they were educated when they went to hospital for treatment or when those specialists visited their schools for HIV/AIDS and other health campaigns.

Eight point eight percent (8.8%) say they were educated during their studies of the subject of biology in school especially when teachers covered the topic of reproduction, through relationship seminars and other seminars related to adolescents. It is only 6.6% of children who report that they received this important education through their parents. Parents here therefore play a very small role in helping their children.

Children Having Close Friends of the Opposite Sex

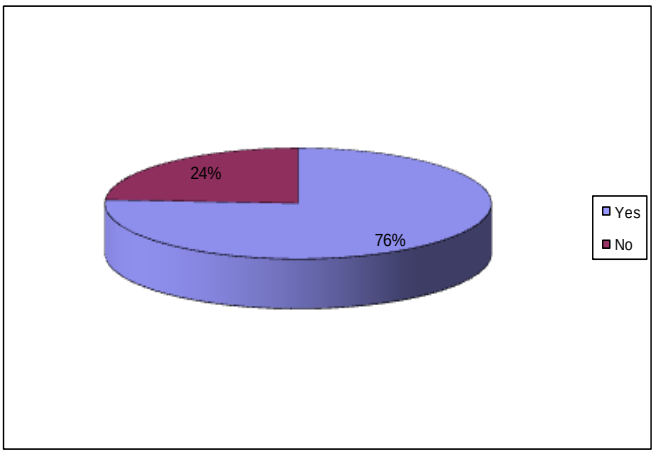

Figure 10: Do Children have a Close Friend of Opposite Sex?
Source: Study area

Seventy six percent (76%) of the respondents children confirmed that they have friends of the opposite sex. 42% of all the respondents reported that they have a relationship that involves sexual intercourse. This means that respondents’ need for sexual health knowledge is very high. It is an inescapable role.

There is an ability for men and women to attain sexual health and well-being which depends on the following four things: Their access to comprehensive, good-quality information about sexuality; their knowledge about the risks on unprotected sexual activity; to access sexual health care; and living in an environment that sustains and promotes sexual health (WHO, 2025).

Discussions about sexual health

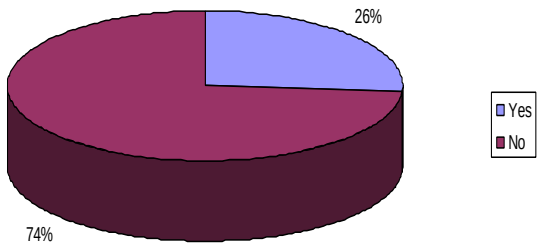

Figure 11: Do Children Discuss with their Parents/Guardian about Sexual Health?

Source: Study area

The majority of children do not normally discuss with their parents/guardians about sexual health. A minority do discuss the topic with their parents although the discussion is very rare at an average of once per month or once per week and others cannot even say what the duration of discussion is.

Those who are not discussing with their parents generally think it is because of culture and worry by their parents. Study which involved sample of 1174 female students aged 13 to 19 years old shows that, those who are less likely to have better reproductive health communication with their mothers are those having family members numbering more than four children which resulted their primary source of reproductive health information to be their friends, classmates or media (Zakaria *et al.*, 2019).

Who is Supposed to Give Sexual Education?

Sexual health term is challenging since sexual health is a broad term that includes many aspects of health and well being of people. The right to be given information and services that will help to have finest sexual health is for all people (ASHA, 2025).

Table 7 .Sexual Health Education to Children – Children's Views

Who is Supposed to Educate Sexual Health Education	**Score**	**Percentage**
Parents	22	44
Grandparents	1	2
Uncles/Aunts	1	2
Elderly respect people	1	2
Friends	2	4
Teachers	8	16
Doctors	15	30
Total	**50**	**100**

Source: Study area

Although the study shows that many children are discussing with their friends about sexual health matters yet the same children indicate the need for their parents to do so, this score being the highest (44%) compared with only 4% who propose friends are enough to share with them on the matter. They imply that it is not satisfactory to be educated by their friends. One respondent say,

"When we discuss with our fellows about most sexual health topics they usually say things with no confidence. I asked one of my friends if he is sure that condoms prevent spread of AIDS and his reply was, 'I hear they say if you use condoms then you will not be infected by AIDS.' We do not have enough education on sexual health." Adolescents say they know things but only partially; they need more assistance on sexual health. During the focus group discussions many children said that they are attracted to all seminars on love matters. One of them said, "when I hear a seminar on love matters I cannot afford to miss it, I want to know many things about sexual health and relationships between boys and girls."

