

# CHAPTER ONE

## BACKGROUND

### 1.1 INTRODUCTION

HIV prevalence has been a health concern in sub-Saharan Africa since the 1980s. It has led to many serious socio-economic problems. More and more money is being spent on treatment and care programs than on preventive measures and health promotion.

It is estimated that 71% of HIV infections occur via heterosexual contacts where condoms are not properly used or are used inconsistently. This has led to the call for Abstinence, Being faithful and Condom use; (ABCs), where C stands for condom use when one fails to abstain (A) or be faithful (B).

Primary health care should be action oriented focused on promotive, preventive, curative and rehabilitative activities within and outside the health sector aimed at tackling the main health problem in the communities paying particular attention to the underserved, at high risk and vulnerable groups such as women, youths and children. Conflicting policies on health by different sectors may lead to future health problems.

The national health policy on health care states that ,“ *the government is committed to the fundamental and humane principle in the development of the health care systems to provide Zambians with equity of access to effective quality health care as close to the family as possible*” (MoH vision, 2030). In order to attain this vision, the government has adopted the primary health care strategy as the most appropriate vehicle to achieving it.

On the other hand the Ministry of Education (MoE) has adopted a no-condom policy in schools. There is no written policy, but this policy arose from a ministerial statement issued in 2005 by the minister of Education. The school health services’ emphasis is on abstinence and treatment only, rather than health education that include protective methods as well, such as condom use.

According to the Zambian Demographic and Health Survey (ZDHS) of 2007, new HIV infections have been increasing at an estimated 67,602 adults in 2006 to a projected 72,019 by 2015 of which 55% are females while 45% are males. This means approximately 185 new infections occur every day.

The National Health Strategic Plan (NHSP) of 2011- 2015 states that *“the creation of strong health systems is not an end in itself. It is rather a means to achieving better health outcomes. Effective and equitable health systems are not only required for achieving the Millennium Development Goals (MDGs) but also to ensure that there is value for money from the various funding sources. There is a broad consensus that to improve the health of people, the Government must shape sound and efficient health systems that provide effective disease prevention and treatment to all women, men ,and children in an equity oriented manner no matter who they are and where they live”*.

There are three main controversial approaches to reducing rates of sexually transmitted diseases and unwanted pregnancies among the school adolescents; abstinence only programs, safer sex education, and making condoms available in schools. Which one of these is effective? The American Medical Association (1997) council on scientific affairs recently concluded that *‘there are no published studies that measure behavior effects of the abstinence-only curricula’*, that *‘evaluation of safe sex shows inconsistencies but promising results’* and that *‘programs that include condom availability in schools usually demonstrate increased condom use’* (AMA, 1997).

## **1.2 ARE CONDOMS EFFECTIVE?**

The data are quite clear. For preventing the spread of HIV and other STDs and in reducing unwanted pregnancy, condoms are very effective. When used properly and consistently, condoms are 98% effective in preventing pregnancy. This means that in one year's time, two couples out of 100 who use condoms will have an unintended pregnancy.

The U.S. Centers for Disease Control and Prevention reported that condoms have been shown to be effective in preventing HIV infection. In a two-year study of couples in which one partner was HIV-positive and the other HIV-negative, no HIV-negative partner was infected when condoms were used correctly and consistently. Among couples in which

Condom use was inconsistent, 10% of the HIV-negative partners became infected (Advocates for Youths, 2012).

Furthermore, a survey was undertaken by Kaiser Family Foundation and Seventeen Magazine (2000) of teens aged between 15 and 17 which revealed the following:

- ✓ More than one-third of teens surveyed (38%) said they had had sexual intercourse.
- ✓ Nine out of 10 teens that've had sex, used birth control products all the time and some or part of the time.
- ✓ Virtually all teens that had had intercourse (98%) have used condoms.
- ✓ Half admitted they'd had sex without a condom.
  
- ✓ Not all Teens abstained from sex among those who were sexually active (Advocates for youths, 2012).

### **1.3 PROBLEM STATEMENT**

Among the six drivers of HIV/AIDS pandemic, is the low and inconsistent use of condoms. This may be impacted further by non-availability of these commodities to the risky groups, in this case the school going adolescents especially in the rural setting. In terms of adolescence health, teenage pregnancy is associated with high morbidity and mortality for both the mother and the baby, which renders social adverse consequences. The teenage pregnancy may lead to school dropouts, early marriages and often re-entries into schools. According to the 2007 ZDHS, 28% of women aged 15-19 have began their child bearing and 22% had a child while 6% were pregnant.

In Kabompo it has been observed that some school-going adolescents are attending family planning at the Maternal Neonatal and Child Health (MNCH) department. Some of the adolescents access the out-patient department for the treatment of STIs. It has further been observed that there are a good number of those seeking those services with threatening abortions.

Baboo (2014) in a report revealed that students are having sex without any fear of sickness such as HIV, SDT and TB. Out of 90% of admissions, 70% are due to abortions. Every hour three new cases of HIV infections are seen. Out of these, two are adolescents.

The only access points for condoms in Kabompo are bars and health facilities. Not all the schools have health facilities within reach and those that are within reach usually have stock outs. On the other hand, most communities do not have bars that sell condoms , while where there are bars that sell this commodity, the under 18yrs olds are not allowed to access the bars to purchase anything and most school going youths fall under this age group (Kabompo HIMS, 2010).

Besides the above factors, in Kabompo, they practice Mukanda Initiation Ceremony (traditional male circumcision and initiation ceremony), that allows a young man usually to practice sex immediately they come of age (12yrs) to prove their manhood. This may expose them to various risk factors such as STIs and impregnating young girls as observed by the researcher after being in the study setting for a number of years

It is also worth noting that there are children who are on Anti-retroviral Treatment (ART) due to one reason or the other e.g. missed Prevention of Mother To Child Transmission (PMTCT) program or defilement. These eventually will be in schools, while others are already in schools, as their lives are prolonged. The possibility is that these children in their youth would be engaged in some sexual intercourse as a result of hormonal changes and peer pressure.

In addition to this, due to the current school policy on condoms, school health services do not tackle condom usage as such there is no comprehensive sexuality education in schools, rendering some knowledge gaps on condoms e.g. access points , expiry dates, proper usage and dangers of non-usage. Out of 18 health facilities in Kabompo, only 12 are offering some basic youth friendly services.

### **1.3.1 Family planning methods sought from MNCH, from 2007-2010 by those aged 15-24yrs:**

- ✓ Depo provera-1034
- ✓ Implants Jadell-36
- ✓ Oral contraceptives-46
- ✓ Female condoms-20

**Table 1.3.2: Statistics of STIs and Abortion from Kabompo HMIS**

Age & complication	2008	2009	2010	2011	2012
15-24 genital ulcers	2	44	44	25	56
0-14 inguinal bulbo	-	2	0	4	0
15-24 inguinal bulbo	0	3	1	0	9
15-24 male urthritis	12	62	50	78	97
0-14 PID	1	5	15	24	7
15-24 PID	18	95	96	150	204
0-14 abortions	0	0	1	2	2
15-24 abortions	-	12	42	47	47

*Statistics showing different STIs and abortion rates in Kabompo district-HMIS*

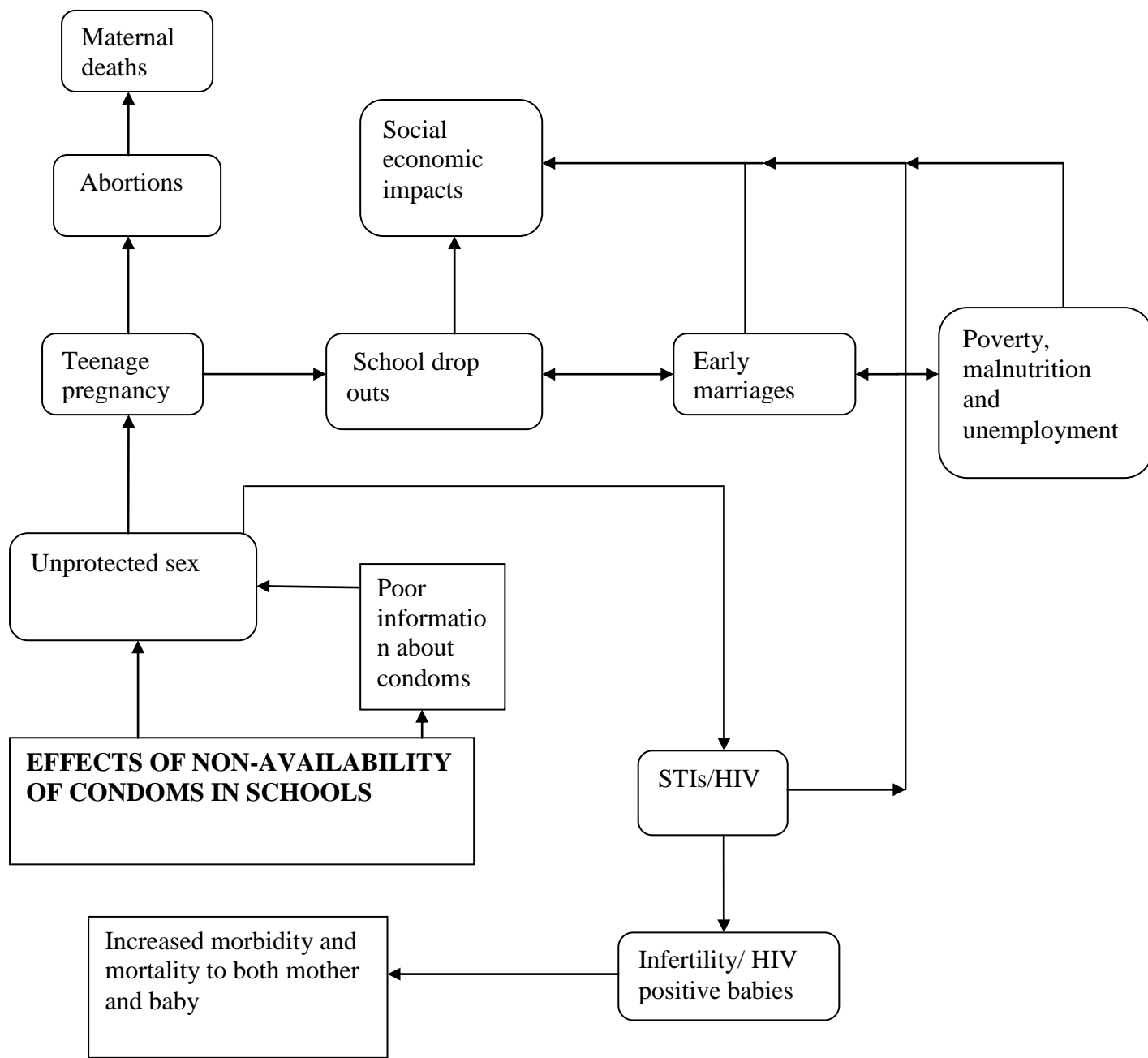
**Table 1.3.3: Numbers of drop-outs and re-entries in Kabompo District secondary and high schools - in a three year period.**

Consequence	2010	2011	2012
Drop outs	820	1043	950
Re entries	181	220	174

*Drop-out rates and re-entries due to pregnancy.*

Some of the effects that have been observed as a result the non-availability of condoms in schools have been highlighted below in the problem analysis diagram, Figure 1.3.1

**FIGURE 1.3.1 PROBLEM ANALYSIS DIAGRAM SHOWING EFFECTS OF NON-AVAILABILITY OF CONDOMS IN SCHOOLS**



## **1.3.4 EFFECTS OF NON-AVAILABILITY OF CONDOMS IN SCHOOLS**

### **1.3.4.1 Teenage Pregnancy:**

Teenage pregnancy as a consequence of non-availability of condoms leads to several outcomes such as school drop-outs that may lead to early marriages which in return cause poverty, malnutrition and unemployment (Equip2 and MoE, 2008).

### **1.3.4.2 Unprotected Sex (Pregnancy):**

Unprotected sex as a result of non-availability of condoms leads to teenage pregnancy which tempts pupils to terminate pregnancy (Abort) consequently causing maternal deaths. Baboo (2014) in a report revealed that students are having sex without any fear of sickness such as HIV, SDT and TB. Out of 90% of admissions, 70% are due to abortions. Every hour three new cases of HIV infections are seen. Out of these, two are adolescents.

