

**PATTERNS OF SEXUAL PRACTICE,  
USE AND KNOWLEDGE OF CONTRACEPTIVE  
METHODS AMONG ADOLESCENTS IN  
LUSAKA URBAN**

**BY**

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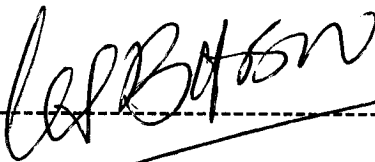
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## DECLARATION

No part of this work in this thesis has been submitted in support of another degree or qualification of this or any other university of institution of learning

SIGNED-----

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APPROVED BY-----

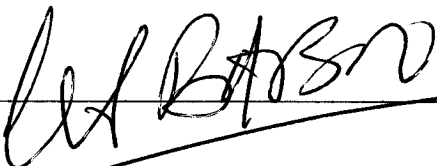
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## APPROVAL

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## **DEDICATION**

This study is with deepest gratitude and affection dedicated to my beloved husband, Clifford Banda for his patience and valuable support throughout my school life and to my beloved brother and sisters who stood with me in prayer and encouragement throughout the programme. I also dedicate this study to my beloved son Chimwemwe Banda who had to be without a mother most of the time while I was at School.

## ABSTRACT

The aim of the study was to determine patterns of sexual practice, use and knowledge of contraceptive methods among adolescents in Lusaka urban Zambia.

A cross sectional study was conducted in 10 secondary schools in Lusaka urban. Stratified sampling method was used to come up with a sample size of 300 randomly selected male and female adolescents. This sample size was calculated at a level of confidence of 95%. 30 respondents were selected from each school using the systematic random sampling method.

Data was collected using a structured questionnaire with both open and closed-ended questions.

The results of the study showed that the majority of the adolescents 69% engaged in sex as early as at the age of 12. This was common among females 44% than males 40% who did not only engage in sex for monetary gain but also for sexual

satisfaction. Contraceptive use was low among adolescents of 29%.

Adolescents found reproductive health information helpful though the study did not ~~on~~ report adequacy of this information.

Adolescents (98%) had knowledge of STI/HIV/AIDS information. Most adolescents (45%) felt comfortable to discuss issues of sexuality with peers. The majority of the adolescents (76%) did not have a youth friendly corner in the area and those who had were not satisfied with the services offered.

Adolescents throughout Lusaka engage in numerous behaviour that put their reproductive health at risk. The potential adverse consequences of sexual activity are well known - STI, AIDS, unwanted pregnancies and unsafe abortions, lack of information, limited access of family planning services, unplanned sporadic nature of sexual relations and lack of awareness of the likelihood of pregnancy, STI and HIV/AIDS are factors in lack of use. There is an urgent need for



expanding and improving reproductive health services. It is also important to implement interventions and strategies that would best meet the needs and have the greatest appeal to those for whom they are intended.

## ACKNOWLEDGEMENTS

I wish to express my gratitude to DANIDA through Central Board of Health for the sponsorship to enable me undertake the Masters degree in Public Health and for providing funds for the project.

I gratefully acknowledge the following:-

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## LIST OF ABBREVIATIONS

1. AIDS - Acquired Immuno - Deficiency Syndrome
2. HIV - Human Immuno Deficiency virus
3. MOH - Ministry of Health
4. NGO - Non-Governmental Organisation
5. STI - Sexually Transmitted Infection
6. UNDP - United Nations Development Programme
7. UNICEF - United Nations Children's Emergency Fund
8. WHO - World Health Organisation

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## **CHAPTER ONE**

### **1.0 INTRODUCTION**

#### **1.1 BACKGROUND INFORMATION**

The beginning of the process of adolescents comes with the morphological and physiological changes in puberty. The World Health Organisation committee on health problems defined the age range of adolescents as 10-19 years and estimated that in 1999, 23% of the population in developing countries and 15% in developed countries were adolescents.

In Zambia, child bearing and sex outside marriage is not culturally accepted. Adolescents throughout Zambia engage in numerous behaviour that put their reproductive health at risk. At the point of first sexual contact, adolescents often lack knowledge about sexuality and reproduction. According to Sambisa and Chibbamulilo (1998), parents attributed early sexual activity to sex videos and films, observing immoral behaviour among adults, lack of parental role models and guidance, peer pressure, alcohol and drug abuse. Young people reported that sex in exchange for money or other forms of payment was common.

Adolescents usually have little bargaining power in their sexual relationship and may be unable to protect themselves. The potential adverse consequences of sexual activity are well known: STIs, AIDS, unwanted pregnancy, the stigma of illegitimate children and unsafe abortion. Indeed first sex is often experimentation and those involved usually do not prepare for it by obtaining contraceptives even if they were to get them. Seats (2000) reported that Adolescents perceived condoms as inappropriate for steady relationships. According to a Participatory Learning and Action (PLA) workshop, one youth said that when you are in love with your girl friend for a long time, she becomes like your wife so you stop using a condom. They believe that pills cause infertility or birth defects.

Although information is scarce on contraceptive usage among adolescents, indicators are that fewer than half use contraceptives at first sexual intercourse relations and only 30% of unmarried adolescents in developing countries ever use contraceptives. Ministry of Health (1997) reported that in 1994, a group of non-governmental organisations in Lusaka realised

that existed primary health clinics were not meeting the needs of young people. One of the priorities identified in meetings that included young people and health staff was the need to increase the direct involvement of young people in the provision of services. As a result, peer counsellors were trained and then made available in the clinics. Involving young people as peer counsellors had the double effect of increasing attendance at the clinic. This is because services were more suitable to the needs of young people and creating strong links between the adults and young people in the community.

World Health Organisation (1994) stated that Lack of information, limited access of services, unplanned sporadic nature of sexual relations and lack of awareness of the likelihood of pregnancy are factors in lack of use. Lack of information is the most important factor in developing countries while emotional factors appear more important in developed countries.

The emergency of the Aids epidemic has increased the fear and conflict associated with issues of sexual behaviour. Health promotion



has an important role to play in these discussions. First by highlighting the value of healthy sexuality as a contributor to health and secondly by supporting the adoption of safe and sexual practices which reduce the spread of HIV/AIDS and other sexually transmitted infections. Knowledge about options safe sexual practice and contraception is essential for healthy sexuality which also requires individuals to have personal skills and characteristics such as self esteem to enable them to define their wishes clearly.

The adolescent population is an important human resource and needs special attention if it is to be sustained. In view of the serious problems affecting adolescent sexual and reproductive health, the researcher felt it necessary to conduct a research to determine the pattern of sexual practices among adolescents and their use and knowledge of contraceptive methods.

## **1.2 STATEMENT OF THE PROBLEM**

In most developing countries, the demographic pyramid is still broad at the base. This means that there is a large and growing population of adolescents. According to World

Health Organisation (1994), the population of young people ages 10-24 world wide is projected to reach 4509 million by the year 2075. Their reproductive and sexual health needs are urgent. The number of women ages 15-19 who experience pregnancy is expected to increase by nearly 25% from 1995 to 2020.

Adolescent sexuality is becoming an increasing concern in Zambia. The last decade has seen a changing pattern of sexuality among this population group. It has been found that urbanisation has been accompanied by a shift in the traditional values associated with sexuality, with the result that more young people are having sexual relations prior to marriage. According to CSO (1996), by the age of 18 years, 70% women have had sexual intercourse, and by the age of 20 years, 85% have had sexual intercourse with the median age of first sexual intercourse being 11. In case of men, 24% age 15-19 years have had sexual intercourse, while 90% of them have had sexual intercourse by age 22.

Although contraceptive awareness in Zambia is reported high (97%), contraceptive use is only 15.2% for all the methods among married women.

CSO (1996) that family planning services are less than adequate and currently meet only one third of the potential demand for family planning. In view of the above inadequate health care services, it is most likely that teenage girl has no access to family planning services as well as being well informed.

Adolescents engaging in sex because of their low use of contraceptive are at high risk of contracting STI/HIV infection. WHO (1994) estimated that about one in 20 adolescents world-wide contract an STI yearly. Furthermore, the presence of certain STIs especially those with ulcerative lesions has been identified as a risk factor for HIV.

Economic factors are mainly due to the need for financial assistance. A lot of girls unfortunately find themselves with unwanted pregnancies. The introduction of privatisation of companies has led to massive retrenchments of a significant number of parents. SAFAIDS (1999) states that a lot of children have turned to the oldest known profession, "prostitution" as a means of raising funds for their well being. With this scenario, adolescents have been made vulnerable to

unintended pregnancy, STD, including HIV/AIDS and unsafe abortion all in search of monetary gain. Today there has been a breakdown in cultural values and family ties have decayed. The values of adolescents express often differ from their behaviour. Their 'ideal' sexual code places emphasis on waiting until marriage to have sex on the practical dangers of being pregnant. These values however must be stretched because of the pressures of everyday life.

