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KNOWLEDGE ON YOUTH-FRIENDLY SERVICES AMONG ADOLESCENTS IN KALOMO

By:

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UNZA 2005

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

KNOWLEDGE ON YOUTH-FRIENDLY SERVICES AMONG ADOLESCENTS IN KALOMO

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Research study submitted to the Department of Post Basic Nursing in partial fulfillment of the Requirements for the Degree of Bachelor of Science in Nursing

January, 2005

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LIST OF ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome
ARHE	-	Adolescent Reproductive Health Education
BIC	-	Brethren in Christ Church
BSc.	-	Bachelor of Science
CBoH	-	Central Board of Health
CSO	-	Central Statistical Office
DHS	-	Demographic Health Survey
FLMZ	-	Family Life Movement of Zambia
HIV	-	Human Immune Virus
ICN	-	International Council for Nurses
MoH	-	Ministry of Health
NGO	-	Non-Governmental Organization
PBN	-	Post Basic Nursing
PPAZ	-	Planned Parenthood Association of Zambia
PRB	-	Population Review Bureau
RCZ	-	Reformed Church in Zambia
SDA	-	Seventh Day Adventist Church
SFH	-	Society for Family Health
SHI	-	Sexual Health Information
STIs	-	Sexually Transmitted Infections
UNFPA	-	United Nations Population Fund
UNAIDS	-	Joint United Nations Programme on HIV/AIDS
UNICEF	-	United Nations International Children' Emergency Fund
USA	-	United States of America
WHO	-	World Health Organization
YFS	-	Youth Friendly Services

DECLARATION

I hereby declare that the work presented in this study for the Bachelor of Science degree in Nursing has not been presented either wholly or in part for any other degree, and is not being currently submitted for any other degree.

SIGNED:..
(Candidate)

DATE: 11. 03. 2005

APPROVED BY: ....
(Supervising Lecturer)

UNIVERSITY OF ZAMBIA
DEPT. OF POST
BASIC NURSING
SCHOOL OF MEDICINE

DATE: 11/03/05

STATEMENT

I hereby certify that this study is entirely the results of my own independent investigations. The various sources to which I am highly indebted are clearly acknowledged in the text and references.

SIGNED: ....
(Candidate)

DATE: 11. 03. 2005

DEDICATION

I dedicate this study to my late parents, James and Mary Mweemba, who so ably guided me through my adolescence and made me believe in what am. May their souls rest in eternal peace!

ABSTRACT

Youth-friendly services can be free standing clinics or attached to existing clinics or recreational facilities. Ideally, they provide a full range of services and information to young people and are affordable welcomging, confidental, conveniently located and affordable. The services help to prevent HIV/AIDS and other STIs, include access to condoms and voluntary counselling and testing for HIV; and help adolescents to say 'No' to drugs/alcohol, unwanted pregnancies and abortions.

The purpose of the study was to determine the knowledge on youth-friendly services among adolescents in Kalomo. Literature was reviewed globally, regionally and nationally based on adolescent's knowledge on youth-friendly services. The study was conducted in Kalomo where fifty (50%) adolescents were sampled from three randomly selected schools.

A descriptive exploratory study design was used. Data analysis collected in September, 2004 using a self-administered questionnaire. The data was checked for completeness and consistency and then was tallied on the data master sheet. The data was analysed manually using a scientific calculator. The findings were presented in form of tables and pie charts.

The findings revealed that majority (58%) of the respondents were aged between 17 and 19 years, all were Christians. Seventy six percent (76%) of the respondents had knowledge on youth-friendly services and (42%) of the

respondents with knowledge on the services got the information from friends. Despite the knowledge on youth-friendly services (60%) of the respondents have never used the services. Sixty two percent (62%) of the respondents had already had sexual intercourse.

Most of the respondents were of the view that youth-friendly workers needed to address their health needs adequately. Eighty two percent (82%) did not visit services for STI prevention and it was attributed to being too young, condoms and family planning not being safe and the negative attitude of health workers.

RECOMMENDATIONS

In view of the findings the following recommendations have been made:

TO THE MINISTRY OF HEALTH

The health care providers should intensify the school health services outreach programme and be consistent in their programmmes so that health education on sexual behaviour and other reproductive health issues can be given to make more adolescents be aware of youth-friendly services. The health care provider should sensitize adolescents on youth-friendly services so that the services will be utilized to the fullest. Health workers who deal with adolescents need to be trained on counseling skills so that they can meet the health needs of young people.

THE MINISTRY OF EDUCATION

The Ministry of education need to put a deliberate policy that will reinforce the education of adolescents on reproductive health, so that the spread of HIV/AIDS and other sexually transmitted infections can be prevented. The policy should be revisited which empower the teacher to instill discipline and promote high moral behaviours to school going adolescents.

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

Zambia is a third world country located in the central region of Africa. It is a landlocked country covering an area of 752,612 kilometres, which is about 2.5% of the total space area of the continent of Africa, (CSO/CBoH, 2003).

Administratively, the country is divided into nine provinces and seventy two districts. The capital city is Lusaka, and there are other cities like Ndola, Kitwe and Livingstone. Kalomo district is in the Southern Province, 354 kilometres south of Lusaka. It is 120 kilometres north of Livingstone, the national tourist capital. It shares borders with Choma in the east, Kazungula in the southwest, Namwala in the north, Itezhi-tezhi in the northwest, Sinazongwe in the south-east and Livingstone in the south.

According to 2000 census, the population of Zambia stands at 10,285,631. Zambia being the third most urbanized country in Africa, the average density in 2000 has gradually reduced. The proportion of the population living in urban areas has decreased steadily from 40% in 1980 to 38% in 1990 and 36% in 2000 respectively, (CSO/CBoH, 2003).

Kalomo has a population of 276,310 and 26% of this population is aged between 10 and 19 years, (Kalomo District Action Plan, 2004). However, 67.5% of the population is under 24 years of age and because of this the large group of adolescents represent an important age group in the growth of Kalomo and the nation as a whole.

Zambia has a mixed economy consisting of a modern urban sector that geographically follows the rail line and a rural agricultural sector. The modern urban sector has been dominated by parastatal organizations, while private

businesses have predominated in construction and agricultural sectors. Since 1991, with the introduction of a liberalized market-oriented economy, the parastatals have been privatized and in some cases liquidated, (CSO/CBoH, 2003).

Copper mining is the country's main economic activity and contributes 45% of government revenue during the decade following independence (1960-1975). In the mid 1970 following a sharp decline in copper prices and a sharp increase in oil prices, the country's economy deteriorated. The 1980's marked the start of the first phase of implementing the Structural Adjustment Programme (SAP) amidst a stagnating economy. The Structural Adjustment Programme (SAP) worsened the economic situation making the poverty levels among Zambians high. Currently, about 73% of Zambians are classified as poor. Poverty is more prevalent in rural areas than urban areas (83 percent and 56 percent respectively), (CSO/CBoH, 2003).

In Kalomo, many men and women are able to make a living by being involved in agriculture and trade. Forty four percent (44%) of the female population derives a major share of its cash from formal employment. Twenty five percent (25%) of agriculture is done in the province, 1.5% of these are commercial farmers while 98.5% are subsistence farmers. The informal sector is fairly active in Kalomo. The informal employment includes trading at the council markets. In addition, other informal employment includes hair dressing and carpentry, (Kalomo District Development Strategic Plan, 2000-2004). Most people in Kalomo live below the poverty datum line. Women and children are the most affected. The poverty levels also affect the adolescents because most of them come from poor families. The high proportion of young people aged under 20 years in Zambia indicates a youthful population and constitutes the productive age which will develop the nation's economy in future as young people are more energetic and are future leaders (UNICEF, 1996).

According to the World Health Organization (WHO), the term adolescent comprises those aged between 10 and 19, the youths are those between 15 and 24, while young people are those aged between 10 and 24. The term 'adolescents' and 'teenagers' are interchangeably used through the transition period and this may differ from place to place, (Chen, V, 1998).

For the purpose of consistency, the definitions employed in this study will be that of an adolescent being a young person between the ages of 10 to 24. Adolescents all over the world are prone to irresponsible behaviour due to the unstable period of development, (Fetters, S. T. and Munkonze, F. 1999). At this time of their lives, their bodies undergo major physiological and developmental changes. The male physical changes include:

- Height increases
- Pimples (sebaceous gland produce too much oil)
- Moustache and beard grow as well as hair on pubic area and armpits
- Voice deepens

The female physical changes include:

- Height increases
- Pimples occur typically around 15 -16 years of age
- Hair appears under the armpits and on pubic area
- Breasts develop at about 10 – 12 years

The adolescents develop new thinking skills and actions and develop pride in themselves. They are often argumentative and full of negativism. The adolescents seek success where they can find it, in both social and anti-social settings. Most of them do not believe accidents can happen to them and have increased experimentation with health risky activities such as drug and substance abuse and unprotected sex.