### **1.3.4.3 Unprotected Sex (STIs):**

STIs/HIV is usually caused by unprotected sex as a result of inconsistencies in the usage of condoms. The long term consequences of certain STIs are infertility and HIV positive babies. This may also have an increased morbidity and mortality to both the mother and baby. The other long term effects are the adverse socio-economic impacts (ZDHS, 2007).

### **1.3.4.4 Poor Information about Condoms**

There was a recorded poor knowledge on family planning of various products especially on the usage of condoms. This consequently leads to unprotected sex, teenage pregnancies, school drop-outs, early marriages, teenage maternal deaths, STIs/HIV, Infertility, morbidity and HIV-positive babies. On information on condoms to the young ones, 56% women and 68% of men supported the idea of condom education for ages 12 to 14 as a way of preventing HIV among youths (ZDHS, 2007).

## **1.4 SIGNIFICANCE OF THE STUDY**

The study hoped to establish the realities of what sexual practices are amongst school going adolescents in the absence of condom protection.

The other benefits would be for the policy makers and implementers to come up with the plans on the condom outlets (around schools) that could easily be accessed- by those in need of them in the rural settings.

The study hoped that MoE in collaboration with MoH would be able to review the school health curricula and come up with policies that would benefit school going adolescents (i.e. the inclusion of comprehensive sexual education)

The long term benefits would be:

- ✓ Reduced social-economic adverse effects,
- ✓ Improved school health services by the district health teams in terms of health information,
- ✓ Reduced government expenditures, as transmissions of diseases would also be reduced and
- ✓ Reduced illiteracies on the girl child, especially in the rural areas consequently leading to reduced young maternal deaths.

## **1.5 OPERATIONAL DEFINITION OF TERMS**

In the study under research there were many operational terms being used, however, for the readers' understanding, the operational definition of terms have been put in a table below (Table1.5.1):

**Table 1.5.1: Operational Definition of Terms**

<b>Operational Terms</b>	<b>Description of Terms</b>
<b>Adolescents</b>	A young person who has undergone puberty but has not yet reached maturity. A transition phase from childhood into adulthood, usually between 10 - 20 years of age.
<b>Condom</b>	A barrier device (sheath) used during sexual intercourse to reduce the probability of pregnancy and the spread of Sexually Transmitted Infections (STIs)
<b>Drop-outs</b>	Pupils leaving a school for one or the other reasons e.g. pregnancy, lack of schools fees poor school systems, long distance
<b>Equity</b>	Equal distribution of resources among different groups of people irrespective of their social class and geographical locations
<b>Mkanda</b>	An initiation ceremony held after a traditional male circumcision in the North-Western of Zambia predominantly among the Lundas and Luvaes
<b>Non-availability</b>	Not provided for, not accessible and not available in a particular locality
<b>Option B+</b>	The putting of mothers on Highly Active Anti-Retroviral Treatment (HAART) as a new PMTCT strategy
<b>Pandemic</b>	An epidemic (breakout) of an infectious disease that has spread through human populations across a large region
<b>Pregnancy</b>	A development of one or more off-springs known as an embryo or/fetus growing in a woman's womb (uterus)
<b>REC/RED Strategy</b>	A strategy to reach out to every child in every district in terms of immunization in under fives children
<b>Re-entries</b>	number of admissions of pupils back into school that had dropped out of school for various reasons e.g. pregnancy
<b>School</b>	An institution designed for the teaching of students or pupils under the direction of teachers
<b>Sexual Indulgence</b>	Physically and emotionally involved into sexual act
<b>Syphilis</b>	A sexually Transmitted Infection caused by a bacteria (i.e. Spirochete Bacterium Treponema Pallidum)
<b>Threatening Abortions</b>	Is the term used to describe vaginal bleeding that occurs in the first 20 weeks of pregnancy

# **CHAPTER TWO**

## **LITERATURE REVIEW**

### **2.1 INTRODUCTION**

The issue of condom distribution has remained a silent one in most countries, maybe mainly due to cultural and religious doctrines.

Condom distribution in schools seems to be contentious as most countries seem to have different views when it comes to adolescents' accessibility to condoms. Researches and surveys have been done in many countries, but since this involves local leaderships, parents, the youth themselves, school administration, religious organizations and political participation; governments tend to be careful in the way they handle the issue.

Most countries have different views on this subject despite statistics showing that in some countries HIV is on the increase among the youths.

### **2.2 GLOBAL PERSPECTIVE**

As stated above, most countries tend to ignore this issue. As such literature is limited to a few countries only. United States of America (USA) has been found to be suitable for global perspective literature due to the fact that different states in that country make their own policies on certain issues and thus may be more representative.

Below are some works and views done by other researchers, surveyors and publishers of research works.

#### **2.2.1 School condom availability**

An increase in sexually transmitted diseases including HIV/AIDS among adolescents has prompted many communities to take action to protect their youth. One proven method is to provide comprehensive sexuality education along with other school based programs that make condoms available to sexually active youths. Numerous national health organizations have adopted in support of school condom availability as a component of comprehensive sexuality education (Dodd, 1998).

### **2.2.2 Condom availability programs are successful**

A comparison of public high schools in New York City and Chicago found positive effects about condom availability programs with the same sexual activity among the senior high school students in both cities (NYC, 59.7%; Chicago, 60.1%). Sexually active students in New York City where there is condom availability program were more likely to report using a condom the last sexual intercourse, than were those in Chicago, where condoms are not available in schools - 60.8% to 55.5% (Ward.et al, 1997).

In a two year study of Philadelphia, Health Resource Centers (HRC) that made condoms available reported the percentage of students using condoms at last intercourse increased from 52% to 58%. In schools with high HRC usage, the number of students ever having sex dropped from 75% to 66%, while condom usage at last intercourse rose from 37% to 50% (Teltler.et al, 1997).

### **2.2.3 Condom availability does not promote sexual activity**

A study in New York City's school condom availability program found a significant increase in condom usage among the sexually active students, though the number of the sexually active remained the same (Ward.et al, 1997).

A World Health Organization (WHO) review on studies on sexuality education found that access to counseling and contraceptives services did not encourage earlier or increased sexual activity,. In Europe and Canada where comprehensive sexuality education and convenient confidential access to condoms are more common, the rates of adolescent sexual intercourse are not higher than those in the USA. (Baldo. et al, 1993).

### **2.2.4 Sexually active teen face risks**

Another study done by Warren (1995) and others on risk behavior revealed that 53% of high school students ever had sex; 20.9% males and 14.4% females had sex with four or more people. Only 54.4% of sexually active reported using a condom at last intercourse; 60.5% males and 48.6% females (Warren. et al, 1995).

### **2.2.5 Adolescents lack access to contraceptives (condoms)**

Adolescents face many obstacles to obtaining and using condoms. Some of those obstacles include confidentiality, cost, access, transportation, embarrassment, objection by partner and the perception that the risks of pregnancy and infections are low (Committee on Adolescents Health Care, 1996).

### **2.2.6 How widespread is condom use among teens?**

A Massachusetts statewide survey in 2005 among 3500 high school students showed that condom usage had increased among teens in that state. About 45% of teens surveyed had had sex at least once. Among those, nearly 2/3 (65%) had used a condom, a rate similar to the national average, and up from 57% in 2003.

For over a decade, Massachusetts has allowed condom distribution to students in schools. The state also admits a health and safety survey, which includes questions about condom usage to high school students every 3 years. In this state, where condoms are distributed to students in high schools, pregnancy rate had been recorded at 22 per 1000 in 2004, far below the national average of more than 80 pregnancies per 1000 (Boston Globe, 2004).

### **2.2.7 The public and public health groups support condom availability**

A 1993 New York City survey of parents of high schools students, revealed that 69% thought students should have access to condoms in schools, while a 1992 gallop of adults surveyed, 68% thought condoms should be available in schools. In another survey, 85% students of Denver high school supported condom availability in their school (Ward et al, 1995), (AdolescHealth, 1996) (Fan burg, et al, 1995).

Furthermore, the Institute of Medicine, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics and the American Medical Association have all adopted policies recommending that condoms be made available to adolescents as part of their comprehensive school health programs (Butler, 1997).

## **2.3. REGIONAL PERSPECTIVE**

There is not so much data on condom distribution in schools in the region. As such South Africa has been picked due to some works done on the related topic. South Africa is also

one of the countries in the region that has a high HIV prevalence. It is worth knowing how they are handling the issues of HIV prevention in schools.

South Africa has recently adopted a Children's Act, provides children the right to access reproductive health services as a way of addressing the HIV pandemic. At the same time there remains the confusion about how these rights will be achieved such as condom access for youth.

Han and Bennish (2009) showed that the Children's Act, together with South African government policies, allows individual schools to decide whether to distribute condoms. At the same time the study revealed that most school staff is unaware of the South African policy and regulations governing condom provision in schools. Because of confusing and contradictory government policies and public pronouncements regarding provision of condoms in public schools, few schools have undertaken to provide condoms, leaving students, especially in rural areas, with few options for obtaining them. PEPFAR regulations potentially conflict with South African law by prohibiting PEPFAR-funded organizations from distributing condoms in schools or providing condom information to youth aged 14 and under.

However Han and Bennish (2009) further found that the Children's Act, states that no person may refuse to sell condoms to a child 12 years or older, or refuse to provide such a child with condoms on request where such condoms are distributed free of charge. No further regulations are needed to effect these rights. However, whether these rights are appropriate remains the focus of intense debate.

In addition to the Children's Act, the South African Department of Education (DOE) policies also govern condom distribution in schools. The current DOE policy is a politically pragmatic solution to the national debate: "let local schools decide for themselves". In a 1999 policy document (still in force) on HIV and AIDS in public schools, the DOE stated that each school can decide "*whether condoms need to be made accessible within a school and if so under what circumstances*" (SADOE, 1999).

The Children's Act thus preserves the schools' right to choose to distribute condoms, with one modification. If schools do distribute condoms, they must provide them to all students 12 and over. The Act does not impose an obligation on the government to distribute

condoms. The condom access clause is a “*negative right*,” which obligates the government to refrain from certain actions. It is not a “*positive right*,” such as the Constitutional right that obligates the government to provide access to health care services. The latter right was the basis for the South African Constitutional Court's decision that drugs to prevent mother-to-child transmission of HIV must be made available to all HIV-infected women giving birth in state health facilities (Han and Bennish. 2009).

### **2.3.1 Community response**

Attitudes about condoms in schools at the community level vary widely. Cultural and moral concerns remain strong among both parents and students, including the preservation of such traditional values as abstinence until marriage. Many parents and some students, but few school staff, felt that condom availability would promote sexual activity and undermine traditional values. These concerns were balanced by a strong sense of the growing urgency of the HIV/AIDS epidemic. Most people indicated AIDS having an emotional impact on the community (Han. et al, 2009).

The study undertaken in KwaZulu-Natal found that government's concern regarding the increase in pregnancies in schools was as a result of low condom use due to limited access more especially in the rural areas. Others, however, stated that pregnancy prevention will not be a compelling reason for condom use because many adolescent girls want the government's child support grant, even though studies have found no correlation between the grant and teenage fertility (Bennish, 2009).

Han and Bennish, (2009) in their recommendations stated that:

- ✓ The government could be similarly bold in policy implementation and mandate that schools provide condoms.
- ✓ The Department of Health (DOH) which already distributes condoms in public access points could add schools as a distribution site.
- ✓ The DOH, the Department of Education (DOE) and the Department of Social Development (under whose jurisdiction the Children's Act falls) could coordinate more closely, perhaps building on existing programs such as DOE Life Orientation curriculum and the DOH School Health Policy, to support more effective education on, and access to, condoms.

- ✓ Programs will need to teach proper condom use and address factors contributing to inconsistent use, such as a lack of perceived risk of HIV, influence of peer beliefs, and unequal power relations between genders.
- ✓ Community concerns may also be mitigated by tailoring the logistics of condom distribution in schools. The degree of adult supervision over the condom supply may depend on the needed balance between open access and potential misuse.