Due to the tremendous number of youths just reaching reproductive age, the growing number of adolescents having births will have serious complications for Africa's future. UNICEF (1997) reported that large number of adolescents' pregnancies will contribute to the regions rapid population growth, limit young women's education opportunities and expose risks associated with illegal abortion and too early child bearing teen.

Young people need realistic, accurate and appropriate reproductive and sexual health information to prepare them for healthy adult relationships. Most adolescents today learn about sex from their peers or the media and

this information is often inaccurate or incomplete.

The media bombard them with messages glorifying unsafe sex behaviour. Parents frequently are unwilling or unable to engage in open and direct discussion of sexuality, even though many young people say that they would most like to learn about sexuality from their parents. Understanding and meeting the information and contraceptive needs of adolescents is a growing area of challenge for scientists and policy makers.

Those who indulge in sexual act at an early stage are often the premature and ignorant. Most of the time such indulgence is found to be demonstration of adulthood to them. In modern time it will be very challenging to find out how an adolescent behaves and what practice it adopts and follows.

The study was undertaken to determine the pattern of sexual practice among adolescents, their use and knowledge of contraceptive methods in Lusaka.

## **JUSTIFICATION FOR THE STUDY**

The high figure of adolescents who indulge in early sexual activities which result into early-unwanted pregnancy, abortion, STI and HIV/AIDS prompted the researcher to carry out a study like this one.

The large population of youth in Zambia with 46% under 5 years presents a major national human resources necessary for national development. Thus, a study to determine patterns of sexual practice, use and knowledge of contraceptive methods among adolescents was a relevant study.

The major undertaking was to finalise the formation of a thesis as a fulfilment requirement of the programme. However the outcome of the study was to provide vital information regarding behaviour practices of adolescents in Zambia which may be the missing link in preventing unwanted pregnancies and STD/HIV at an early stage. Not much work had been done in this respect. Therefore it was felt to be very interesting to carry out a study which focused on the earliest behaviour patterns of an adolescent towards sexuality and contraceptive methods.

**PERCENTAGE OF ADOLESCENTS AGE 15-19 WHO ARE CURRENTLY USING SPECIFIC FAMILY PLANNING METHOD IN ZAMBIA ZDHS 1996**

	<b>METHOD</b>	<b>ALL ADOLESCENTS</b>	<b>MARRIED ADOLESCENTS</b>
1.	Any method	7.4	16.9
2.	Any modern method	4.7	8.8
3.	Pill	1.1	2.8
4.	IUCD	0.0	0.0
5.	Injectables	0.1	0.3
6.	Diaphragm/foam/jelly	0.1	0.0
7.	Condoms	3.5	5.7
8.	Female Sterilisation	0.0	0.0
9.	Male Sterilisation	0.0	0.0
10.	Any Traditional method	2.7	8.1
11.	Natural Family Planning	0.3	0.0
12.	Withdrawal	1.0	4.0
13.	Others	1.4	4.1
14.	Not currently using	92.6	83.1
	<b>TOTAL</b>	<b>100</b>	<b>100</b>
	<b>Number of women</b>	<b>2,003</b>	<b>498</b>

### **1.3 LITERATURE REVIEW**

#### **1.3.1 INTRODUCTION**

Teenage pregnancy and childbirth were associated with early biological maturity, early sexual activity in the absence of adequate and correct knowledge of their reproductive biology as well as lack of contraceptive information.

The main issues that emerged from the literature reviewed included basically these related broad categories:-Adolescents sexual practice, consequences of unwanted pregnancy, Adolescents and Reproductive Health problems, Adolescents and Contraception, Attitude of family planning case

providers and Adolescents utilisation of health services.

### **ADOLESCENTS SEXUAL PRACTICE**

During Adolescence between 10 to 19 years according to WHO (1996), a lot of developmental changes take place in the bodies and minds of teenagers. They seek to establish their own social identity and want to experiment in a lot of things, one of the things they want to experiment is in sex, especially with influence from peers.

This practice exposes adolescents to STI and HIV/AIDS. Other than sexually transmitted infection, they also become vulnerable to unintended pregnancies which are quite common even among 12 year old due to the reduction in the age at which girls attain their menarche. Furthermore, Henshaw (1990) states that Girls who are usually school going and unmarried try to get around this problem by consulting their peers on how to abort or on their own take desperate measures to abort.

SAFAIDS (1999) reported that Statistics were showing that Adolescents are not always making safe choices while adolescents may be forced to sell themselves for affection and emotional closeness. This too is a risky activity which threatens the spread of Aids. In addition most adolescents did not know what condoms were and how



to use them, and almost no access to health care facilities.

While adolescents may be found to sell themselves to adults they look to one another for affection and emotional closeness. This too is a risky activity which threatens the spread of AIDS. In addition, Kelly (2001) stated that most adolescents do not know what condoms are and how to use them. And they have almost no access to health care facilities.

Omy (1998) reported that in Uganda, Anglican Bishop strongly opposed to wholesale distribution of condoms which was feared encouraged sex. Information regarding how condom utilisation can reduce the risk of HIV transmission has also been withheld. These 2 factors places the adolescents at a high risk of contracting AIDS and unwanted pregnancies.

Sex behaviour has a bearing on the risk of unwanted pregnancy and of contracting an STI. It may also influence contraceptive choice. With STI/HIV and unwanted pregnancies on the rise around the world especially among adolescents, the study of sexual behaviour, particularly in developing countries has acquired certain urgency.

## **CONSEQUENCIES OF UNWANTED PREGNANCY**

Unplanned birth is likely to be emotionally distressing and it may place heavy financial burden on the parents of the adolescents.

UNICEF (1997), report done on early child bearing reported that in many communities, an unmarried adolescent who falls pregnant faces disapproval and rejection from family members or spouse. Low use of contraceptives may not necessarily pose serious health hazards. However, WHO (1994) reported that these factors do elevate the risks of abortion, maternal and child deaths which are major public health problems with far reaching consequences for women and their families. An estimated 75,600 deaths are due to unsafe abortions that occur each year in the world, and 33,000 are in Africa accounting for one third of the total deaths.

Proctor (1997) estimated that 3.7 million unsafe abortions occur in Africa each year and the abortion mortality ratio is over 80 per 100,000 live births. Teenagers are at greater risk of severe complications of abortion because they often wait until the second trimester. The complications that may arise include pelvic infection, haemorrhage, uterine perforation and tetanus. If complications are left untreated they may result in sterility, structural damage to the reproductive organs or death.

Cal (1998) states that teenage pregnancy is a major concern because of the psychological, social and economic sequelae of child bearing. It is mostly associated with unplanned or unwanted pregnancy. A pregnant teenage is confronted with maternal ambivalence or rejection which has been acknowledged as a major element in the development of mental or physical illness.

However, according to Maurizo, Cheng (2000) abortion rates among teenagers aged 15 and 19 years have stabilised in recent years in most developed countries.

Apart from human costs in terms of mortality, morbidity and suffering, unwanted pregnancy can place a heavy burden on the health resources of poor countries when women seek abortion services are either not available or not used. WHO (1993) states that in Tanzania a study on women hospitalised with various diagnoses implying complications of abortions found that such diagnosis were the most common reasons for admission to gynaecological wards accounting for between 34% and 57% all admissions.

In developing countries many a pregnancy is terminated in clandestine or otherwise unsafe conditions. Unwanted pregnancy results not only from not using contraceptives but also from the use of less effective methods of contraceptives.

## **ADOLESCENTS AND REPRODUCTIVE HEALTH PROBLEMS**

### **Sexually Transmitted Infection (STI)**

WHO (1992) states that STIs become the most common groups of notifiable diseases in most countries, particularly in the age group 15-50 years. The worldwide spread of sexually transmitted infections has been one of the major disappointments in public health in the past decades.

Jassamine (1999) report that during the past few decades, the burden of a number of traditional venereal diseases like gonorrhoea, syphilis and chancroid has declined particularly in the industrial countries, but they have been amply replaced by new bacterial and viral syndromes associated with chlamydia trachomatis human herpes virus, human papilloma virus and HIV. These agents regarded as the second generation of sexually transmitted organisms are frequently more difficult to identify, treat and control.

Furthermore WHO (1994) reported that untreated STIs can have devastating health effects. For example, untreated gonorrhoea can lead to sterility in men and ectopic pregnancy, tubal infertility and chronic pelvic pain in women. In chronic ill health, disability and death can result as complications of STIs. Blan and Way (1998) stated that the reasons for the high incidence of STIs especially in developing countries should be sought in a

number of variables, in particular urbanisation, unemployment, economic hardships and a relaxation of traditional restraints on sexual activity, as well as the emergence of antibiotic-resistant strains of micro-organisms.

In addition, the population distribution by age in developing countries is such that there are large numbers of people in the age group, which is sexually most active.

Hy Yz (1998) states that not only do women bear burden of ill health associated with reproduction and the burden of fertility regulation. They are also more susceptible to STIs than men. Moreover, women frequently remain asymptomatic for long periods after contracting an STI, which makes it more difficult to detect and diagnose the disease. STIs are the most common cause of infertility and this too carries far greater social and psychological consequences for women than for men. It is very understandably therefore that women's health advocates want contraceptive methods that also provide protection against STIs.