Adolescent health is a primary element in the long term development of any country, for young people are the future leaders, (UNICEF, 1996). There have been efforts by the government to address the health of youths especially regarding their sexual and reproductive health. The public and private organizations have joined forces to address the health of youths by adopting youth-friendly services. Zambia's first youth friendly clinics were established in 1996 in Lusaka by the District Health Board in partnership with Non-Governmental Organizations such as Care International, Planned Parenthood Association of Zambia (PPAZ), Society for Family Health (SFH), Family Life Movement of Zambia (FLMZ) and Church organizations, (UNICEF 2002).

Youth-Friendly health services can be free-standing clinics or attached to existing clinics or recreational facilities. Ideally, they provide a full range of services and full information to young people and are welcoming confidential, conveniently located and affordable. The services help to prevent HIV/AIDS and other sexually transmitted illnesses (STIs), through access to condoms and voluntary counselling and testing for HIV (UNICEF, 2002).

In Zambia, young peer educators have teamed up with nurses in Youth-Friendly clinics to provide information on HIV/AIDS, other STIs, illnesses and pregnancy, while the clinic staff provides STI treatment. The clinics issue condoms and offer counselling and support on relationships, rape and family planning. Well-regarded and respected in their communities the peer educators also use drama, poetry, music and the electronic media to reach a wider public. The clinics maintain close contact with the Police, who have been trained to handle abuse cases and refer victims for counselling and help. (UNICEF, 2002).

Youth-Friendly and reproductive health services in Kalomo started in 1996. A centre for the youths was introduced and one member of staff was trained to coordinate activities at the Youth-Friendly corner. Due to poor turnout of youths to the centre, the Health Management decided to close the centre and

created management officers which were in great need at the time. Another centre was reopened on January, 17, 2003 and is being run by the youths themselves. The main activities at the centre include voluntary counselling, drama, health education and condom distribution (Jabesi, F. 2004). Despite these services being available, they are not utilized effectively especially in rural communities like Kalomo.

1.2 STATEMENT OF THE PROBLEM

Sexual activity begins in adolescence for the majority of people. In many countries, unmarried girls and boys are sexually active before the age of 15. In Zambia, it is estimated that two thirds of adolescents are sexually active by the age of eighteen, (Fetters, S. T. and Munkonze, F. 1999). The Zambia Demographic and Health Survey (1996) reported that by the age of 18 years, 70% of the women have had sexual intercourse and by the age of 20 years, 80% have had sexual intercourse. In case of men, by 15 years, 24% have had sexual intercourse and by the age of 20, 90% have had sexual intercourse. A study by Care International (1996), revealed that girls as early as 8 years are engaged in sexual activities, while the boys would have had sexual intercourse by the age of 10. By 15 years of age, boys would have engaged in drugs/substance abuse like Marijuana and alcohol.

In most cases, the adolescents do not understand the consequences of such behaviours because they have inadequate knowledge or too young to understand, (Senderowitz, J., 1997).

However, accidents account for as many as half of all deaths among 10-24 year olds in many countries. In the United States, 72% of all deaths among school age youth and young adults result from car crashes, accidents, homicide and suicide.

Female adolescents are also prone to unwanted pregnancies and about 15 million 10-15 year old girls give birth annually, accounting for 10% of births worldwide. They end up aborting using unsafe methods for they are not

ready for parenting. This leads to death due to abortion related complications and are the leading cause of death for teenage girls in many countries (ICN, 1997).

An adolescent who experiences sexual intercourse at an early age has higher risk behaviour later in life. The initiation of sexual activity at an early age therefore increases the risk of contracting STIs/HIV/AIDS, unplanned pregnancies and unsafe abortions.

However, the adolescent's sexual behaviour have been influenced by inadequate knowledge or wrong information to enable them make responsible decisions about their sexual behaviour and any other health risk behaviour, (Schultz, K.P. et al, 1992).

Some adolescents may not know that services that address their needs are available within their communities, like in health centres and schools. Some may be aware of the Youth-Friendly services but would not utilize them effectively due to various reasons; for example, they may fear stigmatization. There are several factors that contribute to non availability of knowledge and under-utilization of the Youth-Friendly services.

1.3 FACTORS INFLUENCING ADOLESCENTS' KNOWLEDGE ON YOUTH-FRIENDLY SERVICES

- **SERVICE**

Some youths might not be aware of the availability of services that address their needs or may have inadequate knowledge on the services provided. This might be due to inadequate publicity of Youth-Friendly services in the community. Some may be aware but may not have access to the services due to long distance to the nearest clinic or youth-friendly centre. Health workers may not be friendly, welcoming nor empathetic or skilled to deal with young people, so the adolescents shun the services. Absence or lack of motivated, supportive trained youth peer educators may also affect the

turnout for adolescents because they feel free to talk to fellow adolescents who understand their problems better.

- **TRADITIONAL AND CULTURAL**

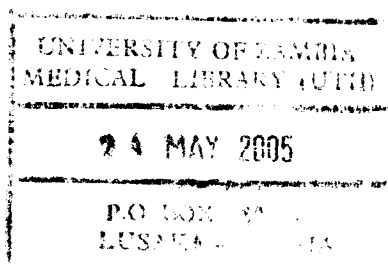
Traditionally, young people are not expected to be involved or talk about sexual issues. The girls would be expected to remain virgins until marriage, so any information related to sex would be avoided. This has created apathy among adolescents towards Youth-Friendly services for they fear to be labeled 'promiscuous' by elderly members of the community, parents, peers and health care providers. Culturally, it is considered as a taboo to talk about sex or practicing sex before marriage.

- **SOCIAL FACTORS**

Adolescents are likely to face a lot of peer pressure especially that they consider peer identity to be very important. The adolescents learn from peers and take ideas from peers 'Gospel truth'. They may end up being involved in dangerous activities such as sex, smoking, and drinking due to peer pressure. The adolescents get interested in programmes on both print and electronic media (television, video, others are equipment and computer) which may influence their sexual behaviour, for example kissing in public and taking drugs may be considered normal and acceptable among adolescents. This may create negativism on any services which promote good morals and behaviour. The adolescent may fear being condemned and rejected by peers if they use Youth-Friendly services.

- **RELIGIOUS**

Christian values are being taught in Zambian churches, homes and through both the print and electronic media. Christian teachings generally condemn sex outside marriage. Churches like the Catholic promote abstinence and discourage members especially adolescents from using any scientific methods of family planning including the use of condoms. This may cause adolescents to fear being seen near the Youth-Friendly centres or accessing any information relating to Youth-Friendly services.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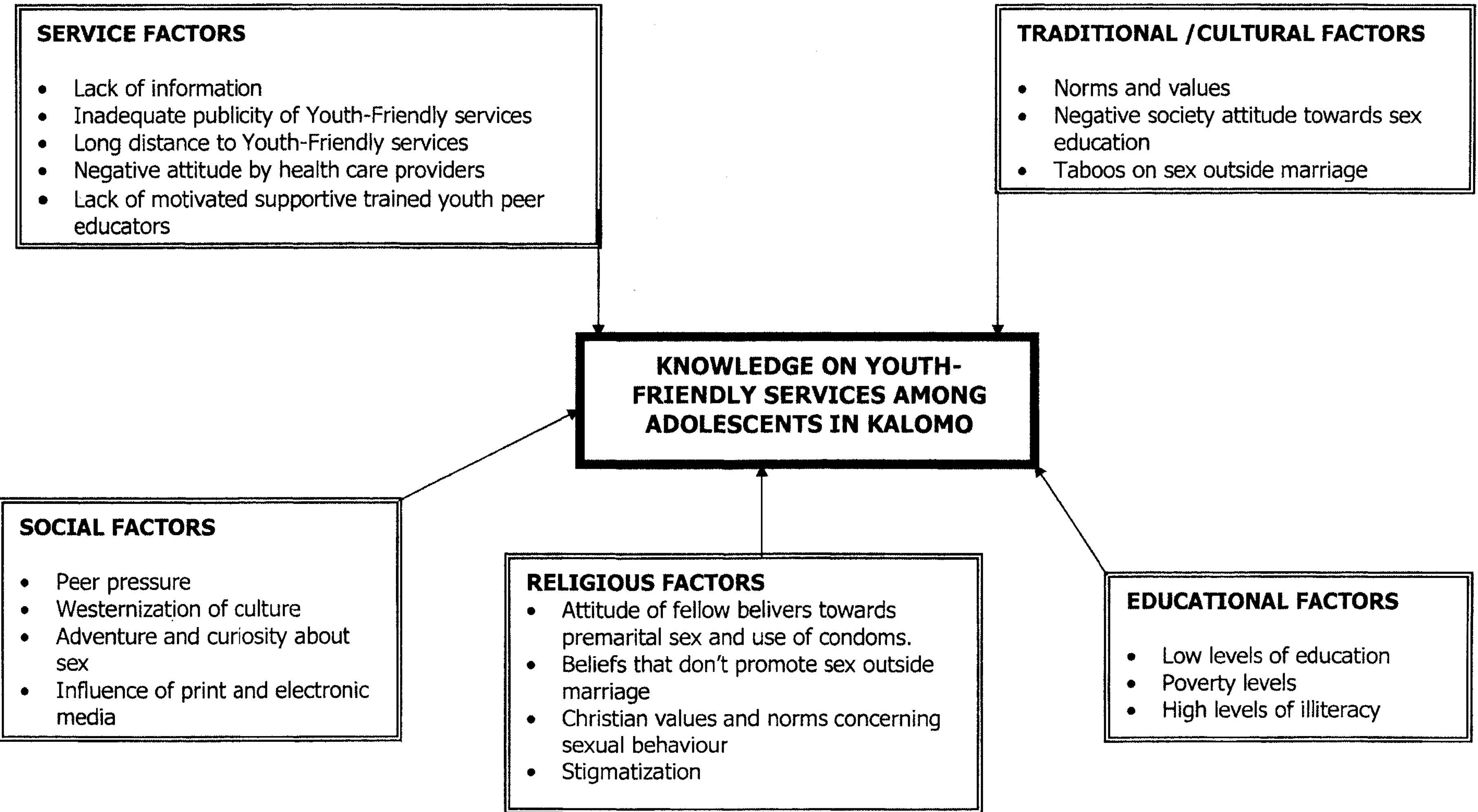
- **EDUCATIONAL**

