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LINKAGE BETWEEN SEXUAL REPRODUCTIVE HEALTH EDUCATION AND CONTRACEPTIVE USE AMONG HIGH SCHOOL STUDENTS IN TANZANIA

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Abstract
It is commonly renowned that knowledge on sexual reproductive health should result into a sexual behaviour that inhibits unwanted pregnancy and STDs. The objective of this study was to explore the high school student's contraceptive use in relation to their understanding on sexual reproductive health. Primary data were collected from 20 high school students (10 male and 10 female) aged 17-23. Interview and focus group discussion were used to supplement the information that was collected from survey/questionnaire. Purposive sampling was used to obtain 20 students as sample size from the population of 240 high school students. Responses/data from questionnaires were summarized and analysed by using computer software (Statistical Package for Social Science SPPS V 20). Responses from the open ended questions were analysed using content analysis where emerging themes werepulled out and categorized accordingly. The results show, regardless of high school students'familiarity and being knowledgeable about contraceptive, high awareness on contraceptive do not translate automatically to use.This is because youth contraceptive utilization is determined by other factors beyond knowledge. This study found that fear of side effect due to insufficient sexual education and knowledge on contraceptives, parental disapproval, and religious disapproval directly led to low contraceptive use among high school students.

Keywords: contraceptives, reproductive health, family planning, Tanzania

Introduction
In Tanzania, the incidences of unplanned pregnancies particularly among the youth have been found to increase health and social problems. Lack of awareness, inadequate accessibility to health services, legal obstacles and negative perception of health providers may inhibit young people from adequate utilization of contraceptives. Apart from individual health benefits, access and utilization of contraceptives among young people may lead to achieving development goals (TDHS-MIS 2015-2016)

According to Tanzania Demographic Health Survey, "unmet need for family planning" use for young people who are married is 23% while 33% is for unmarried. The outcome of huge unmet need of contraceptives is unplanned pregnancies. Addition to that, 24% of pregnancies among married young female ages below 25 are unplanned. Entire demand for family planning is 49% for married young female and 82% for unmarried young female. The reduction of unplanned pregnancy by using contraceptive may help to decrease the

HIV transmission and maternal and infant deaths (TDHS 2010). As pointed out by WHO (2020), there are many direct and indirect societal benefits of utilization of contraceptives among women including theavoidance infant and maternal deaths.

According to UNFPA (2022), in less developed countries, 20,000 girls before age 18 become mothers every day. Early pregnancy leads to rapid change of girl's life. Being pregnant at such an early age may result in elevated school dropout rates for these girls, hindering their future academic and career growth (UNFPA 2022). When they dropout from the school this hinder their chances to get good job in the long run.Additionally, when girls become pregnant at a younger age they are likely to abort the pregnancy. Abortion, for any reason, is an illegal act by the laws governing the mainland Tanzania (Centre for Reproductive Right 2012).

About 63% of population in Tanzania is aged below 24 years and less than 20% are youth (NBS 2012). The implication of having a youthful population includes high fertility rate which is primarily related to youth engagement in sexual activities. According to WHO (2013) it was pointed out that 128 of every live birth are adolescents aged 15-19. It is quite high compared with other Eastern African countries such as Rwanda (41), Burundi (65), and Kenya (106) per 1,000 adolescent girls, in the same year. Highest fertility rate among these teens may result in high maternal and child mortality rate. Apart from that, the rate of HIV prevalence in Tanzania is still high. The percentage of HIV among youth (15-24 years) is 1.7% for male and 3.9% for girls. The percentage of youth (15-24 years) having full understanding on HIV is 43% for males and 48% for females (UNICEF 2012:103). The result of low HIV/AIDS awareness is multiple sexual partnerships practice: "Practice of Multiple sexual partnerships was reported by 45% of women and 14% of men aged 15-24 years in 2012" (Tanzania Narrative Report 2014:18).