#### **HUMAN IMMUNODEFICIENCY VIRUS (HIV)**

Adolescents continue to become infected with HIV at alarming high rates. In Lusaka, up to 20% of girls under the age of 19 are already infected. Although rates for young men are lower, they are still serious.

Stuart and Wells (1995) reported that young people have quite a lot of factual knowledge about HIV, however, they also often have confused ideas, ideas that mixed scientific and traditional beliefs. Another common theme expressed was that although many people knew people with HIV, it was still seen as a shameful disease. Although these adolescents reported that they sought help from a variety of sources, they often received contradictory messages from the church, their reading, their teachers and traditional leaders. These mixed messages end up with young people adopting unsafe sexual practices.

WHO (1994) stated that the AIDS pandemic has further aggravated the already poor reproductive health status of Sub Sahara Africa. This is the region with the most rapidly increasing epidemic. The prevalence rates remain high in Kenya, Tanzania, Uganda, Zambia and in much of Southern Africa. According to MOH (September 1997), young people need the self-confidence and determination to practice safe behaviour. They need to practice being in risky situations but in a safe situation, like role players, so that they know how to say 'no' or how to insist on a condom or other type of safer sex. Everyone has a role and a duty to help young people who are growing up and live in a world where HIV is such an important factor. MOH (December 1997) reported that Family Health Trust had been running Anti-Aids clubs for

10 years. After 10 year of HIV education, surely the time has come for openness and understanding before another generation is lost to HIV.

Evidence suggests that young people aged 10 - 24 are most vulnerable to the poor sexual reproductive health in Sub-Saharan Africa. Jaccard (1996) stated that in most Sub-Saharan African countries, more than one in three women had had sex by age 18 and data suggest that the young have the greatest unmet need for family planning and protection against STIs including HIV. Despite a relatively early onset of sexual activity, few adolescents in Africa use any method and are thus exposed to the risks of unwanted pregnancy and STI/AIDS.

In Zambia MOH (1997) stated that over 12% of the 15 - 16 year old women visiting antenatal clinics were already infected with HIV with this scenario, there is an urgent need for expanding and improving reproductive health services.

### **ADOLESCENTS AND CONTRACEPTION**

In most developing countries there is a large and growing population of adolescents. The last decades have witnessed a changing pattern of sexuality among this population group CSO (1996) reported that fewer adolescents than adults used contraceptives and those that did, relied primarily on condoms.

WHO (1996) stated that Female sterilisation, the intrauterine device (IUD) and the oral contraceptive pill remain the 3 most commonly used methods in the world as a whole. However, WHO (1994) reported that in the more developed countries the oral pill and the condom, among modern methods, and rhythm and withdrawal among traditional methods are much more relied upon than in the less developed countries.

Adolescents can be at high risk of contracting an STI because they tend to engage in short term sexual relationship and do not use condoms. A young women's low social status can also raise her risk for injection with STD/HIV. In societies where women have little decision making power over their lives may fail to convince a man to use a condom.

#### **CONTRACEPTIVE USE: PREVALENCE AND TRENDS**

WHO(1992) states that although records of attempts to avoid contraception date back to as early as 1850 BC, fertility regulation on a large scale is a phenomenon of this century. Over the last 3 decades in particular, there has been an impressive rise in the use of contraceptives all over the world and this is expected to continue during the rest of the decade. According to WHO (1996) It has been estimated that in 1990 up to 57% of all married women of reproductive age or their husbands



were using a method of contraception. This represents an increase of 6% points over the prevalence in 1983.

Furthermore WHO (1994) reported that It was particularly noteworthy that principally, a rise in contraceptive use in developing countries (8%) accounted for this increase. In the more developed regions of the world, contraceptive prevalence was already 70% in 1983 and by 1990 it had increased to 72%. In fact, if one considers the contraceptive prevalence in the early sixties, the rise in contraceptive use in developing countries since then is nothing short of dramatic - from 9% in 1960-1965 to 53% in 1990.

Many young people are eager to develop the skills necessary to postpone sexual intercourse. Abstinence should be presented as a viable option, particularly to those who are younger or not yet sexually active. WHO (1997) generally recommend that if young people are to be helped, it will be through the spirit of the girls getting involved actively rather than passively. Many strategies to prevent pregnancies have been employed for instance resistance skills training options approach, education and acquisition of knowledge and parent-child communication. According to MoH (1997) Zambia has taken a step forward to introduce adolescent clinics known as youth friendly clinics like the ones in Lusaka and Copperbelt where counselling services by CARE are

provided. It is most likely that if more of such clinics were established, they would go a long way in preventing adolescents from HIV/AIDS, abortions and the risk factors of early child bearing. However, there is need to evaluate the effectiveness of such services.

### **ATTITUDE OF FAMILY PLANNING CARE PROVIDERS**

Adolescents are neither children nor adults, though they share some of the characteristics of both groups. The need is for effective health information and services geared specifically towards adolescents at particular stages of development.

With the inception of youth friendly clinics, we hope to see a scenario where youths provide information and a listening ear to their peers. SEATS (2000) stated that peer educators tackled issues ranging from information and worries about pregnancy, to communication with adolescents on issues of sexuality and contraception with confidence.

Winnet (1994) reported that the need to initiate measures to maintain and improve the health of women has been recognised both at international and national level. This is a positive step forward in ensuring quality reproductive health and safe motherhood.

Health care providers are urged to have positive receptive attitudes towards adolescents who wish to utilise antenatal, post natal and family planning clinics.

### **ADOLESCENTS' UTILISATION OF HEALTH SERVICES**

The idea that a girl should remain in school, not be sexually active and hence not to get pregnant should be balanced with the reality of what is happening in this age group, and the socio-economic conditions that surround a school girl and a drop out adolescents. CSO (1996) stated that, the idea appeared to contribute to substantial numbers of self induced abortions. One solution can be directed to change the attitude of young people towards safe sex and contraceptive use.

According to MOH (September, 1997) in a needs assessment carried out in June, it was found that: -

1. Young people feel uncomfortable attending clinics at the same time as adults, especially for reproductive health concerns
2. Youths would like separate clinic facilities or times
3. Adolescents would prefer to have same health care providers.
4. Young people would like adolescent services to be coupled with literacy training and recreation.

Youth friendly clinics were opened as a pilot project in Lusaka. It is hoped that youths will attend clinics if they feel that they are welcome.

Despite huge number of young people who initiate sexual activity and childbearing at an early stage, young people are often marginalised from the current service delivery system.

It was concluded by Kelly (Dec. 2001) that there was need to initiate measures to maintain and improve the health of women has been recognised both at international and national levels. This is a positive step forward in ensuring quality reproductive health and safe motherhood.

Furthermore, WHO (1992) stated that Teens needed to develop the self-esteem and awareness that are integral to making health choices. Youths require access to contraceptive and other reproductive health services so that those who are sexually active can protect themselves from pregnancy and STI/HIV. Accurate information on abstinence, alternatives on intercourse and contraception should be given to inform young people about their options. Adolescents need to know exactly what they must do to protect themselves sexually and this must be communicated directly.

Araoye and Fekeye (1992) suggested that Comprehensive sexual and reproductive health services for adolescents may be offered in hospitals, schools, community-based health facilities. Gynaecological exams, physical exams for males, contraceptive services, pregnancy testing, testing for STIs including HIV and treatment and/or referral for these diseases should be included in these services for youth.

The most effective services are teen-friendly, guarantee confidentiality and offer accessible hours (including walk-in appointments) at convenient locations.

## **CONCLUSION**

Teenage sexual activity poses serious economic, social, cultural, religious, health and moral problems. Not only do they question the moral fabric of society but they also predispose teenagers to risks of unwanted pregnancies and related consequences as well as infection with STDs including the deadly HIV/AIDS. Greater efforts are needed to provide sex and reproductive education and family planning services to adolescents.

## **CHAPTER TWO**

### **2.0 OBJECTIVES**

#### **2.1 GENERAL OBJECTIVE**

To determine the pattern of sexual practices among adolescents, their use and knowledge of contraceptive method so as to make recommendations to relevant authorities for the development of appropriate interventions.