Adolescents who are in school are more likely to have information on Youth-Friendly services for they have lessons pertaining to the topic. The adolescents in secondary schools are given more information on Youth-Friendly services than those in lower primary schools because of the difference in maturity levels. The adolescents who are out of school may have inadequate knowledge on Youth-Friendly services.

It is therefore evident that adolescents engage in risky behaviour like unsafe or unprotected sex, alcohol and substance abuse, and abortions because they have inadequate knowledge on the services that address generally their health, sexuality and reproductive health.

Figure 1

1.4 FACTORS THAT MAY INFLUENCE KNOWLEDGE ON YOUTH-FRIENDLY SERVICES



1.5 JUSTIFICATION FOR THE STUDY

In the world and Zambia, many adolesecents experience many pressures which make them be involved in risky behaviours such as early sexial behaviours, drug and alcohol abuse. A study that was done in 1995 revealed that 80 to 85% of the young people between 13 and 15 years had already engaged in sexual activities, (Nchima, M. C. 2001). Kalomo's adolescents are as well faced with many pressures leading to risk behaviors.

Many have been reported abusing drug/alcohol abuse, unsafe sex, unplanned pregnancies and abortions. Youth-friendly services have been introduced to address issues which concern adolescents but the services have not been introduced to address issues which concern adolescents but the services have not been fully utilized.

Adolescents knowledge related to issues of sexual behaviors leading to experimentation in sex. According to Malibata, C, 1994, the adolescents initiate sexual behaviour in secondary/basic school grades. This has been the case for Kalomo; and this made it imperative to assess their levels of knowledge especially on youth-friendly services.

It is hoped that this study will identify areas in knowledge gaps on youth-friendly services that need emphasis or changes and make recommendations to appropriate authorities to improve utilization of services and bring about behaviour changes. This in turn will prevent the spread of HIV/AIDS, unplanned pregnancies and abortions. The study will also be an evaluation of the anti-AIDS clubs, and school youths knowledge on sexual behaviours in the prevention of HIV/AIDS.

1.6 RESEARCH OBJECTIVES

1.6.1 General Objective

Determine knowledge on Youth-Friendly services among adolescents in Kalomo.

1.6.2 Specific Objectives

1.6.2.1 Determine the adolescents' knowledge on the availability of Youth-Friendly services.

1.6.2.2 Explore factors that may influence knowledge on Youth-Friendly services.

1.6.2.3 Assess the adolescents' knowledge on services being offered at Youth-Friendly services.

1.6.2.4 Determine whether adolescents utilize the local Youth-Friendly services.

1.6.2.5 Identify areas for further research on to Youth-Friendly services.

1.6.2.6 Make recommendations to policy makers for implementation.

1.7 HYPOTHESES

1.7.1 Lack of knowledge on Youth-Friendly services among adolescents leads to low utilization of the services.

1.7.2 Inadequate knowledge on Youth-Friendly services leads to health risky behaviour.

1.8 OPERATIONAL DEFINITIONS

- **Knowledge:** Refers to the information needed and acquired by adolescents on Youth-Friendly services.
- **Adolescents:** Refers to a young person aged 10 to 24 years. This period is characterized by a gradual transformation from childhood to adulthood.

- **Sexuality:** Information needed by young people concerning their physiological changes, reproduction, family planning, unwanted pregnancies and sexual involvement.
- **Peer Pressure:** Refers to the amount of force or influence exerted by age mates or colleagues.
- **Health risky behaviour:** Refers to patterns of behaviour that pose a danger to the health of the individual, for example, alcohol/substance abuse, unprotected sex, etc.

1.9 VARIABLES FOR THE STUDY

The dependent variable for the study is knowledge. A number of independent variables have been identified and these are religion, status, peer pressure, sex and location of service facility. These are shown in the table below:

Table 1: Variables, their Cut off Points and Indicators

VARIABLE	CUT OFF POINT	INDICATORS
Knowledge	• High knowledge • Medium knowledge • Low knowledge	• Correct responses 75% and above • Correct responses 74-50% • Correct responses 49% and above
Sex	• Male • Female	• Adolescent is male • Adolescent is female
Peer pressure	• Subjected to it • Not subjected	• Decisions influenced by friends • Decisions not influenced by friends
Religion	• Religious • Not religious	• Considers religion on sexual issues • Does not consider religion on sexual issues
Location of service facility	• Accessible • Not accessible	• Youth-Friendly services within walking distance from home. • Youth-Friendly services not within walking distance from home.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

"Literature review provides the researcher with the opportunity to determine how much pertinent material is available concerning the potential study and help to put the problem in the content of what has already been done", (Dempsey, P. A. and Dempsey, A. D., 2000). Bless, C. and Achola, P. (1988) defined literature review as a process of reading whatever has been published and what appears relevant to the research topic.

The purpose of literature review is to widen and deepen the theoretical framework of the research, familiarize the researcher with latest developments of knowledge in the area of research as well as in related areas. The researcher will identify gaps in knowledge as well as weaknesses if there are studies on the same topic to determine what has already been done and what is yet to be improved. The purpose of literature review in this study is to determine what is already known about knowledge on Youth-Friendly services so that a comprehensive picture on this topic is obtained. It will give a researcher clues to the methodologies and instruments that people had used before.

2.2. GLOBAL PERSPECTIVE

Adolescents all over the world are faced with various pressures and situations that may expose them to risky behaviour. Adolescents are involved in early sexual relationships exposing them to sexually transmitted illnesses, unplanned pregnancies and unsafe abortions (Lega, M. et al, 1994). Young people's behaviour has acquired international concern mainly due to the HIV/AIDS scourge.

According to studies by UNICEF (2002), it was revealed that a quarter of the boys aged 15 to 19 in Brazil and Hungary are reported to have sex before

they were 15. It was estimated that about one million children are involved in commercial sex exploitation, drug abuse and other unsafe behaviours that put them at risk of HIV/AIDS.

In the same study, it was found that 88% of unmarried boys and 35% of unmarried girls had engaged in sexual activity by the time they were 18 and condom use was inconsistency. Majority (87%) had information about HIV/AIDS, but had inadequate knowledge on how to protect themselves from HIV/AIDS, let alone on Youth Friendly services.

A study that was done in Thailand in 1995 revealed that 'health corners' for adolescents were set up in health clinics. The 'self centre' programme in the United States deployed teams of nurses and social workers to run these health centre for youths. Extensive counselling on reproductive health, values and decision making, drug use, parenting is given to the adolescents. Referrals for young people requiring medical care is also done, (UNAIDS, 2003).

It has been speculated that imparting the adolescents knowledge on Youth-Friendly services will promote good behaviour and prevention of STIs, drug abuse, unwanted pregnancies and abortions. However, a study that was done in the USA refuted such speculations. Respondents from community members disagreed that information on sexuality can be transmitted through health corners because very few adolescents access the services being offered at these centres. However, adolescents are informed on reproductive health through media and schools (Hickerman, 2000).

In 1995, the Bangladesh Rural Advancement Committee (BRAC) set up an adolescent Reproductive Health Education (ARHE) programme to provide information on reproductive health to youths in rural areas. This programme succeeded by mobilizing the community to break the silence and shame about sensitive topics related to reproduction (Rashid, J., 2000).

In 1987, a study was done in Melton in USA on sex education. Successive reports showed that much sex education is learnt from friends. Two thirds of the respondents said that they had some education on contraception from other sources, other than parents and schools and over 60 % of all the under 25 year olds said they had some information from friends. Ten percent (10%) of the adolescents said they learnt about sex education from youth clubs (UNFPA, 2001).

