

**TOPIC: STUDY TO DETERMINE PARENTS'  
KNOWLEDGE, ATTITUDE AND PRACTICE TOWARDS  
SEXUAL ISSUES OF ADOLESCENCE IN LUSAKA**

**BY: DOROTHY C. DAKA**

**UNZA**

**THE UNIVERSITY OF ZAMBIA**

**SCHOOL OF MEDICINE**

**DEPARTMENT OF POST BASIC NURSING**

**A STUDY TO DETERMINE PARENTS' KNOWLEDGE,  
ATTITUDE AND PRACTICE TOWARDS SEXUAL ISSUES  
OF ADOLESCENCE IN LUSAKA**

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**BY**

**DOROTHY CHILUFYA DAKA**

**REGISTERED NURSE 1990, MUFULIRA, ZAMBIA**

**REGISTERED MENTAL NURSE, 1997, LUSAKA, ZAMBIA**

**PUBLIC HEALTH NURSE, 1998, NAROBİ, KENYA.**

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**DECLARATION**

This dissertation is the result of my independent investigation. Where it is indebted to the work of others, acknowledgement has been made.

I hereby declare that this dissertation has not been submitted either in same or different form to this or any other institution for an academic qualification.

D. Saka

Student's signature

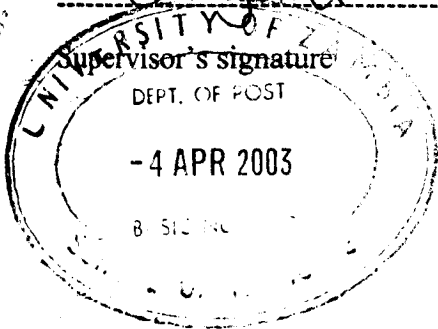
04/04/2003

Date

C. Ngoma

04/04/2003

Date



## DEDICATION

This research report is dedicated to my beloved husband Reuben Daka, our children, Okoma, Talekelesha and Ongani and my brothers Albert and Mike Chilufya for the betterment of our children.



## **ABBREVIATIONS**

<b>AMREF :</b>	African Medical and Research Foundation
<b>YWCA :</b>	Young Women's Christian Association
<b>CYC :</b>	Community Youth Concern
<b>ZDHS :</b>	Zambia Demographic and Health Survey
<b>STI's :</b>	Sexually Transmitted Infections
<b>HIV :</b>	Human Immune Virus
<b>AIDS :</b>	Acquired Immune Deficiency Syndrome
<b>UK :</b>	United Kingdom
<b>UNFPA :</b>	United Nations
<b>OPD :</b>	Out Patient Department
<b>UNICEF:</b>	United Nations International Children's Fund
<b>NGO's :</b>	Non Governmental Organizations
<b>ZIHP :</b>	Zambia Integrated Health Program
<b>PPAZ :</b>	Planned Parenthood Association of Zambia
<b>KAP :</b>	Knowledge, Attitudes and Practice

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## ABSTRACT

The dissertation is based on the results of a study conducted in Kabwata Township in Lusaka District. It was a cross sectional descriptive study carried out between 30<sup>th</sup> October and 30<sup>th</sup> November 2002. The respondents were fifty parents who have children aged between 10 – 19 years. Non-probability sampling method was used to select respondents.

Review of literature on relevant studies reviewed that adolescent sexuality needs to be addressed with urgency and dealt with from all angles. The need for parents to address these issues is crucial because parents know and understand their children better. Parents give advice to their adolescent children on various subjects and therefore it is morally right for them also to impart an understanding on sexual issues. This helps adolescents affirm their moral behaviour, postpone their sexual debut and / or make informed choices on issues of sexuality.

The data collection tool used was an Interview Schedule. Data was analyzed manually and using a scientific calculator. It is presented in form of Tables, Pies and Graphs. The findings of the study showed that 64% of the respondents were females and 44% had secondary school education. Majority of parents 28 (56%), had medium level of knowledge. Most of the respondents with high or medium knowledge level were also in formal employment. This implies that they have limited time to discuss with their adolescent children. Majority of respondents (90%) had negative attitudes towards sexuality issues of adolescence while 76% had negative practice. Parents' cultural orientation had an effect on parents' attitudes and practice towards sexuality issues.

About 46% of the parents had discussed sexuality issues with their children, mainly of the same sex and only on HIV/AIDS, STIs and abstinence from sex until marriage. Some of the parents 22% , reported having not discussed sexuality issues with their children who were 10 years and above, because it is a taboo and / or they did not know how to go about the subject. Dissemination of data findings will be through recommendations to Ministries of Health and Education, and concerned Non Governmental Organizations and holding a seminar / workshop with Kabwata Community.

# CHAPTER 1

## 1. INTRODUCTION

### 1.1. BACKGROUND INFORMATION

Zambia lies in the Southern region of Africa. It is a landlocked country covering an area of 752,614 Kilo Meters squared and consisting of about 2.5% of the area in Africa. It shares borders with eight countries: Democratic Republic of Congo (DRC) and Tanzania in the North, Malawi and Mozambique in the East, Namibia in the Southwest, Angola in the West and Botswana and Zimbabwe in the South. Administratively, the country is divided into Nine Provinces and 72 Districts. The population is sparsely spread across the country with significant concentration in the big towns and cities along the line of rail. There are 73 tribes in the country. Zambia has a population of 10.9 million. It has an annual population growth of 2.9% (Country Profile: 2001). The population of Lusaka District is 1,103,413 and its annual growth rate is at 3.8% (Census Report 2000). The adolescent population is estimated at 26.3% of the total population, (ZDHS, 1996).

In Zambia the traditional family set up consists of father, mother, children, grandparents, uncles, aunties, cousins, nephews and nieces. However, these members of the family do not live in one household. Instead parents live in one house with smaller children while adolescents are accommodated separately from the parents. Socially, family members had channels of communication that were accepted by all, traditionally: for example, female children were not allowed to discuss any issues with their fathers. They were expected to talk to the father while kneeling from a distance while male children could spend time with their fathers and could only communicate with the mother occasionally. However, both male and female children were not allowed to discuss issues of sexuality with their parents. Instead, Grandparents, Uncles, Aunties and Cousins were the ones authorized to discuss issues of sexuality with Adolescents.

Culturally, issues of sexuality were taught when adolescents are about to enter marriage. Premarital sex was discouraged among adolescents till after initiation into adulthood i.e. through "Cisungu", for females and Circumcision and "Nyau"

ceremonies for males. However, it has been observed that many Zambian adolescents are sexually active by their mid-teens. In a national sample of adolescents conducted by the Zambia Demographic and Health Survey (ZDHS) more than two thirds ( $\frac{2}{3}$ ) of adolescents admitted to being sexually active by the age of 18. A study conducted by UNICEF on adolescents in Lusaka also showed 38% of 10-19 year old girls and 71% of boys to be sexually active (ZDHS. 1998).

In addition, sexually transmitted infections (STIs) including HIV/AIDS infection and teenage pregnancies are a major health problem for adolescents. A 1997 study by UNICEF and the National AIDS programme found that adolescents make up 40% of STI clients who present themselves to Out – Patient Department (OPD) in Lusaka. It was also found that one in five 15 year olds had begun child bearing and by the age of 19, more than two thirds of girls had begun childbearing (ZDHS, 1996).

Based on the above statistics, there is enough evidence on how issues of sexuality are affecting adolescents. Due to the broken traditional family set up, parents have now the challenge of offering information on issues of sexuality to their children themselves. Parents who have no information on issues of sexuality either traditionally or elsewhere may lack knowledge on the same. Parents' cultural orientation on issues of Sexuality is also an indicator of their attitude and practice towards Sexuality issues of Adolescents. This will not enable them to equip their adolescent children with necessary skills to deal with sexuality issues of adulthood. Consequently, parents will fail to deal with adolescent problems of Pregnancy, Developmental Crisis and diseases like STIs and HIV/AIDS, which are currently major issues in adolescent health.

## **1.2 STATEMENT OF THE PROBLEM**

Traditionally, young people were socialized on issues of Sexuality by evening gatherings with Grandparents, Uncles, Aunties and other respected elders in the village. "Becoming of age" (called "Cisungu") celebrations for girls, Circumcision and "Nyau" initiations for boys were the mechanisms used to celebrate issues of sexuality. Marriage celebrations done a night before the actual wedding marked the climax on teachings of sexuality issues. However most Zambian cultural practices did not allow parents to directly discuss sex-related matters with their children. Instead grandparents, uncles,

aunties and other respected elders in the village gave information to adolescents on sexuality.

Due to increased mobility, people are no longer static in their villages where family ties are strong. Modernization and western influence have distanced many families from their traditional background and/or culture. This may have influence on parents' knowledge, attitudes and practice. The parents' Knowledge, Attitudes and Practice towards Sexuality issues of Adolescence maybe influenced by several factors. These will be discussed as follows:

### **1.2.1 INADEQUATE INFORMATION ON SEXUALITY ISSUES;**

Many parents may not have adequate information and knowledge on sexuality issues in general, and as they specifically relate to adolescents. Unless the parents are well educated and informed, they may lack information on sexuality issues. Those who might have undergone traditional ceremonies may have been imparted with knowledge affecting sexuality issues affecting adolescents.