#### **2.2 SPECIFIC OBJECTIVES**

1. To find out adolescents' pattern of sexual practice
2. To establish adolescents level of knowledge of contraceptive method
3. To determine adolescents use of contraceptive methods
4. To determine adequacy of reproductive health information received by adolescents at health centres.
5. To assess accessibility by adolescents to clinics offering information on contraception and sexuality
6. To establish the influences of family

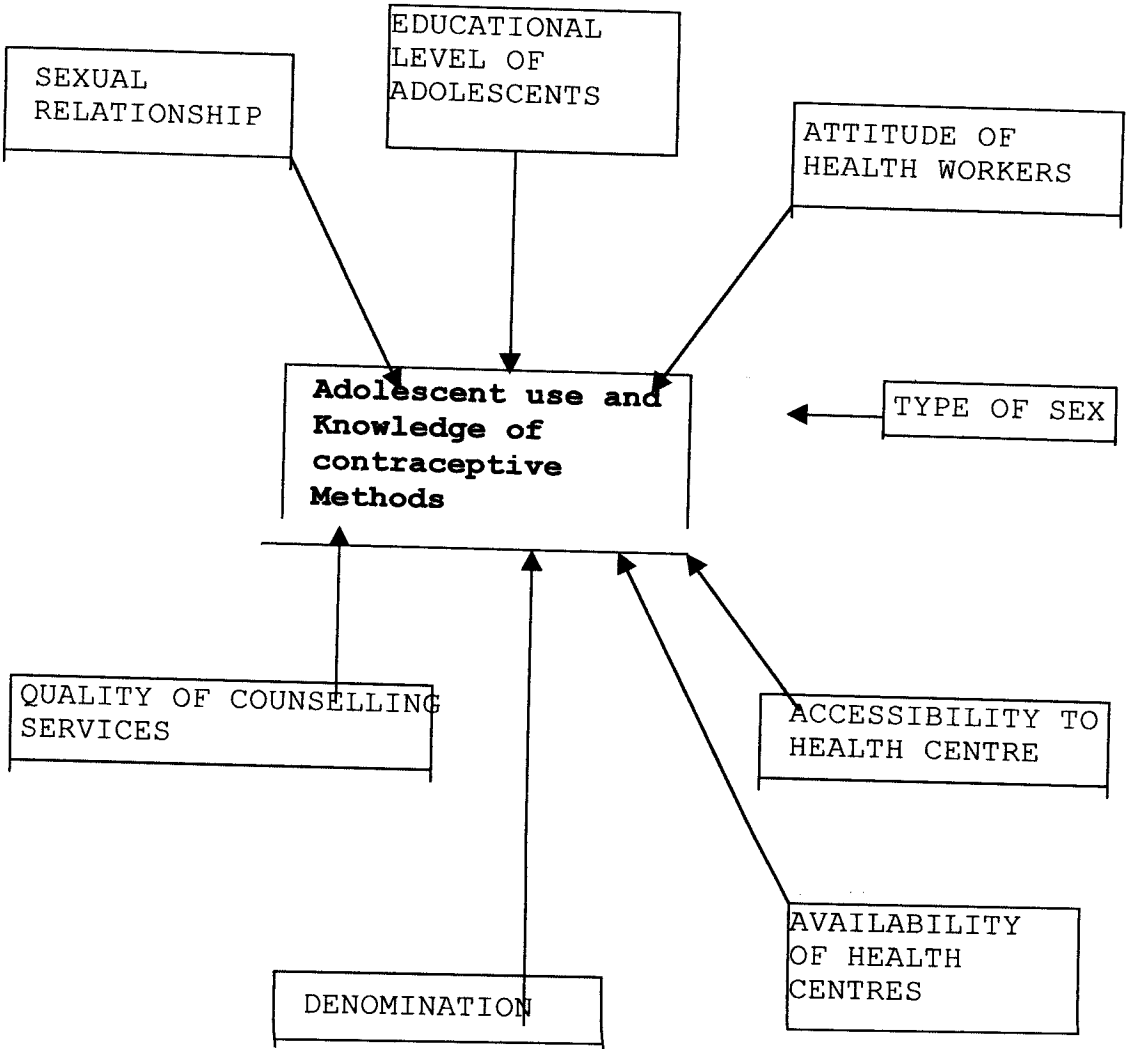
planning care providers on the attitudes, knowledge and practices of adolescents on contraception

7. To make recommendations to policy makers, Reproductive Health Care providers and Non-Governmental Organisations on how best to address the issue of adolescents and contraception.

### **2.3 OPERATIONAL DEFINITIONS**

1. **Adolescent** - Period between puberty and maturity, begins much earlier in girls than in boys, 10-19 years.
2. **Abortion** - Termination of pregnancy, expulsion or extraction of embryo or foetus before 28 weeks of gestation
3. **Pregnancy** - Being with a child, the condition from conception to the expulsion of the foetus
4. **Sexuality** - Constitution and life of individual as related to sex.
4. **Contraception** - The prevention of unwanted pregnancy.

VARIABLES





## **CHAPTER THREE**

### **3.0 METHODOLOGY**

#### **3.1 RESEARCH DESIGN**

The purpose of the study was to determine the patterns of sexual practices among adolescents, their use and knowledge of contraceptive methods. To achieve this a descriptive non-experimental research design was used. This was done during the month of May from 21<sup>st</sup> to 1<sup>st</sup> June 2001.

#### **3.2 RESEARCH SETTING**

The study was conducted in Lusaka Urban, the capital city of Zambia. Lusaka has a population of approximately two (2) million with the youth comprising 25 percent. 10 Government secondary schools were selected out of the 30 Government secondary schools.

#### **3.3 STUDY POPULATION**

The study comprised of school going adolescents both male and female aged between 13 and 19 years. These were selected from grades 10 to 12.

### 3.4 SAMPLING AND SAMPLLE SIZE

Lusaka has 30 Government Secondary Schools. Simple random sampling methods was used to select 10 Secondary Schools from the 30. The following Schools were used in this study: Matero Boys, Ebenezer Secondary School, Lusaka High School, Kwacha, Arakan High School, Libala Secondary School, Metropolitan Secondary School, Wisdom Secondary School, Kabulonga Boys Secondary School and Roma Girls.

30 respondents were selected from each School from the 3 senior grades 10 - 12 using systematic random sampling method. In this study the interval for each School used was calculated using the following formula:

$$K = \frac{N}{n}$$

Where K = Interval  
N = Study Population  
n = Sample size

NAME OF SCHOOL	NO. OF PUPILS IN GRADES 10 - 12	SAMPLE SIZE	Kth NUMBER
1. Matero	500	30	17
2. Ebenezer	400	30	13
3. Lusaka High School	300	30	10
4. Libala	450	30	15
5. Metropolitan	350	30	12
6. Wisdom	300	30	10
7. Roma Girls	360	30	12
8. Kabulonga Boys	700	30	23
9. Arakan	400	30	13

The Researcher used a sample size of 300 respondents. This sample size was calculated using the following formula:

$$n = \frac{Z^2 p (100 - p)}{e^2}, \text{ Where } n = \text{sample size}$$

$p$  = Proportion of School going adolescents who use contraceptives.

$e$  = Standard error

CSO (1996) states that the Proportion of Adolescents in Lusaka who use contraceptives is assumed to be 19%. This was calculated at the level of confidence of 95%.

$$n = \frac{1.96^2 \cdot 19 \cdot (100-19)}{5^2}$$

$$n = \frac{3.8416 \times 1539}{25}$$

$$n = 236$$

Therefore, a total of 300 respondents were used in this study.

### **3.5 DATA COLLECTION**

Data was collected using structured questionnaire with both opened and closed-ended questions. A structured questionnaire was used because it could be easily be understood and completed by the respondents considering their educational level.

Data collection was done with the help of 1 Research Assistant. The Research Assistant was trained for a period of 1 week before data for the main study was collected.

### **3.6 ETHICAL CONSIDERATION**

In order to conduct the study, ethical approval was sought from School of Medicine Ethical Committee University of Zambia. Permission was obtained in writing from the Permanent Secretary, Ministry of Education with a copy to the 10 Headmasters for the selected 10 schools. This was done in recognition of the respective authorities and to gain co-operation. Consent was obtained from the respondents upon explaining the purpose of the study and how the results would be utilized. Information obtained from the respondents was treated with confidentiality.

### **3.7 PILOT STUDY**

A pilot study was conducted at David Kaunda Secondary school on 10 subjects. This was helpful in detecting any flaws or gaps in the

content of the data and necessary corrections were done.

### **3.8 DATA ANALYSIS**

Data analysis was done by EPI Info using column counts, cross tabulation reflecting frequencies, percentages, chi-square and p-values.

### **3.9 LIMITATION OF THE STUDY**

The major limitation of the study was the limited resources such as funds and the time frame, in which the research project was supposed to be completed. It was also difficult to conduct the study because this was the period when teachers were on strike countrywide.

## **CHAPTER FOUR**

### **4.0 PRESENTATION OF FINDINGS AND DATA ANALYSIS**

#### **4.1 PRESENTATION OF FINDINGS**

Results presented in this chapter were obtained from 300 respondents who were adolescents from 10 secondary schools in Lusaka urban which were randomly selected.

Findings from description data obtained from respondents who are adolescents are presented in Section A.

