

**FACTORS INFLUENCING UTILIZATION OF FAMILY
PLANNING SERVICES AMONGST ADOLESCENTS IN
SINAZONGWE DISTRICT**

BY

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A RESEARCH STUDY SUBMITTED IN PARTIAL FULFILMENT OF THE
REQUIREMENT FOR THE AWARD OF BACHELOR OF SCIENCE DEGREE
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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CSO	Central Statistics Office
DMO	District Medical Officer
DNS	Department of Nursing Science
FP	Family Planning
HIV	Human immune- deficiency Virus
IEC	Information, Education and Communication
MOH	Ministry of Health
PLA	Participatory Learning and Action
PPAZ	Planned Parenthood Association of Zambia
PRA	Participatory Rural Appraisal
SPSS	Statistical Package for Social Science
UNPFA	United Nations Population Fund Agency
WHO	World Health Organisation
ZDHS	Zambia Demographic Health Survey
HIMS	Health Management Information Systems
DHS	Demographic Health Survey
STIs	Sexually Transmitted Infections

DECLARATION

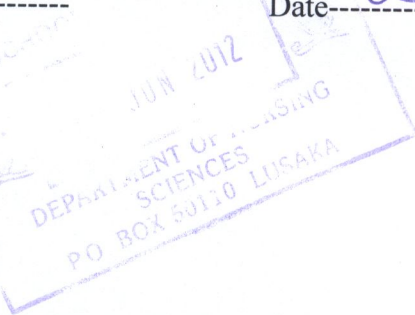
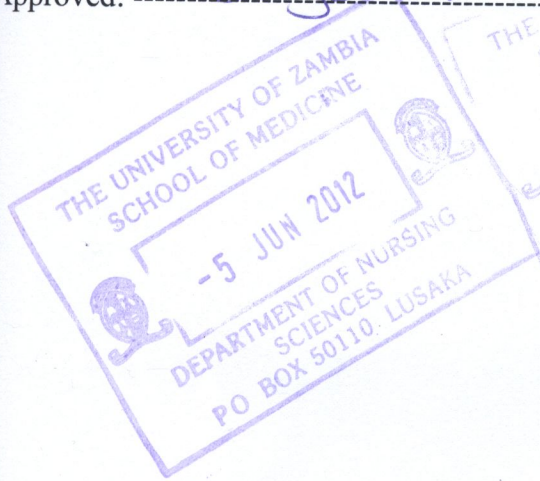
I, **Mataa Isikanda**, hereby declare that with the exception of the assistance acknowledged, the work presented in this study for the Bachelor of Science in Nursing Degree is the result of my own efforts and studies. This work has not been presented either wholly or in part for any other degree and is not being currently submitted for any other degree.

Signed: I. mataa

Date: 05-06-2012

Approved: *P. Ngoma*

Date: 05/06/12



STATEMENT

I, **Mataa Isikanda**, hereby certify that this study is entirely the results of my own independent investigation. The various sources, to which I'm appreciative to, are clearly acknowledged in the text and in the references.

Signed: T. mataa

CANDIDATE

Name: MATAA ISIKANDA

Date: 05-06-2012

DEDICATION

This study is dedicated to my parents Mr. Mataa Situmba and Mrs Annah Situmba for their continued love and encouragement throughout my life; it is also dedicated to my dear husband Sevas and my children Rachael, Austin and Kumoyo for their encouragement and most of all, for their inspiration.

ABSTRACT

Adolescent sexual health is a major public health concern and reproductive health occupies a vital detail in health and development. Effective use of contraception can prevent unwanted pregnancy and sexually transmitted infections among adolescents. The rates of unintended pregnancy among young women due to unmet need for contraception are high. It is widely recognized that providing family planning services to adolescents would not persuade them to indulge in sexual behaviors but would empower them with information on how to protect themselves if sexually active from unwanted pregnancies and sexually transmitted infections. Despite the universal knowledge of at least one modern method of family planning among adolescents in Sinazongwe, use of these methods remains insignificant.

1. **Purpose of the study:** The purpose of this study was to determine factors influencing low utilization of family planning services among adolescents in Sinazongwe District in Southern Province.
2. **Literature review;** Literature review was conducted on some studies done globally, regionally, and nationally. The literature has shown that several studies have been published on adolescent utilization of family planning services. Literature revealed that low educational level, knowledge of family planning, attitude of staff has a great influence on the utilization of family planning amongst the adolescents. Improving education and imparting knowledge of family planning can greatly improve accessibility of family planning by adolescents.
3. **Methodology:** A non interventional quantitative descriptive research design was conducted among the adolescents in five different health centres in Sinazongwe District. A semi structured interview schedule was used to collect data from the respondents. A sample of fifty respondents was selected from five different health centres using a simple random sampling method from adolescents aged 13 to 19 years. The data was entered on the master sheet and analyzed manually.
4. **Results:** The findings revealed that 56% of the respondents were aged 17 and 19 years. Most (78%) of the respondents were single and 75% were females who had attained basic education. The findings showed that all (100%) of respondents had heard about family planning, 96% knew the meaning of family planning and 52% of the respondents had

moderate knowledge of family planning. The study has revealed that 78% of the respondents were not using any family planning method. The majority of the respondents lived near the health facility and took less than 45 minutes to reach the facility and 74% of the respondents knew that family planning services were available at the health facilities. Concerning attitude of staff, the findings revealed that all (100%) the respondents stated that the attitude of staff at the family planning clinics was positive and 62% of the respondent said that they were not aware about religious and cultural beliefs that could hinder them from using family planning method.

5. **Conclusion:** Adolescents' utilization of family planning services in Sinazongwe District is low. It is mainly affected by inadequate and inaccurate knowledge about family planning methods; low educational levels and individual perceived barriers prevent adolescents from using family planning services. Findings suggest that equipping adolescents with proper knowledge and sensitizing the community on unmarried adolescents reproductive health would help adolescents to utilize the available family planning services hence protect them from the sexual health problems. There is need to introduce family planning teaching that is based on accurate knowledge of family planning to school curriculum at an earlier age of adolescents.

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

1.1.1 Adolescent health and sexuality

Adolescence is a transitional stage of physical and mental human development generally occurring between puberty and adulthood (Potter and Perry, 2005). According to Erik Erikson's stages of human development, a young adult is generally a person between the ages of twenty and forty, whereas an adolescent is a person between the ages of thirteen to twenty (Potter and Perry, 2005). During this period sexuality and sexual desire usually begins to intensify along with the onset of puberty. The expression of sexual desire among adolescents might be influenced by family values and the culture and religion they have grown into, peer pressure, social control, taboos, and other kinds of mores. Adolescents complete their physical, emotional and psychological passage to adulthood in a changing world that contains both opportunities and dangers such poverty. Adolescents are full of optimism and represent a positive force in society, an asset now and for the future as they grow into adulthood. However, when supported adolescents can be resilient in absorbing setbacks and overcoming problems (Gondwe, 2008).

1.1.2 Family planning program in Zambia

In Zambia, family planning services are integrated in the reproductive health services so that where ever these services are provided so is a family planning service. This means that every woman can access this family planning service without much difficult. Family planning implies the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. Family Planning is achieved through contraception which is defined as any means capable of preventing pregnancy (Ministry of Health, 2008). The contraceptive effect can be obtained through temporary or permanent means. Temporary methods include: periodic abstinence during the fertile period, coitus interruptus (withdrawal), using the naturally occurring periods of infertility (e.g. during breastfeeding and postpartum amenorrhea), through the use of reproductive hormones (e.g. oral pills and long-acting injections and implants), placement of a device in the uterus (e.g. copper-bearing and hormone-releasing intrauterine devices), interposing a barrier that prevents the ascension of the sperm into the upper

female genital trace (e.g. condoms, diaphragms, and spermicides). Permanent methods of contraception include male and female sterilization (MOH, 2008).

Family planning protects women from unwanted pregnancy thereby saving them from high risk pregnancies or unsafe abortion. It can also reduce the number of deaths among women by reducing the number of women who are at risk by avoidance of unintended pregnancy, which account for about 30% of all birth in Sub-Saharan Africa (WHO, 2008). Other benefits from family planning methods such as condoms include prevention from cervical cancers, sexually transmitted infection and Human Immunodeficiency Virus (HIV). In spite of these benefits the unmet need for family planning services in Zambia remains very high (WHO, 2008).

Strategies to improve access have been put in place at various levels which include community, health post, health centre, first and second level referral health centres. Nurses and community based volunteers are trained to provide family planning at different levels using appropriate methods for the level of care. In the community family planning is provided by community based distributors, community health workers, lay counselors and traditional birth attendants trained in family planning. These provide family planning methods such as pill, condom and lactation amenorrhea method whilst injectables, implants, intra uterine contraceptive device, vasectomy and bilateral tubal ligation methods are provided by trained professionals at the appropriate level. Information communication and education on family planning is provided at all levels through the media, at the health centre in the community by the trained community volunteers. Nongovernmental organization such as Society for Family Health, Planned Parenthood association of Zambia (PPAZ), have come aboard to increase access by providing contraceptive, educating and funding training programmes on family planning. The youth friendly services were introduced to address adolescent reproductive services to facilitate access of these services by adolescents without consent of parents or guardians, spouse or relatives as allowed by current legislation though special concern has to be given for the under sixteen years (WHO 2002).

1.2 STATEMENT OF THE PROBLEM

Although access to safe and voluntary family planning counseling and services significantly reduces unintended pregnancies and abortions and saves adolescents and women's lives, it is still a controversial issue and a major challenge in Africa where teenage pregnancies are increasing each year. Family planning can help young women avoid having children during this high risk time and also avoid the social and economic consequences of early child bearing (Roberta, Baron and Whittaker, 2007). Adolescent pregnancy is recognized as one of the major demographic and public health challenges in Zambia. Teenage fertility is very high. Twenty two percent (22%) of women between the ages of fifteen to nineteen are already mothers and another 6% are pregnant with their first child and many birth to the adolescents are unintended (MOH, 2008). Teenage or adolescent pregnancy is observed to be precipitated by influences of premarital sexual practices and early marriages which are still the social norms of the Zambian societies and partly influenced by rapid urbanization and modernization (CSO, 2009). A teen pregnancy poses health risks not only for the baby but also for the young mother, particularly those under the age of 18 years. Adolescent pregnancy is dangerous for the child because the mother tends not to understand her sexuality and have no skill of taking care of the baby and in addition because of the limited education. Though family planning utilization in Zambia has increased in past years adolescent family planning utilization is as low as 10% (CSO, 2007). This has contributed to unintended pregnancies which have negative consequences which include induced abortions, sexually transmitted infections including HIV/AIDS and many health problems which are particularly associated with negative outcomes of pregnancy during adolescence. Adolescents who give birth before the ages of twenty are at greater risk for complication of pregnancy and delivery than older women, and infants born to adolescent mother, are also at greater risk (Ringheim and Gribble, 2010). The Ministry of Health (MOH) indicated that 16000 maternal hospital admissions nationally were due to abortions performed in the community by non professions and also indicated that 15% of all maternal deaths were occurring amongst patients with abortions. About 23% of incomplete abortions were amongst the adolescents, and twenty five percent accounted for maternal death due to induced abortions in adolescents (MOH, 2008). Maamba district hospital recorded 191 abortions and 150 in 2009 and 2010 respectively and 60 and 80 of these abortions were adolescents respectively (Health Information Management Systems, 2011). This situation indicates unmet needs for family planning methods to prevent a pregnancy. Despite the availability of family planning services at various levels, many

adolescents fail to access these services in turn fail to prevent pregnancies. Only thirty eight percent (38%) of sexually active unmarried adolescent between fifteen and nineteen years were using modern method of family planning (CSO, 2008). This situation prompts that something should be done to improve accessibility of family planning services. Delaying adolescent birth or pregnancies could significantly lower population growth rate, generate broad economic and social benefits, in addition to improving adolescent health (WHO, 2008).

1.3 FACTORS INFLUENCING UTILIZATION OF FAMILY PLANNING AMONG ADOLESCENTS IN SINAZONGWE.

A number of factors may influence accessibility of family planning among adolescents in Sinazongwe. These may include the following;

1.3.1 Client related factor

Most adolescents lack accurate information about available reproductive health services including family planning hence they may incorrectly use or won't use it at all. Some people with little education will be more likely to be influenced by culture and traditional beliefs and may get married and give birth early. Accordingly to WHO, (2008) low levels of education is closely related with early child birth. Some young people may indulge themselves in sexual activity which is worsened by peer pressure (Murray and McKinney, 2006). Some adolescents risk pregnancy and parenthood as a means of gaining or maintaining a relationship and have unplanned sexual intercourse (Murray and McKinney, 2006).

1.3.2 Service related factors

Long distance to healthy facility is likely to prevent adolescents from accessing family planning services. The facility may have no stocks of family planning method. The adolescents may also be deterred by long waiting times and administrative procedures.

Despite having youth friendly corners in some of the health facilities in Sinazongwe, the services are not well utilized by the adolescents. The infrastructure and location of these services may not provide privacy. Adolescents are very sensitive to privacy and confidentiality and do not want their dignity to be stripped away. The healthy worker negative attitude towards work where they are unable to give proper health education on importance and benefits of family planning to adolescent may lead to adolescents not using the family planning services. This attitude may be as a result of health care providers not trained in adolescent reproductive health or motivated. The health care providers may be unfriendly, not listening or are judgmental making it difficult for adolescents to reveal concerns and may not return for follow up. All adolescents both in school and out of school should have access to comprehensive sexual and reproductive information and services which includes family planning. Family planning services are not

provided at school and only if they were integrated in schools, they would maintain a narrow focus on reducing specific sexual risk-taking behaviors, provide accurate information about sexuality, build interpersonal and communication skills to resist sexual pressures, hence the adolescent would be empowered. Effective sex education programs can decrease sexual activity and increase contraceptive use among the sexually active which includes adolescents.

1.3.3 Social Cultural and economic factors

Many societies disapprove premarital sex and consider reproductive health care for young people inappropriate (Williamson, 2009). Adolescents' attitudes, assumptions, and social norms that family planning is for married people to reduce family size makes a barrier for use of family planning services.