### **1.2.2. LEVEL OF EDUCATION OF PARENTS:**

Most of the Zambian parents are illiterate. Poverty and cultural discrimination between male and female children barred most parents from attaining better education. Due to high poverty levels in the country, many parents could not afford to pay school fees for their children. Such are now parents who stopped school in lower primary or never went to school at all. In view of this background, most parents may have no formal education up to Secondary level. Parents who have passed through Senior Primary and Secondary Schools are expected to be knowledgeable on issues of sexuality because of exposure to some literature and / or electronic media.

However this may not be the case especially if we focus on sexuality issues. Those parents who have even never been to school are sadly deficient on knowledge on sexuality issues. Other young people who marry without passing through both traditional and formal schools for sexuality issues are even more deficient in knowledge on sexuality issues.

### **1.2.3. PARENTAL CULTURAL ORIENTATION ON SEXUALITY ISSUES:**

Due to cultural orientation, most parents find it difficult to hold discussions with their children concerning sexuality issues. Culturally, uncles, aunties, cousins, grandparents and other elderly people in the village (“Alangzi” or “Banachimbusa”) are expected to teach a dolescents issues of sexuality. This has made many parents to have negative attitudes towards sexuality issues of adolescence. They perceive it as a taboo and for most parents it is a difficulty subject to venture in for children.

### **1.2.4. GENERATION GAP / DIFFERENCE**

Parents and their adolescent children face generation gap / difference that bar them from reaching each other in understanding. Parents may complain that children of this generation know and experiment sexuality too early for their age. They may complain about adolescents’ exposure to sexuality in schools, print and electronic media as a source of their mischief.

On the other hand adolescents also may complain about their parents’ backwardness in issues of sexuality. They do not understand why parents refuse to discuss sexuality issues with them. They may try to break the silence by asking questions about sexuality



but are told to keep quite and / or to ask the aunties, uncles, grandparents and probably at a later age.

#### **1.2.4. LACK OF APPRECIATION ON PARENTAL INVOLVEMENT IN ISSUES OF SEXUALITY BY OUR COMMUNITIES:**

Parental involvement in sexuality issues of adolescence is a secretive activity in our communities. Parents who communicate sexuality issues directly with their parents may be seen as “abnormally brave / courageous” and / or “extra ordinary.” Talking about sexuality to adolescents may be perceived as encouraging adolescents to experiment sex. Therefore society has not yet seen a need for parents to discuss sexual issues with their children. Instead sexual issues should be taught by aunties, uncles, cousins, grandparents and elderly people like ‘Alangizi / Banachimbusa’.

Society has not really come out in the open wanting parents to communicate directly to their children on sexual issues. Instead parents always look for a third party for communication on issues of sexuality. They may now be looking towards teachers in schools to teach the children issues of sexuality on their behalf since teachers spend more time with children in schools. However the school curriculum may not deal with all sexual issues to the extent that parents wish it to be done.

#### **1.2.5. ABDICATION OF PARENTAL ROLES:**

Parents may have chosen not to fulfill their parental role / duty in the area of sexuality issues of adolescence. They may be hiding in their multiple parental roles. They choose to spend less time with their adolescent children with a view that they have already grown up. They may find it difficult to relate the adolescent children due to difference

in views between them as the adolescents fight for their independence in the home.

They may feel that adolescents are boastful therefore they should be left alone.

#### **1.2.6. CULTURAL BELIEFS THAT PARENTS CANNOT DISCUSS SEXUAL ISSUES WITH THEIR CHILDREN.**

Parents may believe that they are not supposed to discuss issues of sexuality with their adolescent children. Therefore they may be busy looking for “Alangizi” or “Banachimbusa” to teach their adolescent children in place of grandparents, uncles and aunties. These in turn may not be conversant with issues of sexuality or may not be updated.

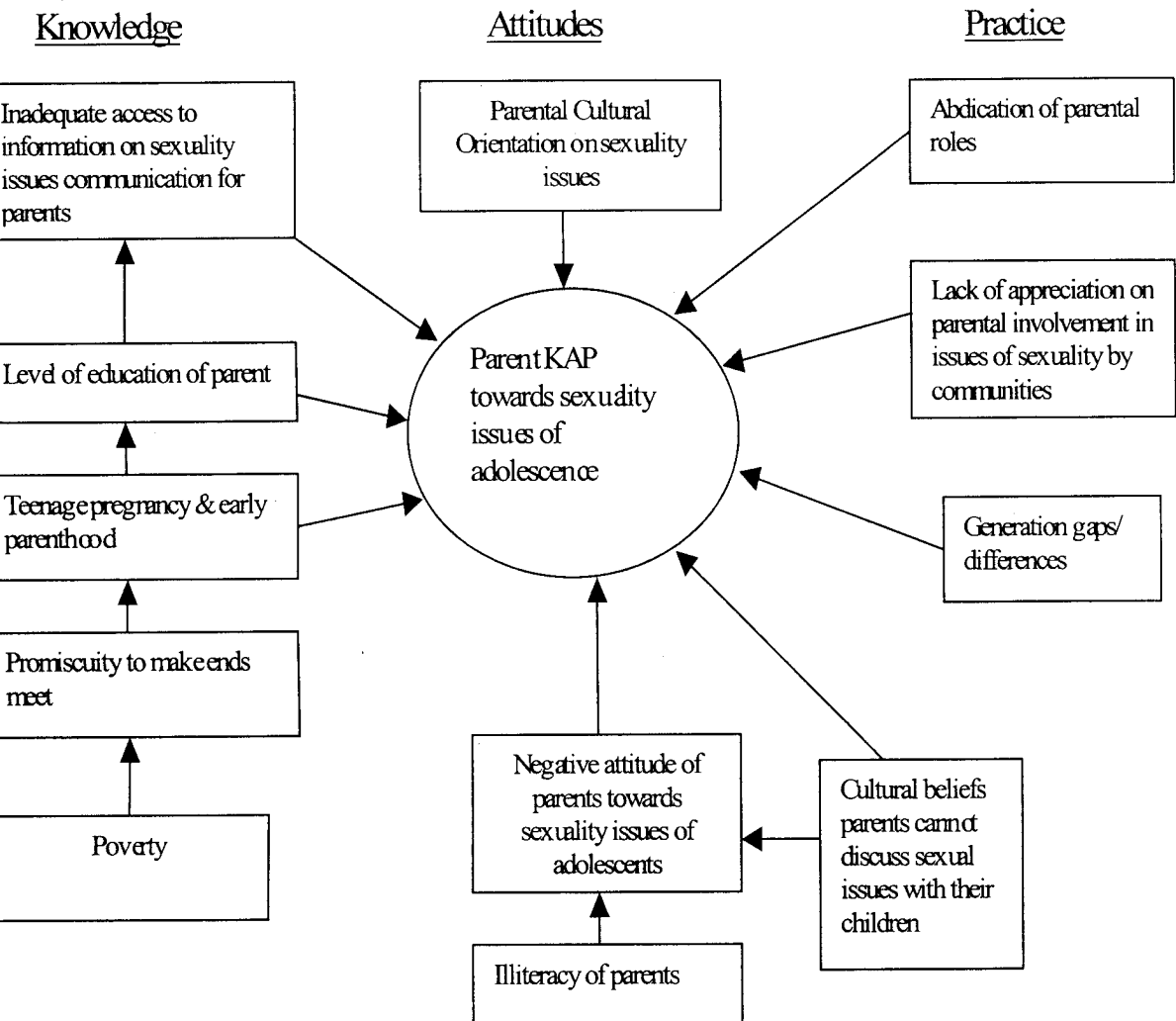
#### **1.2.8. NEGATIVE ATTITUDE OF PARENTS TOWARDS SEXUALITY ISSUES OF ADOLESCENTS.**

Parents’ attitudes towards sexuality issues of adolescents may be negative because most of them believe that such information leads to promiscuity. Therefore they prefer to hold on to information concerning sexuality until the night of the wedding or release distorted messages to scare adolescents from indulging in sex.

Below is a table of problem analysis showing how each factor affect parents’ knowledge, attitude and practice towards sexuality issues of adolescence.

## PROBLEM ANALYSIS

Parent KAP towards sexuality issues of adolescents



#### **1.4. PROBLEM JUSTIFICATION**

Most parents in Zambia are ambivalent regarding their parental responsibilities. Parents uphold their tradition of not discussing issues of sexuality with their children while on the other hand, modern life demand that they discuss sexual issues with their children in order to help and 'save' their lives. However, a number of parents are not conversant with the knowledge on issues of sexuality and worse still to share with the children. The cultural orientation of allowing other people to discuss with children sexual issues has promoted negative feelings for parents to discuss sexual issues with their adolescent children.

This research therefore, seeks to find out parents Knowledge, Attitudes and Practice towards sexuality issues of adolescents. The study will describe the type of information parents have on sexuality issues and the channels they use to communicate this information to their adolescent children.

It is hoped that the information obtained from this study will be of great benefit to the policy makers in the Ministries of Health and Education and the 'NGOs' in assisting improve parents knowledge on sexuality issues and thereafter assist them when dealing with their adolescents.

## **CHAPTER 2**

### **2. OBJECTIVES**

#### **2.1. GENERAL OBJECTIVE**

To determine Knowledge, Attitudes and Practice of parents towards sexuality issues of adolescence.

#### **2.2. SPECIFIC OBJECTIVES**

1. To determine parents' knowledge on sexuality issues of adolescents.
2. To determine parents' attitude towards sexuality issues of adolescents.
3. To assess parents' practice in disseminating information on sexuality issues to their adolescent children.
4. To establish channels of communication parents use to share their knowledge on sexuality issues with their children.
5. To make recommendations to relevant authorities on research findings.