This information proves that the Youth-Friendly services exist but are not utilized effectively. Promoting the reproductive health and rights of young people remains a controversial topic in many countries. United Nations Population Fund (UNFPA) is promoting programmes which foster on Reproductive Health of all people especially youths, (UNFP, 2001). Involving adolescents, schools, parents and churches inform adolescents on Youth-Friendly services would improve their knowledge thus promoting utilization of these services. This will promote safe behaviours which would prevent sexually transmitted infections including HIV/AIDS, unwanted pregnancies and abortions.

2.3 REGIONAL PERSPECTIVE

In the sub-Saharan Africa, studies indicate that young people frequently engage in early sexual activities and have multiple sexual partners, (Zimbabwe SHI, 1996). This has been attributed to lack of sexual information and knowledge on contraceptive use and where to get contraceptives from.

In countries like Cameroon, Central African Republic, Equatorial Guinea, Lesotho and Sierra Leone, more than 80% of the women aged 15 to 24 do not have sufficient knowledge on Youth-Friendly services and HIV/AIDS. Studies have repeatedly identified factors that help adolescents reduce high risk behaviours such as engaging in unprotected sex and using drugs. One recent study in rural Zimbabwe, for example, showed that being a member of

a well-run community youth group improves knowledge and reduces an adolescents' risk of contracting HIV/AIDS, (UNICEF, 2002).

A study done in Nigeria in 2002, showed that boys get information concerning sex from their friends or pornographic films and literature. Even when they do have information, some adolescents engage in unprotected sex because they lack skills to negotiate for abstinence or condom use (UNAIDS, 2003).

In Burkina Faso, 45% of adolescents who use condoms effectively have visited the Youth-Friendly services. A study done in Botswana approximates that 15% of primary and secondary school girls drop out of school due to pregnancy, (Population Concern, 1997).

In Kwazulu Natal, which has been known to have the highest incidence of HIV/AIDS in South Africa, drama groups were formed in schools to educate their adolescents on HIV and produced positive change which has been measured against HIV incident rate (Harvey, B. et al 2001). This meant that peer education in form of drama was effective in modifying the sexual behaviour of adolescents. When peer education is effective, information is very appropriate for the age group, because the language (jargon) which is usually used is appreciated by the adolescents.

In South African, Soul Buddyz, a weekly television drama runs in tandem with a radio series, both of them focusing on issues that range from adolescents' sexuality, HIV/AIDS, drug use and children's rights. By presenting fictional characters who make informed choices, the programmes provide positive role models for adolescents. Good programming in the mass media can counter popular misconceptions about adolescents; reveal what is not clear to them, like Youth-Friendly services, and show the contributions they make to their communities (UNICEF, 2002).

In Namibia, young people are facilitating life skills training to reduce teenage pregnancy and prevent HIV/AIDS, substance abuse and rape. The young

people who have been trained reached 100,000 of their peers both in adolescent centres and school. This improved the adolescents knowledge on sexual issues and improved utilization of adolescents' centres, (UNICEF, 2002).

2.4 NATIONAL PERSPECTIVE

Local studies have shown similar findings like in other countries where studies on adolescents were done. Studies show that even younger ages are engaged in sexual relationships. This has exposed adolescents to hazards like unwanted pregnancies, abortions, sexually transmitted illnesses including HIV/AIDS.

A study which was done in Kasama in 1995 revealed that 80 to 85% of the young people between 13 and 15 years had already engaged in sexual activities. This implies that most adolescents may not fully appreciate the consequences of sexual intercourse, thus need a lot more information to delay sexual relationship until they are mature enough to make informed decisions, (Nchima, M. C. 2001).

A study to test community based approaches for improving adolescent's sexual and reproductive health in Lusaka urban, by Fetters, S. T. and Mukonze, F. (1999), found that the community based interventions of peer counselling, condom promotion, and economic empowerment aimed at stopping or delaying initiation of sexual activity among adolescents, encouraged adolescents to practice safer sex. The emphasis was on use of condoms, though the studies did not mention services available for adolescents like Youth-Friendly services.

Another study which was done by Central Board of Health (CBoH) in 1999 indicated that the main source of information on sexual and reproductive health is friends, mass media, schools, relatives and posters while some adolescents have no source of information. Very few respondents (10%)

mentioned the source of information to be Youth-Friendly services. This may lead to inadequate levels of knowledge, hence most adolescents do not appear to perceive STIs, HIV/AIDS, unwanted pregnancies and abortions to be a real threat to their lives.

A study done by Wonani, M. M., 2002, in Kabwe revealed that youths are not receiving much information from health care providers. The Youth-Friendly corners are not meeting the targeted objectives which meant that adolescents with problems may not seek any advice from Youth-Friendly corners. The study revealed that adolescents turn to colleagues for information who may happen to be misinformed. Adolescents who utilized Youth-Friendly services effectively were abstaining from sex or practiced safe sex; and were less likely to have sexually transmitted infections. This also reduces cases of unplanned pregnancies and abortions.

The study that was done in Chipata in 2001 by Nchima, M. C. showed influence of peer pressure on adolescent sexual activity. This influence can be used positively to influence adolescents' sexual and reproductive health by ensuring that peers have adequate information to influence friends.

A study by UNICEF (2002) revealed that young peer educators have teamed up with nurses in Youth-Friendly clinics to provide information on HIV/AIDS, other STIs and pregnancies. The clinics issue condoms and offer counselling on various issues. The peer educators use drama, poetry, music and the electronic media to reach a wider public.

In each district, a Youth-Friendly Advisory Committee serves as a link between the community and the clinic. Zambia's first Youth-Friendly centre in Bauleni Lusaka is considered as a role model. The peer educators run the centre under the supervision of the midwives and other clinic staff. According to Sulwe, I., 2003, the role of Youth-Friendly services in sex education is to promote knowledge among adolescents so that they can be responsible over

their behaviour, hence make informed choices on issues related to reproductive health.

No studies related to adolescents in Kalomo have been done. However, the centre for adolescents was opened in 1996 and there is high evidence that the centre is not effectively used.

2.5 CONCLUSION

A review of literature has indicated that a lot of studies have been conducted on adolescents. Literature on adolescents' knowledge on Youth-Friendly services have been discussed in related studies on adolescents such as behaviour of adolescents, knowledge on HIV/AIDS and adolescents' attitudes and practices on sexual relationships.

Literature has revealed that peer influence plays a major role in the level of knowledge among adolescents. Misconceptions have a bearing on how adolescents relate the services offered at Youth-Friendly services. Literature also revealed that no studies have been conducted in Kalomo district relating to adolescents' health.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research methodology that was used in the study. Research methodology refers to the development, testing and evaluating research instruments and methods used in research investigation, (Dempsey, P. A. and Dempsey, A. D, 2000) The goal is to ensure reliability and validity in the tool used for data collection.

3.2 RESEARCH DESIGN

"A research design is a scheme of action (Framework) for answering the research questions. It includes such factors as the research settings, operational definitions, assumptions, relationships between variables, delimitations, sampling procedure, instrument, approach to be used, and the method for analyzing data, ethical questions concerning subjects rights and use of data (Treece, E. W. and Treece, J. W, 1986).

"Research design refers to the researcher's overall plan for obtaining answers to the research questions or for testing the research hypothesis", (Polit, D. F.. and Hungler, B. P., 1997).

In this study, a descriptive, quantitative, qualitative and cross sectional study was used. It was descriptive in that the researcher collecting and presenting data systematically. This gave a clear picture of the situation. The design was quantitative because answers to the study was categorized and quantified in numerical forms. The data was collected from subjects at one point in time. It was qualitative because in some cases, the respondents were required to explain with regard to their answers.

3.3 RESEARCH SETTING

This is the physical location and conditions in which data collection takes place in a study (Polit, D. F. and Hungler, B. P. 1997). The study was conducted in Kalomo central. Kalomo is a peri-urban area situated 80kms from the tourist capital, Livingstone. Kalomo central has five basic schools and two secondary schools, which cater for a good number of adolescents in the district. All the schools are co-educational schools. The study site was selected on the ground of convenience and accessibility.

3.4 STUDY POPULATION

"The study population is the entire number of units understudy". (Treece, E. W. and Treece, J. W.,1986). The study population consisted of all adolescents attending co-education basic and secondary schools in Kalomo central. The target population was adolescents from sampled schools. The target was easily accessible in their respective schools.

3.5 SAMPLE SELECTION AND SIZE

Sample selection is a process of selecting a portion of the population to represent the entire population (Treece, E. W. and Treece, J. W. 1986). Three schools in Kalomo central were selected using lottery method without replacement. A list of six schools were made and names of the schools written on separate pieces of paper. The papers were placed in a bowl, and then randomly selecting three schools for the study. The researcher was selected the respondents using simple random sampling.