Discussions with Parents, Friends and Religious Leaders

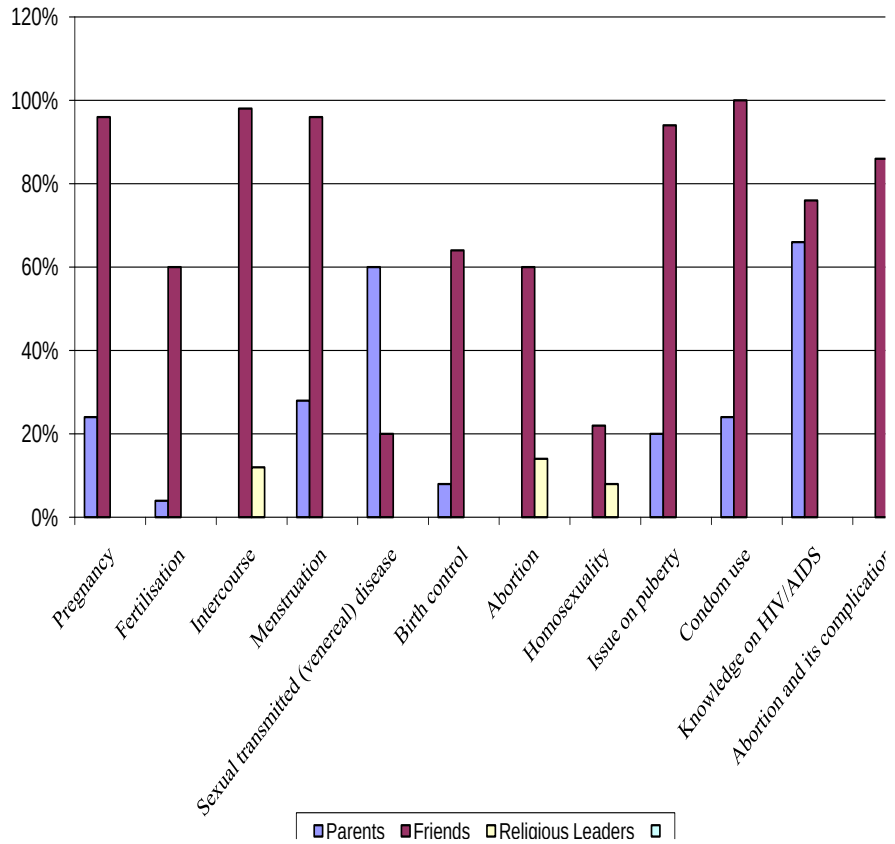

Figure 12: Discussion Children had with Parents, Friends and Religious Leaders

Source: Study area

The graph show that friends are the leading group in the matter of communicating with children about sexual health, far above parents and the last group, namely religious leaders. The shock here is, the expected leading group is the loser but instead the unwanted group is leading in the matter of implanting some basic important knowledge about sexual health to adolescents. This is upsetting and a shame to all who recognise the value of imparting sexual health knowledge to adolescents!

While the research shows that none (0%) of the parents/guardians discuss with their children about pregnancy, very few (5.3%) discuss abortion and its complications, while 84.2% of the same parents/guardians discuss HIV/AIDS. Very few discuss with their children about fertilization (10.5%), while 5.3% discuss birth control, with the same percentage (5.3%) discussing condom use.

For the twelve sexual health topics given, children were asked how much discussion they had on each topic with their Parents, Friends and Religious leaders; Friends dominated almost all topics except one where parents scored more, namely Sexually transmitted (venereal) disease, where parents scored 60% while peers scored 20%. When the researcher goes deeper in evaluating the findings on how the results will be, it seems that parents deal mostly with the outcome rather than prevention as far as the data are concerned. Sexual health education provides knowledge and information related to sexual health including normal male and female reproductive systems, healthy and safe sex, various contraceptive measures and sex-related diseases (Kwon & Im, 2021).

On the question given to children on how much discussion they had with their parents on the twelve sexual health topics, these are the results:- Parents scored more than half on Sexual transmitted diseases (60%) and discuss the knowledge of HIV/AIDS by 66%. Parents close their eyes on intercourse as here the score is 0%. Neither do parents discuss homosexuality with their children, where the score is 0%. Children say they were not told anything by their parents on abortion and its complication (the score is 0%). This means that parents do not bother educating their children on those three topics. Parents score below 25% on puberty, condom use, birth control, fertilisation and pregnancy by 20%, 24%, 8%, 4% and 24% respectively.