A study done by Kaale and Muhanga (2017) reveal that while 86.5% of secondary school students in Morogoro area, Tanzania, were knowledgeable on contraceptive use, only 16.1% of students reported to have ever used birth control method. A related research by Ayubu, Mwasha and Kabeya (2017) among students in secondary education in Dar es Salaam, Tanzania revealed that 93.33% of the respondents had heard about family planning methods but less than 9% had used family planning in their life. Kagashe and Honest (2013), found that "majority (97%) of the girls knew at least one contraception method but only (40%) used any of the methods". In Tanzania a number of researches on contraception in females of childbearing years have been well documented (Mosha, Ruben and Kakoko 2013; Kidayi *et al* 2015, Nkata, Teixeura and Barros 2019). Moreover, a number of studies on knowledge of contraception among secondary school students have been carried out (Kagashe and Honest 2013;Kaale and Muhanga 2017;)Ayubu, Mwasha and Kabeya 2017)but little is known with regard to the real cause of low contraceptive utilization in the studied population. The aforementioned studies reveal that students are at risk of contracting sexually transmitted diseases and unplanned pregnancies (for girls) and this may lead to illegal termination or school dropout. Therefore, this study examines why

there is low contraceptive use among youth regardless of being knowledgeable about sexual reproductive health.

Methodology

The study was done at Dareda High School, Babati District, Manyara Region, Tanzania. Dareda is about 30 km West of Babati Urban. The cross section survey was used to collect data from Form V and VI students. Interview and Focus group discussion were used to supplement the information that was collected from survey/questionnaire. The primary data were obtained through questionnaires with both open-ended and close-ended questions. Open ended questions allow respondent to give their opinion freely and they provide a thorough set of information. Open ended questions were designed to answer the why and how questions which were not further clarified by the closed-ended questions in a questionnaire. Among the open ended question which were asked in this study include "why it was not easy for the youngsters to discuss contraceptive issues at family level?" and "how is your school offer sexual reproductive health education?" Closed ended questions were design to answer what and how much questions to determine the extent of understanding about the use of contraceptives. Since sexual and reproductive health and contraceptive use is a sensitive topic, in most places in Tanzania, 20 respondents were selected. Purposive sampling was used to select Dareda secondary school since was pre-urban and of co-education (both girls and boys in attendance). In the school, students were randomly selected to obtain 20 students (10 male respondents and 10 female respondents) as sample size from the population of 240 Advanced level students. Moreover, purposive sampling was employed because the study was designed to gain in-depth knowledge about causes of low contraceptive use among students. Through purposive sampling respondents rich in information were easily selected to share the information needed by the researcher. Also through this method of sampling, the research was able to save time and money. Responses/data from questionnaires were summarized andanalyzed by using a computer. Computer programs namely Statistical Packages for Social Sciences (SPSS version 20) and Excel were basically used in the analysis process. The information from focused group discussion was analysed by using content/thematic analysis where by the major themes and sub-themes were put together. The major themes were side effects of contraceptive and wrong perception about contraceptive use. In addition to the major themes, the sub-themes were contraceptive use linked with prostitute, contraceptive use linked with sin against God and culture of silence about contraceptive.

Ethical Considerations

Approval of ethical issues was provided by District Education Officer (DEO) and the school management provided permission to conduct a study to students. The respondent who participated in the study were provided a written informed consent and were assured that the information they have given would be confidential. Also the questionnaire didn't bare the name of the respondent.

Results and Discussion

Social-demographic profile of respondents

Social-demographic profile includes Sex, Age, Residence, Religion, Education level, Parents education level and Family income.Table 1 shows social-demographic profile of high school student who participated in the survey. A total of 20 students from Dareda High School were selected which include 10 boys and 10 girls. Most of study respondents were aged 18 to 19 years (65%) while 25% of students were aged 20 to 23 years. For the majority of this study's respondents, their place of origin were situated in rural/village areas (55%) while 45% were located in urban areas. In addition, majority of participants were Christians (85%) while 15% were Muslims. Furthermore, 55% of respondents were Form V students and 45% from Form VI students.