Simple random sampling is the most basic type of probability sampling, wherein a sampling frame is created by enumerating all members of the population of interest and then selecting a sample from the sampling frame through completely random procedures (Polit, D. F. and Hungler, B. P. 1997). The sampling frame consisted of all pupils in basic and secondary schools in Kalomo. At each School, one respondent waas selected using simple random sampling with replacements. Numbers were written on pieces of papers from

1 to 100. The subjects were requested to pick pieces of papers and those who will pick even numbers will be eligible to participate in the study. Fifty respondents were picked for the study.

3.6 DATA COLLECTION TECHNIQUE

"Data collection technique is the process of gathering information needed to address a research problem, (Pilot, D. F. and Hungler, B. D. 1997).

Self-administered questionnaires were used to collect data from respondents. Data was collected over a period of two weeks. Respondents answered questionnaires in a classroom that was provided for the purpose. No consultation among respondents was allowed, and respondents only asked for clarity from the researcher. Respondents were also assured of confidentiality and anonymity by use of serial numbers on the questionnaire instead of names.

3.7 DATA COLLECTION TOOL

Self administered questionnaires were used to collect data from respondents. A questionnaire is a measuring instrument that can be used to measure characteristics of a given population with regard to sex, marital status, religion, occupation and state of health. It contains printed questions used for data collection, (Ghosh, B. N., 2002). The questions can either be open-ended or closed ended. Open-ended questions are those that permit free responses from the respondent and are recorded in the respondent's own words. Closed-ended questions are those that offer a list of possible options from which the respondent chooses.

The advantage of questionnaires is that only relevant information is obtained. The questions are standardized hence analysis of data is easy. A lot of information is collected within a short period of time at a lesser cost. A self-administered provides privacy and anonymity which makes it possible to collect information even on sensitive issues, (Brink, H. I., 1996)

The disadvantages of questionnaires include the fact that the questions are pre-arranged and hence do not allow for further exploration on the topic. If the questionnaire is not clear, it may lead to incomplete responses, thus the need for the researcher to be available for clarification.

3.7.2 VALIDITY

This is the ability of an instrument to measure that variable that is intended to measure, given the context in which it is applied (Brink, H. 1996).

In this study validity was measured by ensuring that the same questions applied to all respondents. The questions were clearly constructed and those which could cause misunderstanding were reconstructed after conducting the pilot study.

3.7.2 RELIABILITY

Refers to the stability and consistency of a measuring instrument over time, it is how well it will produce the same information each time it is used (Dempsey, P. A. and Dempsey D. A. 2000). It has also been defined as being concerned with the consistency, stability and repeatedly of the informants' accounts as well as the investigators' ability to collect and record information accurately (Brink, H. 1996).

The research was tested before the main study in a similar environment on subjects with similar characteristics. This helped to prove reliability of the tool.

3.8 PILOT STUDY

A pilot study is a small scale version, or trial run in preparation for a major study, (Polit, D. F. and Hungler, B. P., 1997). A pilot study was conducted in Kalomo at Namwianga Basic School. The purpose of the pilot study was to identify any flaws in the proposed research instrument, to test its feasibility, reliability, validity and estimate the possible time it would take to complete

the questionnaire. The outcome was necessary for rephrasing a few questions to get appropriate responses. Namwianga Basic School was used for the pilot study because it has similar characteristics with the schools in Kalomo central. Ten (10) respondents were used for the pilot study.

3.9 ETHICAL AND CULTURAL CONSIDERATION

The researcher had to seek clarification on the research proposal and make necessary corrections under the guidance of the supervisor. Consent was obtained from District Education Office in Kalomo, for the pilot study as well as for the main research. Consents was obtained from specific schools management where the study was conducted. Respondents were assured of confidentiality and anonymity regarding the information they would give. No names were put on the questionnaires, and respondents were allowed to complete questionnaires on their own to maintain privacy. Consent was gotten from respondents.

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION

4.1 INTRODUCTION

This chapter provides information from fifty secondary/basic school adolescents in Kalomo. The adolescents were selected randomly from three randomly selected schools in Kalomo and the purpose was to determine the knowledge on youth friendly services among adolescents in Kalomo.

4.2 DATA ANALYSIS

Data analysis is the systematic organization and synthesis of research data and the testing of research hypothesis using these data, (Polit, D. G. and Hungler, B. P. 1997).

Data was collected using a structured self-administered questionnaire. The data was checked for completeness. It was coded and categorized and entered on a data master sheet. Data was analyzed manually by the aid of a calculator.

4.3 PRESENTATION OF FINDINGS

Frequency tables and pie charts were more appropriate for presentation of findings because they were easy to interpret. They also accord one with an idea about the findings even before the discussion of the findings were read. The tables and pie charts are also useful in drawing meaningful inferences. Cross tabulations were used to combine information on two or more variables in order to have a detailed meaning of the problem.

TABLE 2: DEMOGRAPHIC DATA (n=50)

VARIABLE	FREQUENCY	RELATIVE FREQUENCY (%)
Sex		
Male	29	58
Female	21	42
TOTAL	50	100
AGE RANGE		
10 -12	2	4
13 – 16	19	38
17 – 19	29	58
20 – 24	0	0
TOTAL	**50**	**100**
TRIBE		
Ngoni	3	6
Bemba	6	12
Lozi	3	6
Tonga	31	62
Other	7	14
TOTAL	**50**	**100**
EDUCATION LEVEL		
8	5	10
9	23	46
10	4	8
11	13	26
12	5	10
TOTAL	**50**	**100**

VARIABLE	FREQUENCY	RELATIVE FREQUENCY (%)
CONGREGATION		
Roman Catholic	8	16
UCZ	5	10
SDA	14	28
Pentecostal	5	10
Others	18	36
TOTAL	50	100
NEXT OF KIN		
Parent	33	66
Sister/brother	5	10
Grandparent	2	4
Aunt/uncle	9	18
Friend	1	2
TOTAL	**50**	**100**

Fifty eight percent (58%) of the respondents were males while (42%) were females. Fifty eight percent (58%) were aged between 17 and 19 and majority (62%) of the respondents were Tonga by tribe. Forty six percent (46%) were in grade 9 while (8%) were in grade 10. Twenty eight percent (28%) belonged to SDA while (36%) belonged to other religious groups such as Salvation Army (4%), Jehovah's Witness (8%), New Apostle (6%) and Church of Christ (14%). Majority of the respondents (66%) stay with their parents.

TABLE 3: KNOWLEDGE ON YOUTH-FRIENDLY SERVICES (n=50)

KNOWLEDGE ON YOUTH FRIENDLY SERVICES	FREQUENCY	RELATIVE FREQUENCY (%)
Yes	38	76
No	12	24
TOTAL	**50**	**100**

Majority of the respondents (76%) had knowledge on youth-friendly services and (24%) had no knowledge on youth-friendly services.

TABLE 4: SOURCE OF KNOWLEDGE ON YOUTH-FRIENDLY SERVICES (n=50)

SOURCE OF INFORMATION	FREQUENCY	RELATIVE FREQUENCY (%)
Friend	16	32
Teacher	12	24
Parent	2	4
Health worker	7	14
Grandmother	1	2
Not applicable	12	24
TOTAL	**50**	**100**

Majority (32%) of the respondents with knowledge on youth-friendly services got the information from friends.

TABLE 5: DISTANCE FROM YOUTH-FRIENDLY SERVICE (n=50)

DISTANCE FROM YOUTH-FRIENDLY SERVICE	FREQUENCY	RELATIVE FREQUENCY (%)
Less than 15 minutes walk	14	28
30 minutes walk	11	22
45 minutes walk	6	12
More than 1 hour walk	7	14
Not applicable	12	24
TOTAL	**50**	**100**

Twenty percent (28%) of the respondents spent less than 15 minutes to reach the services while (14%) had to walk for more than one hour to reach the services.

TABLE 6: UTILIZATION OF YOUTH-FRIENDLY SERVICES (n=50)

UTILIZATION OF YOUTH-FRIENDLY SERVICES	FREQUENCY	RELATIVE FREQUENCY (%)
Yes	20	40
No	30	60
TOTAL	**50**	**100**

Majority (60%) of the respondents have never used the youth-friendly services.

TABLE 7: KNOWLEDGE ON SERVICES OFFERED AT YOUTH-FRIENDLY SERVICE (n = 50)

SERVICES OFFERED AT YOUTH-FRIENDLY SERVICES	FREQUENCY	RELATIVE FREQUENCY (%)
Family planning	1	2
Condom distribution	8	16
Health education	14	28
Not applicable	27	54
TOTAL	**50**	**100**

Twenty eight percent (28%) of the respondents indicated that the services offered at youth-friendly services was health education, (18%) indicated family planning and condom distribution, while the majority (54%) of the respondents had no knowledge on services offered at youth-friendly services.