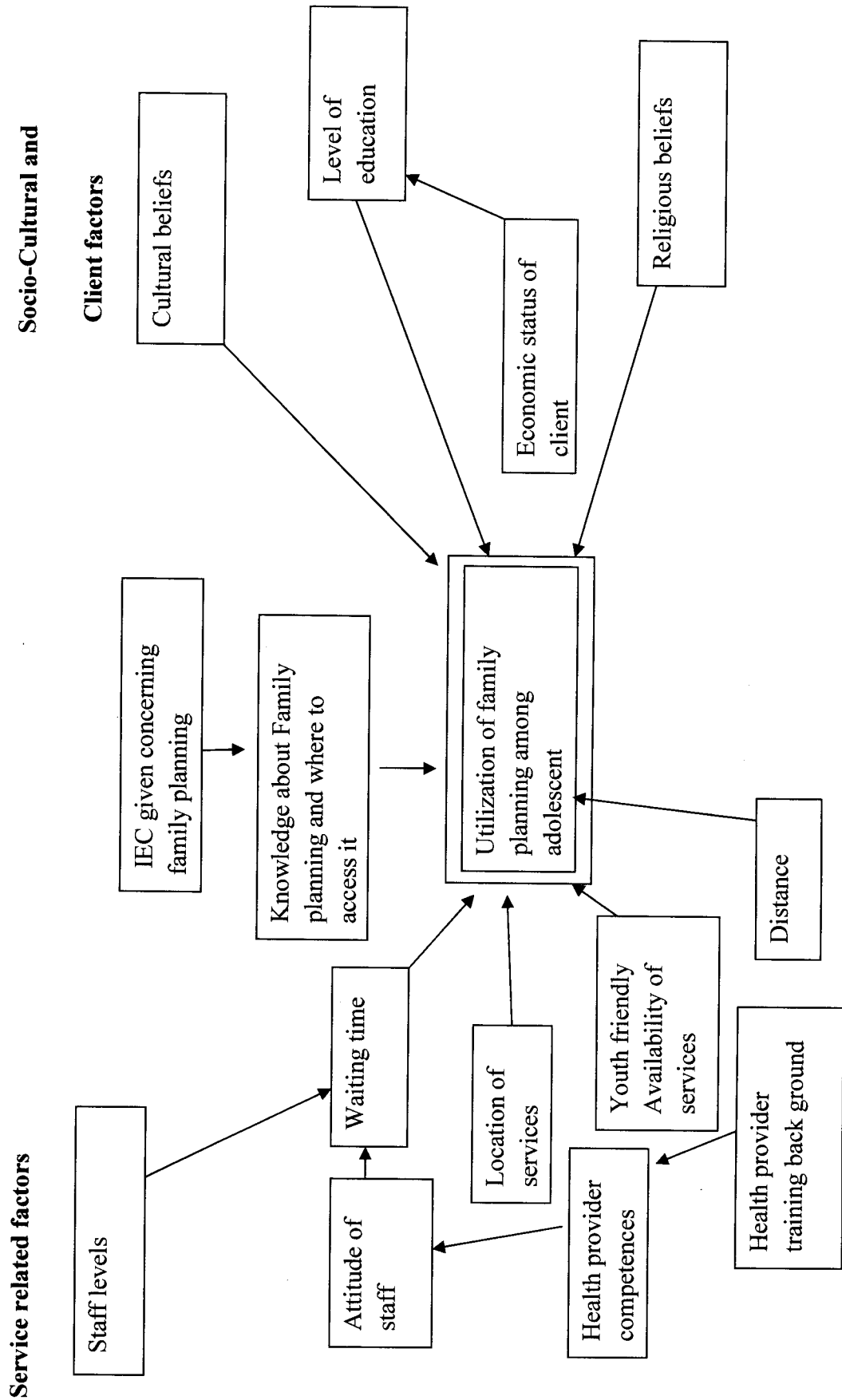
Reproductive health services such as family planning clinics are often restricted, even if condoms are available, health care workers may withhold them from adolescents and the under 18 years need consent from parents or guardian. A 16 year old girl may find it difficult to attend a local clinic for contraception if she knows that she will be seen by a relative or neighbor and if seen they are always stigmatized as a prostitute. In many countries including Zambia and indeed Sinazongwe, a culture of shame discourages adults and children from talking about their bodies or sexual activities. This can make adolescents reluctant to use sexual or reproductive health services including family planning.

Adolescent from a well to do family may be exposed to some information about family through watching television and radio and may be able to understand and utilize the family planning service. People in a high economic status are usually educated and are likely to understand adolescence better than the one who are not educated (Gondwe, 2008).

1.3.4 Religious factors

Christianity is the dominant religion in Zambia comprising of different denominations which has diverse views on family planning. For example, the Catholics do not subscribe to the use of a condom or any method of contraception other than natural family planning. Such religious beliefs have a strong influence on utilization of family planning (Patella, 2006). Christianity emphasizes on abstinence before marriage hence use of family planning by unmarried adolescent may indicate that they are sinning as a result adolescents will not seek family planning services.

FIGURE 1: FACTORS INFLUENCING UTILIZATION OF FAMILY PLANNING AMONG ADOLESCENT



1.5 CONCEPTUAL FRAMEWORK

Introduction

A framework is an abstract, logical structure of meaning that guides the development of study and enables the researcher to link the findings to the body of knowledge for nursing (Burns and Groove, 2005). In attempting to understand adolescents' utilization of the available family planning services in Sinazongwe area, a theory was used. However, this theory merely provides some empirical understanding on some of the potential contributing factors to adolescents' use and non-use of the available family planning services.

1.5.0 Health belief model

Health belief model is a tool used by scientists to try and predict health behaviours. The model was originally developed by Rosenstock in the 1950s and updated by Becker in the 1980s (Basavanthappa, 2009). The purpose of the Health Belief Model is to help in discovering conditions that either facilitate or impede utilization of services. This model points to health beliefs such as attitudes, values and knowledge that might influence adolescents' subsequent perceptions of need and use of health services. The health beliefs can be adolescents' and community perceptions on adolescents' use of family planning services which may have an impact on their decision to use the services. The health model has six constructs namely:

Perceived susceptibility

Personal risks or susceptibility is one of the more influential perceptions in prompting people to take on healthier behaviors. The greater the perceived risk, the greater the possibility of engaging in behavior to decrease the risk. This may prompt adolescents who have sex to use family planning if they know that early pregnancy can lead to serious complications. If adolescents believe that they are at risk for a complication of pregnancy, they are likely to do something to prevent it.

Perceived severity

This construct of perceived seriousness speaks to an individual's belief about the seriousness or severity of a condition. While the perception of seriousness is often based on medical information or knowledge, it may also come from beliefs a person has about the difficulties a disease or condition would create or the effects it would have in her or his life.

Perceived benefits

The construct of perceived benefits is a person's opinion of value or usefulness of a new behavior in decreasing the risk of developing a condition. People tend to adopt healthier behaviours when they believe the new behavior will decrease their chances of developing a condition.

Perceived barriers

This is an individual own personal evaluation of the obstacles in the way of him or her adopting a new behaviour. In order for new behaviour to be adopted, a person needs to believe the benefits outweigh the consequences of continuing with the old behavior.

Cues to action

Cues to action are events, people, or things that move people to change their behavior. Examples include media reports, mass media campaigns, friends, advice from others, and family member about the condition.

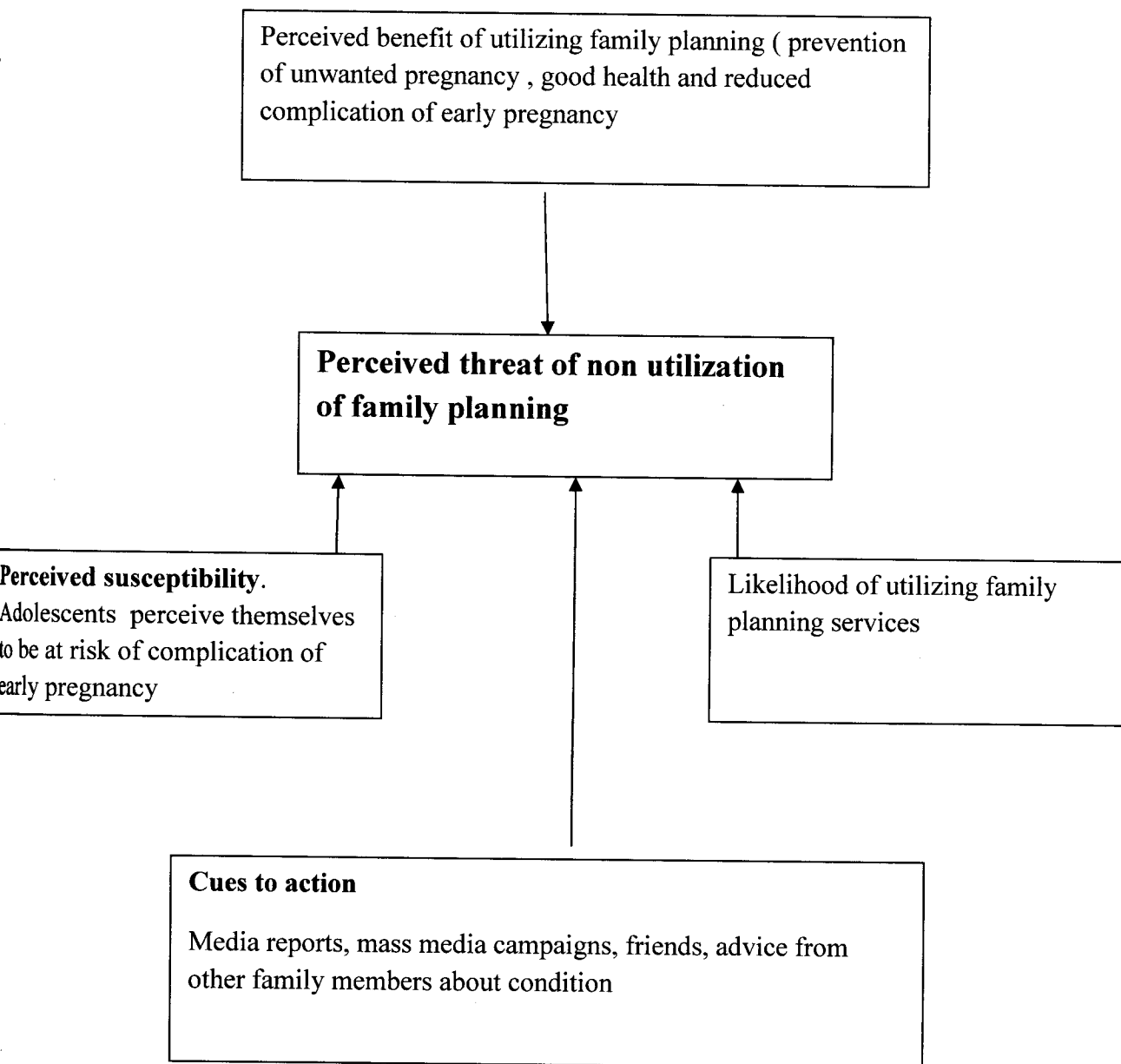
Self efficacy

Self efficacy is belief in one's own ability to do something. Generally people do not try to do something new unless they think they can do it. If someone believes a new behavior is useful, but does not think he or she is capable of doing it chances are that it will not be tried.

The Health belief model provides a framework for understanding the potential influences on an individual's decision to make use of the available health services. The model suggests that people's use of health services is a function of their tendency to using services, factors that enable or hamper use, and their need for the service. The purpose of the Health Belief Model is to help in discovering conditions that either facilitate or impede utilization of services. This model points to health beliefs such as attitudes, values and knowledge that might influence adolescents' subsequent perceptions of need and use of health services. The health beliefs can be adolescents' and community perceptions on adolescents' use of family planning services which may have an impact on their decision to use the services.

Figure 2: Diagram of the health belief Model Individual's perception
Likelihood of action

Modifying factors



Source; Stretcher and Rosenstock, (1997)

1.6 JUSTIFICATION

Adolescent sexuality is becoming an increasing concern in Zambia. About three in ten adolescents have experienced childbearing (CSO, 2009) and child birth in this group is risky to both mother and baby. Delaying adolescent birth or pregnancies could significantly lower population growth, generate broad economic and social benefits, in addition to improving adolescent health (WHO, 2008). Achieving the above is critically dependant on meeting contraceptive needs of adolescents. Adolescent birth rate is an indicator for reducing maternal mortality to achieve millennium development goal number five (Ringheim and Gribble, 2010). The government policy statement explains that providing adolescents with quality family planning services reduces unwanted pregnancies, adolescent fertility and risks of unsafe abortion thereby reducing morbidity and mortality (Ministry of Health, 2009). Therefore youth friendly reproductive health services should be available in all health facilities and community. Despite the above policy accessibility to family planning is still low.

This study will endeavor to determine the factors influencing accessibility of family planning among adolescents in Sinazongwe district. When factors are isolated measures can be put in place to assist adolescent access family planning services. It is hoped that findings of this research will be used to make recommendations to the health care providers, policy maker, and nongovernmental organization to put strategies in place that would tackle the reproductive needs of the adolescents in our country.

1.7 RESEARCH OBJECTIVES

1.7.1 GENERAL OBJECTIVES

To determine factors influencing utilization of family planning services amongst adolescents in Sinazongwe district.

1.7.2 SPECIFIC OBJECTIVES

1. To determine the levels of knowledge about family planning amongst adolescents in Sinazongwe.
2. To determine the level of utilization of family planning services.
3. To the types of family planning method used.
4. To establish factors that prevents adolescents from accessing family services.

1.8 HYPOTHESES

Hypothesis is an assumption statement about the relationship between two or more variables that suggest an answer to the research question (Basavanthappa, 2006).

1. Inadequate information about family planning services leads to adolescent not seeking family planning services.
2. Distance and location of family planning services will influence utilization of the services by adolescents.
3. Availability of family planning service for adolescents will improve utilization of service.