Table 1. Socio-demographic profile of respondents

Attributes	Number of respondents	Percent(%)
Age in years		
Below 18	2	10
18-19	13	65
20-23	5	25
Residence		
Rural/Village	11	55
Urban/Town	9	45
Religion		
Christians	17	85
Muslims	3	15
Form		
Form 5	11	85
Form 6	9	15

Respondent's education level attained by their parents

Table 2 indicates that majority of male parents meaning fathers (45%) have tertiary education followed by 40% that have primary education. 40% of female parents meaning mothers have secondary and primary education likewise. This shows that male parents (fathers) were more educated than female parents (mothers). This is because women/girls have more obstacles to continue with school compared to men/male.

Table 2. Education level attained by parents

Parents Education Level	Father	Mother
None	1(5%)	2(10%)
Primary Education	8(40%)	8(40%)
Secondary Education	2(10%)	8(40%)
Tertiary Education	9(45%)	2(10%)

Respondent's awareness about sex/sexual and reproductivehealth and contraceptives
Sexual reproductive health education

Table 3 shows the respondent's awareness about sexual reproductive health. Participants were asked "have you ever heard about sex/sexual reproductive health?" whereby majority 95% responded yes, they had ever heard about sex/sexual reproductive health. Then the respondents were asked "through which media?" and the research findings have revealed that sex and sexual reproductive health awareness creation was done through school media by 90%, followed by friends (70%) and mass media (70%). Other media for awareness creation about sex/sexual reproductive health include parents (60%), hospital (55%) and religious institutions (30%). In addition to that, one out of five students was involved in sexual activity.

Table 3. Source of information for Sex/Sexual Reproductive Health

Attribute	Number of Respondents	Percent(%)
Ever heard about sex/SRH		
Yes	19	95
No	1	5
Media for Awareness creation about SEX/SRH		
School	18	90
Friends	14	70
Mass Media	14	70
Parents/Guardian	12	60
Hospital	11	55
Religious Institution	6	30
Others	2	10

Awareness on contraceptives

Table 4 shows the respondent's awareness about contraceptives. Participants were asked this question: "have you ever heard about contraceptives?" All twenty respondents responded yes they to affirm they had heard about at least one contraceptives method before. Additional questioning the meaning of the term "contraceptive", majority of respondents seems to be familiar with the concept of contraceptives and they defined contraceptives as methods used to prevent unplanned pregnancy, sexual transmitted infection's and or for family planning purpose. When they were asked through which media the research findingsrevealed that contraceptive awareness creation was done mostly through school media by (85%) followed by mass media (70%) and friends (50%). Other media for awareness creation about contraceptives include hospital (45%), parents (45%), and religious institutions (15%). Among sexually active students, only two use contraceptives. These findings reveal that moststudents obtain contraceptive information from school, media and friends. Unluckily, theinformation from school and friends is often insufficient and sometime inaccurate.

Table 4. Media used for contraceptive awareness creation

Attribute	Number of Respondents	Percent(%)
Ever heard about contraceptive		
Yes	20	100
No	0	0
Media of awareness creation about contraceptive		
School	17	85
Mass Media	14	70
Friends	10	50
Hospital	9	45
Parent/Guardian	7	35
Religious Institutions	3	15
Others	2	10

Table 4 shows parent/guardian and religious institutions to be the last source of information for contraceptive awareness among high school students. In the author's experience with the cultural norms in Tanzania children are not allowed to discussissues related to sex and sexuality because these tendencies are viewed as being disrespectful. Those who talk about sex and contraceptives are regarded to misbehave and that is seen as moral erosion in our society in particular and country at large. In further probing the respondents were asked if it is easy to ask/talk to parents about contraceptive use. The findings show that to half of respondents it was not easy for them to talk/ask their parents/guardians about contraceptives. Among this proportion, 70% were male and 30% female who were not flexible enough to ask/talk to their parents/guardians about contraceptives. These are few reasons claimed by respondents why it was not easy for them to discuss contraceptive issues at family level:

One male student aged 18 commented *"According to our traditions children are not allowedto discuss issues related to sex and sexuality. Those who talk about sex and contraceptives are regarded to misbehave and that is seen as moral erosion in our society in particular and country at large"*
This reveals that social and cultural norm act as a barrier for parents to be a source of information for contraceptive awareness creation to adolescents. Most of adolescent receive information about contraceptive form other media like school which provide insufficient and inaccurate information.