**SECTION A**

**TABLE 1**

**1. SOCIAL DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS**

<b>CHARACTERISTIC</b>	<b>FREQUENCY</b>	<b>PERCENTAGE</b>
<b>SEX</b>		
Female	160	53.3
Male	140	47.7
<b>TOTAL</b>	300	100
<b>AGE</b>		
14	5	1.5
15	31	10.3
16	55	18.3
17	76	25.3
18	30	14.6
<b>TOTAL</b>	300	100
<b>RELIGION</b>		
Roman Catholic	82	27.9
Baptist/Pentecostal	84	28.6
Muslim	4	1.4
Others	123	41.4
<b>TOTAL</b>	300	100
<b>EMPLOYMENT</b>		
Parents employed	180	61.2
Not employed	34	11.6
Business	80	27.2
<b>TOTAL</b>	294	100
<b>GRADES</b>		
Grade 10	14.5	48.3
Grade 11	71	23.7
Grade 12	84	28.0
<b>TOTAL</b>	300	100

Table 1 shows the socio-demographic characteristics of respondents. The respondents were aged between 14 and 19 years. The majority 76 (25.3%) were 17 years old and 55 (18.3%) were aged 16. There were 160 (53.3%) females and 140 (47.4%) males.



Eighty two (27.9%) respondents were Catholics. The majority 180 (61.2%) had their parents in employment.

### SEXUAL PRACTICE

**TABLE 2**

**AGE AT FIRST SEXUAL INTERCOURSE**

<b>AGE</b>	<b>FREQUENCY</b>	<b>PERCENTAGE</b>
10 years	87	29
11 years	0	0
12 years	208	69.3
13 years	0	0
14 years	0	0
15 years	1	0.3
Not indulged	4	1.3
<b>Total</b>	<b>300</b>	<b>100</b>

Table 2 shows that most of the adolescents 208 (69.3%) had their first sexual intercourse at the age of 12. Eighty-seven (29%) had their first sexual intercourse at the age of 10.

**TABLE 3**

**RELATIONSHIP OF THE TYPE OF SEXUAL EXPERIENCE FOR THE PAST ONE MONTH WITH THE SEX OF ADOLESCENTS**

<b>SEXUAL EXPERIENCE</b>	<b>FEMALE</b>	<b>MALE</b>
Casual	49 (30%)	20 (14.2%)
Commercial	13 (8.1%)	10 (7.1%)
Regular	34 (21.2%)	10 (7.1%)
Non	64 (40%)	100 (71.4%)
<b>TOTAL</b>	<b>160 (100%)</b>	<b>140 (100%)</b>

Table 3 depicts that more ( $P = 0.004$ ) female adolescents 96 (60%) had sexual experience for the past one month than the male adolescents 40 (28.5%). The most sexual experience was casual for both sexes: females 49 (30%) out of 96 and males 20 (14.2%) out of 40.

**TABLE 4**

**ADOLESCENTS' PARENTS STATE OF EMPLOYMENT IN RELATION TO  
ADOLESCENTS SEXUAL RELATIONSHIP**

<b>EMPLOYMENT</b>	<b>SEXUALLY ACTIVE</b>	
	<b>YES</b>	<b>NO</b>
Employed	58 (66.6%)	122 (57.2%)
Not employed	9 (10.3%)	25 (11.7%)
Self employed	1 (1.1%)	65 (30.5%)
<b>TOTAL</b>	<b>87 (100%)</b>	<b>213 (100%)</b>

Table 4 shows that out of the 87 adolescents who were sexually active, the majority 58 (66.6) had their parents in employment. Of the 213 who were not sexually active, 65 (30.5) had parents who were self employed.

Results showed an association between the state of employment of their parents and their sexual relationship ( $P = 0.030$ ).

**TABLE 5****RELATIONSHIP BETWEEN ADOLESCENTS TYPE OF NON PENETRATING SEXUAL PRACTICE AND THEIR SEXUAL RELATIONSHIP**

<b>TYPE</b>	<b>SEXUAL RELATIONSHIP</b>	
	<b>YES.</b>	<b>NO</b>
Placing objects in vagina	30 (34.4%)	22 (10.3%)
Fondling of breasts/genitals	27 (31%)	43 (20%)
Masturbation	20 (22.9%)	38 (17.8%)
Non	10 (11.4%)	110 (51.6%)
<b>TOTAL</b>	<b>87 (100%)</b>	<b>213 (100%)</b>

Table 5 shows that out of 213 adolescents who did not have any sexual relationship, the majority 110 (51.6%) did not involve themselves in non-penetrating sexual practice and out of the 87 who had a sexual relationship 30 (34.4) were involved in placing objects in the vagina.

**TABLE 6**

**ADOLESCENTS' NON-PENETRATING SEXUAL PRACTICE IN RELATION TO THE NUMBER OF SEXUAL PARTNERS**

TYPE	SEXUAL PARTNERS		
	NON	1	2+
Placing objects in vagina	7 (4.2%)	35 (38%)	9 (20.9%)
Fondling breasts/genitals	19 (11.2%)	31 (33.7%)	18 (41.9%)
Masturbation	20 (11.8%)	26 (28.2%)	12 (29%)
Non	123 (72.8%)	13 (14%)	4 (9.3%)
<b>TOTAL</b>	<b>169 (100%)</b>	<b>92 (100%)</b>	<b>43 (100%)</b>

Table 6 shows that 92 adolescents who were involved in non-penetrating sexual practice had one sexual partner. Of these 35 (38%) were involved in placing objects. Those who had 2+ sexual partners were 43 and 18 (41.9%) were involved in fondling breasts/genitals. Those who did not have sexual partners and were not involved in non-penetrating sexual practice were 169 and of these 7 (4.2%) were involved in placing objects in the vagina. Results showed an association between adolescents non-penetrating sexual practice and the number of sexual partners (P = 0.041)

## CONTRACEPTIVE METHODS

### ADOLESCENTS USAGE OF CONTRACEPTIVE METHODS

Eighty-six (29%) adolescents out of the 136 (45%) who were sexually active used contraceptive methods.

**TABLE 7**

### KNOWLEDGE OF CONTRACEPTIVE METHOD

METHOD	ADOLESCENTS	PERCENT
Condom	174	66
Loop	4	1.3
Pill	40	13.3
Condom, pill	34	11.3
Condom, loop, pill	9	3
Others	3	1
Non	35	11.7
TOTAL	300	100

Table 7 shows that 265 (88%) adolescents knew at least one method of contraceptive and only 35 (11.7%) did not know any method.

**ADOLESCENTS USAGE OF CONTRACEPTIVE METHODS IN RELATION TO THEIR SEXUAL RELATIONSHIP**

Out of the 82 adolescents who said that they were sexually active 47 said they used contraceptive methods and 35 they did not use any.

**TABLE 8**

**AWARENESS OF STI/HIV/AIDS**

<b>FACTOR</b>	<b>FREQUENCY</b>	<b>PERCENTAGE</b>
<b>ROUTE OF HIV TRANSMISSION</b>		
Correct response	221	93.5
Wrong response	15	6.3
<b>TOTAL</b>	<b>236</b>	<b>100</b>
<b>WHETHER ABSTINENCE IS A SOLUTION TO THE PROBLEM OF HIV/AIDS</b>		
Yes	249	87.4%
No	36	12.7%
<b>TOTAL</b>	<b>285</b>	<b>100%</b>

Table 8 shows that 221 (93.5%) adolescents knew the route of HIV transmission. Only 15 (6.3%) did not know. Furthermore 249 (87.4%) adolescents felt that abstinence was a solution to the problem of HIV/AIDS.

**ADOLESCENTS VIEWS OF WHETHER THEY ARE GETTING THE  
REQUIRED SERVICES IN RELATION TO WHETHER CONFIDENTIALITY  
WAS MAINTAINED**

The majority of adolescents 52 said that they were getting the required services and confidentiality was maintained. Thirty-one said that they were getting the required services though confidentiality was maintained. Meanwhile 10 out of 20 adolescents who indicated that confidentiality was not maintained thought that they got the required services.



**ATTITUDE OF HEALTH WORKERS**

**TABLE 9**

**ADOLESCENTS VIEWS ABOUT DISCUSSING ISSUES OF SEXUALITY IN RELATION TO ATTITUDE OF HEALTH WORKERS**

ISSUES OF SEXUALITY	ATTITUDE OF HEALTH WORKERS			
	GOOD	SATISFACTORY	POOR	TOTAL
Peers	48 (35.2%)	54 (39.7%)	34 (25%)	136 (100%)
H/workers	38 (47.5%)	26 (32.5%)	16 (20%)	80 (100%)
Grandmother /aunt	24 (37.5%)	26 (40.6%)	14 (21.8%)	64 (100%)
<b>TOTAL</b>	<b>110 (36.7%)</b>	<b>64 (21.3%)</b>	<b>106 (35.3%)</b>	<b>300 (100%)</b>

Table 9 shows that 136 adolescents felt comfortable to discuss issues of sexuality with peers and the majority 54 (39.7%) felt that the attitude of health workers was satisfactory. Eighty adolescents felt comfortable to discuss issues of sexually with health workers though 26 (32.5%) felt that the attitude of health workers was satisfactory and 16 (20%) felt that it was poor.