1.9 CONCEPTUAL DEFINITION

1.9.1 Adolescent: Any persons aged 10 to 19 years (WHO, 2002).

1.9.2 Utilization: Is ability to use a product or service, one which can be used by all its intended users, taking into account their different capabilities (WHO 2008).

1.9.3 Knowledge: All the information, facts, truth and principles learned through out time (Hornsby, 2006).

1.9.4 Family planning: A voluntary decision made by an individual or a couple on the appropriate number of children and when to have them (MOH, 2009).

1.10 STUDY VARIABLES

A variable is an attribute or characteristic that can have more than one value such as height, weight and blood pressure (Basavanthappa, 2007). There are basically two types of variables which include independent and dependent variables.

1.10.1 Independent variable

Independent variable is a variable that is purposely manipulated or changed by the researcher; also called the manipulated variable (Basavanthappa, 2007). It is that phenomena in the experimental study used to test the hypothesis to determine the relationship between variable (Basavanthappa, 2007). In this research the independent valuable include, distance, attitude of staff, location, religious beliefs, social economic status, level of education, location of services, and knowledge.

1.10.2 Dependant variables

The variable that changes as the independent variable is manipulated by the research; sometimes called the criterion variable (Basavanthappa, 2007:558). It is sometimes called the effect, behaviour, or outcome that the researcher wishes to study, or explain. These variables can change as a result of manipulation of independent variable. For example in this study, utilization of family planning is the dependent.

Table: 1.1 VARIABLES, INDICATOR AND CUT OFF POINTS

Variable	Indicator	Cut off point	Question number
Dependent; Utilization of family planning	Accessing	Utilizing a family planning method	13-14
	Not accessing	Not using family planning method	
Independent Distance	Far	More than 45minutes	15
	Near	Less than 45minutes	
Knowledge	High level	A score of 7-10 on knowledge questions	6- 11
	moderate	A score of 4-6 on knowledge questions	
	Low	A score of 3 and below on Knowledge questions	
Level of education	High	College/ university	5
	Medium	High school	
	Low	Basic education	
	Never been to school	No education	
Availability	Yes	Facility and service present	15- 16
	No	Facility and service absent	
Attitude of staff	positive	Accommodative and welcoming	17 - 24
	negative	Not accomodative	
Cultural and religious Beliefs	Approves use of FP	Cultural beliefs that discourage FP are absent	25- 33
	Disapproves use of FP (hinder)	Cultural beliefs that discourages FP are present	

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

Literature review refers to a broad, comprehensive, systematic and critical review of scholarly publications, unpublished scholarly print materials audio visual materials and personal communication relevant to the research project (Basavanthappa, 2007). The purpose of literature review is to determine what is already known about the problem being studied, to avoid duplication of work that has been done and reported by researchers and scholar.

The sources of the review were journals, books, unpublished research proposals, published research papers, internet, government reports and records. The literature review focuses on factors influencing accessibility of family planning among adolescents. A number of studies on adolescent sexual and reproductive health (family planning) have been conducted globally, regionally, and local level to identify the gaps in the accessibility of family services amongst adolescents and have come up with different findings and recommendations. The literature review in this chapter has been organized according to variables in the study.

2.2 UTILIZATION OF FAMILY PLANNING SERVICES

Kanthiti (2007) conducted a review of studies from selected developing countries in Africa and Asia. A convenient sample of five studies from five countries in Africa and five in Asia focusing on family planning or reproductive health for adolescents aged 10-19 years were selected. The findings from this review showed that there were some factors that facilitated adolescents' use of family planning services both in Africa and Asia. These factors included: confidentiality and privacy, knowledge of reproductive health and family planning services, providers' positive attitude, friendly environment and availability of services, convenient opening hours and location of clinics, individual risk perception, peer involvement, parental support and age of adolescent.

A study conducted in California by Claire et al (2005) on how to measure access to reproductive health services established that removing cost barriers, increasing number and type of providers offering family planning services, ensuring confidentiality increased numbers of adolescents seeking and utilizing reproductive health services.

2.3 KNOWLEDGE

According to the Demographic Health Survey (DHS) conducted by Centre for International Health in Australia in 33 low and lower middle income countries in the East Asia and Pacific region, found that a significant proportion of women commenced sexual activity and childbearing during adolescence in the context of low contraceptive prevalence and high unmet need for contraception. Adolescent women aged 15-19 years had lower use of contraception, poorer knowledge of family planning and less access to information and services than adult women. The study revealed that early pregnancy carries an increased risk of adverse health and socio-economic outcomes for women and their families. Moreover, this resulted from poor access to information about family planning and the benefits of delaying first birth, poor access to reproductive health services, and socio-cultural expectations of early marriage and childbearing (Kennedy, Gray, Azzopardi and Creati, 2011). A review of DHS report from East Asia and the Pacific indicated that adolescent women have lower use of contraception, poorer knowledge of family planning and less access to information and services than adult women.

A study was done in Ghana by Ohene and Okoto (2008) to identify factors associated with history of sexually transmitted infections in women aged 15 to 24. This study found that majority of the adolescents had lack of knowledge of the source of condoms and this was identified as a risk factor. Tayyaba and Khairkar (2005) conducted a study in India on strength and obstacles to practicing contraception. The study identified major obstacles to contraceptive use among Muslims adolescents and women as; lack of motivation, awareness and knowledge, social and cultural acceptability, perceptions of husband's preferences and attitudes, health concerns, and perceived access to services. The most influenced factor included women's age, age at marriage, number of living sons, quality of local government health care facilities and most religious affiliation. A study conducted in south east Asia in 2010 at Akhar community to determine knowledge and accessibility to adolescent reproductive information and services among adolescent revealed that adolescents

had moderate level knowledge on reproductive health including family planning, low level on STIs/HIV/AIDS and moderate to high knowledge on contraception.

A Malawian study explored factors contributing to low utilization of family planning amongst adolescents (Gondwe, 2008). The findings were that adolescents' utilization of family planning services was mainly affected by lack of community acceptance to acknowledge adolescents sexual activity. Furthermore, norms of the society and messages adolescents were exposed to, through some cultural practices, peers and parents confused adolescents in the understanding of family planning services in general. In addition, lack of proper knowledge pertaining to family planning methods, individual perceived barriers and barriers associated with delivery of services inhibited adolescents' to use the available family planning services (Gondwe, 2008).

A community needs assessment which employed Participatory Rural Appraisal (PRA) and Participatory Learning and Action (PLA) tools was conducted in 2007 in Katuba catchment area in Chibombo district by Silumbwe and Lesa in 2009. The study revealed that there was low access and utilization of family planning services by adolescents and young people. This was evident by the increased number of teenage pregnancies and early unplanned teen marriages caused by early pre - marital sexual practices compounded with lack of adequate and accurate information on Family Planning.

2.4 LEVEL OF EDUCATION

According to demographic and health surveys conducted in nine Latin American countries, in south and central America , the findings showed that the un educated and illiterate women were not accessing family planning compared to better educated women who had two to three children. Although uneducated women typically had six to seven children, they would prefer to have fewer but are not able to fulfill their desires. Education enhances cognitive skills that can affect one's ability to process the surrounding world and possibly influence change. Also, one needs to be literate to understand some of the complex instructions of modern contraceptive methods Martin and Juarez (2009).

A study conducted in India by Guri, Debasis, Bera and Ghosh (2009) on Awareness Level of Family Planning Practices in School Going Adolescent Girls of different socio-economic groups in

rural sectors revealed that the respondents had moderate level of knowledge on reproductive health, low level on STIs/HIV/AIDS and moderate to high knowledge on contraception.

Ringheim and Gribble (2010) conducted an in-depth study in four Sub-Saharan African countries found that 83% of women aged 15–19 in Sub-Saharan Africa live in low-income countries. The study also revealed that these women believed common misperceptions and had poor knowledge about the prevention of unintended pregnancy and HIV. The findings also showed that one third did not know of a source for contraceptives.

2.5 AVAILABILITY OF FAMILY PLANNING SERVICES

A study was conducted between November and December 2008 in six universities located in the southwestern part of Nigeria – two of the universities were federal government owned, two were state government owned and the other two were privately owned. Among the major findings of the study were that all facilities investigated reported high unmet needs for contraceptives for young undergraduates. None of the health facilities had separate clinic days for consultation for undergraduates, while four of the six schools did not have any policy guideline for provision of reproductive health to undergraduates. The study revealed that only two of the six selected schools had youth friendly centers where students could access information on reproductive health services, even these centers were underutilized by the young undergraduates. The findings from this study also showed that there were no specific policies in some of the schools, except for the federal universities that reflect a pro-youth friendly provision of reproductive health services denial or lack of full range reproductive health services to youths in university based health institutions has potential to lead to situations of unmet reproductive health needs of the students thereby leading to support of unsafe sources (Odu and Ikuteyijo , 2008).

2.6 CULTURAL FACTORS

A Ugandan study explored young people's views about obstacles and enabling factors to contraceptive use in two districts. The findings revealed deep-seated misconceptions about methods of contraceptives; over weighted burden of side effects and belief that side effects are permanent; confusion between side effects and misconceptions fear of side effects. Young men and women were more fearful of pregnancy than HIV/AIDS and other diseases. The belief is that a woman capable of negotiating for contraceptive is sexually experienced and is therefore stigmatized.

Women's lack of power in relation to men and lack of decision making power was a major obstacle to contraception use. There was negative peer pressure and rumors especially among male participants which further compromised negotiations to use. Contradictions mainly from male partners, parents, society-church, schools, and health units that had taken conflicting positions in favor and against use resulting different messages on contraceptives and more still health service barriers exist and persistent high fertility in Uganda (Nalwadda, 2009). Moreover, the study revealed that the young people believed that contraceptives interfered with fertility, and they were frightened to use something that could harm their ability to reproduce. Most of the married and unmarried women believed that pills burned the woman's eggs and both male and female participants believed that pills accumulate in the body causing swellings, such as fibroids, cancer, and destruction of the fallopian tubes.

A study by Akintade (2010) in Lesotho to assess the level of awareness of contraceptive and utilization of family planning services among young women at a national university and barriers that hinders effective use of such services was done. The results showed that the level of awareness and utilization of family planning was high among the participants and condom was the most commonly known and used family planning method. Married status was associated with current use, positive perception on health benefits while formal teaching on family planning was associated with misconceptions. A study done by Williamson et al (2009) on modern contraceptives use among young women in developing countries found that the majority of young women in study reported receiving little sex or contraceptive education from parents' health services or elsewhere. Any education they did receive often simply reinforced common misperceptions of modern contraceptives. The results indicated that the young women had inaccurate perceptions of pregnancy risk, including changes over the monthly cycle. Many thought that they could not get pregnant at first sex, or if they had sex standing up or infrequently. The partners' attitudes towards contraception were often crucial and were reported to manipulate, force, threaten, and use violence to get young women not to use contraception. The study further revealed that the adolescent women's reputations and social status was a limit to contraceptive use and there was considerable social disapproval of premarital sex and pregnancy.

2.7 CONCLUSION

Increasing utilization of family planning for adolescent is of great importance as it will improve not only their general health but also the social economic status of adolescents which in turn will enhance quality of life. Literature review has shown that several factors influence adolescents' accessibility of family planning services. The factors include inadequate knowledge; negative attitude of staff, cultural and religious factor, level of education and distance. Most studies included low educational levels and inadequate knowledge as a factor of poor utilization of family planning amongst adolescents. Increasing knowledge of family planning and improving education levels will improve utilization of family planning amongst adolescents.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

INTRODUCTION

Research methodology is the process or plan for conducting the specific steps of the study (Burns and Groove 2009). The research methodology includes the description of the study participants and how the study participants were selected, research settings, a description of tools and techniques that were used to collect data. It describes how the researcher intends to ensure validity and reliability and the ethical considerations to be made. The research methodology also describes how the pilot study was conducted, the plan for data analysis and dissemination of the research findings.

3.1 RESEARCH DESIGN

Research design is the researcher's overall plan or strategy for answering research questions or a blue print the researcher selects to carry out their study (Basavanthappa, 2007). It clearly states the basic strategies that the researcher adapts to develop information that is accurate and interpretable. The study design provides answers to the research questions or for testing the hypothesis.

A non interventional descriptive quantitative research design was used in this study which it involved the systematic collection and presentation of data to describe what existed about the phenomena and gives a clear picture of factors influencing utilization of family planning among adolescents. A descriptive study is a broad class of non experimental studies. It is a non interventional study design because no interventions or manipulations were carried out on both the environment and the respondents. The phenomena understudy was captured during one data collecting period. The study was quantitative as study variables were presented and defined by the investigator, the respondents' responses were quantified and measured objectively, and the data was collected, translated in numbers and statistically analyzed. Qualitative data from open ended questions were analyzed using content analysis. Each response was transcribed, read to get the concepts in the responses. The concepts were derived from the characteristics of the responses, and then developed into themes that were used to categorize the content into meaningful groupings.

3.2 RESEARCH SETTING

Polit and Beck (2008) defines a research setting as a physical and conditions in which data collection takes place in a study. The study was conduct in Sinazongwe District in the Southern province of Zambia. The district is 88km off Lusaka Livingstone road at Batoka turn off. The district has 13 health centres with several villages. This location was chosen for convenience and accessibility. Respondents were chosen from 5 different health centre catchment areas of Sinazongwe district from different back grounds, status and experiences. The study was done in a natural setting to ensure validity, reliability, and non bias of results since villages have different characteristics.

3.3 STUDY POPULATION

A study population refers to category of persons or objects that meet the criteria for the study established by the researcher, any set of persons, objects or measurements having an observable characteristics in common (Basavanthappa, 2006). The population consists of target population and accessible population. The target population is a group of individuals who meet the sampling criteria and to which the study findings will be generalized whilst accessible population is a portion of a target population which the researcher has reasonably access (Burns and Groove 2009). In this case, the study population was adolescents from 13 to 19 years in Sinazongwe District regardless of their tribe, social status, and political affiliation.