One female student aged 19 said: *"There is no direct conversation on sexual related issuesbetween me and my parents. All I know about sexual reproductive health and contraceptives is through school".* Adolescents do not discuss contraceptive with their parents becauseparents believe sex is for married couples only in which one respondent was against it.

A male student aged 20 said: *"They do not allow me to have sex/have a partner because theybelieve that it is only married couples who are allowed to engage in sexual practices a belief that I am personally against".*

Furthermore, adolescents do not discuss contraceptive with their parents because parents are busy one student claimed.

A female student aged 19 claimed: "*My guardians are so busy so it is not easy for me to talkto them about contraceptives. I also never heard of them speaking about use of contraceptives so I do not know whether they use them or not and it is very difficult for me to ask them about that"*.

Then students were asked if it is easy to ask/talk to religious leaders about contraceptive. The findings show that to more than half of respondents it was not easy for them to talk/ask their religious leader about contraceptives. Amon this proportion, 80% were male and 20% female who were not flexible enough to ask/talk to their religious leader about contraceptives. These are few reasons claimed by respondents why it is not easy to discuss contraceptive issues at religious institutions. First they are not allowed to involve in sexual activities so it is not easy to ask contraceptive because it is assumedby the religious leaders that regardless of their sexual active age, they are not involved in practices related to sexual immorality.

One male respondent aged 19 claimed that "*I am not allowed to get involved in sexualactivities. Those who are allowed to ask religious leaders about contraceptives include married couples and those who are engaged/ courted waiting to get married soon".*
Second reason is to avoid being condemned as a sinner like one respondent commented
"Religious leaders oppose the use of contraceptives so if I tend to ask about contraceptives I may be condemned as a sinner".

Not only unmarried couple who are not allowed to have sex, but also married couples are not allowed to use contraceptive due to religious beliefs or doctrines. As one student commented, *"Religious laws and doctrines do not allow unmarried partners to involve in sex and those who are married are not allowed to use family planning methods since God created human beings so that they reproduce and fill the world. Religious teachings want us to control ourselves and not engage in sexual activity using contraceptives while we are not married".*

Reasons for not using contraceptives

Majority (50%) do not use contraceptives because of fear of side effects. 45% of respondents do not use contraceptive due to parent disapproval, followed by religious disapproval 35% and lack of knowledge where to obtain the contraceptives 17%. Table 7 shows the summary of all reasons of not using contraceptives.

Table 7. Reason for Not Using Contraceptives

Reason of not using contraceptives	Number of Respondents	Percent (%)
Fear of side effects	10	50
Parent disapproval	9	45
Religious disapproval	7	35
Partner disapproval	3	15
Lack of information on how to use it	3	15
Ashamed to buy	2	10
Others	4	20

Further probing on the reasons for low contraceptive use among high school students the respondents commented as follows: Majority do not use contraceptive due to unreal fears of side effect e.g. contacting a cancer, weight gain and failure to menstruate regularly each month.

A 22-year old girl claimed, "*Side effects realized from some who happened to usecontraceptives have discouraged me from using them. I know a person who died of cancer resulted from use of contraceptives"*

Another girl 18-year old, *"Contraceptives have side effects like disturbing the normal MP circle hence it is better to opt for natural methods like calendar method/MP".*

Moreover, some students do not use contraceptive due to lack of parental and religious approval.

A female respondent (19) claimed "*Parents might consider me as a prostitute because theyalways think that anyone who uses contraceptives is a prostitute. I also have never heard even one of my brothers or sisters talking about them so it is difficult for me to ask/or talk about contraceptives*".