**TABLE 10**

**THE SOURCE OF CONTRACEPTIVE DEVICES IN RELATION TO WHETHER THEY CAN EASILY WALK IN A HEALTH CENTRE TO GET THE REQUIRED INFORMATION**

SOURCE	HEALTH CENTRE	
	YES	NO
Chemist	35 (23%)	11 (16%)
Health workers	83 (55%)	13 (19%)
Friends	29 (19%)	3 (4%)
Parents	5 (3%)	43 (61%)
<b>TOTAL</b>	<b>152 (100%)</b>	<b>70 (100%)</b>

Table 10 depicts that of the 152 adolescents who said they can easily walk in a health centre to get the required information, the majority 83 (55%) said that they got their contraceptive devices from health workers. Out of the 70 adolescents who felt they could not easily get information from health centres, 43 (61%) said their source of contraceptives was their parents.

Results showed an association between the source of contraceptive devices and whether they can easily walk in a health centre to get the required information ( $P = 0.039$ ).

## **CHAPTER FIVE**

### **5.0 DISCUSSION OF FINDINGS**

#### **OVERVIEW**

The study sought to determine patterns of sexual practices among adolescents, their use and knowledge of contraceptive methods in Lusaka urban by establishing their patterns of sexual practice, level of knowledge of contraceptive methods and adequacy of reproductive health information received by adolescents at health centres. The other aspects looked at were accessibility of adolescents to clinics offering information on contraception and sexuality and the influence of family planning care providers on the attitude, knowledge and practice of adolescents on contraceptives and sexuality.

#### **SOCIO-DEMOGRAPHIC CHARACTERISTICS OF ADOLESCENTS**

Results revealed that most of the respondents were females (53.3%). It was also evident from the results that most of the adolescents (25%) were 17 years old. Most of the adolescents 180 (61%) had their parents in employment. Only 34 (12%) did not have parents in employment. These results suggest that young people did not only engage in sex in

exchange for money. According to the findings other sexual experiences reported were casual. This is contrary to what Sambisa and Chibbamulilo (1998) stated that young people reported that sex in exchange for money or other forms of payment was common. Adolescents seek to establish their own social identity and want to experiment in sex. This practice exposes them to STI and HIV/AIDS. Promotion of condom use among adolescents has met a lot of resistance from religious leaders. Most of the adolescents 123 (41%) belonged to other religions and 82 (28%) were Roman Catholics. SAFAIDS (1999) reported that most religions aim to act as a brake to physical expressions of desire, or emotions before marriage but people no longer seem to accept this. In this study religion did not have an impact on their sexual behaviour. As a result adolescents are at risk of contracting AIDs and unwanted pregnancies.

#### **PATTERNS OF SEXUAL PRACTICE**

Most of the adolescents 208 (69.3%) had their first sexual intercourse at the age of 12. The last decade has seen a changing pattern of sexuality among this age group. According to WHO (1994) it has been found that urbanisation has been accompanied by a shift in the traditional values

associated with sexuality, with the result that more young people are having sexual relations prior to marriage. This is also reflected in this study where only 4 (1%) adolescents had not had their first sexual intercourse. According to CSO (1996), by the age of 18 years, 70% women have had sexual intercourse and by the age of 20 years, 85% have had sexual intercourse with the median age of first sexual intercourse being 11. These are alarming results. Indeed adolescents sexuality is becoming an increasing concern in Zambia. According to Okonofua and Snow (1990) Knowledge about options on safe practice and contraception is essential for healthy sexuality, which requires individuals to have personal skills and characteristics such as self-esteem to enable them to define their wishes clearly.

The majority of the female adolescents 96 (60%) had sexual experience in the past one month more than male adolescents 40 (28.5%). A lot of girls unfortunately find themselves with unwanted pregnancies. Childbearing is the premier event in many girls' lives and frequently, cultural morals offer them few life alternatives. Similarly, Proctor (1997) reported that many adolescent males experience societal pressures to initiate sexual

activity at a young age to have multiple partners and to place little value on the rights or wishes of their partners.

The values that adolescents express often differ from their behaviour. These values must be stretched because of the dangers of today. In this study non-availability of contraceptives and lack of access to friendly family planning services were the two main reasons which were given as to why young people did not use contraceptives.

Out of the 87 adolescents who had a sexual relationship, the majority 58 (67%) had their parents in employment. Only 9 (10.3%) did not have parents in employment.

This suggests that adolescents are not only engaging themselves in sexual relationships for monetary gain but also for casual. This is further supported by Kelly (2001) who stated that the way men, women and the young communicate sexually, certainly not the medical sector, is in charge of people's sexual affairs. To be in control of their own affairs, people must have options and choices in general life and in sexuality. Their choices must be based on

information and knowledge, on access to condoms and services, on romance and pleasure.

Adolescent girls may lack the power, confidence and skills to refuse to have sex. WHO (1992) stated that the gender roles of the submissive female and dominant male make it more difficult for the girl to say no - some adolescents are subject to sexual abuse of varying degrees, including incest and rape.

The study found that out of 213 (71%) adolescents who did not have any sexual relationship, 43 (20%) were involved in fondling of breasts and genitals, 22 (10.3%) were involved in placing objects in the vagina and 38 (17.8%) did masturbate. Adolescents involvement in non-penetrating sexual practice need not be ignored. This type of sexual practice eventually leads to penetrating sexual practice. This is in line with WHO (1994); Who stated that adolescents usually have little bargaining power in their sexual relationship and may be unable to protect themselves against pregnancy, STDs especially adolescent girls.

Rossi (2001) reported that despite the large number of adolescents who initiate sexual activity at an early age thereby increasing their risks of contracting STD/HIV/AIDS, unplanned pregnancies and unsafe abortions remain excluded even from guidance

on sexuality and relationships within their own home environment.

Empowering young people is essential to their making healthy decisions about their sexuality. WHO (1994) concluded that Societies which value youth, consider their needs, involve them in problem-solving and recognise the important role they play in the community contribute greatly to young people.

### **CONTRACEPTIVE METHODS**

The study found that only 86 (29%) adolescents used contraceptives and 214 (71%) did not use them. 265 (88%) adolescents knew at least one method of contraceptives. This is in line with WHO (1996) who confirmed that although information is scarce on contraceptive usage among adolescents, indicators are that fewer than half use contraceptives at first sexual intercourse. Adolescents believe that pills cause infertility or birth defects.

The study found that 82 adolescents who said they had a sexual relationship, 47 (57%) said they used contraceptives and 35 (43%) said they did not use any.

Despite adolescents being knowledgeable about contraceptive methods, only a few use contraceptives



at first intercourse. This shows that adolescents are engaging in sexual activity without using contraceptives. They are at a greater risk of having unplanned pregnancies. Unplanned pregnancies is a major public health problem with potentially serious consequences for the health of the girl or woman and her child.

Low use of contraceptives may not necessarily pose serious health hazards. However, these factors do elevate the risks of abortions, maternal and child deaths which are major health problems with far-reaching consequences for women and their families. Rossi (2000) concluded that If contraceptives and particularly condoms are not available, not accessible or not used, adolescents of both sexes risk sexually transmitted diseases and the girls risk unwanted pregnancy too.

CSO (1996) stated that family planning services are less than adequate and currently meet only 1/3 of the potential demand for family planning. In view of the above inadequate health care services, it is most likely that teenage girl has no access to family planning services as well as being well informed.

## **REPRODUCTIVE HEALTH INFORMATION**

Most adolescents 117 (82%) who were involved in any of the 3 sexual experiences namely; casual, commercial and regular said that they found reproductive health information (sex education) to be helpful. In this study the question asked was on sex education and students were not asked to explain what sex education was.

Therefore it is difficult to conclude that these adolescents had adequate reproductive health information. WHO (1994) stated that reproductive health addresses basic elements of reproductive health which are; responsible reproductive/ sexual behaviour, widely available family planning services, effective control of reproductive tract infections including STD, prevention and management of infertility, elimination of unsafe abortion, prevention and treatment of malignancies of reproductive organs.

Almost all adolescents were aware of STD/HIV/AIDS and they also knew the route of HIV transmission. MOH (September 1997) reported that young people have quite a lot of factual knowledge about HIV, however they also often have confused ideas, ideas that mixed scientific and traditional beliefs.

These mixed messages end up with young people adopting unsafe sexual practices.

Knowledge is essential not only in developing sound advice for people but also in deciding which type of contraceptives will suit people's needs. According to Hope (1999), young people need the self-confidence and determination to practice safe behaviour. Everyone has a role and duty to help young people who are growing up and live in a world where HIV is such an important factor.

Most adolescents 249 (87.4%) knew that abstinence was a solution to the problem of HIV/AIDS. It is stated by Sambisa and Chibbamulilo (1998) that parents attributed early sexual activity to sex videos and films, observing immoral behaviour among adults, lack of parental role models, and guidance, peer pressure, alcohol and drug abuse. Therefore abstinence should be presented as a viable option, particularly to those who are younger or not yet sexually active, or in areas where contraceptives and reproductive health services are not readily available.