3.4 SAMPLE SELECTION

Sample selection is the process of selecting a number of individuals from the delineated target population in such a way that individuals in a sample represent as nearly as possible the characteristics of the entire target population (Pilot and Beck, 2008). In this study, the researcher used simple random sampling method using the lottery technique to select sample. On a daily basis, adolescents from within the selected clinics were given numbers and these numbers were put in a box without replacement and were shaken. The numbers were picked at random from the box to allow chance for every member to participate in the study. An independent person, an adult was asked to pick a paper after shaking the box to ensure randomization. The adolescents whose numbers were picked were the ones who were included in the study population. In each clinic, at least 10 respondents were selected.

3.4.1 Inclusion criteria

The inclusion criteria which is also known as eligibility criteria is defined as those characteristics that the subject or element must possess to be part of the target population (Burns Groove, 2009). Only adolescents aged 13 to 19 years in the selected catchment areas of the health centres in Sinazongwe district were recruited in this study.

3.4.2 Exclusion criteria

Exclusion criteria are defined as those characteristics that can cause a person or element to be excluded from the target population (Burns and Groove, 2009). All adolescent above 19 years and or who did not consent as well as those who did not reside in the study area did not participate in this study.

3.5 SAMPLE SIZE

A sample size is the total number of subjects/participants and consented to take part in a study (Burns and Groove, 2009). The sample size comprised 50 adolescents of Sinazongwe District. The reasons for selecting this sample size included limited time and inadequate resources both material and financial.

3.6 OPERATIONAL DEFINITIONS

3.6.1 Adolescent: Any persons aged thirteen to nineteen years.

3.6.2 Family Planning (FP): Refers to a voluntary decision made by an individual or couple to prevent and delay the time of pregnancy.

3.6.3 Reproductive Health: Is defined as the well being of men, women and young people as it concerns their reproductive functions.

3.6.4 Knowledge: Refers to the range of information and awareness on the benefits of family planning in preventing pregnancy.

3.6.5 Utilization: Availability, able to be obtained, and use a family planning method.

3.6.6 Health facility: An institution that offers family planning services to people and could be a health centre, hospital or health post.

3.6.7 Family planning services: Includes family planning counseling, information, education, Communication, choice of family planning methods and other services on reproductive health issues.

3.7 DATA COLLECTION TOOL

Data collection tool according to Polit and Beck (2006) is an instrument used to collect data. In this study, data was collected using a semi structured interview schedule from respondents. A semi structured interview is the use of strategies that provide an increasing amount of control by the researcher over the content of the interview (Burn and Groove, 2009). The interview schedule comprised a series of questions both open and closed ended designed to measure some variables and the questions were categorized. Section A consisted of questions on demographic data, section B questions on knowledge on family planning, section C questions on accessibility of family planning services, Section D Distance from health facility, Section E availability of family planning services, Section F attitude of staff, Section G religious and cultural beliefs. The interview schedule as a data collection tool was chosen because of the following advantages:

- It was used on both the literate and the illiterate.
- Relatively simple method of obtaining data.
- Items could be constructed easily by beginning researchers.
- It was a rapid and efficient method of gathering information.
- It enabled the research to gather data from a widely scattered sample.
- Questions were clarified if they were misunderstood.

Disadvantages

- Printing could be costly
- Amount of information gathered was limited to the subject's available time and interest span.

3.7.1 VALIDITY

Validity is the degree to which an instrument measures what it is supposed to measure (Polit and Beck, 2008). In this study, the researcher ensured validity by employing strategies that dealt with threats to validity. Validity was maintained by ensuring that all variables under study are covered in the interview schedule. Questions were clearly constructed to avoid ambiguity and were pre tested. The questionnaire was constructed in English language as a standard but translations were done by the researcher when dealing with illiterate respondents. To ensure validity the same questions were asked to all research participants and were made the simple, brief and concise.

External validity refers to the degree to which other environmental or external factors influence the results of the study (Basavanthappa, 2008). To ensure external validity in this study selection of appropriate study design and pre-testing the interview schedule was conducted.

3.7.2 RELIABILITY

Reliability is the degree of consistence or accuracy with which an instrument measures the attributes it is designed to measure (Polit and Beck, 2008). To ensure reliability the research tool was tested before the main study was conducted using a pilot study in a similar environment with similar characteristics.

3.8 DATA COLLECTING TECHNIQUE

According to Polit and Beck (2008), data collection technique is the actual method on how the data is going to be collected. It allows for systematic collection of information from respondents. In this study, data was collected by using interviews. Data was collected over a period of 5 weeks and a range of 4 to 5 interviews were done per day and data was collected by the researcher. It was done from 1400 to 1700 hours and each interview took 25 to 30 minutes. The interviews were conducted in privacy and only one person was interviewed at a time. The interviewer introduced herself to the respondents and explained the purpose of the study. Permission was sought from the respondents to allow the researcher to conduct the interview. Respondents were assured of confidentiality and anonymity. When the respondent appeared relaxed and at ease, the interviewer proceeded with the

interview. Any questions that were not clear to the respondents were repeated and or rephrased ensuring that the meaning of the question was not changed.

The responses were entered as given by respondents. At the end of the interview the respondents were thanked. After the interview, the researcher went through the interview schedule to note any inconsistency in the answers.

3.9 PILOT STUDY

A pilot study is a small scale version of a proposed study conducted to develop or refine the methodology, such as the treatment, instrument, or data collecting process (Burns and Groove, 2005). The researcher used a pilot study to determine and measure the logical sequencing, space for answers, need for further instructions, appropriateness and clarity of the language used in constructing the questionnaire. This enabled necessary adjustment to be made on the questionnaire before the actual study was carried out. It was conducted on 10% of the total sample (10% of 50= 5). The pilot study was conducted at Sinazongwe health centre within the catchment area with the same characteristics. The suggestions from respondents were not included and some questions on knowledge were repeated and some were similar for some questions. Corrections were made to the tool by removing questions that were similar and included the respondents' suggestions.

3.10 ETHICAL CONSIDERATION

Ethical considerations are a system of moral values that is concerned with the degree to which the researcher adheres to professional, legal and social obligations to the study participants (Polit and Beck, 2008).

Written permission was obtained to collect data for pilot and actual study from Sinazongwe Medical Office. Verbal permission was sought with additional personal signed consent from the adolescents who participated in the study. The respondents were briefed about the purpose of the study and that they had the right to participate or withdraw from the study. The respondents were assured of confidentiality of personal information shared with the researcher. No name was written on the interview schedule to maintain anonymity. The completed interview schedules were kept under strict security conditions to avoid unauthorized access to the information contained therein.

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

INTRODUCTION

The purpose of this chapter is to present information on how the research data were analyzed and what information was obtained. Data was collected from respondents using an interview schedule. Fifty (50) respondents participated in the study, ten (10) from each of five different health centres from Sinazongwe district. A pilot study was conducted at Sinazongwe health centre after which the main study was undertaken Sikaneka, Maamba, Sinazeze, Siatwiinda, and Sulwegonde health centres.

4.1 DATA ANALYSIS

Data analysis is the systematic organization and production of research data, and the testing of research hypothesis using those data (Basavanthappa, 2007). After data collection, data was checked for completeness and inconsistencies.

The data was analyzed manually using a data master sheet soon after interviews. Sorting, verification of responses, coding and entering of data on the data master sheet for the quantitative data was done. The data master sheet was partitioned into seven categories namely demographic data, knowledge on family planning, accessibility of family planning, distance, availability of family planning services, attitude of staff and religious and cultural beliefs.

The qualitative data, from open-ended questions, were analyzed using content analysis (Basavanthappa 2007). Each response was transcribed, read to get the concepts in the responses. The concepts were derived from the characteristics of the responses, and then developed into themes that were used to categorize the content into meaningful groupings.

4.2 PRESENTATION OF FINDINGS

The results are presented in two parts. The first part gives the overall findings of the study (descriptive statistics) by using frequency tables. Frequency tables are suitable because they summarize the findings in a meaningful way, which is easy to understand. The second part attempts to make correlations between some variables (inferential statistics) through cross tabulation of dependent and independent variables to show the relationship among variables so that meaningful inferences could be drawn. Pie charts, have also been used to present the data in a meaningful way to enable the reader to understand the findings easily.

4.2.1 SECTION A: SOCIAL DEMOGRAPHIC DATA

TABLE 4.1: RESPONDENTS' AGE DISTRIBUTION (n =50)

Age	Frequency	percentage
13-14	9	18
15-16	12	24
17-19	28	56
Total	50	100

The most 56% (28) of the respondents were aged between 17 and 19 years whilst the least age was 13 to 14 years and accounted for 18% of the respondents.

TABLE 4.2: RESPONDENTS' SEX (n=50)

Sex	Frequency	Percentage
Male	11	22
Female	39	78
Total	50	100

Majority 78% (39) of the respondents were females.

TABLE 4.3: MARITAL STATUS OF THE RESPONDENTS (n=50)

Marital status	Frequency	percentage
Single	38	76
Married	12	12
Total	50	100

Most 76% (38) of the respondents were not married.

TABLE 4.4: RESPONDENTS' RELIGIOUS DENOMINATION (n=50)

Religious denomination	Frequency	Percentage
Roman catholic	2	4
Seventh day Adventist	19	38
Pentecostal	12	24
New apostolic	10	20
United Church of Zambia	7	14
Total	50	100

Most 38% (19) of the respondents were Seventh Day Adventist and the least were Catholics 4% (2)

TABLE 4.5: RESPONDENTS' LEVEL OF EDUCATION (n=50)

Educational level	Frequency	Percentage
Basic	37	74.
High school	13	26
Total	50	100

Majority 74% (37) of the respondents' level of education was basic education which is grades nine and below and none had reached tertiary education.

4.2.2 SECTION B: KNOWLEDGE OF FAMILY PLANNING

TABLE 4.6: RESPONDENTS WHO HAVE EVER HEARD OF FAMILY PLANNING (n=50)

Heard about family planning	Frequency	Percentage
Yes	50	100
No	0	0
Total	50	100

All 100% (50) respondents had heard about family planning.

TABLE 4.7: RESPONDENTS SOURCE OF INFORMATION (n==50)

Information source	Frequency	Percentage
Health worker	16	32
Mass media	1	2
Family member	23	46
Peer	10	20
Total	50	100.

Majority 46% (23%) of the respondents heard about family planning from the family members whilst the 2% (1) heard from mass media.

TABLE 4.8: RESPONDENTS' RESPONSE ON THE MEANING OF FAMILY PLANNING (n=50)

Meaning of family planning	Frequency	Percentage
Know	48	96
Did not know	2	4
Total	50	100

Majority 96% (48) of the respondents knew the meaning of family planning and only 4% (2) did not know.

TABLE 4.9: RESPONDENTS' RESPONSE ON WHETHER CONTRACEPTIVES ARE USED TO CONTROL BIRTH AND SPACE CHILDREN (n=50)

Contraceptive use	Frequency	percentage
Yes	45	90
No	5	10
Total	50	100

Table 4.9 shows that majority 90% (45) of the respondents knew that contraceptives are used to control birth.

TABLE 4.10: RESPONDENTS' RESPONSE ON THE MODERN METHOD OF FAMILY PLANNING. (n=50)

Modern family planning methods	Frequency	Percentage
Pill	42	47
Condom	28	31
Injectables	20	22
Total	90	100

Most of the respondents knew the pill 47% (42) as a modern method of family planning whilst the injectables was least 22% (20) known.

N.B The total does not add up to more than 50 because some respondents knew more than one method of family planning.

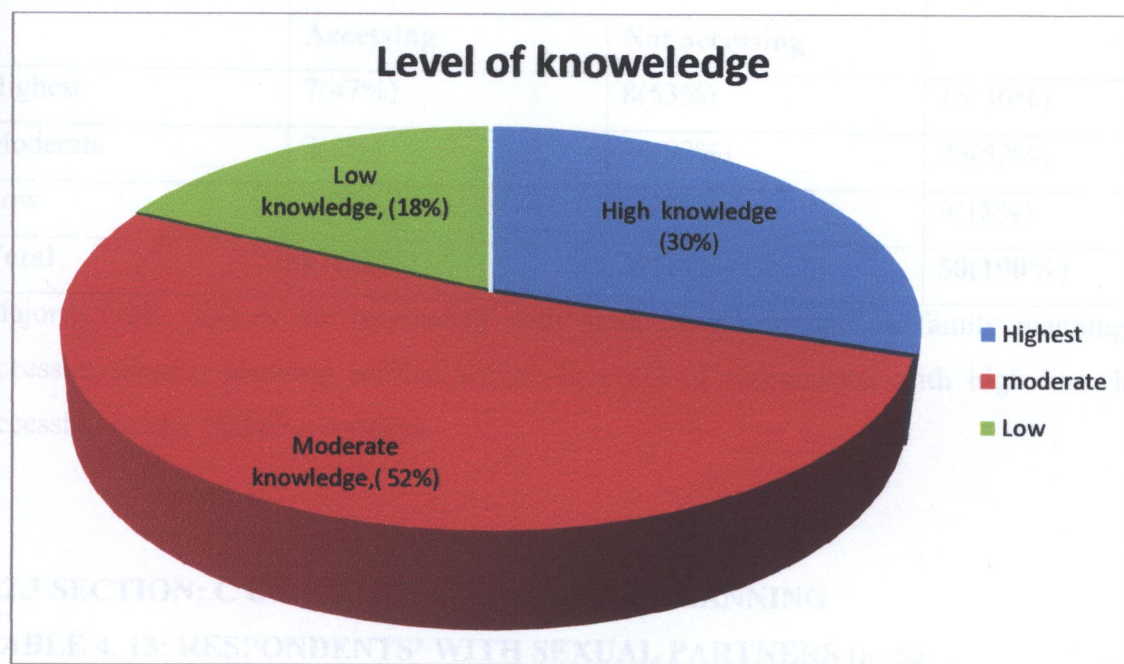
TABLE 4.11: RESPONDENTS' RESPONSES ON THE BENEFITS OF FAMILY PLANNING (n=50)

Benefits of family planning	Frequency	Percentage
Knows	34	68
Do not know	16	32
Total	50	100

The majority 68% (38) of the respondents knew the benefits of family planning.