#### **2.3 HYPOTHESIS**

1. Increased knowledge of parents on sexual issues will influence better sexual knowledge shared with adolescents.
2. Negative attitudes of parents on sexuality issues contribute to negative communication between parents and adolescents over sexuality issues of adolescence.

## **2.4 OPERATIONAL DEFINITIONS**

### **1. SEXUALITY**

Information needed by young people concerning their physiological changes, reproduction, Family Planning, STIs, HIV/AIDS and sexual involvement.

### **2. PARENT**

The biological father and/or mother of a child aged 10-19 years and living with the child or children. It is also a guardian who has raised and supported the child throughout his/ her life.

### **3. ADOLESCENTS**

These are young people aged between 10-19 years. This period is characterized by a gradual transformation from childhood to adulthood.

### **4. KNOWLEDGE**

Refers to the information needed and acquired by parents in relations to sexuality issues.

### **5. ATTITUDES**

Refers to the established and existing patterns of thought of parents, as they perceive the sexuality issues.

### **6. PRACTICE**

Refers to the habitual action performed by parents towards their adolescent children concerning issues of sexuality.

### **7. 'NYAU'**

Refers to traditional ceremonial dance for men.

**8. 'ALANGIZI' / 'BANACHIMBUSA'**

Refers to a traditional woman who imparts knowledge to adolescents / young people regarding sexuality issues.

**9. 'CISUNGU'**

Refers to traditional initiation for females at menarche.

## **CHAPTER 3**

### **3. LITERATURE REVIEW**

#### **3.1 INTRODUCTION**

Young people's sexual behaviour has acquired international concern mainly due to the current HIV / AIDS scourge. When adolescents disconnect themselves from home and family they may get involved in activities that put their health and well being at risk. However, when parents affirm the value of their children, adolescents more often develop positive and healthy attitudes about themselves, (Advocates for youth, 2000). On the other hand, most adults want young people to know about abstinence and how to prevent STIs and HIV/AIDS, while they often have limited knowledge and negative attitudes and practice. Most parents also have difficulties in communicating sexuality issues to adolescent children. Their attitudes and practice on sexuality issues are much to be desired due to their upbringing and cultural orientation.

#### **3.2. GLOBAL PERSPECTIVE**

Globally, parent-child communication on sexual issues has been encouraged because positive communication between them helps young people to establish individual values and make healthy decisions. Parents are challenged to be knowledgeable about sexual issues. The sexual issues include: menarche, pregnancy and abortion, Family Planning, STIs and HIV/AIDS. In a study done in America in 1997, less than 2% of parents believed that they do an excellent job of teaching young people about sexuality at home. 84% of the American mothers acknowledged the need to be helped in approaching the subject of sexuality with their children (Durex corporation, 1997).

In another study done in England, it was noted that youths do not receive the same information at the same ages from parents and that mothers are more likely to speak



with daughters than with sons about HIV/AIDS, (Miller K.S, 1998). Mothers also speak about condoms with sons at an early age (12.9 years) than they do with daughters (13.5 years). In the same study Miller found that mothers who discussed early with their adolescent children about condom use encouraged adolescents to adopt behaviour that protected them from infection like STIs and HIV/AIDS when they became sexually active. He also noted that when mothers discussed condom use before adolescents initiated sexual intercourse. They are more likely to use condoms than those whose mothers never discussed condoms with them. The centers for Disease Control and Prevention concluded that condom use at first intercourse dramatically predicts future use. Another study done among adolescents reported that parents / families where adolescents are freely communicating with their parents are those more likely to delay initiating sexual intercourse and are less emotionally distressed (Resnick M.D, 1997).

The ways of communication used by parents to their children in one study indicated that parents where dominant in their conversations and hence were less effective (Lefkowitz E.S et al, 1998). Therefore most attempts by parents to impact sexuality information to young people tend to be in a “top-down” communication style. This denies young people the opportunity to discuss their own thoughts, feelings and desires or to draw links between their own and their parents’ perspectives (Yowell C.M, 1997). Another research study shows that much of the parental information on sexuality tends to focus on negatives such as pregnancy and prevention of disease rather than on positives such as mutual respect and handling relationships (Jaccard J et al, 1996).

In the same survey, Jaccard said that young people’s perception of good relationships with their mothers and their disapproval of adolescent sexual activity were significantly related to delay in initiation of sexual intercourse Also adolescents who reported

previous discussions of sexuality with their parents were 7 times more likely to communicate effectively with a partner about HIV/AIDS than those who have not had such discussions (Shoop D.M and Davidson P.M, 1994).

These studies confirm that parents struggle as they meet the challenge to communicate with their children on sexual issues and how the children react to these messages from parents. It also indicates the shallow knowledge and poor attitude and practice that parents have towards sexual issues of adolescence.

### **3.3 REGIONAL PERSPECTIVE:**

In the sub-Saharan Africa, studies indicate that young people frequently engage in early sexual activities and have multiple sexual partners (Zimbabwe SRH, 1996). This has been attributed to lack of sexual information and knowledge on contraceptive use, where adolescents mature with little factual information and too little guidance on how to manage sexual relationships (Zimbabwe SRH, 1996).

It has also been reported that in East Africa, most parents think that adolescents are healthy physically, have few psychosocial problems and rarely engage in sexual activity (AMREF, 1994). However, in a regional study conducted in Ethiopia, Uganda, Tanzania and Kenya, most parents recognize the need for young people to get accurate sexual and reproductive health information. The parents also note their limitations in discussing such issues as a result of their socialization. In fact, they have requested for seminars and workshops on communication so that they can be able to have meaningful discussions with the youth (AMREF, 1997).

Issues pertaining to sexual activity are not openly discussed among adolescents and their parents in many communities. The most critical problem is that adolescents' sexuality is not supposed to exist; according to popular belief. The mention of adolescents' sexual education among parents also evokes deep emotions. It has also been observed that adolescents engage in behaviour which risks unwanted pregnancy, STIs including HIV/AIDS and failure to utilize available clinical health services (AMREF Health Systems Development Unit, 1994). Due to this cultural orientation, parents tend to have negative attitude and practice towards sexuality issues of adolescents.

Above all most sub-Saharan countries, advocates of family life and sex education are confronted with the myth that sex education leads to promiscuity (UNFPA, 1997). But the fact is that youths already indulge in sex, for instance in Botswana, approximately 15% of primary and secondary school girls drop out due to pregnancy and less than one fifth re-enroll at a later date (population concern, 1997).

However young people appreciate parents' views on sexuality issues and help them to delay their sexual involvement.

### **3.4 NATIONAL PERSPECTIVE**

Most Zambian adolescents are sexually active by their mid-teens. In a national sample of adolescents conducted by the Zambia Demographic and Health Survey (ZDHS), more than two thirds of adolescents admitted to being sexually active by age 18 (ZDHS, 1996). Also one in five 15-year-old teenagers begins childbearing by age 19

(ZDHS, 1996). In a KAP study conducted in 1990 by Fetters, 46% of mothers of adolescents said that they were in favour of modern methods of contraceptives for adolescents to use, while only 18% of fathers were in favour (Fetters T. et al, 1998). The reasons given for these negative attitudes include concern about side effects that use of family planning leads to prostitution and beliefs that only educated persons can only effectively use modern contraception. (Nyirenda et al in Fetters T. et al, 1998).

The report presented to the international HIV / AIDS Alliance on Gender, Sexuality and HIV / AIDS in Zambia (ZIHP, 2002) noted that men and women had deep rooted traditions that prevented them from discussing sexuality issues freely. Attitudes towards sexuality in relation to sex and sexuality, communities believe that sex decisions were only for men, while women were supposed to be passive. Women were not supposed to demand for sex, even if they wanted it at that time. They were not allowed to refuse whenever a man wanted to have it with them. So there was gender imbalance because men could have sex at anytime and with whomever they wanted.

However Zambia's literature is concentrated on youths or adolescents and sexuality issues rather than parents. Most Non Governmental Organizations in the country focus on adolescent sexuality while programmes concerning parents come in as "by-the-way" activities. The Non Governmental Organizations like Young Women's Christian Association (YWCA), Zambia Integrated Health Programmes (ZIHP), Community Youth Concern (CYC), Planned Parent Association of Zambia (PPAZ) and Movement for Family life are examples of active organizations concerning sexuality issues.

### 3.5. CONCLUSION

More than 50% of the world population is below 25 years. A third of the world (i.e. above 1.5 billion) is between the ages 10 – 24 years. 80% of this age group lives in developing countries (WHO / GPA Surveys, 1996). In many traditional societies sexuality issues are not discussed among adolescents and their parents. But many young people marry in adolescent age and later face the challenges of parenthood while they still have limited knowledge and negative practices towards sexuality issues and its consequences if mismanaged / mishandled. Other young people also face pressure towards premarital sexual activity at an early age and face the risks of unwanted pregnancies, hazardous abortions, STI's and the scourge of HIV/AIDS.

## **CHAPTER 4**

### **4. RESEARCH METHODOLOGY**

#### **4.1. INTRODUCTION**

Research Methodology describes the methods used in this study. A Descriptive Research Design was used to identify Knowledge, Attitudes and Practice of parents about sexuality issues of adolescence. It describes the Knowledge; Attitude and Practice (KAP) parents have towards sexuality issues of adolescents. It also describes the types of information parents give to their children on issues of sexuality.