TABLE 8: REASONS FOR NOT UTILIZING YOUTH-FRIENDLY SERVICES (n=50)

REASONS FOR UTILIZING YOUTH-FRIENDLY SERVICES	FREQUENCY	RELATIVE FREQUENCY (%)
Distance	12	24
Fearing being seen there	14	28
Lacking information on youth-friendly services	16	32
No answer	8	16
Still young to be involved	5	10

*multiple response

Thirty two percent (32%) of the respondents did not utilize youth-friendly services due to lacking information on youth-friendly services, (24%) due to distance, (28%) fearing being seen there and (10%) felt they were still young to be involved in such activities.

TABLE 9: LEVEL OF KNOWLEDGE ON YOUTH-FRIENDLY SERVICES IN RELATION TO SEX (n=50)

SEX	LOW KNOWLEDGE	MEDIUM KNOWLEDGE	HIGH KNOWLEDGE	TOTAL
Male	4 (25%)	22 (70%)	3 (100%)	29 (58%)
Female	12 (75%)	9 (29%)	0 (0%)	21 (42%)
TOTAL	16 (32%)	31 (62%)	3 (6%)	50 (100%)

Twenty five percent (25%) of the respondents with low knowledge on youth friendly services were males, while (75%) were females. Seventy percent (70%) of the respondents with medium knowledge were males while (29%) of respondents with medium knowledge were females. Hundred percent (100%) of respondents with high knowledge were males.

TABLE 10: LEVEL OF KNOWLEDGE ON YOUTH-FRIENDLY SERVICES IN RELATION TO AGE (n=50)

AGE	LOW	MEDIUM	HIGH	TOTAL
10 – 12	0	1 (3.2%)	0 (0%)	1 (2%)
13 – 16	8 (50%)	12 (38.7%)	0 (0%)	20 (40%)
17 – 19	8 (50%)	18 (58.1%)	3 (100%)	29 (58%)
TOTAL	**16 (32%)**	**31 (62%)**	**3 (6%)**	**50 (100%)**

Fifty percent (50%) of respondents with low knowledge on youth –friendly services were aged between 13 and 16 years and 17 and 19 years respectively. Three percent (3%) of respondents with medium knowledge on youth-friendly services were aged between 10 and 12 years while (39%) were aged between 13 and 16 years. Fifty eight percent (58%) of respondents with medium knowledge on youth-friendly were aged between 17 and 19, while all (100%) of respondents with high knowledge were aged between 17 and 19.

TABLE 11: LEVEL OF KNOWLEDGE ON YOUTH-FRIENDLY SERVICES IN RELATION TO RELIGION (n=50)

RELIGION	LOW KNOWLEDGE	MEDIUM KNOWLEDGE	HIGH KNOWLEDGE	TOTAL
Catholic	5 (29.4%)	2 (6.7%)	1 (33.3%)	8 (16%)
UCZ	0 (0%)	5 (16.7%)	0 (0%)	5 (10%)
BIC	1 (5.8%)	1 (3.3%)	0 (0%)	2 (4%)
SDA	4 (23.5%)	10 (33.3%)	0 (0%)	14 (28%)
Salvation Army	0 (0%)	2 (6.7%)	0 (0%)	2 (4%)
Pentecostal	0 (0%)	5 (16.7%)	0 (0%)	5 (10%)
Jehovah's Witness	2 (11.8%)	2 (6.7%)	0 (0%)	4 (8%)
New Apostle	0 (0%)	1 (3.3%)	2 (66.7%)	3 (6%)
Church of Christ	5 (29.4%	2 (6.7%)	0 (0%)	7 (14%)
TOTAL	**17 (34%)**	**30 (60%)**	**3 (6%)**	**50 (100%)**

Twenty nine percent (29%) of respondents with low knowledge on youth-friendly services belonged to Catholic and Church of Christ church, while (23.5%) belonged to SDA church. (33.3%) of respondents with medium knowledge on youth-friendly services belonged to SDA while (87%) belonged to BIC and New Apostle. Sixty seven percent (67%) of the respondents with high knowledge on youth-friendly services belonged to Pentecostal church while (33%) belonged to the Catholic Church.

TABLE 12: AGE IN RELATION TO USE OF YOUTH-FRIENDLY (n=50)

AGE	USE OF YOUTH-FRIENDLY SERVICES		TOTAL
	YES	NO	
10 – 12	0 (0%)	1 (3.7%)	1 (2%)
13 – 16	5 (21%)	14 (52%)	19 (38%)
17 – 19	18 (78%)	12 (44.2%)	30 (60%)
TOTAL	**23 (46%)**	**27 (54%)**	**50 (100%)**

Majority (78%) of the respondents who used youth-friendly services were aged between 17 and 19, while (21%) were aged between 13 and 16. Fifty two percent (52%) of the respondents who did not utilize youth-friendly services were aged between 13 and 16. Forty four percent (44%) were aged between 17 and 19 and (3.7%) were aged between 10 and 12.

TABLE 13: GENDER IN RELATION TO UTILIZAITON OF YOUTH-FRIENDLY SERVICES (n=50)

SEX	UTILIZATION OF YOUTH-FRIENDLY SERVICES		TOTAL
	YES	NO	
Male	15 (65%)	14 (52%)	29 (58%)
Female	8 (35%)	13 (48%)	21 (42%)
TOTAL	**23 (46%)**	**27 (54%)**	**50 (100%)**

Majority (65%) of respondents who utilized youth-friendly services were males and (35%) were females. Fifty two percent (52%) of the respondents who did not utilize youth-friendly services were males and (48%) were females.

TABLE 14: EDUCATION LEVEL IN RELATION TO UTILIZATION OF YOUTH-FRIENDLY SERVICES (n=50)

EDUCATIONAL LEVEL	UTILIZATION OF YOUTH-FRIENDLY SERVICES		TOTAL
	Yes	No	
8	0	4 (13.3%)	4 (8%)
9	8 (40%)	15 (50%)	23 (46%)
10	2 (10%)	3 (10%)	5 (10%)
11	5 (25%)	8 (26.6%)	13 (26%)
12	5 (25%)	0 (0%)	5 (10%)
TOTAL	**20 (40%)**	**30 (60%)**	**50 (100%)**

Forty percent (40%) of the respondents who utilized youth-friendly services were in grade 9, (25%) were in grade 11 and another (25%) in grade 12, while (10%) were in grade 10. Fifty percent (50%) of the respondents who did not use youth-friendly services were in grade 9 (27%) were in grade 11 (13%) in grade 8 and (10%) were in grade 10.

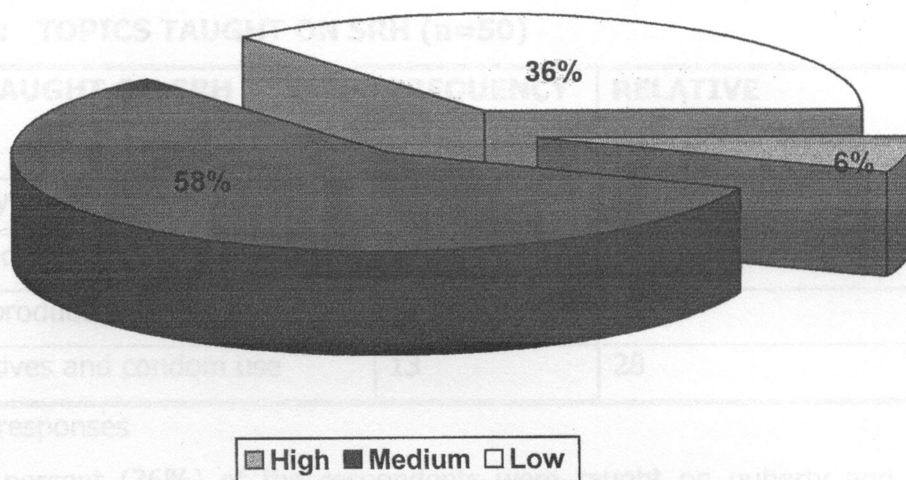
TABLE 15: RELIGION IN RELATION TO YOUTH-FRIENDLY UTILIZATION (n=50)

RELIGION	YOUTH-FRIENDLY SERVICES UTILIZATION		TOTAL
	Yes	No	
Catholic	2 (9.1%)	6 (21.4%)	8 (16%)
UCZ	3 (13.6%)	2 (7.1%)	5 (10%)
BIC	0 (0%)	2 (7.1%)	2 (4%)
SDA	8 (36.4%)	6 (21.4%)	14 (28%)
Salvation Army	1 (4.5%)	1 (3.5%)	2 (4%)
Pentecostal	3 (13.6%)	2 (7.1%)	5 (10%)
Jehovah's Witness	1 (4.5%)	3 (10.7%)	4 (8%)
New Apostle	3 (13.6%)	0 (0%)	3 (6%)
Church of Christ	1 (4.5%)	6 (21.4%)	7 (14%)
TOTAL	**22 (44%)**	**28 (56%)**	**50 (100%)**

Thirty six percent (36%) of the respondents who utilized youth-friendly services belonged to SDA church, (13.6%) to UCZ, while (4.5%) belonged to Salvation Army, Jehovah's Witness and Church of Christ.