TABLE 4.12: LEVEL OF KNOWLEDGE IN RELATION TO UTILIZATION OF FAMILY PLANNING SERVICES (n=50)

FIGURE 3: LEVEL OF KNOWLEDGE OF FAMILY PLANNING (n=50)



Most of 52% (26) of the respondents had moderate knowledge of family planning whilst 18% (9) had low knowledge.

Table 4.13 shows that most 66% (33) of the respondents had sexual partners.

TABLE 4.14: RESPONDENTS' RESPONSES ON THE FAMILY PLANNING METHODS UTILIZATION (n=50)

	Frequency	Percentage
Yes	12	24
No	38	76
Total	50	100

Majority 76% (38) of the respondents stated that they were not using any method of family planning

TABLE 4.12: LEVEL OF KNOWLEDGE IN RELATION TO UTILIZATION OF FAMILY PLANNING SERVICES (n=50)

LEVEL OF KNOWLEDGE	UTILIZATION OF FAMILY PLANNING SERVICES		TOTAL
	Accessing	Not accessing	
Highest	7(47%)	8(53%)	15(30%)
Moderate	2(8%)	24(92%)	26(52%)
Low	2(22%)	7(78%)	9(18%)
Total	11(22%)	39(78%)	50(100%)

Majority 92% (24) of the respondent with moderate knowledge on family planning were not accessing family planning service whilst 47% (7) of respondents with high knowledge were accessing family planning services.

4.2.3 SECTION: C UTILIZATION OF FAMILY PLANNING

TABLE 4. 13: RESPONDENTS' WITH SEXUAL PARTNERS (n=50)

	Frequency	Percentage
Yes	33	66
No	17	34
Total	50	100

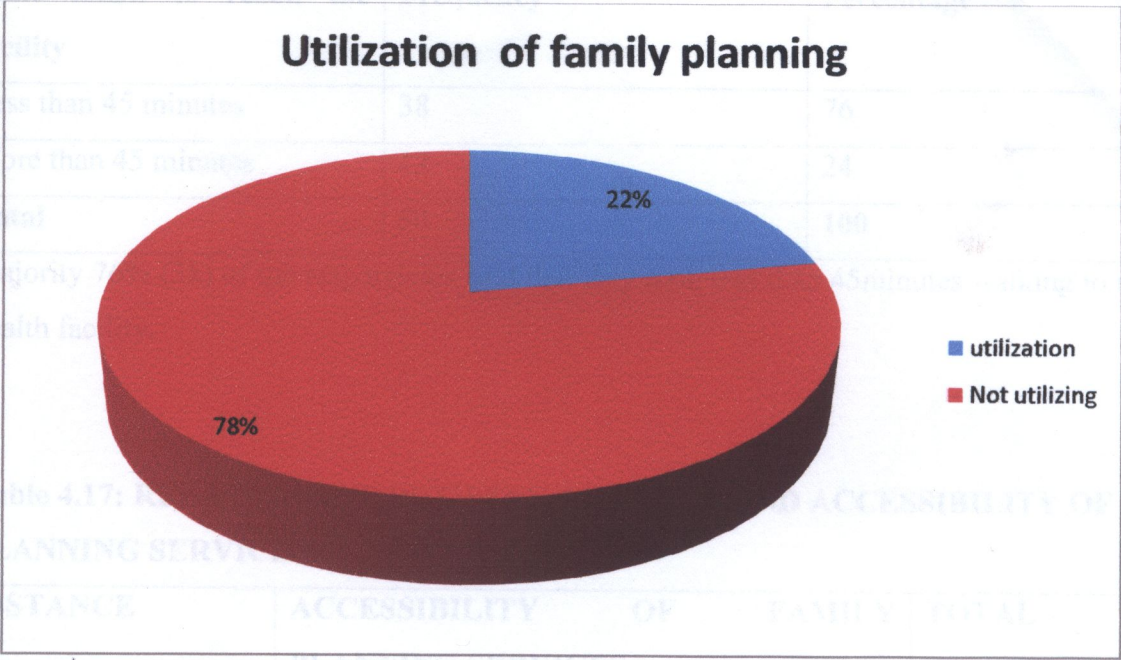
Table 4.13 shows that most 66% (33) of the respondents had sexual partners.

TABLE 4 .14: RESPONDENTS' RESPONSES ON THE FAMILY PLANNING METHODS UTILIZATION (n==50)

	Frequency	Percentage
Yes	12	24
No	38	76
Total	50	100

Majority 76% (38) of the respondents stated that they were not using any method of family planning

FIGURE 4: RESPONDENTS RESPONSE ON WHETHER THEY WERE UTILIZATION FAMILY PLANNING METHOD (n=50)



Majority 78% (39) of the respondents said that they were not utilization family planning method.

4.2.4: SECTION: D DISTANCE TO THE HEALTH FACILITY

TABLE 4.16: RESPONDENT’S RESPONSES ON THE TIME TAKEN TO REACH THE FACILITY (n=50)

Time taken to reach the facility	Frequency	Percentage
Less than 45 minutes	38	76
More than 45 minutes	12	24
Total	50	100

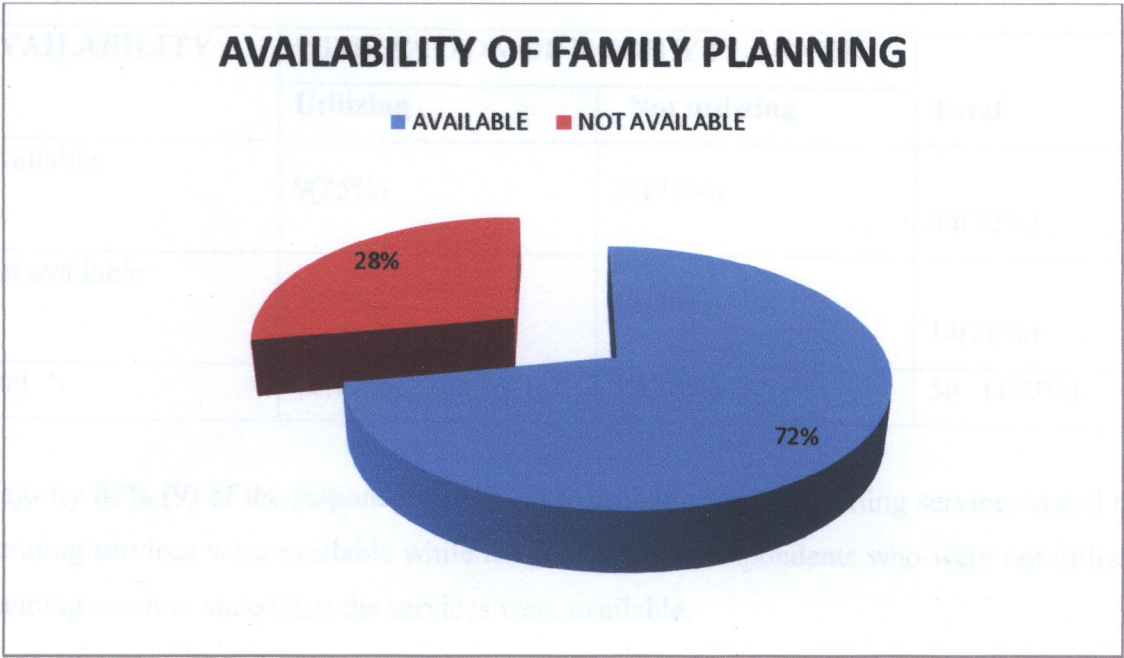
Majority 76% (38) of the respondents said that they took less than 45minutes walking to reach their health facility.

Table 4.17: RELATIONSHIP BETWEEN DISTANCE AND ACCESSIBILITY OF FAMILY PLANNING SERVICES

DISTANCE	ACCESSIBILITY OF FAMILY PLANNING SERVICES		TOTAL
	Accessing	Not accessing	
Near (Less than 45 minutes)	9(24%)	29(76%)	38(72%)
Far (more than 45 minutes)	2(17%)	10(83%)	12(24%)
Total	11(22%)	39(78%)	50(100%)

Majority 76% (29) of the respondents who were not utilization Family planning services took less 45 minutes to reach the health facility

FIGURE: 5 AVAILABILITY OF FAMILY PLANNING



Most 72% (36) of the respondents mentioned that family planning services were available at their health facility

4.2.5 SECTION F: ATTITUDE OF STAFF

TABLE 4.20: RESPONDENTS' RESPONSES ON WHETHER THEY HAD EVER VISITED A FAMILY PLANNING CLINIC (n=50)

Ever visited family planning clinic	Frequency	Percentage
Yes	14	28
No	36	72
Total	50	100

Majority 72% (36) of the respondents stated that they had never visited a family planning clinic.

TABLE 4.19: AVAILABILITY OF FAMILY PLANNING SERVICES AND UTILIZATION (n=50)

AVAILABILITY	UTILIZATION OF FAMILY PLANNING		Total
	Utilizing	Not utilizing	
Available	9(25%)	27(75%)	36(72%)
Not available	2(14%)	12(86%)	14(28%)
total	11(22%)	39(78%)	50 (100%)

Majority 82% (9) of the respondents who were utilizing family planning services stated that family planning services were available while 69.% (27) of the respondents who were not utilizing family planning services stated that the services were available.

4.2.6 SECTION F: ATTITUDE OF STAFF

TABLE 4.20: RESPONDENTS' RESPONSES ON WHETHER THEY HAD EVER VISITED A FAMILY PLANNING CLINIC (n=50)

Ever visited family planning clinic	Frequency	Percentage
Yes	14	28
No	36	72
Total	50	100

Majority 72% (36) of the respondents stated that they had never visited a family planning clinic.

TABLE 4.21: REASONS FOR THE VISIT TO THE FAMILY PLANNING CLINIC (n=14)

Reason for visiting the clinic	Frequency	Percentage
To get contraceptives	12	86
For advice	2	14
Total	14	100

Majority 86% (12) of the respondents who visited the family planning clinic went to get contraceptives.

TABLE 4.22: RESPONDENTS' RESPONSE ON WHICH HEALTH PROVIDER ATTENDED TO THEM (n=14)

Provider	Frequency	Percentage
Nurse	14	100
Doctor	0	0
Clinical officer	0	0
Cleaner	0	0
Total	14	100

All 100% (14) the respondents who visited the health facility for family planning services were attended to by a nurse.

TABLE 4.23: RESPONDENTS RESPONSE ON THE RECEPTION BY THE MEMBERS OF STAFF (n=14)

Staff s' reception	Frequency	Percentage
Good	14	100
bad	0	0
Total	14	100

All 100% (14) the respondents stated that the reception from members of staff was good.

TABLE 4.24: CATEGORY OF ATTITUDE (n=14)

Attitude	Frequency	Percentage
Positive	14	100
Negative	0	0
Total	14	100.0

All 100% (14) the staff had positive attitude towards the clients who visited the health facility for family planning services.

4.2.7 SECTION G: RELIGIOUS AND CULTURAL BELIEFS

TABLE 4.25: RESPONDENTS RESPONSE ON WHETHER THEIR RELIGIOUS DENOMINATION ALLOWED THEM TO USE FAMILY PLANNING (n=50)

Religious denomination allow to use family planning	Frequency	Percentage
Yes	22	44
No	4	8
I don't know	24	48
Total	50	100

Most 48% (24) of the respondents didn't know whether their religious denomination allowed them to use family planning methods or not whilst the 8% (4) said that their denomination did not allow.

TABLE 4.26: RESPONDENT RESPONSES ON WHETHER THEY HAD DISCUSSED FAMILY PLANNING WITH THEIR SPOUSE/PARTNER (n=33)

Discussed with spouse	Frequency	Percentage
Yes	16	48.5
No	17	51.5
Total	33	100

Most 51.5% (17) of the respondents who had partners/spouse said that they did not discuss with their partners on use of family planning.

TABLE 4.27: RESPONDENTS' RESPONSES ON WHETHER THEIR SPOUSE/PARTNER ALLOWED THEM TO USE FAMILY PLANNING METHOD (n=16)

Spouse allow use of family planning	Frequency	Percentage
Yes	14	87
No	2	13
Total	16	100

Majority 187% (14) of the respondents who discussed family planning with their spouse/partner stated that their spouse/partner agreed the use of family planning method and 13% (2) did not agree.

TABLE 4.28; RESPONDENTS' RESPONSE ON WHETHER THEY WERE AWARE ABOUT BELIEFS THAT MAY PREVENT THEM FROM SEEKING AND USING FP (n=50)

Aware of beliefs that prevent use of family planning	Frequency	Percentage
yes	30	60
No	20	40
Total	50	100.0

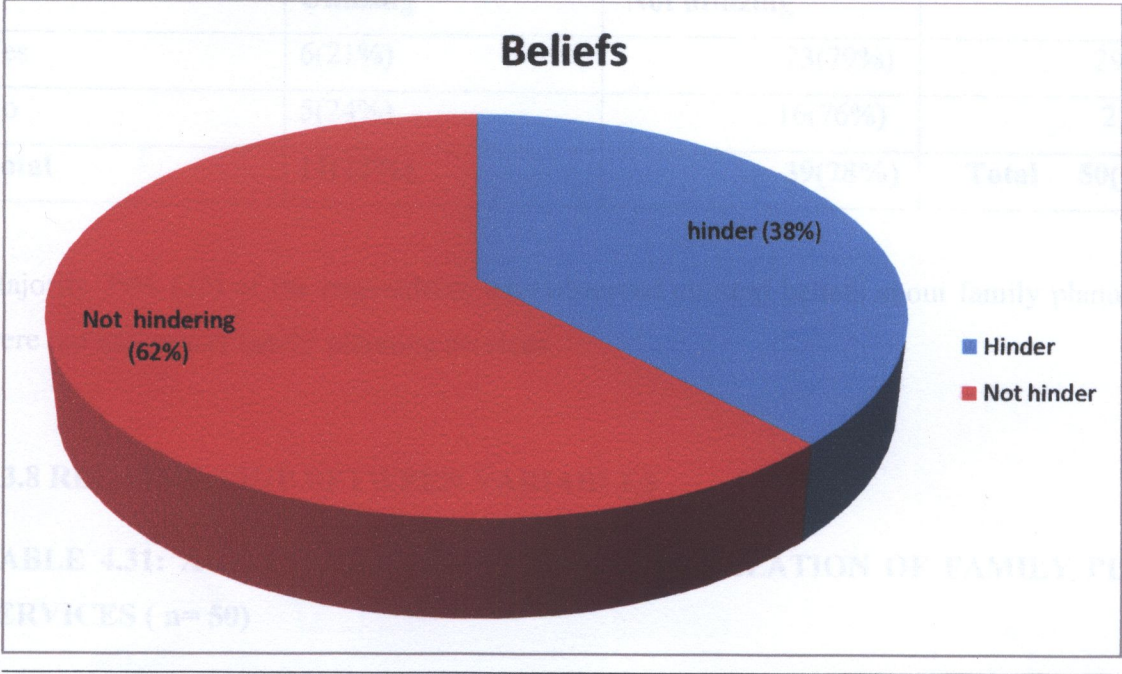
Most 60% (30) of the respondents mentioned that there were some beliefs that prevent them from seeking and utilizing family planning.