Children also have their perceptions of why their parents do not communicate with them about sexual health education. According to the interviews the researcher carried out to get some clarifications for some answers, children sometimes put themselves on the side of their parents and speak about their perceptions like,

Children will know automatically about sexual health and we cannot waste our time talking to them; We were curious like them but now we know that is why we have husbands/wives!; They are grown up; they know what is going on and about the dangers; they will be taught during wedding preparation.

Another point children discuss in this way was that parents are busy! “We are very busy in life; Talking to children is waste of time.” The point that they are very young is also discussed, “We cannot share these sensitive things with babies, they will not understand us; their capacity is very small; They will ask us many questions.”

The last thing adolescents shared with the researcher during the interviews was worry about intercourse,

Mmh, how can we start to tell our daughters/boys about sexual matters? Revealing this will be a welcoming note. When they remain untold they will be safer, because they do not know!; Discussing sexual related matters with children is like undressing ourselves and remaining naked before them, we cannot dare to do this!

The fact that friends take on a much bigger role in communicating with children about sexual health than any group is not only a family disaster but it should be counted seriously as a national calamity, something which is really bad and will cause a lot of future damage and suffering for children and the nation.

The failure of the talks between parents/guardians and their children on sexual health could have catastrophic consequences. The findings show that all delicate topics like intercourse, menstruation, pregnancy and condom use are dominated by neither parents/guardians nor religious leaders but friends by a large margin and this means it needs much discussion. The increasing of reproductive health related risks, makes the parent-adolescent reproductive health communication to be one of the potential sources of information for adolescents on the topic (Zakaria, Xu, Karim & Cheng, 2019).

Friends have courage, in that they discussed all 12 topics of sexual health, while Parents discussed 8 topics and Religious Leaders discussed 3 topics, achieving a very low score. Generally the scores show that friends had more discussion with children about sexual health than any group among the three: parents, religious leaders and friends as the table makes clear.

There is only one item/topic where we see parents scoring more than friends and that topic is sexual transmitted (venereal) diseases, by 60% to 20% respectively. The only two topics where friends score below half are homosexuality (score 22%) and sexual transmitted (venereal) diseases (score 20%).

There was no topic about which religious leaders scored more than a half and there was no discussion on sexual health between religious leaders and children on these topics; pregnancy, fertilisation, menstruation, sexually transmitted (venereal) disease, birth control, the issue on puberty, condom use, knowledge on HIV/AIDS, abortion and its complications. Indeed the research shows only 3 discussions taking place between religious leaders and children on intercourse, 14% on abortion and 8% on homosexuality.

It seems that religious leaders on whom many Tanzanians are dependent care only about spiritual matters but not about the physical (health) of their followers, especially children, the future believers who are expected to take up a position in religion too. It seems that religious leaders need some special training on sexual health matters.

Research done by Ott *et al.* (2011) shows that when seminaries participated in a survey of the sexuality education provided by religious professionals and clergy, the results of its phase one study pointed to an overwhelming need for improvement in the quality of sexuality education provided to seminarians and the overall sexual health in seminaries.

On the question of parents, it is a shame to read that parents escape the biggest responsibility which they themselves support, namely that their children should receive sexual health education from them in order to save children from the negative effect caused by not receiving sexual health education.

The study shows that parents do not discuss anything with their children about intercourse (0%), abortion (0%), abortion and its complication (0%) problems which deeply affect the young children of the nation in their everyday life and can destroy them because of lack of such knowledge.

Despite knowing about the fast approaching problem of homosexuality, parents have no concern about opening their children's young minds on the issue as if it is not their responsibility. The score on the topic was 0%, meaning that there was no discussion between parents and their children on homosexuality.

There were not only four topics which parents do not take seriously in educating their children whereby the score gives below half, there are other six topics where their scores did not do well, starting from the least these are:- fertilization (4%), birth control (8%), issues about puberty (20%) and condom use (24%) which coincides with pregnancy (24%) and menstruation (28%).

A friend to educate their fellow young child for sure is not a reliable source. As far as we know no adolescent has either an experience of sexual health or has been well educated on the matter due to the actual fact of the age and the period of pressure that they pass through. Yet still peers are left with the very serious responsibility of sexual health education as the research discovered.