Another participant, an 18-year boy claimed, *"Some religious leaders believe that birthcontrol is the responsibility of God himself hence no man should interfere the will of God in relation to birth giving and life perpetuation".*

In addition to the general reasons for low contraceptive use among high school students, the respondents revealed that there is low utilization of contraceptive because it is strictly prohibited for student to carry contraceptives within the school premises or to be involved in any sexual activities. The school does not allow contraceptive to avoid sexual activities in school environments, because there is a general belief that if students are allowed to carry contraceptives; this would be an indirect permission of promiscuous behaviour. They want their students to concentrate with their studies only. They assume that allowing student to have contraceptives will motivate other students who are abstained from sexual activities to start getting involved in sexual activities.

Conclusion and Policy Recommendations

Most of respondents were aware and knowledgeable about sexual and reproductive health including contraceptives. But being knowledgeable alone does not lead to high contraceptive use. The reasons which hinder or lead to low contraceptive use among high school students were first, fear of side effects; second, parent disapproval; and third, religious disapproval.

Fear on side effects was most cited reason for low contraceptive use among high school students. This could be due to myth and misconception that reveals lack of genuine information on the different birth control methods. This study reveals that school, friends and media were the sources of information for sexual and contraceptive use. Regardless of introduction of sexual education in Tanzanian schools, the sexual and reproductive health education and contraceptive information seem to be insufficient and inaccurate. The schools offer sex education in terms of obstructing for sexual behaviour. Emphasis is on the merits and demerits of involving in sexual activities and no emphasis isput on the use of contraceptives. In addition to that sex education offered is partial in terms of time and content since it is done for short time that is not sufficient enough for a student to understand the details. These mean no enough time to learn comprehensively about contraceptives, their use and associatedside effects.

Parent disapproval was the second reason for low contraceptive use among high school students. In this study parents are not immediate source of information forcontraceptive use to their teens. They are unlikely to discuss sex, pregnancy and contraceptive use due to social norms. Parents donot allow their teens to have sex or have a partner because they believe that it is only married couples who are allowed to engage in sexual practices. Due to this environment youth end up getting involved in sexual activities without enough knowledge on how to use contraceptives. Since they practice sexual activities secretly, it is not easy for them to buy contraceptives like condom for duel prevention of pregnancy, HIV and sexual transmission disease. In addition to that contraceptive information from parents insists on the side effects of using contraceptives.

Furthermore, religious disapproval was the third reason cited by students for low contraceptive use among high school students. Unmarried youth are not supposed to engage in sexual activities according to diverse religious beliefs. Youths are supposed to remain virgins. This situation makes youth not free to ask and understand sexual education and contraceptive use. Religious leaders should teach youth about sexual reproductive health and contraceptive use in relation to religious behaviour. These could be done through youth seminars. A number of youth seminars facilitated by religious leaders could allow youths to ask any questions concerning contraceptive and sexual reproductive health. Through seminars, religious leaders could give good advice and guidance to youths on the use of contraceptives and give good Godly advice such as abstaining themselves from sex and how to control their sexual desires before marriage. In addition to that, if youths receive accurate information on sexual and contraceptive use; they will make good

decisions about their sex. This study shows that even if religious leaders have youth seminars, their teachings insist on sex avoidance and disallow contraceptives not only for youths butalso for married couples. Religious leaders have responsibility to offer spiritual and social education as well including family planning so as to reduce the incidence of sexual transmitted diseases, unwanted pregnancies and street children.

Therefore the paper recommends that high school students should be educated about sexuality and contraceptives use. Students should be given enough time and conducive environment to ask questions about the topic. Skilled teachers who are comfortable to teach sexual education in schools should be employed. If the skilled teachers are not available, the schools should invite skilled teachers from nearby schools. In addition to that, available teachers should be given opportunity to attend several refresher training courses on sexuality and contraceptive use so that they can be comfortable and competent enough to teach sexual education. Not only that but also the school should provide teaching materials to facilitate delivering of information to students since sexual education is sensitive issue. The limitation of this study includes lesser sample size in relation to both number of participants and secondary school covered.

Area for further study

Contribution of different stakeholder in changing mind set of the society towards usage of modern contraceptive among students.

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