TABLE 4.29: RESPONDENTS RESPONSES ON BELIEFS THEY KNEW REGARDING USE OF FAMILY PLANNING METHODS (n=30)

Beliefs about use of family planning	Frequency	Percentage
Disabled baby	5	17
Infertility	18	60
For married only	7	23
Total	30	100

Most 60% (18) of the respondents stated that using family planning methods can lead to infertility.

FIGURE 6: RESPONDENTS' RESPONSES ON RELIGIOUS AND CULTURAL BELIEFS HINDERING USE OF FAMILY PLANNING (n=30)



Most 62% (19) of the respondents said that they not aware about religious and cultural beliefs that hinder them from using family method.

TABLE 4.30: RELATIONSHIP BETWEEN BELIEFS ABOUT FAMILY PLANNING AND UTILIZATION

CULTURAL BELIEFS	UTILIZATION OF FAMILY PLANNING SERVICES		TOTAL
	Utilizing	Not utilizing	
Yes	6(21%)	23(79%)	29(58%)
No	5(24%)	16(76%)	21(42%)
Total	11(22%)	39(78%)	Total 50(100%)

Majority 79% (23) of the respondents who observed cultural beliefs about family planning beliefs were not utilization family planning services.

4.3.8 RELATIONSHIP BETWEEN VARIABLES

TABLE 4.31: AGE OF RESPONDENTS AND UTILIZATION OF FAMILY PLANNING SERVICES (n= 50)

AGE	UTILIZATION OF FAMILY PLANNING		TOTAL
	Utilizing	Not Utilizing	
13-14	1(9%)	9(23%)	10(20)
15-16	2(18%)	11(28%)	13(26%)
17-19	8(73%)	19(49%)	27(54%)
Total	11(22%)	39(78%)	50(100)

Majority 73% (8) of the respondents aged 17 to 19 were utilizing family planning though 49% (19) were not utilizing.

TABLE 4.32: SEX OF RESPONDENTS AND UTILIZATION (n=50)

SEX	UTILIZATION OF FAMILY PLANNING		TOTAL
	Utilizing	Not Utilizing	
Male	3(27%)	8(73%)	11(22%)
Female	8(20%)	31(80%)	39(78%)
Total	11 (22%)	39(78%)	50(100%)

Majority 80% (31) of the respondents not utilizing family planning services were females.

TABLE 4.33: RELATIONSHIP BETWEEN MARITAL STATUS AND UTILIZATION OF FAMILY PLANNING (n=50)

MARITAL STATUS	UTILIZATION OF FAMILY PLANNING		TOTAL
	Utilizing	Not Utilizing	
Single	8(21%)	30(79%)	38(76%)
Married	3(25%)	9(75%)	12(24%)
Total	11(22%)	39(78%)	50(100%)

Majority 79% (30) of the single respondents were not utilizing family planning services and the least 21% (8) of the singles were utilizing family planning services.

TABLE 4.34: RELATIONSHIP BETWEEN LEVEL OF EDUCATION AND UTILIZATION OF FAMILY PLANNING SERVICES (n=50)

HIGHEST LEVEL OF EDUCATION	UTILIZATION OF FAMILY PLANNING		TOTAL
	Utilizing	Not Utilizing	
Basic education	6(16%)	31(82%)	37(74%)
High school	5(38%)	8(62%)	13(26%)
Total	11(22%)	39(78%)	50(100%)

Majority 82% (31) of the respondent with basic education did not utilize family planning service whilst 16% (6) of respondent with basic education were utilizing family planning.

TABLE 4.36: HEARD ABOUT FAMILY PLANNING AND UTILIZATION

HAVE HEARD ABOUT FAMILY PLANNING	UTILIZATION OF FAMILY PLANNING		TOTAL
	Utilizing	Not utilizing	
Yes	11(22%)	39(78%)	50(100)
No	0(0%)	0(0%)	0(0%)
Total	11(22%)	39(78%)	50(100%)

Majority 78% (39) of the respondents who had heard about family planning were not utilizing any family planning method and 22% (11) were utilizing family planning services.

TABLE 4.37: SOURCE OF INFORMATION OF FAMILY AND UTILIZATION

SOURCE OF INFORMATIO N ABOUT FP	UTILIZATION OF FAMILY PLANNING SERVICES		TOTAL
	Utilizing	Not utilizing	
Health worker	7(44%)	9(56%)	16(32%)
Mass media	0(0%)	1(100%)	1(2%)
Family member	4(17%)	19(83%)	23(46%)
Peer	0(0%)	10(100%)	10(20%)
Total	11(22%)	39(78%)	50(100%)

All 100% (10) of the respondents who had heard about family planning from peers were not utilizing family planning while 44% (7) of the respondents who were using family planning had heard about it from a health worker.

5.0 DISCUSSION OF FINDINGS AND IMPLICATIONS FOR THE HEALTH CARE

FIGURE 7: SUGGESTIONS BY THE RESPONDENTS ON HOW TO IMPROVE UTILIZATION TO FAMILY PLANNING SERVICES AMONG ADOLESCENTS (n=50)

5.1. CHARACTERISTICS OF THE SAMPLE

This chapter presents the findings and discussions of the study which was aimed at determining

the utilization of family planning services among adolescents in the study area. The

results were based on the analysis of data obtained from a sample of 50 adolescents aged 13 to 19

years. The demographic characteristics of the sample are relevant to the study as they provide a

religious demographic profile of the sample. The demographic characteristics were

essential for the study as they provide a profile of the sample.

5.1. DISCUSSION

5.1.1. SOCIO-DEMOGRAPHIC CHARACTERISTICS

Most 56% (28) of the respondents were aged 13 to 14 years while 18% (9) were aged

between 15 and 19 years. The majority of respondents, 34% (17) of the respondents

were females. The Zambia Demographic and Health Survey (2007) indicates that there are more

females than males in Zambia and that the males are slightly more than females in the rural areas

which did not compare with this study which indicated that they are more females. The findings of

this study show that majority of the respondents 74% (38) were single and 24% (12) were married

and 2% (1) were divorced. The majority of the respondents were Seventh Day Adventists

denomination most 36% (19) of the respondents were Seventh Day Adventist (Table 4.4). This

could be so because most of the Tonga speaking people in Southern Province are Seventh Day

Adventists as the church originated from Southern Province.

Majority of the respondents 74% (37) had basic education meaning that their grades ranged from

grade one to nine while 26% (13) had high school which includes grades ten to twelve (Table 4.5).

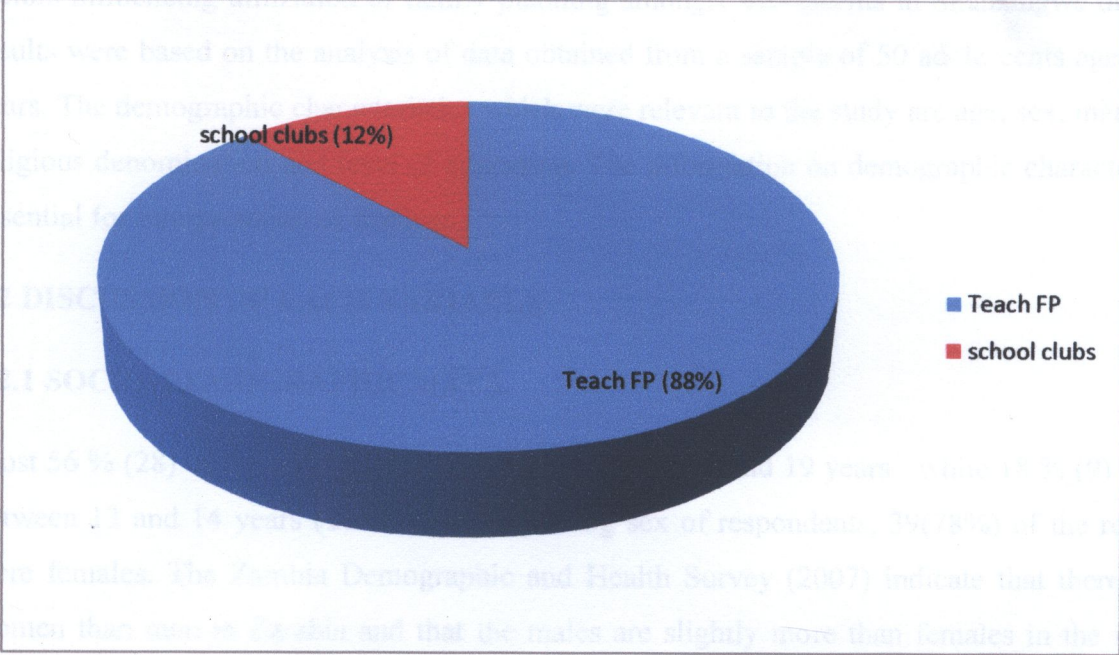
None of the respondents had studied tertiary education. This result shows that Zambia is

progressing towards the achievement of the Millennium Development Goal 2 on attainment of

universal primary education for all by 2015. However, the country still needs to do a lot as there are

people in rural areas especially women who do not attain or reach grade twelve before nineteen.

This result confirms the findings of CBO (2007) which showed that only 38% of females aged 15-



Most 88% (44) of the respondents recommended that adolescents should be taught about family planning whilst 12% (6) recommended that youth clubs should be introduced in schools.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS AND IMPLICATIONS FOR THE HEALTH CARE SYSTEM

5.1. CHARACTERISTICS OF THE SAMPLE

This chapter presents the findings and discussions of the study which was aimed at determining factors influencing utilization of family planning amongst adolescents in Sinazongwe district. The results were based on the analysis of data obtained from a sample of 50 adolescents aged 13 to 19 years. The demographic characteristics which were relevant to the study are age, sex, marital status, religious denomination and level of education. The information on demographic characteristic was essential for interpretation of findings.

5.2 DISCUSSION OF EACH VARIABLE

5.2.1 SOCIO-DEMOGRAPHIC DATA

Most 56 % (28) of the respondents were aged between 17 and 19 years while 18 % (9) were aged between 13 and 14 years (**Table 4.1**). Regarding sex of respondents, 39(78%) of the respondents were females. The Zambia Demographic and Health Survey (2007) indicate that there are more women than men in Zambia and that the males are slightly more than females in the rural areas which did not concur with this study which indicated that they are more females. The findings of this study show that majority of the respondents 76% (38) were single and 24 % (12) were married (**Table 4.3**). Most of respondents were single because they were still in school. Regarding religious denomination most 38% (19) of the respondents were Seventh Day Adventist (**Table 4.4**). This could be so because most of the Tonga speaking people in Southern Province are Seventh Day Adventists as the church originated from Southern Province .

Majority of the respondents 74% (37) had basic education meaning that their grades ranged from grade one to nine while 24% (12) had high school which includes grades ten to twelve (**Table 4.5**). None of the respondents had attained tertiary education. This result shows that Zambia is progressing towards the achievement of the Millennium Development Goal 2 on attainment of universal primary education for all by 2015. However, the country still needs to do a lot as there are people in rural areas especially women who do not attain or reach grade twelve before nineteen. This result confirms the findings of CSO (2007) which showed that only 38% of females aged 15 -

19 have attained some secondary education but not completed grade 12. The study also correlates with a study done by Ringheim and Gribble (2010), in four Sub-Saharan African countries which found that 83% of women aged 15 - 19 in Sub-Saharan Africa live in low-income countries and their education levels are low.

5.2.2 KNOWLEDGE ABOUT FAMILY PLANNING

Knowledge is a state of knowing about a particular fact and situation (Hornby, 2006). Knowledge about family planning is essential to help adolescent to access family planning and in turn prevent early and unwanted pregnancy. The study attempted to measure the respondents' knowledge levels regarding family planning and the following questions were asked; Have you ever heard of family planning, what is the definition of family planning, state the methods of family planning and what benefits are derived from using family planning. The results indicated that 100% (50) of the respondents had heard about family planning (**Table 4.6**). Most 46% (23) of the respondents heard of family planning from a family member while 32% (16) heard from a health worker (**Table 4.7**). The findings do not agree with the study conducted in Ethiopia by Gizaw and Regass (2011) on Family planning service utilization which revealed that majority of respondents heard information about family planning from a health worker. This could indicate that visit the health facility and or the health workers interact with the community more than health workers in Sinazongwe district. People may behave in a certain way according to the information they get therefore, accurate information is very cardinal and will make some positive behavioral change. Accurate information is likely to be gotten from a health worker and then the benefits will be well understood. The health belief model construct about perceived benefits is a person's opinion of value or usefulness of a new behavior in decreasing the risk of developing a condition. Benefits will only be perceived if one has accurate information. Therefore it is important to educate the adolescents with accurate information on family planning.