Finally Han and Bennis, (2009) in their conclusion stated that the need to balance sensitivity to local attitudes and urgent national health needs is neither unique to the issue of condom access for youths, nor to South Africa, but is part of any policy discussion on socially divisive issues with compelling public health implications.

Their experience with the South African and PEPFAR policies regarding condom distribution in schools indicated that the present balance disfavors the health of the country's youth and demonstrates a need for clearer and more decisive national action (Han .et al,2009).

## **2.4 LOCAL PERSPECTIVE**

The Zambian National Union of Teachers (ZNUT) rejected the distribution of condoms in schools as a way of preventing pregnancies among pupils stating that it was not the best intervention and that the trend promoted immorality and sexual abuse among school going children (ZNUT, 2012).

According to the research commissioned by USAID funded education quality improvement program 2 (Equip2) and the Ministry of Education (MoE), the number of girls at basic school level who fell pregnant while at school increased from 3,663 in 2002 to 12,370 in 2008. The forum for African Women Educationalists in Zambia records show as many as 15000 pupils fall pregnant every year (Equip2 and MoE, 2008).

In 2004, Zambia banned the distribution of condoms in schools as a measure to counter the spread of HIV/AIDS. In a report by MoE (2012) was stated that condoms were encouraging young people to have premarital sex but instead should abstain from sex as a measure to fight the disease instead of being urged to use condoms which promoted immorality.

There is no written policy in Zambia that prohibits or allows condom distributions to students in schools but all these were as a result of political pronouncements (MoE, 2012).

A Zambia Demographic Health Survey (2007), conducted by the Central Statistical Office (CSO), the Ministry of Health (MoH), the Tropical Diseases Research Centre (TDRC) and the University of Zambia (UNZA) found teenage pregnancy to be high as childbearing started as early as 15yrs among the surveyed (15-19yrs) teens. Teenage pregnancy was found to be a major health concern because of its association with higher morbidity and mortality for both the mother and the child. Childbearing during the teenage years also frequently had adverse social consequences, particularly on female educational attainment, because women who became mothers in their teens were more likely to curtail education. The survey also found that teens in the urban areas were more exposed to family planning through the media than their counterparts in the rural areas (ZDHS, 2007).

Condom use is one of the most effective means of combating HIV. However, educating the youth about condom use is sometimes controversial, with some people believing it promotes early sexual initiation. To gauge attitudes towards condom education for youths, the 2007 ZDHS asked respondents if they thought that young people aged 12-14 should be taught about using a condom to avoid HIV infections. 56% women and 68% of men supported the idea of condom education for ages 12 to 14 as a way of preventing HIV among youths (ZDHS, 2007).

On the other hand only 34% female youths and 37% male youths had comprehensive knowledge about HIV. Knowledge was higher in the urban areas (42%) than in the rural areas (26.9%), North Western province had the lowest at 23% (ZDHS, 2007).

**Table 2.4.1: Selected Statistics from the District Education Board Secretary’s (DEBS) Kabompo office.**

Grade	2010		2011		2012	
	boys	girls	boys	girls	boys	girls
8	982	924	1041	827	899	763
9	1133	886	1059	888	1026	824
10	646	384	491	317	464	362
11	500	285	564	335	520	345
12	437	244	435	282	544	355
<b>Totals</b>	<b>3698</b>	<b>2723</b>	<b>3590</b>	<b>2649</b>	<b>3453</b>	<b>2649</b>

*The number of girl child reduces more than that of a boy child as they progress to higher grades.*

According to the 2007 ZDHS, 28% of women aged 15-19 had begun their child bearing and 22% had a child while 6% were pregnant.

## **2.5 CONCLUSION**

From the global perspective, a number of studies that were undertaken, revealed that some schools that had adopted the condom distribution policy through the Health Resource Centers (HRCs), where health education is emphasized and condoms made available to pupils (e.g. Philadelphia, New York City and Massachusetts) had shown that the usage of condoms among the sexually active teens had increased, while the number of sexually active teens was decreasing.

At regional level, it was found that the HIV prevalence among the youths and the teenage pregnancy was high while at the same time there are no clear deliberate policies that support condom distribution to schools, as it is clear on the PMTCT policy on drug distribution. There have been different views from the community where the majority regards the condom distribution as culturally inappropriate.

Locally, there is a MoE policy in place which prohibits condom distribution to schools and family planning services. Therefore, the study was undertaken to review the current policy on how the non-availability of condoms in schools affects sexual behavior.

## 2.6 RESEARCH QUESTION, HYPOTHESIS AND OBJECTIVES

### 2.6.1 Research Question

Does the current school policy (non- availability of condoms) have an effect on the number of STI's, abortions and school-dropouts?

### 2.6.2 Hypothesis

No-condom policy in schools is not leading to abstinence among school going adolescents.

### 2.6.3 General objective

- ✓ To establish how the non-availability of condoms in schools affect sexual behavior among school going adolescents in Kabompo District.

### 2.6.4 Specific objectives

- ✓ To establish whether non-availability of condoms in schools leads to abstinence among the school going adolescents.
- ✓ To establish the levels of condom use by those who are sexually active among the school going adolescents.
- ✓ To assess knowledge levels of safer sex by school going adolescents.

# CHAPTER THREE

## RESEARCH METHODOLOGY

In order that the study objectives are met, there was need to analyze the variables and ascertain their associations/relationships. This chapter will discuss the study design, study setting, study population that will include the inclusion and exclusion criteria, sample selection, sample size, sample selection methods, data collection techniques and tools, plan for data capture and ethical considerations in order to help come up with solutions.

### 3.1 STUDY VARIABLES

The intention was to assess the association and not the causes and effects, therefore no dependent and independent variables were categorized. This is in accordance with other researchers: (Blaikie, 1993 and Creswell, 2007). In addition to this, Earl Babbie (2009), states that in some instances there may be no need to itemize the dependent and independent variables in cases where we are not looking at the causes and effects (i.e. especially in social sciences research, unlike the experimental research). This research tried to have a basic outlook on the association that existed between the various variables as a result of an already existing school policy.

The attached questionnaire (**Appendix V**) formed the basis for the selected study variables for computation during data analysis as per the study objectives.

Therefore the study variables were as follows:

- ✓ Age of respondent
- ✓ Gender of respondent
- ✓ Grade of respondent
- ✓ Type of School
- ✓ School Dropout Rate
- ✓ Knowledge of Family Planning
- ✓ Practice of Sexual Intercourse
- ✓ Practice of Family Planning
- ✓ Ever used condom
- ✓ Experience of Sexual Indulgence
- ✓ Multiple sexual partners
- ✓ General School Experience

- ✓ Personal Perspective on Condom Availability

## **3.2 STUDY DESIGN**

It was a cross sectional analytical study restricted to the available high/secondary schools in Kabompo District.

## **3.3 STUDY SETTING**

The research was conducted in Kabompo District, North Western Province of Zambia (it has now been split into two Districts that includes Manyinga which was part of study setting). It included four secondary schools, two in the rural and two urban secondary schools.

Kabompo District is situated in the North-Western Province of Zambia. It is about 14,532 square kilometers with much of the area being bushy and sparsely populated in many places. It is approximately 376 km from Solwezi, the provincial capital, along the Mutanda – Chavuma road, the M8. The District shares borders with Mwinilunga in the north, Zambezi in the west, Mumfumbwe in the east and Lukulu in the south-west.

### **3.3.1 Social Economic Profile**

The District has three traditional rulers, namely; Senior Chief Sikufele residing at Manyinga sub-District, 30km from the civic centre, Chief Kalunga with his palace at Chikenge, 50km from the centre and Chief Chiyengele at Kayombo Palace, some 96km away from the civic centre. All the three chiefdoms conduct their traditional ceremonies yearly, attracting people from different parts of the province and other places outside the province as well. Male circumcision is conducted traditionally on the youths, famously known as Mkanda ceremony.

Most people live in the remote parts of the District. There are seven tribes in the District namely Mbunda, Luvale, Lunda, Nkoya, Chokwe, Luchazi and Mbundu.

The major economic activities are farming, lumbering, charcoal burning, small scale fishing, bee-keeping and merchant selling. There are no major industries for formal employment for the locals, and as such most of them migrate to Solwezi for better opportunities in the mine industries.

### 3.3.2 Health and Education

The District has 114 schools of which six are secondary schools and two are high schools namely Kabompo and Manyinga, while the rest are community schools. There are no colleges in the District. Illiteracy levels among school going age group stands at around 49% (CSO 2007). The illiteracy levels are higher among women and girls than their male counterparts. There are two first level referral hospitals namely, Kabompo District and Loloma Mission Hospitals. There are 19 rural health centers and three health posts.



Figure 3.3.2: Map of Kabompo District

### 3.4 STUDY POPULATION

The target population was all school going children in Kabompo District. However, the study population for this study was all grades 8 to 12. The study used the rotary method to recruit the respondents (secondary school pupils) randomly in order to get a representative sample.

#### 3.4.1 Inclusion Criteria

All pupils aged 14 to 20 years who consented and signed a consent/assent form were included into the study.

#### 3.4.2 Exclusion Criteria

Pupils below 14 and above 20 years of age who did not sign consent/assent forms were not included in the study.

### 3.5 SAMPLE SIZE

The Yamane (1967) sampling formula was employed to select the sample size

#### 3.5.1 Sampling

$$n = \frac{N}{1 + N(e)^2} \text{ (Yamane, 1967)}$$

**Where:**

**n** = the sample size

**N** = the size of populations (this shows the actual population as the numerator while the target population as the denominator according to Yamane formula)

**e** = the error of 5 percentage points

$$n = \frac{98000.00}{1 + 1435 (0.5)^2}$$

$$n = 272.9 + 10\% \text{ dropout rate}$$

$$n = 300.19 \Omega$$

$$n = 300$$

### **3.6 SAMPLE SELECTION METHODS**

The sample selection was done in Kabompo District. Multi-stage and systematic sampling methods were used.

#### **3.6.1 Stage One**

This stage involved stratification of schools into urban and rural. The urban schools being those within a 5km radius from the civic Centre (boma), whereas rural, those beyond 5 km radius. Using the above stratification method, eight secondary schools in Kabompo District (4 in the urban and 4 in the rural) were selected to constitute the sampling frame.

However, a total of four schools were selected for inclusion in the study using simple random method. Two schools were selected from the urban area and the other two from rural area. A rotary technique was used to select all the four schools, two from the first stratum (urban) and the other two from the second stratum (rural) were included in the study.

#### **3.6.2 Stage Two**

This involved the identification of a sampling frame of all the eligible pupils from the selected schools that were included in the study. Class registers from the heads of schools were used to identify pupils within the selected age group (ages 14 – 20). A total of 75 pupils from each school were enrolled into the study using systematic sampling method, where every 6<sup>th</sup> pupil on the class register became a respondent out of an average of 480 pupils from grades 11 to 12. A minimum of 38 questionnaires over a period of one week were administered at each school.

### **3.7 DATA COLLECTION TOOLS**

Data collection was done using a structured questionnaire which was administered to the students. The questionnaires only included closed-ended questions. The closed ended questions formed the basis of quantitative data analysis. As for further information on statistics the study sought further information from the District Education Board Secretary (DEBS) on the number of marriages, pregnancies, drop-outs and re-entries segregated by gender to help come up with cross tabulation tables and frequencies in the analysis.

### **3.8 ETHICAL CONSIDERATIONS**

Permission to conduct the study was obtained from the Biomedical Research Ethics Committee of the University of Zambia (UNNZA-BREC). Study participants were provided with detailed information concerning participation and the consequence of the study, and were informed that participation was voluntary.

In order to observe confidentiality and enhance trustworthiness of the collected data, no names or personal identifiers were collected or documented on the questionnaires. No biological samples were required to be collected from the participants.

Permission from the District Education Board Secretary to conduct the study in their facilities was sought. Further permission letters were sought and signed by the parents/guardians to permit their children to participate in the study. Consent forms were then availed to those that were 18yrs old and above, while those below the age of 18 were availed with assent forms for their voluntary participation.