For young children being educated by their fellows on condom use, the score reads 100%. Discussing condom use means they discuss intercourse and that is why the percentage somehow resembles that for the very sensitive topic of intercourse for which the score was 98%. When you discuss

about condoms and intercourse you cannot end there as one of the children's worries is pregnancy and how can one have safe sex naturally. The research showed that young children are educated by their friends about pregnancy and menstruation, both topics scoring 96%.

The fourth weightiest item of communication between friends and children was puberty with a score of 94%. Parents and guardians do not know what friends say to their children about this stage of physical development where a child changes to an adult with the ability to have children.

Eight six percent (86%) is the score for the topic of abortion and its complications. When the researcher asked one girl about that topic she said,

Our discussion is, if you get an unplanned pregnancy you have to find a professional doctor for the abortion otherwise the death is on your hand. No one accepts pregnancy and we are scared of our parents. We do share that many people died for this action.

Parents/guardians discussion with their children on sexual transmitted (venereal) diseases and homosexuality scored 20% and 22% respectively; these two topics are some of the negative outcomes of not knowing about sexual health early.

Table 8. Why not Discussing Sexual Health – Children's Views

Reason from Children	Number	Percentage
Cultural restrictions	30	60
Worry on intercourse	25	50
They are shy	19	38
We are very young	18	36
Respect will be lowered	10	20
We don't know why	10	20
Parents are busy	10	20
Children know automatically	5	10

Source: Study area

Children bitterly recognise that their parents do not discuss with them because of cultural restrictions (60%). This item scores highest among the eight reasons children gave.

The following are the major four reasons from children as to why their parents do not discuss with them about sexual health. The leading reason of all is cultural values and restrictiveness which scored 60%, followed by the fear that children will start sexual intercourse (50%), while the third reason given by adolescents is shyness of their parents (38%) and the fourth is that children are still very young (36%).

The minority argue, 'children know automatically sexual health' which scored the lowest at 10%. The above results are not helpful to this upcoming generation!

Participants' Voices

The UNICEF report reads that adolescence marks a period of major biological and psychological changes that can make adolescents more vulnerable to the risk of HIV infection (UNICEF, 2020). The report furthermore reads adolescent HIV rates, although declining, remain high, while adolescent childbearing also remains persistently high.

Ten adolescents (five girls and five boys) were included in the focus group discussion. Only one adolescent out of ten (10%) discussed with parents on how to know when you are ready to have sexual intercourse and another one (10%) discussed with their parents how to talk with their lover about sexual issues such as pregnancy, birth control and STIs.

Seven out of ten respondents (70%) confirmed that they have lovers, leaving three respondents (30%) who do not. Three of them (43%) out of seven indicated that they discussed with their lovers about sexual issues such as pregnancy, birth control and STIs while four out of seven (57%) did not. Sexual health requires an approach which should be positive and respectful to sexuality and sexual relationships (WHO, 2025). Sexual health should be viewed as the possibility of having pleasurable and safe sexual involvements, free of compulsion, discrimination and violence.

Nine out of ten (90%) said they cannot start communication with their parents about sexual health matters simply because their parents are not approachable. Only one (10%) said that they can communicate. Out of nine who cannot approach their parents for sexual health discussion two reasons were given, six (67%) of them said that they cannot dare because they fear that their parents will accuse them of already being sexually active, and eight (89%) of them said that they did not know how to bring up the subject with their parents.

All adolescents (100%) said that other people (beside parents, close relatives and the aged people) are very helpful in providing education on sexual health issues although they admit that this group is not dependable. They reported that the topics of sexual health are very interesting and every adolescent is curious to know something about them, that they are almost everyday topics of discussion, are discussed in schools among the students, and everywhere where adolescents gather for a long time.

Negative consequences of Sexual health-related issues are infections with human immunodeficiency virus (HIV), sexually transmitted infections (STIs), reproductive tract infections (RTIs) and their opposing outcomes such as cancer and infertility; unintentional pregnancy and abortion; sexual dysfunction; sexual violence and harmful practices such as female genital mutilation, FGM (WHO, 2025).

If the opportunity is given, all five female adolescents (100%) prefer to discuss sexual health topics with their mothers rather than their fathers. The reasons given for this are culture taboo, fear, and that some of their male parents/guardians are very strict whereas their mothers are welcoming. Menstruation, sexual transmitted diseases and condom use were popular topics that all female adolescents prefer to discuss with their mothers, sexual abstinence with fathers, and sexual intercourse with their friends.