#### **4.2 RESEARCH DESIGN**

“Research Design refers to the researchers’ overall plan for obtaining answers to the research questions or for testing the research hypothesis” (Polit & Hungler, 1997).

Brink (1996) also states that the Research Design is the set of logical steps taken by the researcher to answer the research questions. It forms the blueprint, pattern or recipe for the study and determines the methods used by the researcher to obtain subjects, collect data, analyse the data and interpret the results.

A Descriptive Research Design was used to identify Knowledge, Attitudes and Practice of parents about sexuality issues of adolescence. This method was suitable because it gave an accurate account of characteristics to the sample and provided a proper basis for understanding and finding ways of solving the problem under investigation. The study looked at parents’ knowledge, attitude and practice towards sexuality issues of adolescence.

#### 4.3. RESEARCH SETTING

This is the physical location and conditions in which data collection takes place in a study (Polit and Hungler, 1997).

The research study was conducted in Lusaka urban. Lusaka is the capital city of Zambia. It is centrally located with a number of modern facilities. All ethnic groups in the country are represented in the city. The study was undertaken in Kabwata Township, which is one of the townships in Lusaka urban. The study site was selected on the grounds of convenience and accessibility.

#### 4.4. STUDY POPULATION

A population is the entire aggregation of cases that meets a designated set of criteria. (Polit and Hungler, 1997).

The study sample consists of 50 parents from Kabwata Township. The 50 respondents were drawn from those cases that conform to the eligibility criteria and that was accessible to the researcher as a pool of subject for the study.

#### 4.5 SAMPLE SELECTION

Quantitative data was solicited from both male and female parents who were present at their households during the visits. The first household was selected by using a non-probability sampling method. Convenience sampling was used which involved choosing readily available people for the study. The sample size was fifty respondents. This number was decided upon for convenience due to the researcher's limited time, resources and the number of available personnel.

#### 4.6 DATA COLLECTION TOOL

An Interview Schedule was used to collect both qualitative and quantitative data from parents. An interview schedule is a data collection instrument where questions are asked orally in a face-to-face format. (Polit and Hungler, 1997).

An Interview Schedule as a questionnaire that is read to the respondent and responses are recorded by the researcher (Treece & Treece, 1986).

The researcher used Interview Schedule as data collection tool because it can be used for both literate and illiterate respondents. It is also effective in obtaining opinions, attitudes and values.

#### 4.7 DATA COLLECTION TECHNIQUE;

An Interview Schedule was used to collect data from parents. A total number of fifty (50) instruments were used. Data was collected within thirty working days.

#### 4.8 PILOT STUDY

A pilot study is the preliminary small-scale trial run of the research study. (Treece and Treece, 1986).

A pilot study is a small-scale study that is conducted before the main study on a limited number of subjects from the same population as that intended for the eventual project (Brink, 1996).

The purpose of the pilot study was to investigate the feasibility of the proposed study and to detect possible flaws in the data-collecting instruments. Pitfalls and errors that proved costly in the actual study were identified and avoided. Five parents were selected for interviews. The interview was conducted for each respondent using the interview schedule. The respondents were picked from Burma residential area using the



convenient sampling method. Data was analyzed manually and the following were the results: the average age of respondents was 34.2 years. There were three females and two male respondents. All respondents had one or two children aged between 10 - 19 years. There were three respondents with medium knowledge level and two respondents with high knowledge on sexuality issues of adolescence. All respondents had negative attitudes and practices towards sexuality issues.

#### 4.9 VALIDITY AND RELIABILITY

Validity refers to an instrument's ability to actually test what it is supposed to test (Treece and Treece, 1986).

Reliability is defined as the ability of the data-gathering device to obtain consistent results. (Treece and Treece, 1986).

Establishing validity requires determining the extent to which conclusion effectively represents empirical reality and assessing whether constructs devised represent or measure the categories of human experience that occurs. The interview schedule was tested for validity and reliability before using it in the actual study. This was to ensure that the process of the study was consistent and reasonably stable.

#### 4.10. ETHICAL CONSIDERATIONS

An introductory letter from the Department of Post Basic Nursing, University of Zambia was used to gain access to the township. Written permission was also obtained from the community chairman to gain access to the respondents in the community. The researcher introduced herself to the individual respondents and explained the purpose of study. The respondents were asked for consent to participate in the study and informed on the purpose of the study. The respondents were assured of confidentiality of the information to be collected and their anonymity.

#### 4.11 VARIABLES

A variable is anything that changes or anything that is to vary. (Treece and Treece, 1986).

The variables used in this study are both independent and dependent variables. The dependent variables are knowledge, attitudes and practice. The independent variable is channels of communication parents' use.

Below is a table of variables and cut off points.

**VARIABLES AND CUT OFF POINTS TABLE**

NUMBER	VARIABLE	CUT OFF POINT	INDICATOR	QUESTION NUMBER
1.	KNOWLEDGE	LOW	Responses to knowledge questions with scores 0 – 19	8 – 21
		MEDIUM	Responses to knowledge questions with scores 20 – 39.	8 – 21
		HIGH	Responses to knowledge questions with scores 40-58	8 – 21
2.	ATTITUDE	Negative	Responses to knowledge questions with scores 0 – 8	22 – 33
		Positive	Responses to knowledge questions with scores 9- 16	22 – 33
3.	PRACTICE	Negative	Responses to knowledge questions with scores 0 -8	34 – 40
		Positive	Responses to knowledge questions with scores 9 – 16.	34 – 40

## CHAPTER 5

### 5. DATA ANALYSIS AND PRESENTATION OF FINDINGS

#### 5.1. INTRODUCTION

In this chapter the analyzed data is presented in form of frequency tables, cross tabulations and numerical description is given for each table. Data was analyzed manually and using a scientific calculator. A total of fifty (50) respondents were selected using non-probability sampling. All respondents were drawn from Kabwata Township.

#### 5.2. DATA ANALYSIS

Data collected from respondents was analyzed in December 2002. Data was first edited for completeness and later transferred on the data master sheet to avoid losses and mixing up data. Responses to open-ended questions were categorized and coded. Simple tallying made frequencies. Questions to certain variables were cross-tabulated to show relationship between particular variables.

#### 5.3. PRESENTAION OF FINDINGS

The findings of the study were presented in frequency tables, and cross tabulations. The tables are presented in order of questions presented in the interview schedule.

**TABLE 1: SEX DISTRIBUTION OF RESPONDENTS**

SEX	FREQUENCY	PERCENTAGE
MALE	18	36
FEMALE	32	64
TOTAL	50	100%

The table shows that majority 32 (64%) respondents were females.

**TABLE 2: AGE DISTRIBUTION OF RESPONDENTS**

AGE GROUP	FREQUENCY	PERCENTAGE
25-34	10	20
35-44	23	46
45-54	12	24
55-64	5	10
TOTAL	50	100 %

The table shows that majority of the respondents 23(46%) were aged between 35-44yrs.

**TABLE 3: LEVEL OF EDUCATION OF RESPONDENTS.**

LEVEL OF EDUCATION	FREQUENCY	PERCENTAGE
Primary	11	22
Secondary	20	44
College	17	34
University	2	4
TOTAL	50	100%

Table shows that majority 20 (40%) of the respondents had secondary school education level.

**TABLE 4: MARITAL STATUS OF RESPONDENTS**

MARITAL STATUS	FREQUENCY	PERCENTAGE
Single	3	6
Married	35	70
Widowed	7	14
Divorced	2	4
Co-habiting	1	2
Separated	2	4
<b>TOTAL</b>	50	100%

The table shows that majority 35(70%) of the respondents was married.

**TABLE 5: EMPLOYMENT STATUS OF RESPONDENTS**

Employment status	FREQUENCY	PERCENTAGE
Formal	23	46
Informal	8	16
None	19	38
<b>TOTAL</b>	50	100%

The table shows that most 23 (46%) respondents are in formal employment.

**TABLE 6: NUMBER OF CHILDREN OF RESPONDENTS**

NUMBER OF CHILDREN	FREQUENCY	PERCENTAGE
1	19	38
2	17	34
3	7	14
4	6	12
5	0	0
6	1	2
<b>TOTAL</b>	50	100%

The table shows that majority 19 (38%) respondents had one child aged between 10 – 19 years.

**TABLE 7: RELIGIOUS AFFILIATION OF RESPONDENTS**

DENOMINATION	FREQUENCY	PERCENTAGE
Catholic	14	28
Pentecostal	5	10
UCZ	23	46
Baptist	2	4
SDA	1	2
Presbyterian	4	8
None	1	2
<b>TOTAL</b>	50	100%

The table shows that majority 23 (46%) of respondents belonged to the United Church of Zambia, with 14 (28%) to the Catholic Church.

**TABLE 8: RESPONDENTS' LEVEL OF KNOWLEDGE**

KNOWLEDGE	FREQUENCY	PERCENTAGE
Low	8	16
Medium	28	56
High	14	28
<b>TOTAL</b>	50	100%

Table shows that majority 28 (56%) had medium level of knowledge on sexuality issues.

**TABLE 9: ATTITUDE LEVEL OF RESPONDENTS**

ATTITUDE	FREQUENCY	PERCENTAGE
Negative	45	90
Positive	5	10
<b>TOTAL</b>	50	100%

Majority of respondents 45 (90%) had negative attitudes towards communicating sexuality issues to adolescents.