# **CHAPTER FOUR**

## **DATA ANALYSIS AND RESEARCH FINDINGS**

### **4.1 DATA PROCESSING AND ANALYSIS**

The study employed a survey method approach considering the specific objectives of the study which were to: establish how the non-availability of condoms in schools affect sexual behavior among school going adolescents, establish the levels of condom use by those who are sexually active among the school going adolescents and assess their knowledge levels of safer sex. The study analyzed the quantitative data (i.e. structured interview guide) using two software; STATA version 11 and Epi- info.

#### **4.1.1 DATA ANALYSIS**

The data entry was done using Epi-Info and then STATA Version 11.0 was used for the actual analysis. After data was collected, it was first coded and then checked for consistency and completeness before entry. The checked data was then entered into Epi-Info then variables created. Entered data was exported into a statistical package (STATA version 11.0) for data management and statistical analysis. After exporting the data into STATA version 11.0, data analysis was carried out, this involved running of frequencies and cross tabulations.

A Pearson Chi-Square test and Fishers exact tests were used for analysis in order to determine the associations between the selected variables. Confidence interval was set at 95% and all p-values < 0.05 were considered statistically significant.

#### 4.1.2 SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

This section shows the frequencies of all the socio-demographic characteristics that were discussed in the study research (i.e. age, grade, gender economic-status). There is some missing data due to non-response.

**Table 4.1.2.1: Socio –Demographic Characteristics of Respondents**

<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Age ( In years)</b>		
14 – 16years	73	25.3
>16 – 20 years	215	74.7
<b>Total</b>	<b>288</b>	<b>100</b>
<b>Level of Education (Grade)</b>		
Nine	13	4.5
Ten	68	23.6
Eleven	141	49.0
Twelve	66	22.9
<b>Total</b>	<b>288</b>	<b>100</b>
<b>Gender</b>		
Male	137	47.5
Female	151	52.5
<b>Total</b>	<b>288</b>	<b>100</b>
<b>Economic Status</b>		
Poor	85	29.5
Middle Class	143	49.6
Rich	22	7.6
<b>Total</b>	<b>250</b>	<b>86.7</b>

**Age**

Age Distribution was cut off at 16 considering that those below are underage in terms of sexual indulgence which is considered as defilement in Zambia, as such the researcher wanted to establish the levels of indulgence among the two age groups (table 4.1.7.1)

**Level of Education**

The majority of the participants were in grade 11.

**Gender Distribution**

The Table shows that there was an almost equal distribution of respondents in terms of gender, although females were slightly in the majority as compared to the males.

**Economic Status**

About 60% of the respondents in the middle class and all the rich were from peri-urban areas while a third of the poor were from the rural areas.

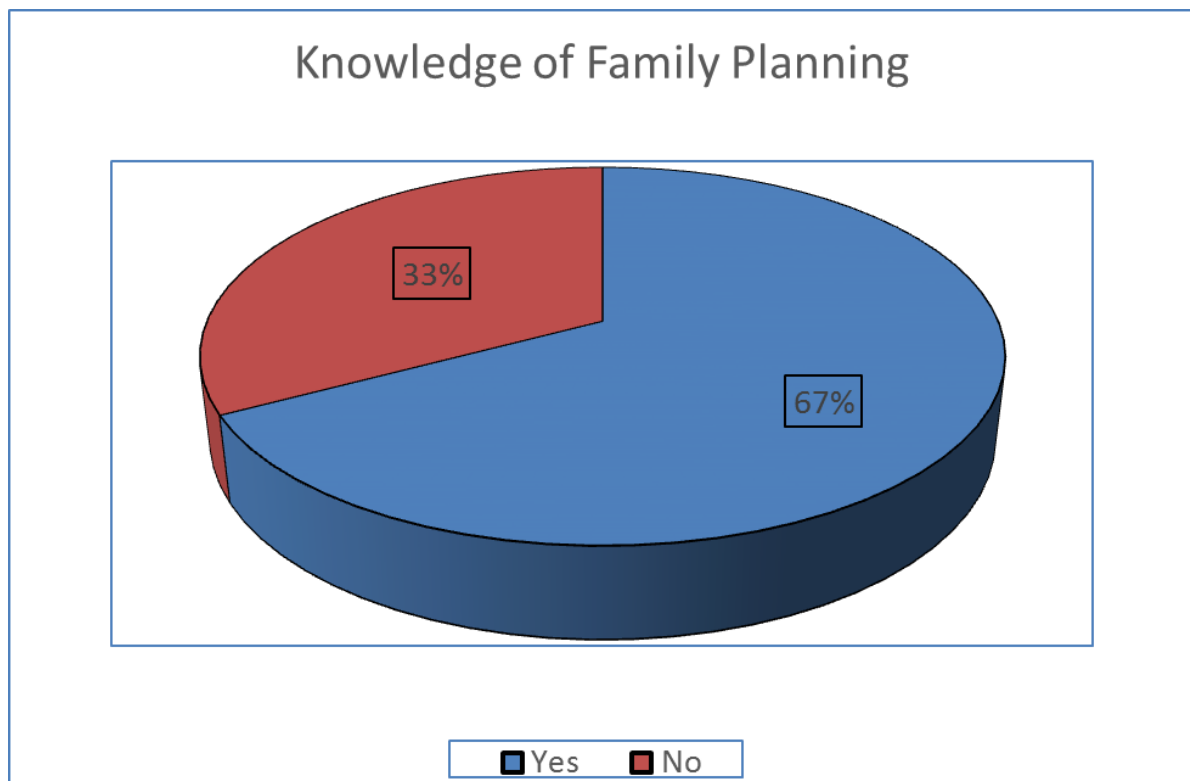
### 4.1.3 SECTION B: KNOWLEDGE ON FAMILY PLANNING

This section describes the various factors that suggest whether the respondents who participated in the study had knowledge about Family Planning and the methods. It also highlights the usage of condoms and their importance as elaborated in Tables 4.1.3.1 to 4.1.3.4 as follows: (Some tables may not show 100% response and the actual number of respondents due to missing data).

**Table 4.1.3.1: Ever discussed Family Planning with parents/guardians**

Ever discussed FP	Frequency	Percentage
Yes	65	22.5
No	216	75.0
<b>Total</b>	<b>281</b>	<b>97.5</b>

The table shows that three quarters of the respondents had never discussed Family Planning with parents/guardians while about a quarter only, indicated that they had discussed Family Planning with their parents/guardians



**Figure 4.1.3.2: Knowledge of Family Planning**

It is indicated that some of the respondents had Knowledge about Family Planning though they did not fully understand it (Table 4.1.3.2) while a third of them did not have any idea of what Family Planning was.

**Table 4.1.3.2: Description of Family Planning by respondents**

<b>Family Planning Methods</b>	<b>Frequency</b>	<b>Percentage</b>
Pills	74	25.6
Injectable	23	7.9
Implant	1	0.3
Condoms	24	8.3
Menstrual Cycle	5	1.7
All the above	64	22.2
<b>Total</b>	<b>191</b>	<b>66</b>

The table above shows the description of Family Planning and their distribution between the respondents according to their understanding of Family planning. A third of the respondents thought that family planning was pills, while some thought it was injectables. Another group thought family planning was condoms while others related it to the menstrual cycle. The least of the respondents indicated using an implant. Only less than half of the respondents had full knowledge.

**Table 4.1.3.3: Ever heard about condoms**

<b>Heard about condoms</b>	<b>Frequency</b>	<b>Percentage</b>
Yes	274	95.1
No	13	4.5
<b>Total</b>	<b>287</b>	<b>99.6</b>

The table shows that almost all of the respondents had heard about Condoms while only a minority had never heard of them.

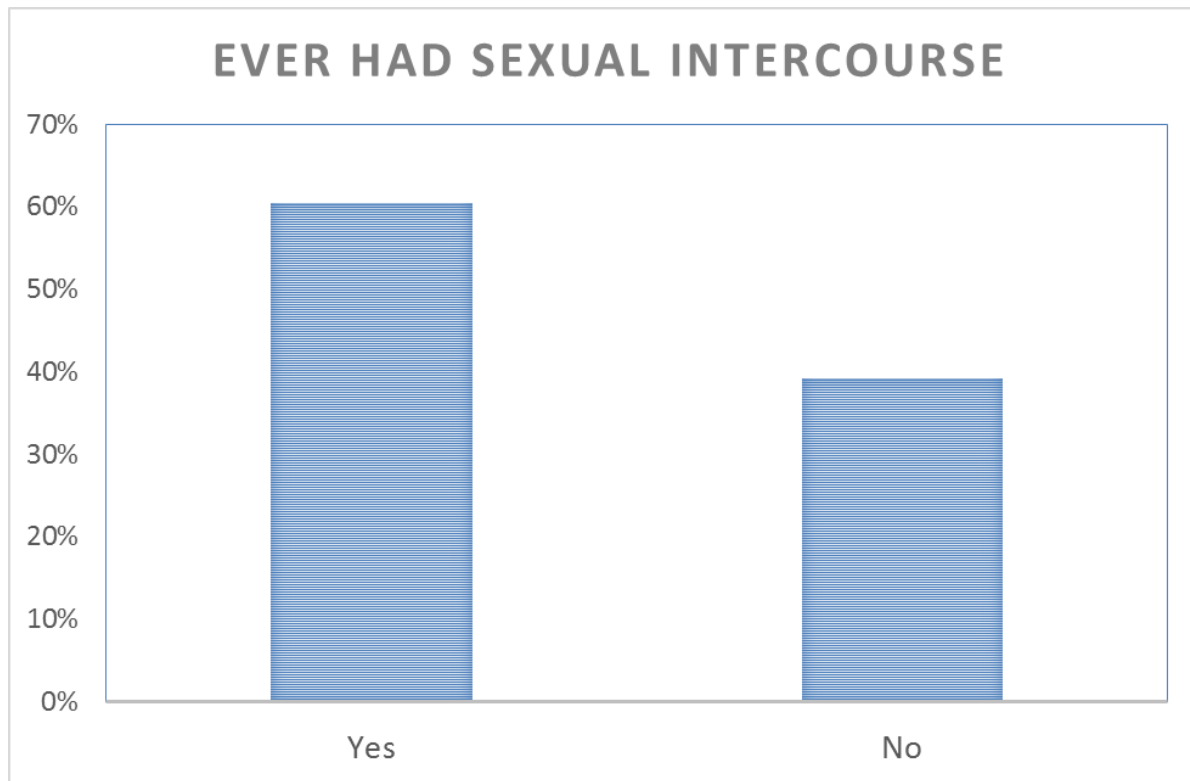
**Table 4.1.3.4: Importance of condoms**

<b>Importance of Condoms</b>	<b>Frequency</b>	<b>Percentage</b>
Prevent STI/HIV	110	38.1
Prevent unwanted pregnancy	80	27.7
Don't know	2	0.6
Prevent STI/HIV & unwanted pregnancy	82	28.4
<b>Total</b>	<b>274</b>	<b>94</b>

This Table is about the knowledge and the importance of condoms by the respondents. Less than half fully knew the importance of condoms while the majority had partial knowledge over the importance of condoms. Some had no idea about the importance of condoms.