Three male adolescents out of five (60%) preferred to discuss sexual health topics with their fathers rather than their mothers, the reasons given being culture taboo and that they feel shy to discuss sexually related topics with their mothers. The remain two male adolescents (40%) said that they did not need their parents to discuss sexual health issues with them, to them was like an abuse, and they would find out themselves from the different sources available.

In comparison, adolescents prefer to discuss sexual intercourse with their friends rather than with their parents, the main reason given being respect for their parents, the respect which is part of the cultural taboo, and embarrassment.

The young people complained that they cannot establish anything on sexual health because they are treated as children and not as mature individuals. “We are not listened to, so how can we share these important adult topics while we are counted as small kids before our parents?; We do not have a conducive environment to allow us be free before our parents, most of the time we are lectured to, warned, and instructed in everything, especially when they see a mistake is made. Sexual and

reproductive health is a key constituent for adolescents and young adults with congenital heart disease CHD who require medical investigation (Kwon & Im, 2021). Sexual health is a significant characteristic of one's quality of life. Despite its widely recognized importance, education to promote sexual health remains a sensitive and, occasionally, controversial issue.

Comparison in Sexual Health Education Received between Parents and Their Children

UNICEF (2020) encourages the engagement of adolescents through participatory communication and new technologies by supporting initiatives like U-report which provides real-time messaging on sexual reproductive health and HIV services to adolescents and young people.

Offering Sexual Health Education

Sibling scored the last but one (4.4%) among the eight different groups which offered adolescents sexual health education and the results agreed with that of the parents' side where the sibling score was the last but one (8.4%) among the six mentioned groups. Baron (2009) argues that, among the elementary school children, those who have no siblings are found to be less liked by their classmates and to be more aggressive or to be more victimised by aggressors than those with siblings, presumably because having brothers or sisters proved a useful interpretational learning experience. He (*ibid*) shows that sibling relationships, unlike those between parent and child, often combine feelings of affection, hostility and rivalry.

Rites score the last (2.2%) among the eight mentioned in the group and on parents' side, those offered education through rites scored highest at 34.7% among the six groups offering sexual health education. This gives a picture that there is a big gap between parents and their children on this issue and more attention therefore needs to be given to those adolescents of the contemporary world.

Discussions on Sexual Health

The research gave the following results: on why parents do not discuss with their children about sexual health education, the leading reason is cultural taboo which score 35% among the 4 reasons given by parents/guardians respondents; the same results on the children's side which show culture restrictiveness (taboo) is leading by scoring 60% among the 8 reasons given by children respondents. Through these results it shows that culture is still a very big hindrance to education delivery from parents/guardians to their children.

Worries about sexual activity scored second after culture on the side of parents/guardians respondents and the same results were obtained on their children respondents' side. Children know how their parents consider them and that is why they both produce interesting results. But is it true that educating adolescents about sexual health will make them become sexual offenders? Parents/guardians contradicted themselves on this issue. When measuring the parents/guardians attitude on sexual health the result show that the majority of parents/guardians respondents say that children should not be protected from hearing about sex (score 86%); while the majority of parents/guardian respondents (76%) say that there is usually nothing wrong with a child who asks a lot of questions about sex. Newcomer *et al.* (1985) argue that many analysts appear confident that adolescents who talk with their parents about sexually related issues will be "more responsible" in their sexual behaviour – meaning that they will be either less likely to engage in sexual relations or more likely to use contraceptives effectively.

The studies done by the Medical Society of North America (2011) show that some parents worry that having such open conversations will encourage their children to have sex at an early age - or have more of it. Studies show, however, that is not usually the case. Teens who feel they can talk to their parents about sex are more likely to make responsible decisions about sex.

Fogarly *et al.* (2009) comment that adolescents want to be treated as adults, but may feel talked down to when discussing sex with parents or other adults and that teens may not talk about sex with their parents because they see parents as close-minded, uncompassionate or not clued in to the problems that today's teens face. While the score for children being regarded as too young to be educated about sexual health was the third, behind sexually active, on the parents/guardians respondents' side, the score agreed with the that of children respondents' side which also showed third.

Santrock (2006) mentions Behavioural and Social Cognitive Theory of Motivation Approaches introducing a concept of self-efficacy by Albert Bandura. Self efficacy has much in common with mastery motivation and intrinsic motivation. Self efficacy is the belief that "I can"; helplessness is the belief that "I cannot." Because of this, therefore, if adolescents are encouraged, due to the fact that they are at high risk as shown in the results of this work, then the adolescents with high self efficacy may agree with such statements as "I will be able to learn about sexual health" and "I will be on the safe side after knowing each and everything about sexual health knowledge."