**TABLE 10: RESPONDENTS' PRACTICE LEVEL**

PRACTICE	FREQUENCY	PERCENTAGE
Negative	38	76
Positive	12	24
<b>TOTAL</b>	50	100%

Table shows majority respondents 38 % have negative practice towards sexuality issues.



**TABLE 11: RESPONDENTS KNOWLEDGE IN RELATION TO SEX**

SEX	LEVEL OF KNOWLEDGE			TOTAL
	LOW	MEDIUM	HIGH	
Male	3 (6%)	9 (18%)	6 (12%)	18 (36%)
Female	5 (10%)	19 (38%)	8 (16%)	32 (64%)
<b>TOTAL</b>	<b>8 (16%)</b>	<b>28 (56%)</b>	<b>14 (28%)</b>	<b>50 (100%)</b>

Table shows that majority 32 (64%) of respondents had medium level of knowledge and were females.

**TABLE 12: RESPONDENTS' LEVEL OF KNOWLEDGE IN RELATION TO EDUCATION LEVEL.**

EDUCATION LEVEL	LEVEL OF KNOWLEDGE			TOTAL
	LOW	MEDIUM	HIGH	
Primary	2 (4%)	6 (12%)	3 (6%)	11 (22%)
Secondary	6 (12%)	10 (20%)	4 (8%)	20 (40%)
College	0	10 (20%)	7 (14%)	17 (34%)
University	0	2 (4%)	0	2 (4%)
<b>TOTAL</b>	<b>8 (16%)</b>	<b>28 (56%)</b>	<b>14 (28%)</b>	<b>50 (100%)</b>

Table shows that majority of respondents 20 (40%) have secondary education level and 28 (58%) have medium level of knowledge on sexuality issues.

**TABLE 13: RESPONDENTS' LEVEL OF KNOWLEDGE IN RELATION TO EMPLOYMENT STATUS.**

<b>EMPLOYMENT STATUS</b>	<b>LEVEL OF KNOWLEDGE</b>			<b>TOTAL</b>
	<b>LOW</b>	<b>MEDIUM</b>	<b>HIGH</b>	
Formal	2 (4%)	15 (30%)	7 (14%)	<b>24 (48%)</b>
Informal	1 (2%)	2 (4%)	4 (8%)	<b>7 (14%)</b>
None	5 (10%)	12 (24%)	2 (4%)	<b>19 (38%)</b>
<b>TOTAL</b>	<b>8 (16%)</b>	<b>29 (58%)</b>	<b>13 (26%)</b>	<b>50 (100%)</b>

Table shows that majority 24 (48%) of respondents has medium level of knowledge and 29 (58%) are in formal employment.

**TABLE 14: RESPONDENTS' LEVEL OF KNOWLEDGE IN RELATION TO NUMBER OF CHILDREN.**

<b>NUMBER OF CHILDREN</b>	<b>LEVEL OF KNOWLEDGE</b>			<b>TOTAL</b>
	<b>LOW</b>	<b>MEDIUM</b>	<b>HIGH</b>	
1	2 (4%)	11 (22%)	6 (12%)	<b>19 (38%)</b>
2	4 (8%)	11 (22%)	2 (4%)	<b>17 (34%)</b>
3	0	3 (6%)	4 (8%)	<b>7 (14%)</b>
4	2 (4%)	2 (4%)	2 (4%)	<b>6 (12%)</b>
5	0	0	0	<b>0</b>
6	0	1 (2%)	0	<b>1 (2%)</b>
<b>TOTAL</b>	<b>8 (16%)</b>	<b>28 (56%)</b>	<b>14 (28%)</b>	<b>50 (100%)</b>

Table shows that majority of the respondents 28 (56%) had medium level of knowledge while 19 (38%) had one child aged between 10-19 years.

**TABLE 15: RESPONDENTS' ATTITUDE IN RELATION TO AGE**

AGE	LEVEL OF ATTITUDE		
	NEGATIVE	POSITIVE	TOTAL
25-34	7 (14%)	2 (4%)	9 (18%)
35-44	22 (44%)	2 (4%)	24 (48%)
45-54	10 (20%)	2 (4%)	12 (24%)
55-64	4 (8%)	1 (2%)	5 (10%)
<b>TOTAL</b>	<b>43 (86%)</b>	<b>7 (14%)</b>	<b>50 (100%)</b>

Table shows majority of the respondents 24 (48%) are aged between 35-44 years and 42 (84%) had a negative attitude towards issues of sexuality being taught to adolescents.

**TABLE 16: RESPONDENTS' ATTITUDE LEVEL IN RELATION TO SEX**

SEX	LEVEL OF ATTITUDE		
	NEGATIVE	POSITIVE	TOTAL
Male	15 (30%)	3 (6%)	18 (36%)
Female	30 (60%)	2 (4%)	32 (64%)
<b>TOTAL</b>	<b>45 (90%)</b>	<b>5 (10%)</b>	<b>50 (100%)</b>

The table shows that majority of the respondents 45 (90%) had negative attitude and 32 (64%) were females.

**TABLE 17: RESPONDENTS' ATTITUDE IN RELATION TO EDUCATION LEVEL**

LEVEL OF EDUCATION	LEVEL OF ATTITUDE		
	NEGATIVE	POSITIVE	TOTAL
Primary	11 (22%)	0	11 (22%)
Secondary	18 (36%)	2 (4%)	20 (40%)
College	15 (30%)	2 (4%)	17 (34%)
University	1 (2%)	1 (2%)	2 (4%)
<b>TOTAL</b>	<b>45 (90%)</b>	<b>5 (10%)</b>	<b>50 (100%)</b>

Majority of the respondents 45 (90%) had negative attitude and 20 (40%) had Secondary School Education.

**TABLE 18: RESPONDENTS' ATTITUDE IN RELATION TO LEVEL OF KNOWLEDGE**

LEVEL OF KNOWLEDGE	LEVEL OF ATTITUDE		
	NEGATIVE	POSITIVE	TOTAL
Low	8 (16%)	0	8 (16%)
Medium	26 (52%)	2 (4%)	28 (56%)
High	11 (22%)	3 (6%)	14 (28%)
<b>TOTAL</b>	<b>45 (90%)</b>	<b>5 (10%)</b>	<b>50 (100%)</b>

Table shows that majority of the respondents 28 (56%) had medium level of knowledge and 45 (90%) had negative attitude.

**TABLE 19: RESPONDENTS' ATTITUDE IN RELATION TO PRACTICE LEVEL**

LEVEL OF PRACTICE	LEVEL OF ATTITUDE		
	NEGATIVE	POSITIVE	TOTAL
Negative	36 (72%)	2 (4%)	38 (76%)
Positive	9 (18%)	3 (6%)	12 (24%)
<b>TOTAL</b>	<b>45 (90%)</b>	<b>5 (10%)</b>	<b>50 (100%)</b>

Table shows that majority of the respondents 38 (76%) had negative attitude and had negative practice while only 36% of the respondents had positive attitude and practice.

**TABLE 20: RESPONDENTS' LEVEL OF KNOWLEDGE IN RELATION TO PRACTICE**

LEVEL OF PRACTICE	LEVEL OF KNOWLEDGE			
	LOW	MEDIUM	HIGH	TOTAL
Negative	8 (16%)	23 (46%)	7 (14%)	38 (76%)
Positive	0 (0%)	6 (12%)	6 (12%)	12 (24%)
<b>TOTAL</b>	<b>8 (16%)</b>	<b>29 (58%)</b>	<b>13 (26%)</b>	<b>50 (100%)</b>

Majority of the respondents 23 (46%) had medium knowledge and had negative practice.

**TABLE 21: RESPONDENTS' PRACTICE IN RELATION TO SEX**

SEX	LEVEL OF PRACTICE		
	NEGATIVE	POSITIVE	TOTAL
Male	14 (28%)	4 (8%)	18 (36%)
Female	24 (48%)	8 (16%)	32 (64%)
<b>TOTAL</b>	<b>38 (76%)</b>	<b>12 (24%)</b>	<b>50 (100%)</b>

Majority of the respondents 24 (48%) were females and had negative practice while 4 (8%) of the males had positive practice.

**TABLE 22: RESPONDENTS' PRACTICE IN RELATION TO AGE**

AGE GROUP	LEVEL OF PRACTICE		
	NEGATIVE	POSITIVE	TOTAL
25-34	7 (14%)	3 (6%)	10 (20%)
35-44	17 (34%)	6 (12%)	23 (46%)
45-54	9 (18%)	3 (6%)	12 (24%)
55-64	3 (6%)	2 (4%)	5 (10%)
<b>TOTAL</b>	<b>36 (72%)</b>	<b>14 (28%)</b>	<b>50 (100%)</b>

Table shows that 17 (34%) of the respondents were aged between 35-44 years and had negative practice while only 2 (4%) had positive practice and were aged between 55-64years.

**TABLE 23: RESPONDENTS' LEVEL OF PRACTICE IN RELATION TO EDUCATIONAL LEVEL**

EDUCATIONAL LEVEL	LEVEL OF PRACTICE		
	NEGATIVE	POSITIVE	TOTAL
Primary	7 (14%)	4 (8%)	11 (22%)
Secondary	18 (36%)	2 (4%)	20 (40%)
College	12 (24%)	5 (10%)	17 (34%)
University	1 (2%)	1 (2%)	2 (4%)
<b>TOTAL</b>	<b>38 (76%)</b>	<b>12 (24%)</b>	<b>50 (100%)</b>

Table shows that majority of the respondents 18 (36%) had primary level of education and had negative practice.