#### **ACCESSIBILITY TO REPRODUCTIVE HEALTH SERVICES**

The study revealed that the majority adolescents 178 (62.5%) had no access to a youth-friendly corner in

the area. As for those who were getting the required services, only 52 (63%) said that confidentiality was maintained. Despite the availability of youth-friendly corners in some areas, some adolescents still felt that they were not getting the required services.

This suggests that few psychosocial counselling services exist for younger people, although youths in their early teens are sexually active. According to MOH (December 1997) in studies done by CARE, UNICEF and SEATS in Lusaka between 1996 and 1997, adolescents talked on the unavailability of information and services on reproductive health.

If contraceptives are not available, not accessible or not used, adolescents of both sexes risk sexually transmitted diseases and the girls risk unwanted pregnancies. Fogel (1990) reported that Young people benefit most by receiving information or services from providers who are sensitive to their unique issues and styles of communication.

Young people are more likely to avoid becoming pregnant or contracting STI/HIV if they have the information and tools to do so, but also if they believe that they have options in life and future

prospects. All young people should have access to a comprehensive range of sexual health services.

Hope (1999) stated that information helps adolescents understand how their bodies work and what the consequences of their actions are likely to be. It dispels myths and corrects inaccuracies.

Information should stress the need to use contraception and for instance, explain how to use condoms. It should also include details of the services that are available, the opening times, the fees and the fact that these services are confidential.

#### **ATTITUDE OF HEALTH WORKERS**

The study revealed that most adolescents 136 (45.6%) felt comfortable to discuss issues of sexuality with peers and not with health workers, friends or parents/aunt.

The majority 110 (37%) reported that the attitude of health workers was good and 106 (35%) felt that it was satisfactory.

According to MOH (September 1997) youth-friendly corners have been set up in some health centres in order to meet the sexual reproductive needs of young people. The sexual and reproductive health needs of adolescents throughout the world must be better met

because of its changing conditions in which young people live. Since adolescents felt comfortable to discuss issues of sexuality with their peers. Peer educators need to be trained and equipped with skills and knowledge in order for them to answer adolescents questions.

WHO (1993) stated that helping adolescents develop in a healthy and fulfilling way is the best investment a society can make for its future. As adolescents undergo physical, psychological and social change and development. The aim of adolescent health services must be to enable them to undergo those changes in safety, with confidence and with the best prospects for a health and productive adulthood.

Therefore there is need for effective health information and services geared specifically towards adolescents at particular stages of development. Youths who know they have alternatives to early childbearing or sexual activities that put them at risk of contracting STIs/HIV are best prepared to make healthy decisions for life.

## CHAPTER SIX

### 6.0 CONCLUSION AND RECOMMENDATIONS

#### 6.1 CONCLUSION

In this study adolescents mostly females (59%) engaged in sexual intercourse as early as 12. The most sexual experience mostly practised was casual (50%) out of the (87%) adolescents who were sexually active. The majority 67% had their parents in employment. This suggests that adolescents are not only involving themselves into sexual relationships for monetary gain but other reasons. With this scenario, adolescents are vulnerable to unintended pregnancies, STD including HIV/AIDS furthermore. The majority 46% adolescents felt comfortable to discuss issues of sexuality with their peers and only 32% felt that the attitude of health workers was good. Therefore there is need for establishment of more separate clinics for youths.

Findings from the study revealed low contraceptive use among adolescents of 29% and

88% adolescents were knowledgeable about the methods of contraceptives. The main reasons given for non use were non availability of contraceptives and lack of accessibility to reproductive health services. Almost all adolescents 93% knew the route of HIV transmission. There is still an urgent need for adolescents to learn how to keep themselves from becoming infected with HIV/AIDS.

This call for comprehensive sexuality education, improvement in family planning and accessibility of Reproductive Health Services.

## **6.2 RECOMMENDATIONS**

1. The government in liaison with donors such as USAIDS, family Life Movement should provide youth friendly corners in all health centres in order to ensure that sexual and reproductive health services are available for adolescents.
2. The government through the Ministry of Education should ensure that sexuality education be included as an integral part of the school curriculum on healthy living skills, health promotion for adolescents and young adults.



3. Family planning services should ensure that condoms and other contraceptive methods are easily available in order to prevent sexually transmitted infections, HIV infections and unwanted pregnancies.
4. Counselling and other relevant services eg. Youth friendly corners should be accessible, affordable and confidentiality should be available to all adolescents.
5. Evaluation of such counselling services should be done in order to improve the quality of services being rendered.

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APPENDIX 1 - QUESTIONNAIRE

INSTRUCTIONS TO RESPONDENTS

1. No names should appear on the Questionnaire.
2. Tick against the most appropriate answer in the spaces provided on the right or write in the space provided.
3. Kindly answer all questions.

DEMOGRAPHIC DATA

1. How old are you?
  - a. 13
  - b. 14
  - c. 15 ( )
  - d. 16
  - e. 17
  - f. 18
  - g. 19
2. Which grade are you in?
  - a. Grade 8
  - b. Grade 10 ( )
  - c. Grade 11
  - d. Grade 12
3. Which church do you go to?
  - a. Roman Catholic ( )
  - b. Baptist/Pentecostal
  - c. Muslim
  - d. Other
4. What do your parents do?
  - a. Employed
  - b. Not Employed

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c. They do Business

SEXUAL PRACTICE

5. Do you have a sexual relationship?
- a. Yes
  - b. No ( )
6. At what age did you first had sexual intercourse?
- a. 10 years
  - b. 12 years ( )
  - c. 15 years
7. Is it right to have a sexual relationship? Give reasons for your answer.
- a. Yes
  - b. No
8. How many sexual partners do you have?
- a. 1
  - b. 2 ( )
  - c. 3
  - d. 4
9. What type of sexual experience did you have for the past 1 month?
- a. Casual
  - b. Commercial
  - c. Regular

10. Which sexual route do you prefer?
- a. Oral
  - b. anal
  - c. vagina
11. Which type of non penetrating sexual practice do your prefer?
- a. Placing objects in the vagina.
  - 3 b. Fondling of genitals/breasts
  - c. Masturbation.
12. Do you have reproductive health (sex) education?
- a. Yes
  - b. No ( )
13. Do you find reproductive health (sex) education lessons helpful.
- a. Yes
  - b. No

CONTRACEPTIVE METHODS

14. Do you use any contraceptive devices?
- a. Yes
  - b. No ( )
15. What are the reasons for using contraception devices?

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16. Which contraceptive methods do you know?



- a. Condoms
- b. Loop
- c. Pill
- d. Others

17. Where do you get contraceptive methods?

- a. Chemist ( )
- b. Health Centre
- c. Friends
- d. Parents

18. What is a condom used for?

- a. Protection against STD/HIV
- b. Protection against pregnancy
- c. Both

19. Have you ever been exposed to sexuality and contraception information?

- a. Yes ( )
- b. No

20. From whom did you get this information?

- a. Nurse
- b. Youth
- 3 c. Parents

AWARENESS OF STD/HIV

21. What is the route of HIV Transmission.

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22. Is absence a solution to the problem of HIV/Aids

a. Yes

b. No ( )

23. Do you know any common sexually transmitted infections apart from HIV? FOR OFFIC

a. Yes

b. No ( )

24. Name one of the sexually transmitted infection.

\_\_\_\_\_ ( )

ACCESSIBILITY TO REPRODUCTIVE HEALTH SERVICES

25. Do you have a youth friendly corner in your area?

a. Yes

b. No ( )

( )

26. If your answer is yes, are you getting the required services?

a. Yes

b. No ( )

27. Do you perceive you can be welcomed at any health centre by the health care providers?

a. Yes

b. No

28. Do you perceive confidentiality can be maintained by the health care providers?

a. Yes

b. No

29. If you don't have a youth friendly corner in your area, can you easily walk in any health centre to get the required information?  
Give reasons for your answer.
- 
- 

ATTITUDE OF HEALTH WORKERS

30. With whom do you feel comfortable to discuss issues of sexuality?
- a. Peers
  - b. Health Workers
  - c. Grandmother/Aunt
31. What is your description of a nurse at a health institution in Zambia?
- a. Approachable
  - b. Rude
  - c. Unapproachable
  - d. Friendly
32. How is the attitude of the health worker?
- a. Good
  - b. Poor
  - c. Satisfactory
32. Please give examples of how reproductive health services

FOR OFFIC.

b. No

29. If you don't have a youth friendly corner in your area, can you easily walk in any health centre to get the required information?  
Give reasons for your answer.
- 
- 

ATTITUDE OF HEALTH WORKERS

30. With whom do you feel comfortable to discuss issues of sexuality?

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- d. Friendly

32. How is the attitude of the health worker?

- a. Good
- b. Poor

c. Satisfactory

32. Please give examples of how reproductive health services FOR OFFIC

can be made youth friendly

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Thank you for your co-operation and participation.