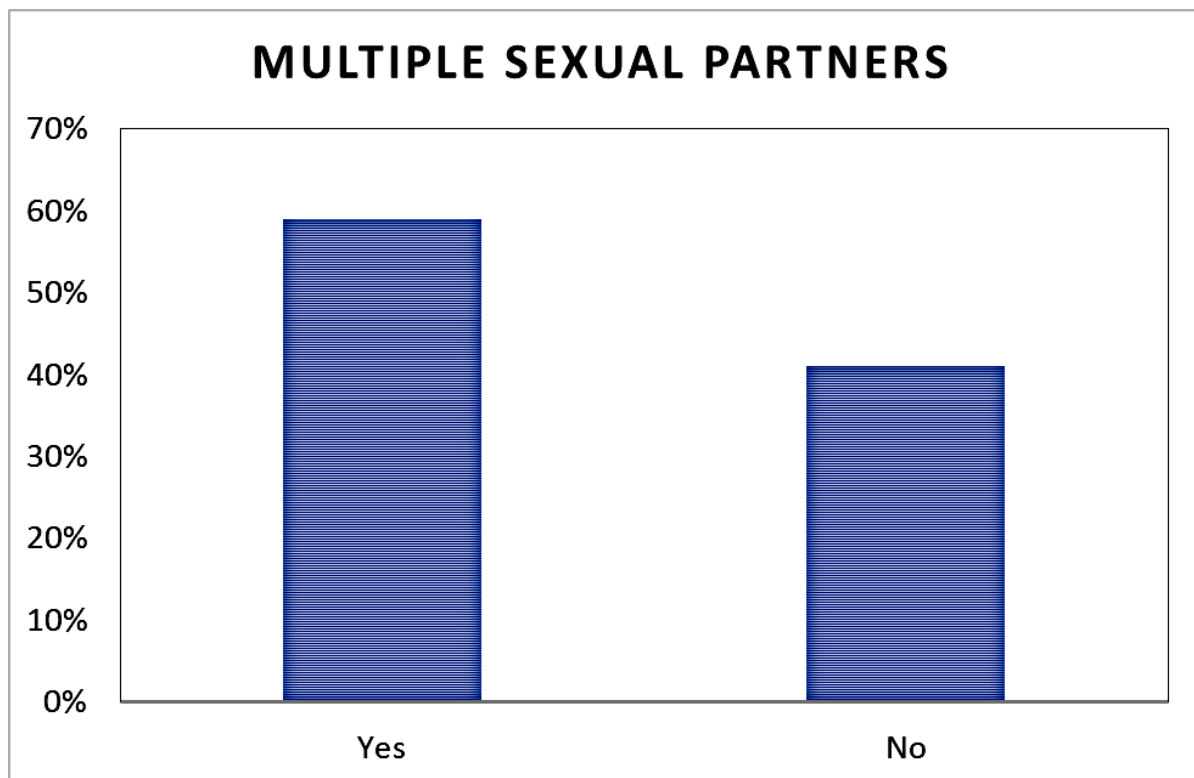
#### 4.1.4 SECTION C: PRACTICE OF SEXUAL INTERCOURSE

This section mainly looks at what the practice of sexual intercourse is among the respondents.



**Figure 4.1.4.1: Showing respondents who had indulged in sexual intercourse**

The result about respondent's practice in terms of sexual intercourse is indicated in Fig. 4.1.4.1. Majority of the respondents have had sexual intercourse.



**Figure 4.1.4.2: Showing respondents who were sexually active with multiple partners**

It is shown above in Fig 4.1.4.1, that more than half of the respondents had indulged in sexual intercourse with concurrent multiple partners.

**Table 4.1.4.1: Ever used any form of Family Planning method**

Ever used FP	Frequency	Percentage
Yes	100	34.7
No	188	65.3
<b>Total</b>	<b>288</b>	<b>100</b>

It is indicated in the Table above that well over half had never used any form of Family Planning, while only a third of the respondents had used some form of Family Planning products.

#### 4.1.5 SECTION D: EXPERIENCE OF SEXUAL INDULGENCE

This section mainly looks at what the experience of sexual indulgence was, among the respondents.

**Table 4.1.5.1: Ever suffered from any form of STI**

Ever suffered from STI	Frequency	Percentage
Yes	32	11.1
No	256	88.9
<b>Total</b>	<b>288</b>	<b>100</b>

The results about respondent's experience in terms of sexual indulgence are indicated in Table 4.1.5.1. It is interesting to note that the majority of the respondents had never suffered from any form of STI, while only a minority of the respondents had actually suffered from an STI.

**Table 4.1.5.2: Ever Aborted**

Ever Aborted	Frequency	Percentage
Yes	40	26.5
No	111	73.5
<b>Total</b>	<b>151</b>	<b>100</b>

The table shows the female respondents on abortions.

**Table 4.1.5.3: Place of Abortion**

Place of Abortion	Frequency	Percentage
Health Facility	20	50
Home	10	25.0
School premises	4	10.0
Traditional Healer	6	15.0
<b>Total</b>	<b>40</b>	<b>100</b>

For those that had aborted when further probed where the abortion took place, half of the respondents indicated a health facility, while the rest at home/ a traditional healer. A 10% indicated they aborted within school premises.

**Table 4.1.5.4: Person who carried out Abortion**

<b>Person conducted Abortion</b>	<b>Frequency</b>	<b>Percentage</b>
Clinician	15	37.5
Myself	14	35.0
Friends	7	17.5
Traditional Healer	4	10.0
<b>Total</b>	<b>40</b>	<b>100</b>

When asked about the person who conducted the abortion, the respondents indicated; more than half were conducted by clinicians and by-one-self, while the remaining by a friend and a traditional healer. The Table further reveals that a lot of the abortions were unsafely conducted (oneself).

**Table 4.1.5.5: Use of condoms in next intercourse**

<b>Condom Use</b>	<b>Frequency</b>	<b>Percentage</b>
Yes	191	66.3
No	97	33.7
<b>Total</b>	<b>288</b>	<b>100</b>

The table above shows the willingness to use condoms in the next intercourse by the majority while over a third still thought that they would not use a condom at next intercourse due to accessibility, affordability and not knowing how to use it.

#### 4.1.6 SECTION E: GENERAL SCHOOL EXPERIENCE

This section shows the general school experience of the respondents (Some tables may not show 100% response and the actual number of respondents due to missing data).

**Table 4.1.6.1: Ever repeated**

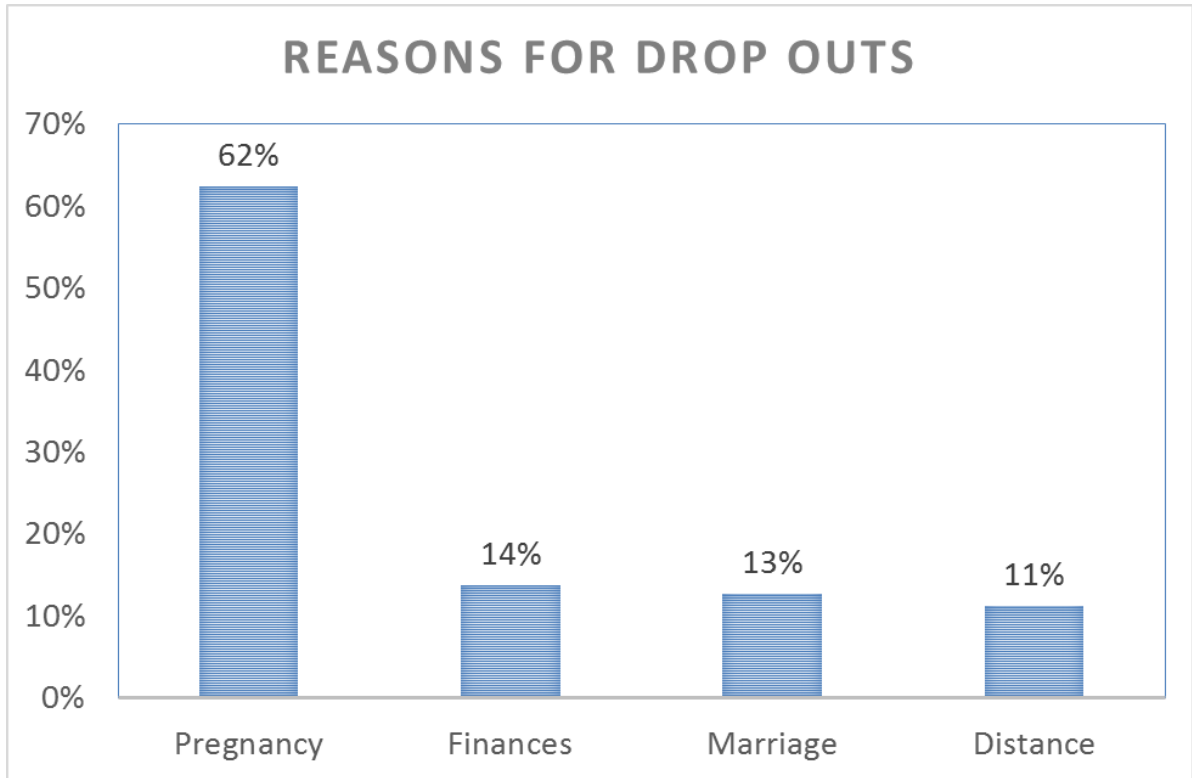
<b>Ever Repeated</b>	<b>Frequency</b>	<b>Percentage</b>
Yes	87	30.2
No	201	69.8
<b>Total</b>	<b>288</b>	<b>100</b>

Most of the respondents had never repeated before while almost a third of them had actually repeated.

**Table 4.1.6.2: School drop-outs**

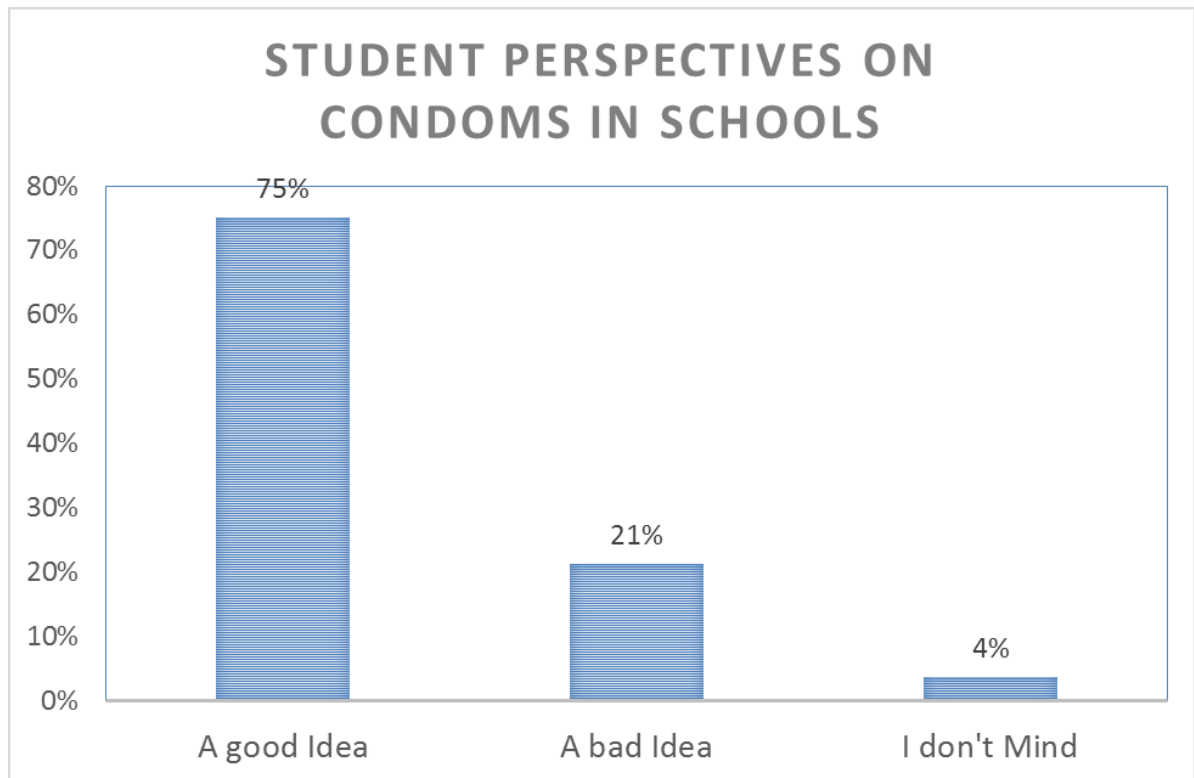
	<b>Frequency</b>	<b>Percentage</b>
Yes	205	71.2
No	83	28.8
<b>Total</b>	<b>288</b>	<b>100</b>

According to Table, the majority of the respondents said that they knew at least someone who had dropped out of school and when further probed about reasons for the drop-outs (see Fig 4.1.6.1), the majority indicated pregnancy as a major cause.



**Figure 4.1.6.1: Giving various reasons for respondents dropouts**

When the respondents were asked about reasons for drop-outs, their responses revealed that mostly was due to pregnancy. Finances and early marriage are among the other reasons. The minority dropping out was due to long distances to the school facility.