The findings revealed that 96% (48) defined the term family planning correctly and only 4% (2) did not know (**Table 4.8**). Most 90% (45) of the respondents said that contraceptives were used to control births (**Table 4.9**). Majority 68% (34) of the respondents knew the benefits of family planning (**Table 4.3.12**). Generally, most 52% (26) of the respondents had moderate knowledge of family planning while 30% (15) had high knowledge (**Figure 1**). This may be attributed to the low level of education of the respondents as most of them attained only basic education. The finding in this study also correlates with the study done in Ethiopia by Tegegn, Yazachew and Gelaw (2009)

which indicated that the level of knowledge about family planning services among adolescents were moderate to high. In this study, majority of the respondents knew the pill as a modern method of family planning which correlates with the Zambia Demographic Health Survey 2007 which also indicated that the pill was mostly known as a modern method of family planning in the country (**Table 4.10**). Akintade (2010) carried out a study in Lesotho, on awareness, use and barriers to family planning services among female students at the national University of Lesotho and found that lack of detail and accurate information on contraceptive influenced adoptions of family planning method among the female students. However, awareness of family planning was high among the participant (98.3%) which correlates with the findings of the current study where awareness levels was 100% except that a condom was the most commonly known and used family planning method instead of the pill. Another study done by Kennedy' Gray, Azzopardi and Creati in 2008 on adolescent fertility and family planning in East Asia and the Pacific revealed that adolescent had lower use of contraception, poorer knowledge of family planning, which also correlates with this study .

The finding of this study on the level of knowledge also correlates with a study done in Malawi by Gondwe (2008) on factors contributing to low utilization of family planning amongst adolescents. It indicated that lack of proper knowledge pertaining to family planning methods, inhibited adolescents' to use the available family planning services. The study has revealed that majority of the respondents with moderate knowledge on family planning were not accessing family planning services (**Table 4.12**). Inadequate knowledge is likely to hamper an individual from using services because the need to use the service will not be perceived important and useful. The findings in this study indicated that adolescent believed that family planning was for married people. This in line with the health belief model construct about self efficacy which explains that people do not try to do something new unless they think they can do it. Even if someone believes a new behavior is useful, but does not think he or she is capable of doing it, there is likelihood of it not being tried.

5.2.3 UTILIZATION OF FAMILY PLANNING

The study showed that majority 78% (39) of the respondents were not utilizing family planning services while 22% (11) were utilizing (**Figure 2**). This may be attributed to lack of information and low education levels of the adolescents. The findings in this study are similar to what was indicated in a Demographic and Health Survey for nine Latin American countries, in South and Central America, which showed that the uneducated and illiterate adolescents were not utilizing family planning compared to better educate one. Education level may have a great influence on the understanding of family planning benefit. The high the education level the better the understanding. The findings revealed that majority 44% (97) of the respondents who had heard of family planning from a health worker were utilizing (**Table 4.37**). This may mean that the respondents had accurate information of family planning services and hence motivated to use the service. The findings explain the health belief model construct about cues to action in this case the health workers motivated the adolescents to use family planning services.

Similarly, a study done in Chibombo district in 2009 revealed low access and utilization of family planning services by adolescents and young people (Silumbwe and Lesa 2009). A study by Kennedy , Gray , Azzopardi and Creati (2011) conducted from the 33 low and lower middle income countries in the East Asia and Pacific region, is also in line with this current study which showed that adolescent women aged 15 - 19 years had lower use of contraception. This study further indicated that 24% (12) of the respondents were using a method of family planning and 9 of these were using injectables (**Table 4.15**). The findings in this study revealed that 73% (24) of respondents who were not accessing family planning services reported not having been involved in sexual activities (**Table 4.35**). The findings to some extent correlates with Tayo, Akinola, Babatunde, Adewunmi and Osinusi (2011) study which revealed that amongst the respondents who were not using any method of family planning 67% did not indulge in sexual activities. According to the Zambia Demographic and Health Survey (2007), about 20% of the adolescents aged 15-19 in Zambia were using a family planning method except that most of the respondents were using oral contraceptive pill unlike in this study where most of the respondents were using injectables. This study indicated that most 57% (4) of respondent who were using a family planning method were aged 19 years while 17% (1) was 14 years (**Table 4.31**). However, utilization of family planning services increased with age (**Table 4.31**). A study by Amazigo (2007) from Africa reported similar

findings. This could be facilitated by the fact that older adolescents, especially those married were slightly able to negotiate for the use of contraceptives.

A study done in Lesotho at a University on awareness of family planning services revealed that utilization of family planning was high amongst the participant. A condom was the most commonly known and used family planning method while in this study utilization was low and a few respondents who were using a family method used injectables. The difference is due to the high education level in the university respondents. Similarly, utilization was high in married adolescents than the unmarried (**Table 4.33**). A study done in Nigeria by Tayo (2010) about Contraceptive knowledge and usage amongst female secondary school students revealed that, 85% of the sexually active respondents were not bothered about using contraception. This agrees with this study which indicated that 73% (24) of sexually active respondents were not accessing family planning services (**Table 4.35**). A review of DHS report from East Asia and the Pacific (2011) indicated that adolescents women have lower use of contraception; less access to information and services than adult women, the findings concurs with this study which revealed a low utilization of family planning services among the adolescents. The findings revealed that all 100% (6) of the respondents aged 14 and 15 years respectively were not utilizing family planning services (**Table 4.28**) and that the majority of the respondents who were not utilizing family planning services were females (**Table 4.32**). This may be due to gender inequalities which make a female not to negotiate for utilization. However, majority 79% (39) of the respondents who were not utilizing were single (**Table 4.33**) and had basic education as the level of education is still low(**Table 4.34**). In this study, majority 88% (15) of the respondents who reported having had no sexual partners were not utilizing as it is obvious one without a sexual partner would not use family planning services (**Table 4.35**) and 78% (39) of those who had heard about family planning were not utilization the services (**Table 4.36**). The results also show that all the respondents who had heard about family planning from peers were not utilization family planning services (**Table 4.37**).

5.2.4 DISTANCE FROM HEALTH FACILITY

The findings show that majority 83% (10) of the respondents who said that they took more than 45 minutes to reach the health facility were not accessing family planning while 17% (2) were accessing family planning services (**Table 4.17**). Respondents who walked more than 45 minutes were not utilization family planning this correlates with the finding in the study done by Mekonnen

(2011) which identified long distance as one factor which hinder accessibility of family planning services. Bersamin and Todd (2011) in their study of effects of distance on utilization of family planning services among adolescents suggested that long distance decreased the chances of utilizing family planning services. Increased options for family planning services such as outreach may lead to increase access of family planning.

5.2.5 AVAILABILITY OF FAMILY PLANNING SERVICES

The findings show that majority 74% (37) of the respondents stated that their nearest health facility was offering family planning services (**figure 3**). Among the respondent who were not utilizing family planning services 86% (12) stated that the services were not available. (**Table 4.19**). Odu and Ikuteyijo, (2008) in their study indicated that non availability of family planning service led to underutilization of family planning service by the adolescent which correlate with the current study. In contrast, a similar study done in Canada by Buhi and Goodson (2007) on Predictors of adolescents' sexual behavior and intention revealed that adolescents did not know where to go to seek for contraception.

5.2.6 ATTITUDE OF STAFF

All the respondents 100% (14) who visited the family planning clinic stated that the attitude of staff was good and were all attended to by nurses (**Table 4.24**). Equally, the study done by Kanthiti (2007) both in African and Asian adolescents showed that providers' positive attitudes towards the respondents was an attracting and facilitating factor in service utilization.

5.2.7 BELIEFS ABOUT FAMILY PLANNING

The findings revealed that majority 79% (23) of the respondents who observed some cultural beliefs that prevent them from seeking family planning were not accessing family planning services (**Table 4.30**). The common beliefs were that family planning was for married people only, it could bring infertility and it can make one give birth to a disabled baby (**Table 4.29**). Most 60% (18) of the respondents mentioned infertility as one of the complications of using contraception (**Table 4.29**). This correlates with a study by Gondwe (2008) which revealed negative beliefs pertaining to different family planning methods which are probably due to poor knowledge they have on the methods in general. In addition, such beliefs had influenced their low utilization of the available family planning services.

This study has revealed that most 48% (24) of the respondents did not know whether their religion allowed the use of family planning methods (**Table 4.25**). On the other hand, a study by Akintade (2010) revealed that religion was a barrier to use of modern contraceptives which does not correlate with this study. A study conducted in Uganda by Nalwadda (2010) revealed that the young people believed that contraceptives interfered with fertility, and they were frightened to use something that could harm their ability to reproduce. Most of the married and unmarried women believed that pills burned the woman's eggs. The findings in this Ugandan study concur with this study that revealed that respondents believed that infertility is one of the complications of using contraceptives.

5.3 SIGNIFICANCE TO NURSING

5.3.1 NURSING EDUCATION

The study findings revealed that all 100% (50) of the respondents had heard about family planning, 32% (16) got the information from a health worker while majority 60% (32) got it from other sources. It also shows that Fifty two percent of the respondents had moderate knowledge. An individual should have accurate and adequate knowledge in order for them to make an informed decision. This implies that the nurse educator should prepare nurses to be able to meet the health needs of all age groups. The Nurse educator should equip nurses with adequate knowledge on reproductive health and methodology to use in order for them to be able to impart this knowledge into adolescents. The nurse educator should emphasize the component of information education and communication on the importance of using family planning. The Nurse Educators should be provided with educational and financial support in order for them to perform their tasks effectively.

5.3.2 NURSING PRACTICE

The role of the Nursing professionals as a source of information for the adolescents seems to be insignificant or eroded. This is demonstrated by this study which revealed that only 32% (16) got the information about family planning from a health worker. Interaction between the adolescent and the nurses in health institutions is minimal. There is a discordance rate between knowledge and utilization when it comes to the use of family planning services as it includes sensitive issues such as sexual related health problems. This implies that there is inadequate dissemination of health information by health workers. Innovative ways of disseminating information should be used and this may include the use of more integrated approach by involving all stakeholders particularly adolescents' families and other health professionals who have a vital role to ensure adequate knowledge and favorable attitudes for utilization of the reproductive health in the locality. Reaching out to the adolescents in villages and intensifying school health services to give accurate information about family planning would also assist with improving health for adolescents.

5.9.3 NURSING ADMINISTRATION

This study revealed that all 100 % (50) the respondents had heard about family planning and only 32% (16) got the information from a nurse. This could be due to shortage of nurses who may not have enough time to educate the community on family planning. This could in turn have negative effect on provision of quality reproductive health services. Nurse Managers should ensure that necessary stocks of contraceptives and other supplies are available all the time. They should supervise family planning nurses regularly to ensure that they give IEC to clients. More nurses should be sent to the rural areas so that they can improve on staffing levels hence improve on service delivery. Nurse Managers should advocate for training of nurses on adolescent reproductive health issues so that adolescents are handled appropriately and hence quality and effective health services of adolescents will be provided. Training of peer educators could be of vital significance in this matter and Nurse Manager should advocate for resources to train peer educators in the community and secondary schools.

5.3.4 NURSING RESEARCH

This study indicates that most 53% (8) of respondents who had high knowledge were not accessing family planning services. More research should be conducted on utilization of family planning by adolescents for instance, further community based studies should be conducted on adolescents who are out of school. This will allow for an understanding of how to effectively serve this larger group of the community.

5.4 CONCLUSION

The study sought to determine factors influencing accessibility of family planning services amongst adolescents in Sinazongwe district in Southern province. The study objectives were met which needed to determine the levels of knowledge of family planning and to establish factors that prevent adolescents from utilizing family planning service. Fifty adolescents aged from 13 -19 years were selected from different villages in Sinazongwe. A semi structured interview schedule was used to collect data. A simple random sampling method was used to select data the respondents. Data was entered on the data master sheet and analyzed manually. The study revealed that most of the respondents had attained basic education. The finding of the study showed that the adolescents had inadequate and inaccurate knowledge about family planning. The study showed a relationship between knowledge and utilization of family and also between the educational level and

knowledge. Despite the high rate of sexual activity in the group studied, the contraceptive usage rates were low. Because of lack of accurate information about reproductive health services, young people may face the risk of early, frequent, or unwanted pregnancy, increased morbidity, both individually and their children and the spread of HIV.

There is a need for aggressive support about adolescent reproductive health before beginning of sexual activity and dissemination of information on family planning methods amongst the adolescents. The researcher failed to reject the null hypothesis accepted because the findings indicate that most of the adolescents had moderate knowledge. The other hypotheses which indicated that distance to a health facility is a factor which may influenced utilization and the availability of family planning services were rejected because even adolescents who took less than 45minutes to reach the clinic were not utilizing family planning services. Equally, when the family planning services were available most adolescents did not utilize the service.

5.5 RECOMMENDATIONS

5.5.1 MINISTRY OF HEALTH (POLICY MAKERS)

The Ministry of Health as a Policy Maker should make it compulsory for all Health Centres in the country to offer youth friendly services where adolescents can access reproductive health information. The Ministry of Health should also collaborate with the Ministry of Education so the education program/curriculum should be designed based on current available scientific knowledge to impart correct and accurate knowledge about family planning and sexual health. This is to avoid continuous mis-information and wrong teaching that constitute the present unstructured teaching on family planning. Majority 88% (44) of the respondents recommended that adolescents should be taught about family planning so that they could have accurate information to allow them to make informed decision. There is need for young women to receive information about contraception and promote women's right to manage their reproductive health, create awareness and dispel myths about contraceptives.

The Ministry of Health should employ more nurses and other workers so that they can work effectively to deliver health services.

5.5.2 TO THE DISTRICT MEDICAL OFFICE

The District Medical officer should ensure that health care delivery centres have adequate staffing so that quality health services are delivered. There is the need for continuous retraining of family

5.5.2 TO THE DISTRICT MEDICAL OFFICE

The District Medical officer should ensure that health care delivery centres have adequate staffing so that quality health services are delivered. There is the need for continuous retraining of family planning service providers so that they are up to date with emerging trend in contraceptive advancement and provision of effective counseling. Programmes to train peer educators should be continuous to increase effort to offer reproductive health services that are well motivated and responsive to the sexual and reproductive needs of adolescents. The adolescents should participate in planning adolescents' activities in the community so that they feel part of the programmes and will easily implement them.