Twenty one percent (21.4%) of the respondents who did not utilize the youth-friendly services belonged to Catholic and Church of Christ, while (10.7%) belonged to Jehovah's Witness.

FIGURE 1: RESPONDENTS LEVEL OF KNOWLEDGE ON YOUTH-FRIENDLY SERVICES (n=50)



Majority (58%) of respondents had medium knowledge on youth-friendly services and only 6% had high knowledge on youth-friendly services. However (36%) had low knowledge.

TABLE 16: SOURCE OF INFORMATION OF YOUTH-FRIENDLY SERVICES (n=50)

SOURCE OF INFORMATION	FREQUENCY	RELATIVE FREQUENCY (%)
Friend	11	23
Parent	6	13
Grandparent	10	21
Teachers	28	60
Health worker	15	32
TV/radio/books	14	30

* Multiple responses.

Majority (60%) of the respondents got the information on sexual and reproductive health from teachers only 13% got this information from parents.

TABLE 17: TOPICS TAUGHT ON SRH (n=50)

TOPICS TAUGHT ON SRH	FREQUENCY	RELATIVE FREQUENCY (%)
Personal hygiene	6	13
Puberty and growing up	17	36
Human reproduction	17	36
Contraceptives and condom use	13	28

* Multiple responses

Thirty six percent (36%) of the respondents were taught on puberty and growing up, another (36%) on human reproduction while (13%) were taught on personal hygiene.

TABLE 18: INFORMATION ON SEXUAL AND REPRODUCTIVE HEALTH (SRH) (n=50)

INFORMATION ON SEXUAL AND REPRODUCTIVE HEALTH	FREQUENCY	RELATIVE FREQUENCY
Ever taught on SRH	47	94
Have not been taught on SRH	3	6
TOTAL	**50**	**100**

Majority (94%) of the respondents have been taught on sexual reproductive health and only (6%) have not been taught on sexual and reproductive health.

TABLE 19: PREFERRED PERSON TO TEACH SRH (n=50)

PREFERRED PERSON TO TEACH SRH	FREQUENCY	RELATIVE FREQUENCY (%)
Friend	8	16
Parents	2	4
Health worker	25	50
Teachers	13	26
Other	2	4
TOTAL	**50**	**100**

Half (50%) of the respondents preferred health workers to teach them on sexual and reproductive health. Twenty six percent (26%) preferred teachers while only 4% preferred parents to teach them on SRH. Sixteen percent (16%) mentioned friends while (4%) mentioned other people like Pastor and grandparents.

TABLE 20: SEXUAL BEHAVIOUR (n=50)

VARIABLE	FREQUENCY	RELATIVE FREQUENCY (%)
DATING		
Yes	23	46
No	27	54
TOTAL	50	100
SEXUAL INTERCOURSE		
Yes	31	62
No	19	38
TOTAL	**50**	**100**
SEX WITH WHOM?		
Regular partner	21	42
Casual partner	10	20
Not applicable	19	38
TOTAL	**50**	**100**

Table 20 continued

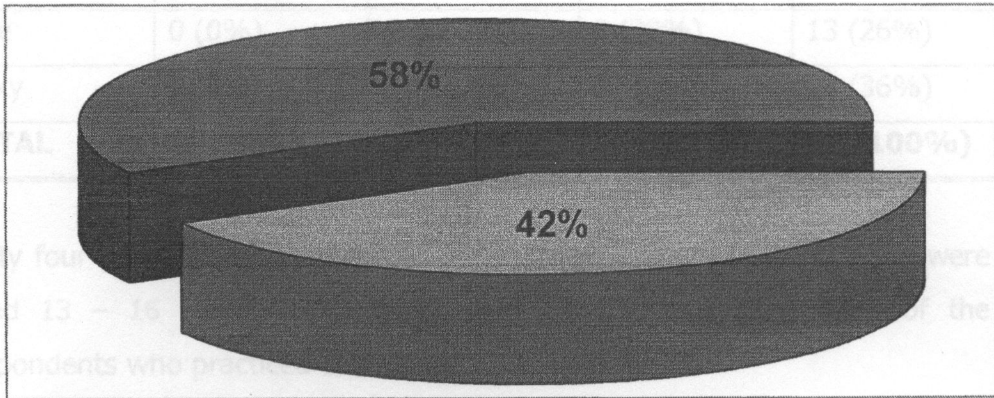
VARIABLE	FREQUENCY	RELATIVE FREQUENCY (%)
WHY HAD SEX		
Financial	3	6
Peer pressure	18	36
Curiosity	10	20
Not applicable	19	38
TOTAL	**50**	**100**
NUMBER OF PARTNERS		
One	19	38
2 -5	10	20
More than 5	2	4
None	19	38
TOTAL	**50**	**100**
CONDOM USE		
Always	15	30
Sometimes	8	16
Never	8	16
Not applicable	19	38
TOTAL	**50**	**100**
WHY CONDOM		
Protection	22	44
To please partner	0	0
Are available	0	0
Not applicable	27	54
Friends taught me to	1	2
TOTAL	**50**	**100**

Table 20 continued

VARIABLE	FREQUENCY	RELATIVE FREQUENCY (%)
REASONS FOR NOT USING CONDOMS		
Partner uncooperative	1	2
Condoms not 100% safe	8	16
Trust partner	1	2
Still young not engaged in sex	19	38
Not sure of where to get them	7	14
Not applicable	15	30
TOTAL	**50**	**100**
USE OF ALCOHOL OR DRUGS BEFORE SEX		
Yes	1	2
No	30	60
Not applicable	19	38
TOTAL	**50**	**100**

Forty six percent (46%) of the respondents were dating while (54%) were not dating. Sixty two percent (62%) of the respondents had already had sexual intercourse of which 42% was with regular partners and (20%) with casual partners. The reason cited for indulging in sexual intercourse was mainly due to peer pressure (36%) and due to curiosity (20%). The majority (38%) had had one sexual partner while (4%) had more than 5 several partners. thirty percent (30%) of respondents always used condoms while (16%) had never and the main reason for use of condoms was protection (44%). The main reason cited for not using condoms was that the respondents (38%) were still young and not engaged in sex. Sixteen percent (16%) cited condoms not 100% safe and (2%) trusted their partner and another (2%) cited the partner not cooperative on condom use while (14%) were not sure where to get them. The use of drugs/alcohol prior to sex was only (2%) with (60%) not practicing it.

FIGURE 2: RESPONDENTS DECISION INFLUENCED BY PEERS (n=50)



Majority (58%) of the respondents' decision in relation to sexual issues was influenced by peers, while (42%) of the respondents' decisions was not influenced by peers.

TABLE 21: SEXUAL BEHAVIOUR IN RELATION TO GENDER (n=50)

SEXUAL BEHAVIOUR	MALE	FEMALE	TOTAL
Abstinence	8 (26%)	11 (58%)	19 (38%)
Safe	8 (26%)	5 (26%)	13 (26%)
Risky	15 (48%)	3 (16%)	18 (36%)
TOTAL	**31 (62%)**	**19 (38%)**	**50 (100%)**

Fifty eight percent (58%) of the respondents who practiced abstinence were females and (26%) were males. Twenty six percent (26%) of both males and females practiced safe sex while (48%) males practiced risky sexual behaviour and (16%) females practiced risky sexual behaviour.

TABLE 22: SEXUAL BEHAVIOUR IN RELATION TO AGE (n=50)

SEXUAL BEHAVIOUR	10 -12	13 – 16	17 -19	TOTAL
Abstinence	1 (100%)	8 (44.4%)	10 (32.2%)	19 (38%)
Safe	0 (0%)	4 (22.2%)	9 (29%)	13 (26%)
Risky	0 (0%)	6 (33.3%)	12 (39%)	18 (36%)
TOTAL	**1 (2%)**	**18 (36%)**	**31 (6.2%)**	**50 (100%)**

Forty four percent (44%) of the respondents who practiced abstinence were aged 13 – 16 while (32%) were aged 17 -19; and all (100%) of the respondents who practiced abstinence were aged 10-12.

Twenty nine percent (29%) of the respondents who practiced safe sex were aged 17 -19 while (22%) were aged 13 – 16. Thirty nine percent (39%) of the respondents who practiced risky sexual behaviour were aged 17 -19 while (33%) were aged 13 - 16.

TABLE 23: SEXUAL BEHAVIOUR IN RELATION TO EDUCATION LEVEL (n=50)

SEXUAL BEHAVIOUR	GRADE8	GRADE 9	GRADE 10	GRADE 11	GRADE 12	TOTAL
Abstinence	3 (75%)	9 (39%)	3 (60%)	4 (31%)	0 (0%)	19 (38%)
Safe	0 (0%)	7 (30%)	0 (0%)	4 (31%)	2 (40%)	13 (26%)
Risky	1 (25%)	7 (30%)	2 (40%)	5 (38%)	3 (60%)	18 (36%)
TOTAL	**4 (8%)**	**23 (46%)**	**5 (10%)**	**13 (26%)**	**5 (10%)**	**50 (100%)**

Seventy five percent (75%) of the respondents who practiced abstinence were in grade 8 while (39%) were in grade 9. Thirty eight (38%) of the respondents who practiced risky sexual behaviour were in grade 11 while (30%) were in grade 9. Sixty percent (60%) of respondents who practiced risky sexual behaviour were in grade 12, compared to (40%) of those who were in grade 10.