**Figure 4.1.6.2: Showing students' perspective on condoms**

The views on condom availability and accessibility in schools are displayed in the figure above. It revealed that most of the respondents thought it was a good idea, while others thought it was a bad idea and the minority indicated that they did not mind.

#### 4.1.7 SECTION F: BIVARIATE ANALYSIS

This section identifies the relationships and associations that may be existing between the socio-demographic characteristics and having indulged in sexual intercourse, condom use, ever used family planning method and school type and family planning knowledge. (Some tables may not show 100% response and the actual number of respondents due to missing data).

**Table 4.1.7.1: Socio – Demographic Characteristics by Sexual Indulgence**

Variable	Sexual Indulgence		X <sup>2</sup>	P-value
	Yes	No		
<b>Age (In years)</b>				
14-16 years	15(13.4)	52(31.9)	27.29	0.000
>16-20 years	97(86.6)	111(68.1)		
<b>Total</b>	<b>112(100)</b>	<b>163(100)</b>	<b>27.29</b>	<b>0.000</b>
<b>Gender</b>				
Male	54(53.5)	50(33.8)	42.18	0.002
Female	47(46.5)	98(66.2)		
<b>Total</b>	<b>112(100)</b>	<b>163(100)</b>	<b>42.18</b>	<b>0.002</b>

#### Age

The findings in Table 4.1.7.1 show that the respondents 16-20 years of age were more likely to be sexually active compared to those <16years of age. This implies that the older age group (≥16 years) was indulging more in sexual intercourse.

The results also show that there was an association between age and sexual indulgence with a p-value of < 0.001. Age was found to be statistically significant (older respondents were more likely to indulge in sexual intercourse as compared to the younger respondents).

### Gender

Table 4.1.7.1 indicates that there was a very strong association between gender of respondents and their sexual indulgence. The male respondents were more likely to indulge in sexual intercourse compared to their female counterparts.

The results also show that there was an association between gender and sexual indulgence with a p-value of 0.002. Therefore, there was a statistical difference between gender and sexual indulgence.

**Table 4.1.7.2: Gender and Condom Use**

Variable	Condom Use (%)		Chi-Square	P-value
	Yes	No		
Male	81(52.9)	16(26.7)	27.32	0.001
Female	72(47.1)	44(73.3)		
<b>Total</b>	<b>153(100)</b>	<b>60(100)</b>	<b>27.32</b>	<b>0.001</b>

### Gender

Table 4.1.7.2 shows an association between gender of respondents and the use of condoms. Majority of the male respondents, who were indulging in sexual intercourse, reported using a condom as compared to their female counterparts.

The study revealed a statistical difference between gender and the actual condom use with a p-value of 0.001.

**Table 4.1.7.3: Gender by Knowledge of Family Planning**

<b>Variable</b>	<b>Knowledge of Family Planning (%)</b>		<b>Chi-Square</b>	<b>P-value</b>
	<b>Yes</b>	<b>No</b>		
Male	71(43.0)	56(62.2)	44.82	0.003
Female	94(57.0)	34(37.3)		
<b>Total</b>	<b>165(100)</b>	<b>90(100)</b>	<b>44.82</b>	<b>0.003</b>

### Gender

The Table indicates that males were less likely to have had knowledge of family planning compared to the females.

The results and findings of Table 4.1.7.3 show that there was a statistical difference between Gender and Knowledge of Family planning with a p-value of 0.003.

**Table 4.1.7.4: School Type by Ever Used Family Planning Method**

<b>Variable</b>	<b>Ever Used Family Planning Method (%)</b>		<b>Chi-Square</b>	<b>P-value</b>
	<b>Yes</b>	<b>No</b>		
Boarding	32(35.6)	94(58.4)	44.82	0.001
Day	58(64.4)	67(41.6)		
<b>Total</b>	<b>90(100)</b>	<b>161(100)</b>	<b>44.82</b>	<b>0.001</b>

### School Type

The Table indicates that the respondents that were in day (64.4%) were more likely to have used family planning methods compared to the respondents in boarding (35.6%) who were less likely to have ever used family planning methods.

The results and findings of Table 4.1.7.5 show that there was a statistical difference between School Type (boarding and day) and ever used family planning method with a p-value of 0.001.

# CHAPTER FIVE

## DISCUSSION OF FINDINGS

### 5.1 Summary of Findings:

This study contributes to the body of knowledge on the current scarce literature of the non – availability of condoms in schools in Zambia, resulting in teenage pregnancies and communicable diseases such as STIs/HIV. The findings of the study showed that the majority of the respondents were aged between 16 to 20 years and were in grade 11. A minority of the respondents were female while on the other hand, the majority of the respondents were from the middle class. The study also revealed that almost half of those that had indulged in sexual intercourse had more than one sexual partner. Of those indulging in sexual activities, more than half did not use any form of family planning (Table 4.1.4.1). These results were consistent with a study done by ZDHS (2007) which revealed that more teenagers indulge in premarital sex as early as 15yrs on average which may put them at risk of pregnancy/STIs.

The study further showed that over half of the respondents had some knowledge about family planning with only a third being able to fully describe what family planning was (Table 4.1.3.2). Although the majority had heard about condoms, very few fully understood the importance of family planning (Tables 4.1.3.3 and 4.1.3.4). The researcher's assumptions were that sexual education does not take place in many homes with either parents or guardians, which may lead to pupils lacking knowledge on the importance of condoms if sexually active, therefore predisposing the adolescents to practicing unsafe sexual intercourse which may lead them into having unplanned for pregnancies, unsafe abortions (outside the health facility e.g. by one self, by friends or a traditional healer) and contracting other forms of STIs. The study revealed that over a third of the respondents fell pregnant while a quarter aborted. The majority of these abortions were unsafely done.

In addition, the study showed that the majority of respondents who indulged in sexual intercourse, over half of them were male and reported using a condom as compared to their female counterparts. The researcher's assumption was that males (boys) usually have more access to condoms and in the African context/culture, it is a taboo for female (girls) to carry condoms around otherwise they will be labeled as prostitutes, whereas boys easily carry them around in case they need to use them.

Finally, the study also revealed that the respondents that were day scholars were more knowledgeable on family planning services as compared to the boarders. The researcher's observation was that generally, day scholars had more access to either health facilities (i.e. Maternal Child Health services, Youth Friendly Corners, World Aids Days programmes and Voluntary Counselling and Testing services which the respondents in boarding are restricted to, making it almost impossible to have knowledge on family planning services.

Generally, the findings from the discussion show that there was a statistical difference and very strong association between the respondents' Age, Gender, School Type and Sexual Indulgence, Condom Use, Family Planning Knowledge and Ever Used Family Planning Method with p-values ranging from ( $p = 0.000$  to  $p = 0.003$ ).

## **5.2 Discussion of the Study Findings:**

A number of variables were tested against the first objective which brought out Age and Gender as having shown statistical difference. This helped to ascertain whether the non-availability of condoms in schools leads to abstinence among the school going adolescents.

Age has been a major factor in several studies undertaken regarding research. In this study it has shown that the older respondents  $\geq 16$  years had been more exposed to sexual indulgence compared to the younger ones  $\leq 16$  years old (table 4.1.7.1). The findings show that the respondents  $\geq 16$  years of age were more sexually active compared to those  $\leq 16$  years of age. The researcher's assumptions were that teenagers of  $\geq 16$  years old have just experienced puberty (i.e. this usually causes hormonal changes in their bodies, more especially to the boys (i.e. between the ages 14 – 19 years) and peer pressure from colleagues. due to the longer duration spent at school among the  $\geq 16$  years of age. These results are consistent with findings from the ZDHS (2007) which revealed that teenage pregnancy was high and childbearing started as early as 15 years among the surveyed (15 – 19 years) teens. Teenage pregnancy was found to be a major health concern because of its association with higher morbidity and mortality for both the mother and the child. This has shown that it affects the female educational attainment in that it curtails education of the girls because of social consequences of being a mother at a tender age especially for those in the rural areas (ZDHS, 2007). This also leads to school drop outs. See fig: 4.1.6.1

Like elsewhere on the globe, Warren and others (1995) in their study revealed that 53% of high school students in their teens that had indulged in sexual intercourse were 20.9% of males and 14.4% females who had indulged in risky behavior, had had sex with four or more people (multiple concurrent partners) thereby pre-disposing themselves to either STIs/HIV and or early pregnancies. However, only 54.4% of the sexually active reported using a condom at last intercourse. Of those that had used a condom at last intercourse 60.5% were male while 48.6% were females. The researcher's assumptions are that age was a factor when it came to making decisions of sexual indulgence as most of the teenagers  $\geq 16$  years are in high school and are susceptible to high risk behavior due to peer pressure.

Further studies done by Baldo and others (1993), review of studies on sexuality education by the world health organization, found that access to counseling and contraceptives services did not encourage earlier or increased sexual activity. In Europe and Canada where comprehensive sexuality education and convenient confidential access to condoms are more common, the rates of adolescent sexual intercourse are not higher than those in the USA. Age being a factor that showed association with sexual indulgence had a very strong statistical difference with a p-value of 0.000.

Gender is also another important facet in most studies that have been undertaken when looking at associations. This study particularly looked at school going adolescents considering their sexual behavior in relation to the absence of condoms in the school premises. The findings of the results showed a very strong association between gender of respondents' and sexual indulgence. The male respondents indicated a higher sexual indulgence compared to the female respondents.

Generally, sexual intercourse was largely practiced among the boys compared to girls. The researcher's assumptions were that the males indicated a higher percentage as compared to that of the girls in terms of sexual indulgence as a result of the cultural practices in this part of the country (north-western province) i.e. Mukanda Initiation Ceremony (traditional male circumcision and initiation ceremony), that allows a young man usually to practice sex immediately they come of age to prove their manhood. This may expose them to various risk factors such as STIs and impregnating young girls as observed by the researcher in this study setting. In addition to this, sexual education is a taboo by most African families and cultures. Usually sex is not addressed by parents/guardians to their children due to the culture aspect in the African setting, hence immediately girls become of age, they undergo

an initiation ceremony where they are taught to take care of a man and then some parents take advantage of this and marry them off. Since these girls are unable to have access to condoms because of lack of education on sexuality issues, they are predisposed to STIs/HIV and early pregnancies. The researcher's assumption is that if girls are exposed to early sexual education it could help curb the likelihood of teenage pregnancies. The study results are supported by a study done by Dodd (1998) whose findings were that if comprehensive sexuality education was provided along with other school based programs that make condoms available to sexually active youths; it would actually reduce the risks of teenage pregnancy and STIs by over 80% of the infection rate.

Furthermore, Han and others (2009) also revealed in their study that attitudes about condoms in schools at the community level vary widely. Cultural and moral concerns remained strong among both parents and students, including the preservation of such traditional values as abstinence until marriage. The majority of the parents, with a few students and school staff, felt that condom availability would promote sexual activity and undermine traditional values and encourage HIV/AIDS prevalence to be high which would then impact the community negatively (Han. et al, 2009).

Another study done by ZDHS (2007) revealed that condom use is one of the most effective means of combating HIV. However, educating the youth about condom use is sometimes controversial, with some people believing it promotes early sexual initiation. To gauge attitudes towards condom education for youths, ZDHS asked the young people aged 12-14 years whether they should be taught about using a condom to avoid HIV infections. About 56% of the women and 68% of the men supported the idea of condom education for ages 12 to 14 as a way of preventing HIV among youths (ZDHS, 2007).

This study showed that 62% of the respondents are not abstaining from sexual intercourse (see fig 4.1.4.1). This qualifies the first objective that the non-availability of condoms in schools does not lead to abstinence, hence the researchers' assumption is that sex education and condom use is imperative in order that more teenage pregnancies and STIs/HIV are avoided and lives preserved. The results showed that there was an association between gender and sexual indulgence with a p-value of 0.002 indicating a statistical difference between gender and sexual indulgence.

A number of variables were tested against the second objective which brought out only Gender as having shown statistical difference. This helped to establish the levels of condom use by those who are sexually active among the school going adolescents. However, gender which showed significant results has been highlighted below and also related to other studies done elsewhere.