**TABLE 24: RESPONDENTS' PRACTICE IN RELATION TO MARITAL STATUS**

MARITAL STATUS	LEVEL OF PRACTICE		
	NEGATIVE	POSITIVE	TOTAL
Single	2 (4%)	1 (2%)	3 (6%)
Married	26 (52%)	9 (18%)	35 (70%)
Widowed	5 (10%)	2 (4%)	7 (14%)
Divorced	2 (4%)	0	2 (4%)
Cohabiting	1 (2%)	0	1 (2%)
Separated	2 (4%)	0	2 (4%)
<b>TOTAL</b>	<b>38 (76%)</b>	<b>12 (24%)</b>	<b>50 (100%)</b>

The table shows that 35 (70%) of the respondents were married and 38 (76%) had

**TABLE 25: RESPONDENTS' LEVEL OF PRACTICE IN RELATION TO DENOMINATION**

DENOMINATION	LEVEL OF PRACTICE		
	NEGATIVE	POSITIVE	TOTAL
Catholic	11 (22%)	3 (6%)	14 (28%)
UCZ	18 (36%)	5 (10%)	23 (46%)
Pentecostal	3 (6%)	2 (4%)	5 (10%)
Baptist	2 (4%)	0	2 (4%)
SDA	0	1 (2%)	1 (2%)
None	1 (2%)	0	1 (2%)
Presbyterian	3 (6%)	1 (2%)	4 (8%)
<b>TOTAL</b>	<b>38 (76%)</b>	<b>12 (24%)</b>	<b>50 (100%)</b>

The table shows that majority of the respondents 23 (46%) were UCZ members and 38 (76%) had negative practice.



**TABLE 26: RESPONDENTS' LEVEL OF PRACTICE IN RELATION TO EMPLOYMENT STATUS**

EMPLOYMENT STATUS	LEVEL OF PRACTICE		
	NEGATIVE	POSITIVE	TOTAL
Formal	18 (36%)	5 (10%)	23 (46%)
Informal	3 (6%)	5 (10%)	8 (16%)
None	17 (34%)	2 (4%)	19 (38%)
<b>TOTAL</b>	<b>38 (76%)</b>	<b>12 (24%)</b>	<b>50 (100%)</b>

The table shows that majority of the respondents 18 (36%) were in formal employment and had negative practice while only 2 (4%) of the respondents had positive practice and were not in employment.

**TABLE 27: RESPONDENTS' EDUCATION LEVEL IN RELATION TO KNOWLEDGE**

EDUCATION LEVEL	LEVEL	OF	KNOWLEDGE	
	LOW	MEDIUM	HIGH	TOTAL
PRIMARY	2 (4%)	4 (8%)	3 (6%)	9 (18%)
SECONDARY	4 (8%)	16 (32%)	2 (4%)	22 (44%)
COLLEGE	0	10 (20%)	7 (14%)	17 (34%)
UNIVERSITY	0	2 (4%)	0	2 (4%)
<b>TOTAL</b>	<b>6 (12%)</b>	<b>32 (64%)</b>	<b>12 (24%)</b>	<b>50 (100%)</b>

The table shows that majority of the respondents 16 (32%) had medium knowledge and had secondary school education.

**TABLE 28: CHANNELS OF COMMUNICATION USED BY PARENTS.**

METHODS OF COMMUNICATION	FREQUENCY	PERCENTAGE
Discussion	23	46
Buy books to read	5	10
Provide T.V / Video to watch	4	8
Ask a relative / friend	7	14
Do not discuss	11	22
<b>TOTAL</b>	<b>50</b>	<b>100%</b>

The table shows that 23 (46%) of respondents discuss issues of sexuality with their adolescent children particularly STIs, HIV/ AIDS and abstinence.

### 6. DISCUSSION OF FINDINGS

#### 6.1 INTRODUCTION

The discussion contained in this study is based on the data that was collected and analyzed and the results are discussed under the various sub-headings, in line with the objectives of the study. The study was designed to determine the Knowledge, Attitudes and Practice of parents toward Sexuality issues of adolescence. The data obtained from the study could provide information to policy makers and health care providers as well as NGOs on the areas that need improvement. The key findings of this study are highlighted and presented in the following sub-sections

1. Demographic data
2. Knowledge of parents about sexuality issues of adolescence.
3. Parents' attitudes toward sexuality issues of adolescence.
4. Parents practice on sexuality issues of adolescence.
5. Channels of communication used by parents.

#### 6.2. DEMOGRAPHIC DATA

There were fifty (50) respondents who were both male and female. The study revealed that majority of the respondents 64% (Table 1) were females, who were available at home during the visits. Female parents were more mainly because most of the male parents had gone out of home for work. Most of the respondents 46% were aged between 35-44 years (Table 2). This may imply that this is the reproductive age group that has children who are now adolescents or just entering their adolescence age.

Majority of respondents 44% (Table 3) had secondary school education level. This implies that they have knowledge/ information on sexuality issues according to what is

taught in secondary schools. This confirms with what curriculum centre –M.O.E offers to the pupils at grade 8 and 12 level. However the curriculum for primary school now offers information on HIV/AIDS and physiological changes occurring at puberty. At secondary school level, the curriculum offers information on physiological changes at puberty, biology of the reproductive system, fertilization and HIV/AIDS. The methods of Family Planning are mentioned as well to enlighten the pupils about them but no further details are given. However this information is disseminated well according to individual teacher preference and emphasis. Due to the limited time these pupils have to invest in acquiring knowledge, it contributes to the limited knowledge they have when they become parents in future.

This could also imply that parents are engulfed in many parental roles and are left with no time to acquire further knowledge especially on sexuality issues of adolescents. This is similar to what Mandona (1996), found when he looked at the attitudes and practices of parents regarding sex education of their children. Majority of the parents 70% were married (Table 4) and had at least one child aged between 10-19 years (Table 6).

### **6.3. LEVEL OF KNOWLEDGE OF PARENTS ON SEXUALITY ISSUES OF ADOLESCENCE**

Majority of the respondents 56% had medium level of knowledge on sexuality issues, 28% had high knowledge while 16% had low knowledge level (Table 8). Those who had medium level of knowledge were also in formal employment (Table 13). This means that although they have the knowledge/information, they have limited time to spend with their adolescent children. This confirms the researcher's findings on why most male parents were not home during the time of the visits. On the other hand this is so because of the many roles parents have to play.

On the other hand, it is a taboo in our culture for parents to discuss sexuality issues with their own children, instead Uncles, Aunties, Grandparents, Cousins and other elderly people of society e.g. Alangizi / Banachimbusa have always played this role. This also confirms the researcher's findings where parents admitted not having discussed sexuality issues with their children (Table 28), especially children from the opposite sex. This has been their cultural orientation and besides they claim that the subject is too heavy for them to pass on to their children at that age.

However this traditional taboo can negatively affect the adolescents' Knowledge Attitudes and Practice concerning sexuality. Most adolescents have confidence in their parents and take their advice seriously. Adolescents expect their parents to give them first hand information on sexuality issues as other sources, e.g. peers print and electronic media may not give parental direction. Lack of knowledge among parents also contributes to the perpetuation of ignorance being shared among the 'would – be' parents of tomorrow. Therefore this also perpetuates its negative effects.

Adolescents with no knowledge on sexuality issues may mismanage their adolescence phase leading to rebellious, uncontrollable and social misfit adolescents, (Wojwang K.L, 1996). Most parents showed high knowledge in the following issues of sexuality:

1. HIV/AIDS

2. Puberty

HIV/AIDS knowledge is confirmed with the National findings where almost nine in ten people know about the disease, (WHO, GPA Survey, 1996). This is similar to what Macwang found in his study that knowledge about HIV/Aids in Lusaka is high although it is not accompanied with behaviour change (Macwang, 1993). Knowledge on puberty may be coming from cultural ceremonies, which are used as methods of teaching sexuality issues to female adolescents. This is in support with Mzumara's findings that 50% of young mothers' knowledge on sexuality was from traditional initiation ceremonies and friends (Mzumara, 1996).

Knowledge of parents in relation to respondents' education level may be due to Zambia's Ministry of Education, recognition of the importance of Sex Education and the formation of attitudes in relation to HIV/ AIDS (Table 27). Ministry of Education policy is to ensure that close attention is given to HIV/AIDS through health education programs, development of life skills sexuality and personal relationship programmes and Anti-AIDS clubs. This may have contributed to the medium knowledge being displayed by the parents presently.

#### **6.4. PARENTS' ATTITUDES TOWARDS SEXUALITY ISSUES**

Attitudes are developed from what a person knows. Therefore inadequate knowledge and misconception can lead to development of wrong or negative attitudes towards a

particular situation or concept. Majority of the respondents 90% had negative attitude towards sexuality issues being communicated to adolescents (Table 9) This is in line with our cultural orientation where parents are not expected to talk/discuss sexuality issues with their children (Table 28). Most parents have had this kind of orientation and it is difficult for them to suddenly break it. The other reason for parents' negative attitude towards sexuality issues is the belief that adolescents are still young and information on sexuality will lead them to experiment or practice- thus they will be promiscuous. This confirms the researcher's hypothesis of the study as 22% of the respondents said that they had not communicated with their adolescents' sexuality issues because the message may encourage the adolescents to practice.