5.5.3 TO THE DISTRICT EDUCATION BOARD SECRETARY (DEBS)

There is the need for the schools to incorporate sexual health programmes for students in the school curricula. They should be introduced to reproductive health services whilst at school. This will to a larger extent impact life skill in the young people who will be empowered and enable them develop the appropriate negotiation skills especially in the area of reproductive and sexual health.

5.6 DISSEMINATION OF FINDINGS

A report on the findings of the research was compiled at the end of the study which will be submitted to the University of Zambia for references, Department of Nursing Sciences, Medical Library for reference, Ministry of Health for implementation of more programmes in the community, Sinazongwe Medical Office for reference and so that they can implement some programmes in the community. The researcher went back to the community where the study was conducted to disseminate the findings. This was done through School meetings and village meetings in which adolescents' were also involved. Attempts were made to disseminate the finding of the study at any scheduled conference or seminar for public knowledge and action to motivate adolescent utilization of family planning services.

5.7 LIMITATION OF THE STUDY

The following are the limitation of this study:

- The study of adolescents from 5 health centres that is results might not be generalized to all the health centres in the district and the sample 50 was too small therefore generalization should be made with caution.
- Funding of the study project was not adequate therefore the researcher failed to employ assistants.
- Mainly closed ended questionnaire were used to collect data from respondents in this study which could have limited the response options of participants.
- Face to face interview was used and there was possibility of the respondents not have reviewed sensitive information in the presence of the interviewee.

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INTERVIEW SCHEDULE FOR ADOLESCENTS

TOPIC: FACTORS INFLUENCING UTILIZATION OF FAMILY PLANNING
AMONGST ADOLESCENTS IN SINAZONGWE DISTRICT

INTERVIEW SCHEDULE NUMBER.....

Place of interview.....

Name of Interview.....

Duration of interview.....

Serial Number of respondent.....

INSTRUCTIONS TO THE INTERVIEWER

1. Introduce yourself to the respondent.
2. Explain the purpose of the interview.
3. Get verbal consent from the interviewee.
4. Assure the respondents of confidentiality and anonymity.
5. Do not write the name of the respondents on the schedule to ensure anonymity.
6. Tick in the box next to the chosen response, for questions with alternatives or fill responses in the space provided.
7. Write all responses clearly.
8. Thank the respondent at the end of each interview.

1. What was your age on your last birthday?

2. What is your sex?

- a. Male []
- b. Female []

3. What is your marital status?

- | | | |
|---------------------------|-----|-----|
| a. Single | | [] |
| b. Married | [] | |
| c. Divorced | [] | |
| d. Widowed | [] | |
| e. Others (Specify) _____ | | |

4. What is your Religious denomination?

- a. Roman Catholic []
- b. Seventh Day Adventist []
- c. Jehovah's Witness []
- d. Pentecostal []
- e. New apostolic []
- f. Others (Specify) _____

5. What is your highest level of education?

- | | | |
|-------------------------|-----|-----|
| a. Primary | [] | [] |
| b. Secondary | [] | |
| c. Tertiary | [] | |
| d. Never been to school | [] | |

SECTION B: KNOWLEDGE ON FAMILY PLANNING

SERVICES

6. Have heard about family planning/ contraception?

- a. Yes []
- b. No []

7. If yes, what were the sources of information about family planning?

- a. Health workers []
- b. Mass media [] []
- c. Family members []
- d. Peers []
- e. other, specify _____

8. What is family planning / contraception?

- a. Having children frequently []
- b. Having children when you want them [] []
- c. Stopping couples from having children. []

9. Do you know that contraceptives are used to control births and space children?

- a. Yes []
- b. No []

10. What modern methods of family planning do you know?

Tick from the list.

- a. Pill []
- b. Condom []
- c. Injectable []
- d. Inplants []
- e. Using herbs []

11. What are the benefits can one derive from family using planning?

(you can tick more than one)

- | | | |
|---|-----|-----|
| a. Control number of birth | [] | [] |
| b. Prevent unplanned/unwanted pregnancy | [] | |
| c. Prevent sexually transmitted infection | [] | |
| d. Enhance sexual performance | [] | |
| e. No significant positive effect | [] | |
| f. I do not know | [] | |

SECTION: ACCESSIBILITY OF FAMILY PLANNING

12. Do you have a sexual partner

- a. Yes []
b. No []

13. Are you using any method of family planning

- a. Yes []
b. No []

14. If yes to question 13, which method are using?

.....

SECTION D: DISTANCE

15.

- | | | |
|-------------------------|-----|-----|
| a. Less than 45 minutes | [] | [] |
| b. More than 45 minutes | [] | |

SECTION E: AVAILABILITY OF FAMILY PLANNING**SERVICE**

16. Does your health facility offer family services?

a. Yes []

b. No []

[]

17. Where can family planning services be accessed?

a. Health facility []

b. Trading shop []

[]

c. Community health workers []

SECTION F: ATTITUDE OF STAFF

18. Have you ever visited a family planning clinic?

a. Yes []

[]

b. No []

19. If yes to item 18, what was the purpose of the visit?

.....

20. Which service provider attended to you ?

a. Doctor []

b. Nurse []

c. Clinical officer []

d. Cleaner []

[]

e. Others specify.....

21. Was the reception from the members of staff?

a. Good []

b. Bad []

[]

22. Have you ever been denied contraceptives before/ family planning service before?
- a. Yes
 - b. No
 - c. Not applicable

23. Are the hours the facility open convenient for you?
- a. Yes
 - b. No

SECTION G; RELIGIOUS AND CULTURAL BELIEFS

24. Does your religious denomination allow the use of family planning?
- a. Yes []
 - b. No [] []
 - c. Don't know []

25. Give reasons for your response.

.....

.....

26. Have you ever discussed with your spouse/partner about use of Family Planning?
- a. Yes [] []
 - b. No []
 - c. Not applicable []

27. If the answer is yes, did your spouse agree to your use of family planning []
- a. No []
 - B Yes []

28. Are there any beliefs that may prevent you from seeking and utilizing family planning?

a. No []

b. Yes []

29. If yes to question 28, what are they?

.....

.....

30. What should be done in order to improve accessibility of family planning among adolescents? Write down your suggestions.

END OF INTERVIEW

THANK YOU FOR PARTICIPATING

University of Zambia,
School of Medicine,
Dept of Nursing Sciences,
P.O Box 50110,
LUSAKA.

17TH October, 2011

The District Medical officer,
Sinazongwe Medical Office,

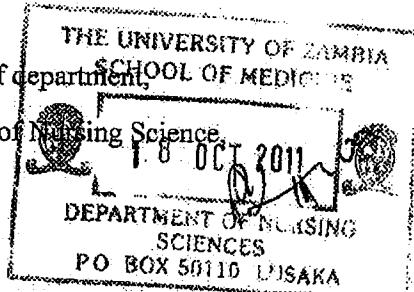
SINAZONGWE

u.f.s The Head of department,

Department of Nursing Science,

LUSAKA.

Dear Sir,



**RE: REQUEST FOR PERMISSION TO UNDERTAKE A PILOT AND ACTUAL STUDY
IN SINAZONGWE DISTRICT.**

I am a fourth (4th) year student undertaking a Bachelor of Science in Nursing degree at the Department of Nursing Sciences of the School of Medicine at the University of Zambia.

During my fourth year of study, I am required to carry out a research project. My topic of study is "To determine factors influencing accessibility of family planning amongst adolescents in Sinazongwe District."

I therefore request for your permission to administer questionnaires to the adolescents that will be sampled in Sinazongwe. The data will establish what factors prevent adolescents from accessing family planning services so that measures will be put in place to improve accessibility of these services. I intend to carry out this exercise in five (05) different villages within the district starting in the Month of November, 2011.

Your assistance will highly be appreciated.

Yours faithfully,

I mataa

Mataa Isikanda RN/RM



REPUBLIC OF ZAMBIA

MINISTRY OF HEALTH

SINAZONGWE DISTRICT MEDICAL OFFICE
P.O. Box 630208
CHOMA

27th October 2011

Ms Maata Isikanda
University of Zambia
School of Medicine
Department of Nursing Sciences
Box 50110
LUSAKA.

Dear Madam,

**RE: PERMISSION TO UNDERTAKE A PILOT AND ACTUAL STUDY IN
SINAZONGWE DISTRICT**

Kindly refer to the above captioned subject.

This office has granted permission to Ms Maata Isikanda, a 4th year Student pursuing a BSc Degree in Nursing at University of Zambia ; School of Medicine, under the Department of Nursing Sciences to conduct a research **"To determine factors influencing accessibility of family planning amongst adolescents in Sinazongwe District "**.

The research data collection will be done in 4 weeks starting from Monday, 1st of November 2011 to Wednesday 30th of November 2011.

This office will appreciate if research findings can be made available to this office for the purpose of findings remedies to improve on accessibility of Family Planning Methodologies amongst adolescents in Sinazongwe district as whole.

Yours faithfully
SINAZONGWE DMO

A handwritten signature in black ink, appearing to be 'E. Chipandwe'.

Dr E. Chipandwe
Ag/ DISTRICT MEDICAL OFFICER

cc: Dean School of Medicine.
cc. Head of Department of Nursing Sciences

APPENDIX: 2 THE GANTT CHART

TASK TO BE PERFORMED	RESPONSIBLE PERSON	JUN 2011	JUL 2011	AUG 2011	SEPT 2011	OCT 2011	NOV 2011	DEC 2011	JAN 2012	FEB 2012	MARCH 2012
Literature proposal review	researcher	→									
Literature review	researcher									→	
Compiling research proposal	researcher				→						
Clearance from school and authority	Researcher				→						
Pilot study	Researcher					→					
Data collection	Researcher					→					
Data analysis	Researcher						→				
Report writing	Researcher							→			
Draft to DNS	Researcher								→		
Finalize report	Researcher									→	
Submission of research report	Researcher										→
Monitoring and evaluation	Researcher									→	
Dissemination of results	Researcher										→

APPENDIX: 3**WORK SCHEDULE**

ACTITIVITY	TIME FRAME		RESPONSIBLE PERSON
	DATES	DURATION	
Research Proposal Review	15/06/11-31/07/11	46 days	Researcher/supervisor
Literature review	Continuous	Continuous	Researcher
Clearance from school and authority	03/10/11- 15/10/11	10 days	Researcher
Collection Tool Preparation	16//09/11- 30/09/10	10 days	Researcher/supervisor
Pilot study	21/10/11-22/10/11	2 days	Researcher
Collection tool amendment	25/10/11-27/10/11	3 days	Researcher
Data Collection	30/10/11-21/11/11	22 days	Researcher
Data Analysis	01/12/11-31/12/11	30 days	Researcher
Report Writing	01/01/12-30/01/12	29 days	Researcher
Draft Report To DNS Supervisor	31/02/12-15/02/12	15 days	Researcher
Finalize Report	16/02/12-08/03/12	20 days	Researcher
Monitoring and evaluation	continuous	continuous	Researcher/supervisor
Publication of Results	09/03/11-31/03/12	20 days	Researcher

APPENDIX: 5 BUDGET

DESCRIPTION	QUANTITY	UNIT COST(ZMK)	TOTAL (ZMK)
STATIONERY			
Bond paper	3	35,000	105,000
Pens	5	1000	5000
Pencils	3	1000	3000
Rubber	3	1000	3000
Note books	3	35000	10500
Scientific calculator	1	100,000	100,000
Stapler	1	40,000	40,000
Perforator	1	40,000	40,000
Flip chart	1	60,000	60,000
Markers	3	5,000	15,000
Manila files	10	1,500	1,500
File clips	1pkt	25,000	25,000
Box file	3	10,000	30,000
Folder	3	10,000	30,000
Ruler	2	3,000	6,000
Sub Total			537,500
Personnel Costs			
Researcher	1x20	50,000	1,000 000
Subtotal			1,537,500
Secretarial services			
photocopying	50	250	12,500
Typing	200 pages	3,500	700,000
Binding	4	70,000	280,000
Subtotal			992,500
Transport			
Fuel	40litres	9,000	360,000
Other transport costs	3	50,000	150,000
Subtotal			510,000
Contingency 10%			304,000
Subtotal total			510,000

BUDGET SUMMARY

NO	DETAILS	TOTAL AMOUNT
1	Stationery	537,500
2	Secretarial services	992,000
3	Transport	510,000
4	Personnel cost	1,000 000
	Grand total	3,049,000
	Contingency	304,000
	Grand total	3,353,000

BUDGET JUSTIFICATION

The budget for this research proposal has been divided into four parts namely; stationery, personnel costs, secretarial services and transport costs. The budget is intended to facilitate a smooth conducting of the study. For this to be possible, a number of costs will be incurred as administrative and technical costs.

Stationery is needed in this project for research proposal writing, preparation of questionnaires, data processing and analysis. Finally, stationery will be required for the final research report.

The research project will also incur some personnel related costs such as payment of lunch/meal allowances to the researcher and the two research assistants as they be required to work outside normal working hours especially during data collection and analysis.

Secretarial services such as typing, photocopying, editing and printing are inevitable and these will be an added cost to the research project. Finally, the researcher will need some funds for transport to move here and there in the course of the research project.

APPENDIX: 6

INFORMED CONSENT

Dear participant,

My name is Mataa Isikanda. I am a student at the University of Zambia, School of Medicine pursuing a Bachelor of Science in Nursing Programme in the department of Nursing Science.

In partial fulfillment of the degree of Bachelor of Science in Nursing, I am required to undertake a research project. My topic is on Factors influencing accessibility of family planning among Adolescents in Sinazongwe District. I also wish to assure you that information gathered during this interview is confidential. To ensure confidentiality, I will not ask you, your names but rather some characteristics about yourself. Having said this, I would like to inform you that participation in this study is voluntarily. Whether you agree to participate or not, this will not affect you in all aspects of your life in this community and country.

Ihereby called the participant understands the guidelines of this study and I am willing to participate in the study

Date.....

Signature /thumb print of respondent.....

Signature of interviewer.....

*Property of UNZA Library



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