According to the study, more male respondents were indulging in sexual intercourse and used a condom in comparison to the female respondents (tables 4.1.7.2). These results were consistent with the study done by Warren (1995) and others which revealed that only 54.4% of sexually active youths reported using a condom at their last intercourse, with a percentage of 60.5 for males and 48.6 for females.

Furthermore, Ward (1997) in a comparative study revealed that usage of condoms among schools that had adopted condom availability programs with the same sexual activity was very high as compared to those that did not have. The senior public high schools (New York City (NYC) and Chicago) recorded positive effects only in places which had adopted these programs. The results showed that condom usage at last intercourse was higher in NYC (60.8%) because of supporting the condom availability programs in schools compared to Chicago (55.5%) which recorded less usage because of the absence of these programs.

In addition, studies examining gender differences in self-reported sexual behavior suggest that over-reporting and under-reporting does sometimes occur. In national probability surveys, adult men relative to women tended to report greater numbers of sexual partners (Dolcini, et al. 1993, Morris, 1993 and Smith, 1992) and among people with risk factors for HIV/STIs, men were more likely to report using condoms than women (Catania, et al. 1992).

Further studies done by Zambia Demographic and Health Survey (ZDHS) of 2007 revealed that, due to the hetero-sexual conduct, new HIV infections have been increasing at an estimated 67,602 adults in 2006 to a projected 72,019 by 2015 of which 55% are females while 45% are males. This means approximately 185 new infections every day.

Another study undertaken in KwaZulu-Natal (South Africa), found that government's concern regarding the increase in pregnancies in schools was as a result of low condom use due to limited access more especially in the rural areas. Others, however, stated that pregnancy prevention will not be a compelling reason for condom use because many

adolescent girls want the government's child support grant, even though studies have found no correlation between the grant and teenage fertility (Bennish, 2009).

The study showed a drop-out of 62%. According to the researchers' assumptions, this high level of dropout rate could have been attributed to pregnancy (see Fig 4.1.6.1). The non-use of condoms may also predispose the respondents to STIs/HIV. This is consistent with Baboo (2014) report, which revealed that for each hour, there are three new cases of HIV infection and out of these two are adolescents. The study showed a very strong association between gender of respondents and the use of condoms with a p-value of 0.001. This showed a statistical difference between gender of respondents and usage of condoms.

The third objective was assessing knowledge levels of safer sex by the respondents. A number of variables were tested against the third objective and showed a statistical difference. Gender and school type in relation to family planning knowledge and family planning method showed a strong association ( $p = 0.003$  and  $p = 0.001$  respectively). These have been highlighted below and also related to other studies done elsewhere.

The study showed that having tested gender against the family planning knowledge. The findings showed that the females were more likely to have had knowledge about family planning compared to the males (see Table 4.1.7.3).

The results show that there was a very strong association between gender and knowledge of Family Planning with a p-value of 0.003. Therefore there was a statistical difference between gender and knowledge of Family Planning. These findings were consistent with a study done by Teltler (1997) and others in Philadelphia who revealed that in as far as the Health Resource Centers are concerned (HRCs), knowledge levels and condom use where such facilities existed were extremely high.

Furthermore, the study also evaluated the school type against family planning method. Boarders and day scholars are usually exposed to different activities and hence results may vary as observed by the researcher. It also revealed that the respondents that were in day school were more likely to have used family planning methods (see Table 4.1.7.4) compared to the respondents that were boarding school. The researchers' assumption is that boarders may usually be kept indoors thereby restricting from a lot of public services and

information. Therefore, the day scholars in this case were more likely to have had access to family planning services and or methods compared to the boarders because they would gain access to facilities that provide services such as Youth Friendly Corners, Voluntary Counselling and Testing (VCT) days and world-AIDS days where health talks are usually given into detail compared to boarders who may not have access to other media like the television, radios and other credible information. The results and findings of the study showed that there was a statistical difference between school type (boarding and day) and ever used family planning method with a p-value of 0.001.

These results were consistent with a study done by Teltler (1997) and others which showed that schools that were giving sexual information recorded a higher condom usage at last intercourse compared to those which did not have RHCs.

### **5.3 Limitations of the Study**

The study had some limitations in that certain things could not be done due to the following reasons:

- ✓ The self-reported researcher-administered questionnaire used could have led to under-reporting due to the sensitive nature of the topic especially to those under 16years of age more especially on the issues of abortions, pregnancies and multiple partners.
- ✓ The respondents may not have been free to disclose their sexual health behaviors because the study was conducted within school premises during school days.
- ✓ It was not a comparative study hence did not bring out variances between two different groups or time periods i.e. where condoms were distributed and not.
- ✓ The study was only done in Kabompo and Manyinga District, and 288 respondents were interviewed, which made it difficult to generalize the findings to other parts of the country.

#### **5.4 Conclusion and Recommendations**

In conclusion, in terms of the specific objectives of the study, it has been revealed that the no - condom policy in schools does not lead to abstinence among all sexually active school going adolescents, therefore the non-availability of condoms does not affect sexual behavior as can be seen that more than half (60%) of the respondents were indulging in sexual activities. This was equally demonstrated elsewhere by other studies recorded by the Advocates for youths (2012). Though the knowledge levels about FP were high, (64%) the pupils still indulged in unprotected sexual activities which put them at risk of STIs and unwanted pregnancies.

On the third objective about the knowledge levels of safer sex, it was discovered that males were less knowledgeable about family planning products and methods as compared to the female counter parts. On the other hand it was surprising to observe, in the second objective, that more males reported using a condom during their sexual encounters more than the females. Females were less likely to use condoms as compared to their male counterparts even though they had the knowledge with a statistical difference compared to the males. The researchers' assumptions are that males easily access condoms in the bars as compared to the females who may not feel free to walk into a drinking place where condoms are normally sold. It is worth noting at this point that restriction on age in terms of accessing the bars in Kabompo is not strictly observed. In addition, studies examining gender differences in self-reported sexual behavior suggest that over-reporting and under-reporting does sometimes occur (Catania, et al. 1992).

In conclusion, based on the above findings and discussions, the study reviewed and addressed the study question of whether the current school policy (non-availability of condoms) had an effect on the numbers of STIs, abortions and school-dropouts and found to be consistent with the study hypothesis which states that, no condom policy in schools is not leading to abstinence among school going adolescents, and therefore came up with the following recommendations:

- ✓ It is recommended that the Ministry of Education (MoE) in collaboration with the Ministry of Health (MoH) and the Ministry of Community Development Mother and Child Health (MCDMCH) come up with policies that would support plans on the condom outlets alongside counseling around schools, especially in the rural settings,

where Youth Friendly Corners should be established and strengthened where they offer basic services.

- ✓ Other organizations like the Planned Parenthood Association of Zambia (PPAZ) together with the United Nations Population Fund Agency (UNFPA) to intensify, and train, the community peer educators on abstinence, being faithful, condom use (ABCs) and general counseling on FP and sexuality matters in relation to the STIs and early pregnancies.
- ✓ We further recommended that MoE in collaboration with MoH and MCDMCH review the school health curricula and come up with policies that benefit school going adolescents (i.e. the inclusion of comprehensive sexual education e.g. condom benefits and usage) alongside other strategies like continuous counselling and enhances on abstinence. While condom accessibility and demonstration are not meant to encourage the youth to start using them, one of the benefits of condom usage are to promote growth and development of infants through Exclusive Breast feeding by not getting pregnant while having an infant that has not wined yet which might promote malnutrition.
- ✓ In comparison to other deliberate policies which the government through the MoH has put in place like the option B+ in PMTCT and the REC/RED strategy, the government could also do the same and bring in deliberate policies that will support schools by providing condoms which will be accessible by the sexually active adolescents that may end up either contracting STIs especially HIV and unwanted pregnancies.
- ✓ In order to promote respect for sex before marriage and curb early marriages, it is recommended that traditional leaders be brought on board to sensitize their communities on traditional values that embrace behavioural change and mind-set for both the adolescents and their parents/guardians.
- ✓ MoE through PTAs meeting under the DEBS to come up with deliberate topics that should encourage parents and guardians to discuss family planning issues.

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## **APPENDIX I: INFORMATION SHEET**

### **INTRODUCTION**

My names are Dr Shajanika Stephen. I work at Kabompo District Community Health Office as a District Community Medical Officer (DCMO). Currently I am a Master of Public Health student at the University of Zambia, school of Medicine, in my research year. I am hereby requesting for your participation in my research.

### **TOPIC: HOW DOES NON-AVAILABILITY OF CONDOMS IN SCHOOLS AFFECT SEXUAL BEHAVIOR – A CASE STUDY IN KABOMPO DISTRICT**

### **PROCEDURE OF RESEARCH**

The procedure will be very simple. I have the structured administered questionnaires which will be given to you to answer a yes or no question. There will be no blood to be taken from you, no surgery to be conducted nor anything that might bring pain or embarrassment to anyone.

### **CONFIDENTIALITY**

Your personal information like names will not be required on the answer sheets and any information requested for will be anonymous. Therefore there is nothing to fear for you to be known as to who answered what. In that case I am kindly asking you to be as truthful as you can.

### **RISKS AND DISCOMFORTS**

The procedure is risky free and no discomfort whatsoever.

### **VOLUNTARY PARTICIPATION**

Your participation will be purely voluntary. You may at any time wish to stop the participation if you feel uncomfortable about the research, and seek further clarifications concerning the same.

## **BENEFITS**

The information you are going to provide will greatly contribute to the Ministry of Health and Education in trying to understand the policies which are in place concerning condom policy issue in schools.

## **CONTACTS FOR FURTHER CLARIFICATIONS**

My physical address is Manyinga Street, plot # 192, Kabompo.

Office contact: Kabompo District Community Health Office.

P.O BOX 140046

Kabompo

Tell # 08-375053 cell; 0977414100

**OR**

## **THE CHAIRPERSON**

BIOMEDICAL RESEARCH ETHICS COMMITTEE OF THE UNIVERSITY OF  
ZAMBIA

P.O. BOX 50110

LUSAKA, ZAMBIA

Tell # 01-256067

**APPENDIX II: CONSENT FORM**

The purpose of this study has been explained to me and I fully understand what is involved including the risks and benefits. I have therefore volunteered to participate with my own free will.

Signed:..... Name:.....

**WITNESSED BY:**

Date: ...../...../.....

Witness: .....

**CONTACTS**

**Principal investigator**

**DR SHAJANIKA STEPHEN**

KABOMPO DCHO

UNZA

P.O. BOX 140046

KABOMPO.

TELL # 08-375053 CELL # 0977414100

**Principal Supervisor**

**DR SELESTINE NZALA**

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Cell # : +260979176779

**OR**

**The Chairperson**

BIOMEDICAL RESEARCH ETHICS COMMITTEE

UNIVERSITY OF ZAMBIA

P.O. BOX 50110

LUSAKA, ZAMBIA.

TELL # 01-256067

## **APPENDIX III: ASSENT FORM**

### **ASSENT FORM FOR YOUNGER PARTICIPANTS (PUPILS)**

Date...../...../.....

Dear Student:

My name is Dr Shajanika Stephen. I am working at Kabompo District Health Office as a District Medical Officer. Currently I am a student at the University of Zambia in the Department of Public Health, a Department that seeks to improve the health of the communities. I am asking you to participate in a study that seeks to examine the effects of non-availability of condoms in schools, especially in the rural setting. Sometimes parents find it hard to understand what you and your friends go through during your teens especially during school years. My study looks at some of the concerns that you may face now or might face in the future.

I am asking you to complete a short questionnaire that will take about 15-30 minutes. Your parents or legal guardians have already given permission for you to participate in this study, but you do not have to participate if you choose not to. You may quit this study at any time by simply writing on the questionnaire “Stop” or “I do not wish to participate.” Your participation in this study will not affect your grades in any way. To protect your confidentiality, the questionnaire will not bare your names nor be shared with anyone unless required by law. These questionnaires will be kept by me. That way no one will know the answers you provide on the questionnaire.

If you agree to participate, the study will assist establish whether abstinence only policy is working. That way we hope to use the information for the informed decisions. You are therefore requested to be as truthful as possible.