APPENDIX 2 - GHANT CHART

	TASK	PERSONNEL	J U L Y	A U G U S T	S E P T E M B E R	O C T O B E R	N O V E M B E R	D E C E M B E R	J A N U A R Y	F E B R U A R Y	M A R C H	A P R I L
1	Finalise Research proposal writing	Researcher	X									
2	Seek Permission from relevant authorities	Researcher	X									
3	Pre-test	Researcher		X								
4	Recruit and Train Research Assistants	Researcher		X								
5	Print Questionnaire	Researcher and Research Assistants		X								
6	Data Collection	Researcher and Research Assistants			X	X						
7	Data Analysis	Researcher and Research Assistants					X					
8	Report Writing	Researcher						X	X			
9	Submission of Report	Researcher									X	
10	Feedback to DHMT and funding authority	Researcher										X

APPENDIX 3 - WORK SCHEDULE

	<b>TASK</b>	<b>DATES</b>	<b>PERSONNEL ASSIGNED</b>
1.	Finalise Report Writing	Weeks 1 - 4	Researcher
2.	Seek Permission from relevant Authorities	Weeks 5-8	Researcher
3.	Recruit and train Research Assistants	Weeks 9-10	Researcher
4.	Print Questionnaires	Week 11	Researcher
5.	Pre-test	Weeks 12	Researcher and Research Assistant
6.	Data Collection	Weeks 13- 16	Researcher and Research Assistant
7.	Data Analysis	Weeks 17- 18	Researcher and Computer Analyst
8.	Report Writing	Weeks 19- 20	Researcher
9.	Submission of Report	Week 21	Researcher
10.	Feed-back	Weeks 22- 23	Researcher
11.	Feed-back to funding Authority	Weeks 24- 25	Researcher

APPENDIX 4 - BUDGET

No.	ITEM	UNIT COST IN KWACHA	QUANTITY	TOTAL COST
A.	STATIONERY			
1.	Duplicating Paper	K17,000 per ream	2 reams	K34,000.00
2.	Paper	K17,000 per ream	4 reams	K68,000.00
3.	Pencils	K500 each	10 pencils	K5,000.00
4.	Rubbers	K300 each	4 rubbers	K1,200.00
5.	Pens	K500 each	10 pens	K5,000.00
6.	Typing/Setting	K30,000 per copy	20 copies	K600,000.00
7.	Binding Services	K50,000 per copy	5 copies	K250,000.00
<b>SUB-TOTAL</b>				<b>K</b>
<b>963,200.00</b>				
B.	SECRETARIAL SERVICES			
8.	Typing Services	K3,000 per page	300 pages	K900,000.00
9.	Duplicating Services	K1,000 per page	300 pages	K300,000.00
10.	Data Entry	K200,000	2 Services	K400,000.00
11.	Find Analysis	K300,000	1 Service	K300,000.00
<b>SUB-TOTAL</b>				
<b>K2,200,000.00</b>				
C.	PERSONNEL			
12.	Main Researcher Meal Allowance	K40,000	10 days	K400,000.00
13.	Two Researchers Assistants	K40,000	10 days	K800,000.00
14.	Transport Allowance - Daily Data Collection	K100,000	3 Research Assistants	K300,000.00
<b>SUB-TOTAL</b>				
<b>K1,500,000.00</b>				
<b>TOTAL</b>				
<b>4,663,200.00</b>				
<b>10%</b>				<b>CONTINGENCY</b>
<b>466,320.00</b>				
<b>GRAND TOTAL</b>				
<b>K5,129,520.00</b>				



**APPENDIX 5:**

University of Zambia  
School of Medicine  
Department of Community Medicine  
P.O Box 50110  
LUSAKA

12<sup>TH</sup> July, 2000

Dear Sir/Madam,

**Re: PERMISSION TO CARRY OT A STUDY IN SCHOOLS - LUSAKA**

I wish to seek permission to carry out a study entitled "Patterns of Sexual Practice and use of Contraceptive Methods among Adolescents in Lusaka Schools" that will be randomly selected in partial fulfilment of the course.

I am a postgraduate student in Masters of Public Health at the University of Zambia. Confidentiality will be maintained and informed consent will be obtained from all respondents.

If permission is granted, the study will be conducted between August and December, 2000.

Your co-operation will be greatly appreciated.

Yours faithfully,

Honester Nyaunde Banda

**APPENDIX 6**

PARTICIPANT INFORMATION AND CONSENT FORM

Dear \_\_\_\_\_

You are cordially invited to participate in our research on issues relating to adolescent sexuality and contraception. Your participation will contribute greatly to reproductive and sexual research programmes for the youths country wide.

In view of the above, a Questionnaire has been prepared and we request you to answer all questions if possible, as truthfully as possible. Please feel free to ask where you do not understand.

Answers will be treated with strict confidence and your name will not appear anywhere in our records.

Thank your for you consideration.

Researcher

**CONSENT**

The above information has been explained to me clearly and I fully understand. Therefore I hereby consent to my participation in this study.

Full Name: \_\_\_\_\_

Signature/thumb print: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_



# The University of Zambia

## DIRECTORATE OF RESEARCH AND GRADUATE STUDIES

Telephone: 290258/291777  
Telegrams: UNZA LUSAKA  
Telex: UNZALU ZA 44370  
Fax: + 260 - 1 - 290258/253952  
E-mail DirectorPostgrad@postgrad.unza.zm

P O Box 32379  
Lusaka, Zambia

Your Ref:  
Our Ref:

---

2<sup>nd</sup> November 2000

Ms Honester Nyaunde Banda  
C/O Community Medicine Department  
School of Medicine  
UNZA

Dear Ms Banda

**RE: RESEARCH PROPOSAL**

Your research proposal entitled "*A Study to look at Patterns of Sexual Practice and use of Contraceptive methods among adolescents in Lusaka*" was discussed at the 56<sup>th</sup> meeting of the Board of Graduate Studies held on 27<sup>th</sup> October, 2000. The Board accepted and approved the proposal.

You may now proceed to Part II of your programme. Your Supervisor is Professor K. S. Baboo and the Co-supervisor is Dr C. Michelo.

Congratulations!

Yours sincerely

  
Dr G. P. A. Banda  
ACTING DIRECTOR

Cc Dean, School of Medicine  
Assistant Dean (PG), School of Medicine  
Head, Community Medicine  
Professor K. S. Baboo, School of Medicine  
Dr C. Michelo, School of Medicine


The University of Zambia  
School of Medicine  
Department of Community Medicine  
P.O Box 50110  
**Lusaka**

19<sup>th</sup> January 2001

The Permanent Secretary  
Ministry of Education  
P.O Box 50093  
**Lusaka**

u.f.s The Head of Department  
School of Medicine  
Department of Community Medicine  
P.O Box 50110  
**Lusaka**

HEAD COMMUNITY MEDICINE  
SCHOOL OF MEDICINE  
UNIVERSITY OF ZAMBIA  
P.O. BOX 50110, LUSAKA



Dear Sir,

**Re: PERMISSION TO CARRY OUT A STUDY IN SECONDARY  
SCHOOLS-LUSAKA URBAN**

I am a postgraduate student in Masters of Public Health at the University of Zambia. I wish to seek permission to carry out a study entitled "**patterns of sexual practice and use of contraceptive methods among adolescents in Lusaka schools**" that will be randomly selected in partial fulfilment of the course.

Confidentiality will be maintained and informed consent will be obtained from all respondents. If permission is granted, data collection will be conducted in February in 8 schools.

Your cooperation will be highly appreciated.

Yours faithfully,



Honester Nyaunde Banda (Mrs.)  
**MASTERS OF PUBLIC HEALTH STUDENT (MPH)**

All communications should be addressed to:  
The Permanent Secretary to the Ministry of Education  
and not to any individual by name.

Telephone: 250055/251293/251315  
251283/251298/251318  
251291/251306/251319



REPUBLIC OF ZAMBIA

# MINISTRY OF EDUCATION

P.O. BOX 50093  
LUSAKA

In reply please quote:

No.....


**TO: ALL HIGH SCHOOL HEADS**

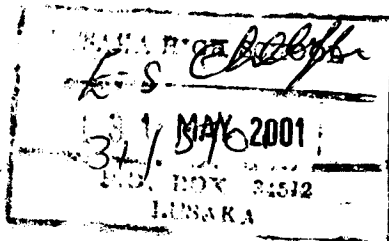
15<sup>th</sup> May, 2001


**SUBJECT: STUDY ON SEXUAL BEHAVIORS OF PUPILS IN  
HIGH SCHOOLS**

Kindly assist Mrs. H.N. Banda collect information on sexual behavior of pupils in your respective schools for her study.

The bearer of this letter is a student at the University of Zambia and this study is part of the fulfillment for her degree.

  
Goodson Sinyenga  
Senior Statistician  
For/Permanent Secretary  
Ministry of Education



  
12/11 31/5/01