Parents' misconceptions about sexuality issues were highlighted in the research findings on Family Planning, Teenage pregnancies, Abortions, and STIs. Parents had limited knowledge in the above topics. Thus, it is not surprising to see their negative attitudes in return, because they do not understand the subjects fully. However, on the other hand, majority of the respondents 46% had a positive attitude towards communicating HIV/AIDS, and abstinence to adolescents (Table 28). These are the two topics that parents showed willingness to share with their adolescent children. This implies that parents are willing to prevent HIV/AIDS pandemic even among their own children. The positive attitude towards communicating the known STIs among parents implies that parents perceive STIs as a risk factor to HIV/AIDS.

All respondents showed positive attitude towards abstinence from sex for adolescents until marriage for both sexes. Sharing information about condom use among adolescents was highly rejected by parents. This implies that condom use among parents for their adolescent children is highly condemned. This also implies that parents

do not support use of condoms as a way of preventing HIV/AIDS and STIs. On the other hand, negative attitudes harbored by parents on sexuality topics like Family Planning, Pregnancy, Abortions and Physiological changes occurring at puberty, may inhibit the implementation of behavioural change and making informed choices among adolescents. Empowering of adolescents with knowledge is highly emphasized on as a method of promoting healthy sexual behaviour. Therefore, there is need to embark on educating parents on sexuality issues to influence change in attitudes.

Majority of the respondents with negative attitude (48%) were aged between 35 – 44 years (Table 15). This implies that even the younger generation of parents is not willing to communicate sexuality issues with their adolescent children. Therefore the culture of parents not discussing sexuality issues with their children is a strong traditional and will take a long time to break. On the other hand, female parents have more negative attitudes towards sexuality issues compared to male parents (Table 16). Most of the parents (36%) who have secondary school education also have negative attitude towards sexuality issues of adolescents (Table 17).

Even though parents' attitudes towards sexuality issues of adolescents have been negative and/ or arguing that adolescents may be promiscuous, the youth's attitudes towards the same may be influenced by peers, print and electronic media and are sexually active (ZDHS, 1998). They also continue to be infected with STIs (ZDHS, 1996). Even when parents feel negative about talking about sexuality issues with their children and withdraw, their adolescent children continue to acquire other attitudes towards the same, which may be destructive on the other end.



## **6.5. PARENTS' PRACTICE TOWARDS SEXUALITY ISSUES**

The study shows 76% of respondents with negative practice towards sexuality issues of adolescence, and only 24% with positive practice (Table 10). Majority of the respondents 48% were females and had negative practice (Table 21), while only 8% of the males had positive practice.

From the above data, one can assume that the negative practice of parents towards sexuality issues is due to cultural orientation coupled with limited knowledge and information (Table 20). Further findings were that 34% of respondents who had negative practice were aged between 35-44 years (Table 22). This may imply that the cultural beliefs about sexuality issues for adolescents are still very strong even among the younger generation. This negative practice of parents has a bearing towards sexuality issues of adolescents. As parents retrieve in facing the challenges of sharing information with their adolescents, the generation gap continues to widen and misconceptions on the topics are perpetuated from one generation to another.

The Zambian government has seen this gap and has introduced sex education to be taught in schools. This in some way has given parents a hope that teachers will teach children sexuality issues because they spend more time with them. This is in support with Beare et al (1989) findings that there are very high expectations that schools will educate the whole child across the broad spectrum of intellectual, social, moral, aesthetic, cultural, physical and spiritual domains. In practice, most schools find this impossible. Instead they concentrate on only a few of those areas that give emphasis in their curriculum to intellectual development.

## **6.6 CHANNELS OF COMMUNICATION USED BY PARENTS**

The study revealed that 46% of parents had communicated sexuality issues to their children (Table 28). The method commonly used is through discussions. The topics dealt with mainly were HIV/AIDS, puberty and abstinence. Parents mention the commonly known STIs like Syphilis and Gonorrhea. They however, admitted that their discussions are shallow because they have limited information. Parents also eluded that they did not know how to go about teaching the subject.

This implies that parents are not yet free to discuss all topics of sexuality issues with their children. It is therefore still a taboo in our communities. This confirms the respondents' negative attitude and practice towards sexuality issues of adolescents (Table 19). Family Planning topic is one of those highly rejected to be discussed between parents and their adolescent children. On the other hand the church was mentioned to help in communicating sexual issues to adolescents. It implies that the church play a role in shaping and imparting morals of adolescents. Although parents are the least in participation for communication among adolescents on sexuality issues, they are the most preferred among youths according to the findings in Mandona's study (1996).

## **6.7. IMPLICATIONS TO THE HEALTH CARE SYSTEM**

The findings of this study revealed that parents' Knowledge on sexuality issues of adolescents was medium. The knowledge level contributes to poor knowledge shared with adolescents. This means that parents share information to their adolescent children according to what they know. There is no standard of format that parents can look to for guidance in this area.

Parents showed negative attitudes and practice towards communication of sexuality issues with their adolescent children. This means that children will continue to be deprived of sexuality information by their parents. This in turn makes the adolescents vulnerable to early sex and its consequences. It also deprives information, which may help them make informed decisions and choices concerning sexuality issues.

Government through Ministry of Health and Education are tirelessly working hard to reduce the spread of HIV/AIDS, STIs, Teenage Pregnancies and Abortions among adolescents. On the other hand, parents have not understood this strategy and hence are working antagonistic with the government. This in turn will continue to over burden and stress the medical services in the country. Due to the shortage of staff in the health facilities the disease burden will continue to be a problem because patients will receive less/ minimal nursing care that contributes to quick recovery. Therefore the efforts may be fruitless in the end.

## 7. CONCLUSION

This study was aimed at establishing the Knowledge, Attitudes and Practice of parents towards sexuality issues of adolescents in Lusaka. This was essential in establishing the reasons why parents do not discuss issues of sexuality with their own children. This study reviewed that majority of parents have medium knowledge level on sexuality issues. This has been mainly due to the high illiteracy levels in the country. Most parents showed knowledge on HIV/AIDS and puberty / physiological changes that occur at menarche. Most respondents with medium and high knowledge level were in formal employment.

The respondents' attitudes towards sexuality issues were negative. Parents feel that it is wrong to teach adolescents sexuality issues because it teaches / encourages them to be promiscuous. It is also a cultural practice for parents not to talk about sexuality issues to their adolescent children. They feel that adolescents should abstain from sex until they are married. Parents however highlighted that they need to be taught on how to go about when teaching sexuality issues to adolescents. The researcher achieved the research objectives and both hypotheses were proved to be true / correct.

Both of the researcher's hypotheses were proved true in that parents with high knowledge were trying to share information on sexuality issues while parents with low knowledge level did not want to share such information with adolescents. Most parents had negative attitude towards sexuality issues of adolescents hence their practice was also negative. Parents communicate selected topics of sexuality issues of adolescents that suit their cultural / traditional practice.

## **7.1. RECOMMENDATIONS**

1. Government through Ministry of Health should formulate updated information on sexuality issues that will be targeting parents.
2. Ministry of Health and Ministry of Education together with other concerned Non Governmental Organizations should formulate deliberate programmes to target parents and sexuality issues of adolescents.
3. Parents should be empowered on how to deliver messages of sexuality to their adolescent children through holding seminars and workshops.
4. The study should be done on a large scale to generalize the findings.

## **7.2. STUDY LIMITATIONS.**

- The researcher had limited time and financial resources. Hence the sample size was restricted to fifty respondents. This made it difficult for the researcher to make inferences on the whole population.

## **7.3. DISSEMINATION OF FINDINGS**

- The researcher will disseminate the findings of the study through seminars and workshops with the Kabwata community.
- The researcher will disseminate the findings of the study through distribution of the research report to Ministry of Health and Ministry of Education.

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## **9. APPENDICES**

Appendix 1 Interview schedule for parents

Appendix 2 Written permission for data collection

**QUESTIONNAIRE No. ....**

**INTERVIEW SCHEDULE FOR PARENTS**

**TOPIC:** A STUDY TO DETERMINE KNOWLEDGE ATTITUDE  
AND PRACTICE OF PARENTS ABOUT SEXUALITY  
ISSUES OF ADOLESCENCE.

**INSTRUCTIONS TO INTERVIEW**

1. Please do not indicate the name of the subject on the questionnaire.
2. Tick all appropriate responses using the box (es) provided
3. For open-ended questions write responses in the spaces provided.
4. The information given in this paper is strictly confidential
5. Answer all questions



## SECTION A: BIODATA

Q1. Sex

1. Male
2. Female


Q2. Age on last birthday.....

Q3. What is the highest level of education you have attained?

1. None
2. Primary
3. Secondary
4. College
5. University


Q4. What is your marital status?

1. Single
2. Married
3. Separated
4. Divorced
5. Co-habiting
6. Widowed


Q5. What is your occupation?

1. None
2. Informal
3. Formal


Q6. Number of children aged between 10-19 years

1. One
2. Two
3. Three
4. Four
5. Others specify.....


Q7. What is your religion/denomination?

1. None
2. Catholic
3. SDA
4. UCZ
5. Pentecostal
6. Baptist
7. Others specify .....


## SECTION B: KNOWLEDGE

Q8. What is Puberty?

.....

.....