If you have any question about this study, please contact any numbers below.

Dr Shajanika; Cell: 0977414100 or The Chairperson Ethics Committee. Phone: 01-256067

Sincerely yours,

Dr Shajanika, (Researcher)

## **Agreement**

I agree to participate in this research project and I have understood fully the risks and benefits.

---

*Student's Name (Please Print)      Student's signature      Date*

I have explained to the above named individual the nature and purpose, benefits associated with participation in this research. I have answered all questions that have been raised.

## APPENDIX IV

### **Letter to Parents or Guardians of a pupil for permission**

Date...../...../.....

Dear Parents/Guardian

My name is Dr Shajanika Stephen and I am a District Medical Officer at Kabompo District Health Office. I am sending this letter to explain why I would like your child to participate in my study. While many parents have a lot of influence over how their children spend time and whom to play with when they are young; as children mature their friends become stronger influences in their lives. I am studying whether middle-school children think their parents or friends influence them more in various daily activities. (e.g. trying out for a play or team, attending a party rather than studying). In addition, I want to see if children's opinions are linked to their grades in schools or to how much family members talk to each other.

With your permission, I will ask your child to complete a short questionnaire that would take about 15-30 minutes. Your child's participation in this study is completely voluntary and will not affect his/her grades in any way. Your child may quit this study at any time by simply writing on the questionnaire "Stop" or "I do not wish to participate." The study will be conducted during school break periods, so no school time would be lost. There are no known risks involved in this study and your child will not receive any compensation for his/her participation apart from some drinks and biscuits during the study.. To protect your child's confidentiality, your child's name will not appear on the questionnaire. This questionnaire will not be shared with anyone, unless required by law. The results of this questionnaire will be maintained by me. If you have any questions or if you would like to receive a final copy of this report please contact me at cell: 0977414100 or The Chairperson, Research Ethics Committee. UNZA, at: 01-256067.

This letter will serve as a consent form for your child's participation and will be kept at the District Health Office for Data analysis. If you have any questions about your child's rights as a participant, you may contact the Chairperson on the above phone number given.

Please have your child return this form to his/her Head teacher by...../...../.....

Sincerely yours,

Dr Shajanika Stephen (researcher)

**Statement of Consent**

I read the above consent form. The nature, demands, risk, and benefits of the have been explained to me. I am aware that I have the opportunity to ask questions about this research. I understand that I may withdraw my consent and discontinue my child’s participation at any time without penalty. In signing this form, I am not waiving any legal claims, rights, or remedies.

---

*Child’s Name*

---

*Signature of Legal Guardian* *Date*

I certify that I have explained to the above named individual the nature and purpose, the potential benefits and possible risks associated with participation in this research study. These elements of Informed Consent conform to guidelines of the research policy on the use of Human Subjects.

---

*Student Researcher* *Date*

## **APPENDIX V: PERMISSION REQUEST**

The District Education Board Secretary  
Ministry of Education  
P.O Box 140097  
Kabompo.

UFS: The Head of Department  
School of Medicine  
Department of Public Health  
University of Zambia.

Dear Sir,

### **RE: PERMISSION TO CONDUCT A RESEARCH FROM YOUR SCHOOL FACILITIES.**

I am a Master of Public Health student at the University of Zambia, school of Medicine. I am majoring in Health Policy and Management.

As part of the fulfillment of the study, I am required to conduct a research study in a related field.

I am therefore requesting your office for permission to conduct my study from your school facilities of the upper grades of 11 and 12.

My study is policy related and would like to look at how non-availability of condoms in schools affects sexual behavior in the rural setting.

Your favorable response will be highly appreciated.

Yours faithfully

Dr Shajanika Stephen

**MPH STUDENT.**

CC: The Provincial Medical Officer-Solwezi

## **APPENDIX VI: STRUCTURED QUESTIONNAIRE GUIDE**



**THE UNIVERSITY OF ZAMBIA**

**SCHOOL OF MEDICINE**

**DEPARTMENT OF COMMUNITY MEDICINE**

**INTERVIEW/QUESTIONNAIRE GUIDE FOR NON-AVAILABILITY OF CONDOMS STUDY**

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**TITLE: HOW DOES NON-AVAILABILITY OF CONDOMS IN SCHOOLS AFFECT  
SEXUAL BEHAVIOR – A CASE STUDY IN KABOMPO DISTRICT**

Dear Respondent,

I am a Master of Public Health (MPH) Student in the School of Medicine - University of Zambia. I am conducting a survey on non-availability of condoms in schools and how it affects the sexual behavior age group between 14 and 20 years in selected schools of Kabompo and Manyinga Districts.

It has been discovered that a lot of school going age group (14-20) are going to the hospitals for abortion and treatment of STIs.

The main objectives for my study are as follows:

- ✓ (i) To establish how the non-availability of condoms in schools affect sexual behavior among the school going adolescents.
- ✓ (ii) To establish the levels of condom use by those who are sexually active among the school going adolescents.
- ✓ (iii) To assess knowledge levels of safer sex by school going youths.

You have been randomly selected to assist in this study. Your participation in this research is voluntary. Please note that your views in this interview shall not be, in any way used for any other purpose other than the advancement of this study. You are therefore assured that your views shall not be used in any way that might damage/destroy your reputation as an individual or otherwise compromise on your integrity, emotions as the information provided will be treated with high level of confidentiality.

Your cooperation in this exercise will be highly appreciated.

Yours Sincerely,

**Dr Shajanika Stephen.**



**(Tick once where applicable)**

**Q1.** Have you ever discussed family planning with your parents/guardians?

1. Yes [ ] 2. No [ ]

**Q2.** Do you know what family planning is? 1. Yes [ ] 2. No [ ]

**Q3.** If **YES** to Q2, what is it?

1. Pills [ ]  
2. Inject able [ ]  
3. Implants [ ]  
4. Condoms [ ]  
5. Menstrual Cycle [ ]  
6. All of the above [ ]

**Q4.** Have you ever heard about condoms? 1. Yes [ ] 2. No [ ]

**Q5.** If **YES** to Q4, what is the importance of condoms?

1. Prevent STD/HIV [ ]  
2. Prevent unwanted pregnancy [ ]  
3. Do not know [ ]  
4. The first 2 [ ]

### **Practice of Sexual Intercourse**

My next questions are concerned with the actual indulging in sexual relations.  
Please feel free to express yourself?

**Q6.** Have you ever had sexual intercourse? 1. Yes [ ] 2.No [ ]

**Q7.** Have you had intercourse with more than one person? 1. Yes [ ] 2. No [ ]

**Q8.** If **YES** to Q7, when was the last time?

1. Less than three months [ ]

2. Less than six months [ ]	
3. Less than a year [ ]	
4. Over a year [ ]	
<b>Q9.</b> What period of the school calendar was it when you had your sexual intercourse?	<input type="checkbox"/>
1. School holidays [ ]	
2. School days [ ]	
3. School activities, such as inter-schools? [ ]	
4. In the school premises [ ]	
<b>Q10.</b> Do you have a boy/girlfriend (lover) in the school premises? 1. Yes [ ] 2. No [ ]	<input type="checkbox"/>
<b>Q11.</b> If <b>YES</b> to 10, how long have you been in this relationship?	<input type="checkbox"/>
1. Less than three months [ ]	
2. Less than six months [ ]	
3. Less than a year [ ]	
4. Over a year [ ]	
<b>Q12.</b> Have you ever had sexual intercourse with your partner (boy/girlfriend)? 1. Yes [ ] 2.No [ ]	<input type="checkbox"/>
<b>Q13.</b> If <b>YES</b> to Q12, did you use protection like condom?	<input type="checkbox"/>
1. All the time [ ]	
2. Sometimes only [ ]	
3. Not at all [ ]	
Q8	

### Practice of Family Planning

My next questions are concerned with family planning. Please feel free to express yourself?

**Q14** Have you ever used any form of family planning methods? 1. Yes [ ] 2. No [ ]

**Q15.** If **YES** to Q14, what type of family planning methods did you use?

1. Inject able [ ]

2. Implant [ ]

3. Condoms [ ]

4. Menstrual Cycle [ ]

5. None [ ]

6. Pills [ ]

**Q16.** Are you currently using any form of family planning methods? 1. Yes [ ] 2. No [ ]

**Q17.** If **YES** to Q16, what type of family planning methods are you using?

1. Pill [ ]

2. Inject able [ ]

3. Implant [ ]

4. Condoms [ ]

5. Menstrual Cycle [ ]

### Experience of Sexual Indulgence

This section deals with your sexual indulgence if at all. Please try and express

yourself of yourself

**Q18.** Have you ever suffered from any form of an STI? 1. Yes [ ] 2. No [ ]

**Q19.** Have you ever aborted? 1. Yes [ ] 2. No [ ]

**Q20.** If YES to Q19, where did it occur from

1. Health facility [ ]

2. Home [ ]

3. In school premises [ ]

4. At the traditional healers place [ ]

**Q21.** Who conducted it?

1. Clinician [ ]

2. Myself [ ]

3. Friends [ ]

4. Traditional healer [ ]

**Q22.** Do you have a child? 1. Yes [ ] 2. No [ ]

**Q23.** If YES to Q22, at what age did you have the first child?

1. Between 12 and 14

2. Between 14 and 16

3. Between 16 and 18

4. Above 18

**Q24.** Did you plan for it? 1. Yes [ ] 2. No [ ]

**Q25.** Would you use a condom the next time you have sex? 1. Yes [ ]

2. No [ ]

**Q26.** If NO to Q25 give details?

1. I can't afford [ ]

<p>2. I am unable to freely access [ ]</p> <p>3. I don't know how to use a condom [ ]</p> <p>4. I don't like using condoms [ ]</p> <p><b>Q27.</b> How easily accessible are condoms to you?</p> <p>1. Easily accessible [ ]</p> <p>2. Not accessible [ ]</p> <p>3. Difficult to access [ ]</p> <p>4. Never bothered [ ]</p> <p style="text-align: center;"><b>General School Experience</b></p>	<p style="text-align: center;"><input type="checkbox"/></p>
<p><b>Q28.</b> What has been your general view on school condom policy? Please feel free to share your experiences....</p> <p><b>Q29.</b> Have you ever repeated or been re-admitted into school. 1. Yes [ ] 2. No [ ]</p> <p><b>Q30.</b> If <b>YES</b> to Q29, give reasons?</p> <p>1. Pregnancy [ ]</p> <p>2. Got married [ ]</p> <p>3. Lack of funds [ ]</p> <p>4. Long distance to school [ ]</p> <p><b>Q31.</b> Do you know anyone who has dropped out of school? 1. Yes [ ] 2. No [ ]</p> <p><b>Q32.</b> If <b>YES</b> to Q31, give one specific reason</p> <p>1. Distance [ ]</p> <p>2. Pregnancy [ ]</p> <p>3. Finances [ ]</p>	<p style="text-align: center;"><input type="checkbox"/></p> <p style="text-align: center;"><input type="checkbox"/></p> <p style="text-align: center;"><input type="checkbox"/></p> <p style="text-align: center;"><input type="checkbox"/></p>

4. Marriage [ ]	
<b>Q33.</b> What is your view on condom availability and accessibility to students in schools?	<input type="checkbox"/>
1. A good idea [ ]	
2. A bad idea [ ]	
3. I don't mind [ ]	

## APPENDIX VII: GANTT CHART

ACTIVITY	2013										2014
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	
Training of team members.											
Testing of the questionnaire											
Field work											
Data analysis and compilation											
Finalizing research work											

## **APPENDIX VIII: BUDGET FOR THE SURVEY**

<b>ITEM DESCRIPTION</b>	<b>QUANTITY</b>	<b>UNIT PRICE</b>	<b>TOTAL COST</b>
Allowance	12*2 days	K600	K1200
Ream Of Paper	3	K35	K105
Training	2	K1000	K2000
Fuel	140 Liters	K8.50	K1190
Printing	5*40 pages	K500	K1000
Binding	5	K25	K125
Biscuit For Participation	1400	K5	K7000
Drink For Participation	1400	K5	K7000
Secretarial/Data Entry	2*2	K50	K200
<b>Total</b>			<b>K19,820</b>