Parents/guardians recommended that parents must be the leading people to educate their children about sexual health and the score was 61.1%, the highest among the six proposed groups. This result was the same rank on the children's side but the difference was in the percentage score where children recommend by 44% that parents should be the leading group in educating them on the matter among the seven groups proposed.

Conclusions and Recommendations

Conclusions

This section draws major conclusions with respect to the main findings.

Almost all parents know something about sexual health although to most of them it is not professionally, but can be enough for their children; however the vulnerable group, i.e. children, do not have this knowledge and that is why the introduction of this work and its literature review reveal many effects on them such as: they become sexually active, unprotected sex exposes them to the risk of unintended pregnancy, unwanted childbearing and abortion; they are in danger of contracting sexually transmitted diseases and they experience teenage pregnancy which is one of the major reasons for school dropout among girls. The study revealed that many parents recognise and know their importance in the role of communicating with their children about sexual health and still it is their recommendation that parents are responsible for giving sexual health education to their children.

There are some factors which can be avoided because they act as barriers for some parents, while other parents take advantage of these hindrance factors to escape from one of their basic roles of informing their adolescent children about sexually related matters; this escapism therefore produces the results that only a few parents discuss sexual health with their children and for many parents there is no interaction at all.

They are also not sure of the time when they should start communication and they think (due to what they have inherited) that it is not their responsibility to educate their children about sexually related matters. After pointing out the barriers, on the other side they give the answer when answering the question, 'who is supposed to give the sexual health knowledge to their children', they say, parents (meaning themselves) as their first choice.

The children also follow the same steps as their parents. They accept that their parents do not normally discuss sexual health issues with them just like their parents say citing cultural restrictiveness as the reason. When the majority of parents say that parents are supposed to educate their children rather

than grandparents, uncles/aunts, elderly respected people, initiation rites, teachers and other health professionals, their children also agree, saying that parents are supposed to educate them about sexual health rather than grandparents, uncles/aunts, elderly respected people, friends, teachers and health professionals. Parents are the most important ingredients in the upbringing of their children, as they are the individuals who have the earliest influence.

The importance of sexual health education for young people is very high in preparing them to be sexually responsible and reducing the potential outcomes from risky sexual behaviour at this time due to the disappearance of traditional institutions like initiation rites and because of globalisation, where different cultures meet and change the original. In addition, modernisation including such factors as urban migration, schooling, less extended families where grandparents and other members are less available to provide sex education to adolescents, effectively erode the system and therefore create a very big gap between adults and adolescents.

The main problem is cultural taboo and this plays a greater role than others in restricting communication between parents and their children, indicating that the issue is taboo in the Tanzanian context and that most parents therefore are neither discussing nor interacting with their children on sexual health issues.

Most parents say that, culturally grandparents, uncles/aunts and elderly respected people or through initiation rites are the proper ways to educate their children about sexual health matters. Other reasons behind culture is the fear that their children of the given age (10 – 19 years) are still very young and because of being young they fear others this adds another reason that their children can be easily trapped and become sexually active.

This work revealed some barriers hindering sexual health communication between parents and their children; parents, it seems are willing to communicate if the barriers are removed. When asked why parents do not discuss with their children about sexual health, a majority of parents mention culture, their fear on causing their children to become sexually active and the need to maintain respect from their children.

Recommendations

This section provides recommendations for action and further research.

i. It would be very wrong to generalize the findings of this study for the whole of Tanzania, although the difference might not be very big if another study is conducted, but even that small difference would be important. Therefore this study can just be a bridge for future studies which could work towards exploring the relationships between perceived parent-child communications on sexual health issues.

ii. The relevant authorities should prepare a national policy on sexual health education insisting that parents provide such knowledge from early adolescence through communication between them and their children. In order to succeed, some techniques should be applied in public health centres and schools by making information available. The Government can use her agencies in the campaign through the media by use of advertisements. Suitable written and video materials, brochures for community centres such as libraries can be disseminated. Billboards and banners could be prepared and given prominence during the inauguration of the campaign.

iii. Kind of collaboration should be created between; researchers and programme developers, parents and government officials (as stakeholders), students as the target groups and recipients as well as teachers as deliverers.

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