Q9. What are the signs of puberty in a girl child? (Tick the correct answers)

1. Breasts enlarge

2. Hair grows in private parts

3. Monthly Periods begin

4. Hips grow big and wide

5. Others specify.....

Q10. What are the signs of puberty in a boy child? (Tick the correct answers)

1. Voice deepens

2. Pimples appear on the face

3. Body becomes masculine

4. Hair grows in private parts

5. Is able to produce sperms

6. Others specify... ..

Q11. What do you understand by family planning?

1. It is a way of spacing children to enable them grow better

2. It is when women take in pills in order not to get pregnant

3. It is having a limited number of children

4. It is an evil way of restricting a couple to have children

5. Others specify.....

Q12. What methods of family planning do you know?

1. Pills

2. Injection

3. Condoms

4. Norplant

5. Vasectomy

6. Bilateral Tubal Ligation (BTL)

7. Natural Family Planning

8. Loop

9. Spermicides

10. Vaginal Caps

11. Abstinence

12. Others specify.....

Q13. How can pregnancy be prevented?

1. Abstinence

2. Use any one of the family planning methods

3. Use traditional methods

4. Others specify.....

Q14. What are the signs of pregnancy?

1. Morning sickness

2. Pica

3. Breasts grow bigger

4. Amenorrhoea

5. Mood swings
6. Increased fundal height
7. Fetal movements
8. Others specify.....


Q15. What is abortion?

.....

.....

Q16. What do you understand by Sexually Transmitted Infections (STIs)?

1. These are diseases one gets from a partner through having sexual intercourse
2. These are diseases for women
3. These are diseases brought by men due to unfaithfulness sexually
4. Others specify.....


Q17. What type of STIs do you know?

1. Gonnorrhoea
2. Syphilis
3. Chlamydia
4. Chancroid
5. Granuloma inguinale
6. HIV infection/AIDS
7. Lymphogranuloma Venereum
8. Others specify.....


Q18. What are the signs and symptoms of STIs?

1. Pain in the lower abdomen
2. Discharge from the Penis/Vagina
3. Swelling in the groins
4. Sores on the private parts
5. Fever
6. General body rash
7. Others specify.....


Q19. What is HIV infection?

1. This is an infection which destroys the body's defense system
2. It is an infection which leads to AIDS
3. It is a disease you get when you are bewitched
4. Others specify.....


Q20. How would you recognise someone with AIDS?

1. Weight loss
2. Persisted diarrhoea
3. Chronic oral candidiasis
4. Muscle wasting
5. Persistence fever
6. Body rash
7. Presence of opportunistic infections
8. Others specify.....


Q21. What is the treatment for AIDS?

- 1. None
- 2. Take a lot of antibiotics
- 3. Use traditional medicine
- 4. Have sex with a virgin
- 5. Have sex with a small child
- 6. Others specify.....


**SECTION C: ATTITUDE**

Q22. In your opinion, should family planning be taught to adolescents?

- 1. Yes
- 2. No


Q23. If yes to question 22, what do you want them (adolescents) to be taught?

- 1. Family Planning methods
- 2. How to use family planning methods
- 3. Types of family planning methods
- 4. Where to get family planning methods
- 5. Others specify.....


Q24. If no to question 22, give reasons for your answer.

- 1. Adolescents are still young to be taught family planning
- 2. It is against our tradition
- 3. It encourages the adolescents to be promiscuous
- 4. Family planning may make the adolescents to be barren
- 5. Others specify.....


Q25. In your opinion, should an adolescent undergo an abortion in case of an unplanned pregnancy?

- 1. Yes
- 2. No


Q26. If yes to question 25, give reasons for your answer.

- 1. It is legal action if performed by medical personnel
- 2. In order to continue with school, a child can abort
- 3. To avoid expenses on the unwanted child
- 4. Others specify.....


Q27. If no to question 25, give reasons for your answer.

- 1. Life is sacred, it should not be terminated at any cost
- 2. Abortion is murder
- 3. Abortion has emotional repercussions that may be tormenting in future
- 4. Others specify.....


Q28. Would you like sex education to be taught to adolescents?

- 1. Yes
- 2. No


Q29. If yes to question 28, what would you want them to learn about?

1. Family Planning methods

2. Prevention of STIs

3. Changes that occur at puberty

4. Protected sexual intercourse

5. Others specify.....

Q30. If no to question 28, give reasons for your answer.

1. It teaches adolescents promiscuity

2. It is too early for them to learn such things

3. It is uncultured to give such information to the unmarried

4. Others specify.....

Q31. What is your opinion regarding sex education being offered in schools?

1. Beneficial

2. Waste of time

3. Teaches promiscuity

4. Encourages children to go and practice

5. Others specify.....

Q32. How would you feel if you found out that your adolescent child had STI?

1. I would feel angry

2. I would feel disappointed

3. I would feel bad

4. I would feel depressed

5. I would feel confused

6. Others specify.....

Q33. How would you feel if you found out that your child had HIV infection?

1. I would feel hopeless and helpless

2. I would feel devastated

3. I would feel a failure as a parent

4. I would feel confused

5. I would feel ashamed

6. I would feel as if he/she is already dead

7. Others specify .....

**SECTION D: PRACTICE**

Q34. Do you discuss sexual issues with your adolescent child (ren)?

1. Yes

2. No

Q35. If yes to question 34, what do you discuss?

1. Puberty issues

2. Family planning

3. Pregnancy

4. Abortion

5. Abstinence

6. Sexually transmitted infections
7. HIV/AIDS
8. Others specify.....


Q36. If no to question 34, explain.

1. It is a taboo in our custom
2. I would not know what to say
3. The child is too young
4. I cannot discuss with my child because he/she is of the opposite sex
5. Others specify.....


Q37. If yes to question 34, what methods do you use to communicate with your adolescent child about Sexuality issues?

1. Discussion
2. Buy them books to read
3. Provide them with video films/TV programmes to watch
4. Ask a relative/friend to speak to them
5. Others specify.....


Q38. What would your reaction be if you found out that your adolescent child had an STI?

1. Discuss the STI with the child
2. Take him/her for medical treatment
3. Discipline the child
4. Provide condoms to prevent further infections
5. Others specify.....


Q39. What would your reaction be if you found out that your adolescent child had HIV infection?

1. Scorn and ridicule the child
2. Warn the rest of the children not to be infected
3. Accept and support the child
4. Isolate the child
5. Send the child to the clinic or hospital
6. Emphasise on protected sexual intercourse
7. Others specify.....


Q40. Do you have any suggestions on parents and sexuality issues of adolescents?

.....

.....

.....

.....

.....

**Thank you for your co-operation and participation.**

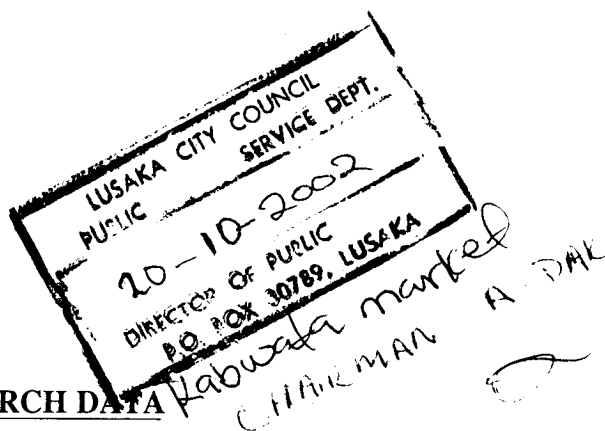


**THE UNIVERSITY OF ZAMBIA**  
**SCHOOL OF MEDICINE**  
**DEPARTMENT OF POST BASIC NURSING**

Telephone: 252453  
Telegrams: UNZA. LUSAKA  
Telex: UNZALUZA 44370  
Fax: +260-1-250753

P.O. Box 50110  
Lusaka, Zambia

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\_\_\_\_\_  
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Dear Sir/Madam,

Re: PERMISSION TO COLLECT RESEARCH DATA

The bearer DOROTHY C. DALLA is a forth year student at the Department of Post Basic Nursing, School of Medicine, University of Zambia. She/he is pursuing a Bachelor of Science in Nursing Degree. She/he is expected to carry out a research study in partial fulfilment of the requirements of the programme. Her/his research topic is Knowledge, attitudes and Practice of Parents towards Sexuality Issues of adolescence.

I am requesting your good office to avail her with the information she needs for her/his project. For any further clarifications you could contact the undersigned. Your continued support is highly appreciated.

Thank you,

*Mweemba*  
Mweemba Prudencia (Ms).  
COURSE CO-ORDINATOR.

PERMISSION GIVEN

By A. DAKA



UNIVERSITY OF ZAMBIA  
SCHOOL OF MEDICINE  
POST BASIC DEPARTMENT  
P.O. BOX 50110  
LUSAKA.

20<sup>TH</sup> October 2002.

Dear Sir / Madam,

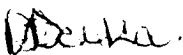
**RE: RESEARCH STUDY; PERMISSION TO COLLECT DATA.**

I am a fourth year student pursuing a Bachelor of Science Degree in Nursing in the school of Medicine, Department of Post Basic Nursing of the University of Zambia.

In partial fulfillment of the degree programme, I am required to carry out a research study. My topic is: KNOWLEDGE, ATTITUDES AND PRACTICE OF PARENTS TOWARDS SEXUALITY ISSUES OF ADOLESCENCE. I am kindly asking for permission to collect data in Kabwata Township.

Your assistance will be highly appreciated.

Yours faithfully,



**DOROTHY CHILUFYA DAKA.**

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