TABLE 24: SEXUAL BEHAVIOUR IN RELATION TO RELIGION

SEXUAL BEHAVIOUR	CATHOLIC	UCZ	BIC	SDA	SALVATION ARMY	PENTECOSTAL	JEHOVAH'S WITNESS	NEW APOSTLE	CHURCH OF CHRIST	TOTAL
Abstinence	2 (25%)	2 (40%)	0 (0%)	3 (21.4%)	1 (50%)	4 (80%)	3 (75%)	1 (33.3%)	3 (43%)	19 (38%)
Safe	3 (37.5%)	1 (20%)	1 (50%)	5 (36.7%)	0 (0%)	0 (0%)	0 (0%)	1 (33.3%)	2 (28.3%)	13 (26%)
Risky	3 (37.5%)	2 (40%)	1 (50%)	6 (42.8%)	1 (50%)	1 (20%)	1 (25%)	1 (33%)	2 (28.5%)	18 (36%)
TOTAL	**8 (16%)**	**5 (10%)**	**2 (4%)**	**14 (28%)**	**2 (4%)**	**5 (10%)**	**4 (8%)**	**3 (6%)**	**7 (14%)**	**50 (100%)**

Eighty percent (80%) of the respondents who practiced abstinence belonged to Pentecostal church, (75%) to Jehovah's Witness church, while (21%) from SDA church. Fifty percent (50%) of the respondents who practiced safe sex belonged to BIC church, while (29%) from Church of Christ. Fifty percent (50%) of the respondents who practiced risky sexual behaviour belong to BIC while (25%) belonged to Church of Christ church.

TABLE 25: RESPONDENTS' SCHOOLS THAT WERE VISITED BY HEALTH WORKER (n=50)

RESPONDENTS' SCHOOLS THAT WERE VISITED BY HEALTH WORKERS	FREQUENCY	RELATIVE FREQUENCY (%)
Visited	34	68
Not visited	16	32
TOTAL	50	100%

Sixty eight percent (68%) of the respondents indicated that their schools had been visited by health workers while (32%) indicated that their schools had not been visited by health workers.

TABLE 26: PERIOD THE HEALTH WORKERS LAST VISTED THE SCHOOLS (n=50)

PERIOD THE HEALTH WORKERS LAST VISITED THE SCHOOLS	FREQUENCY	RELATIVE FREQUENCY (%)
This month	1	2
This year	12	24
Last year	14	28
Last term	6	12
Not been visited	16	32
This term	1	2
TOTAL	**50**	**100**

Thirty two percent (32%) of the respondents had not been visited by the health worker while (28%) had been visited the previous year. Only (2%) had their school visited by a health worker that month and another (2%) had their school visited that term.

TABLE 27: SOURCE OF SERVICES FOR STI PREVENTION (n=50)

SOURCES FOR STI PREVENTION SERVICES	FREQUENCY	RELATIVE FREQUENCY (%)
Health worker	3	6
Health centre/hospital	38	76
VCT/YFS	3	6
Do not know	6	12

The majority of respondents (76%) stated that the health centre or hospital was the main source of services on STI prevention, while (12%) of the respondents did not know.

TABLE 28: UTILIZATION OF SERVICES FOR STI PREVENTION (n=50)

UTILIZATION OF SERVICES FOR STI PREVENTION	FREQUENCY	RELATIVE FREQUENCY (%)
Yes	9	18
No	41	82
TOTAL	**50**	**100**

Eight two percent (82%) of the respondents did not utilize the services for STI prevention, while (18%) utilized the services.

TABLE 29: REASONS FOR NOT COLLECTING CONDOMS AND FAMILY PLANNING SERVICES AT THE CLINIC (n=50)

REASONS FOR NOT COLLECTING CONDOMS AND FP SERVICES AT THE CLINIC	FREQUENCY	RELATIVE FREQUENCY (%)
Too young	19	38
Negative attitude of health workers	6	12
Condoms and family planning not safe	7	14
Does not know if the services are available	4	8
Does not know how to use them	5	10

*Multiple responses.

Thirty eight percent (38%) of the respondents did not visit the clinic to collect condoms and family planning at the clinic because they felt they were too young. Fourteen percent (14%) cited condoms and family planning not being safe for them while (8%) did not know if these services were available. Ten percent (10%) did not know how to use condoms and family planning.

TABLE 30: RECEPTION RESPONDENTS RECEIVED AT THE CLINIC (n=50)

PERCEPTION THE RESPONDENTS RECEIVED AT THE CLINIC	FREQUENCY	RELATIVE FREQUENCY (%)
Welcomed and assisted	11	22
Not welcomed nor assisted	7	14
Not applicable	32	64
TOTAL	**50**	**100**

Twenty-two percent (22%) of the respondents who had visited the clinic were welcomed and assisted by health care providers while (14%) were not welcomed nor assisted.

TABLE 31: RESPONDENTS' PARENTS VIEWS ON ADOLESCENTS USING CONDOMS (n=50)

PARENTS VIEWS ON ADOLESCENTS USING CONDOMS	FREQUENCY	RELATIVE FREQUENCY (%)
Approved	20	40
Disapproves	30	60
TOTAL	**50**	**100**

Majority (60%) of the respondents indicated that parents disapproves use of condoms by adolescents while (40%) indicated that parents approve the use of condoms by adolescents.

TABLE 32: RESPONDENTS' RELIGION'S VIEW ON ADOLESCENT USING CONDOMS (n=50)

RELIGION'S VIEW ON ADOLESCENTS USING CONDOMS	FREQUENCY	RELATIVE FREQUENCY (%)
Approves	22	44
Disapproves	11	22
Does not know	17	34
TOTAL	**50**	**100**

Forty four percent (44%) of the respondents' religion approved condom use by adolescents (11%) disapproved the use of condoms by adolescents while (34%) of the respondents did not know if their religion approved or disapproved the use of condoms by adolescents.

TABLE 33: REASONS FOR RESPONDENTS RELIGION NOT APPROVING CONDOM USE (n=50)

REASONS FOR RESPONDENTS RELIGION NOT APPROVING CONDOM USE	FREQUENCY	RELATIVE FREQUENCY (%)
Respondent's religion promotes natural family planning	7	14
Sex should be reserved for marriage	2	4
Condoms promotes immorality	9	18
No response	10	20
Not applicable	22	44
TOTAL	**50**	**100**

Eighteen percent (18%) of the respondents religion did not approve condom use by adolescents because they promote immorality; (14%) promoted natural family planning (4%) reserved sex for marriage while (20%) did not respond to why their religion was not approving condom use. However, (44%) of the religion approved condom use.

TABLE 34: GENDER IN RELATION TO LEVEL OF KNOWLEDGE ON STI PREVENTION (n=50)

SEX	LEVEL OF KNOWLEDGE			TOTAL
	Low	Medium	High	
Female	5 (56%)	8 (47%)	8 (33%)	21 (42%)
Male	4 (44%)	9 (53%)	16 (67%)	29 (58%)
TOTAL	**9 (18%)**	**17 (34%)**	**24 (48%)**	**50 (100%)**

Fifty six percent (56%) of the respondents with low knowledge on STI prevention were females while (44%) were males. Fifty three percent (53%) of respondents with medium knowledge on STI prevention were males while (47%) were females. Sixty seven percent (67%) of respondents with high knowledge on STI prevention were males while (33%) were females.

TABLE 35: AGE IN RELATION TO LEVEL OF KNOWLEDGE ON STI PREVENTION (n=50)

AGE	LEVEL OF KNOWLEDGE			TOTAL
	Low	Medium	High	
10 -12	1 (11%)	0 (0%)	0 (0%)	1 (2%)
13 – 16	5 (56%)	7 (41%)	6 (25%)	18 (36%)
17 – 19	3 (33%)	10 (59%)	18 (75%)	31 (62%)
TOTAL	**9 (18%)**	**17 (34%)**	**24 (48%)**	**50 (100%)**

Fifty six percent (56%) of the respondents with low knowledge on STI prevention were aged 13 – 16, while (11%) were aged 10 -12. Fifty nine percent (59%) of the respondents with medium knowledge on STI prevention were aged 17 -19 while (41%) were aged 13 -16. Seventy five percent (75%) of the respondents with high knowledge on STI prevention were aged 17 – 19 while (25%) were aged 13-16.

TABLE 36: LEVEL OF KNOWLEDGE ON STI PREVENTION IN RELATION TO LEVEL OF EDUCATION (n=50)

LEVEL OF KNOWLEDGE ON STI PREVENTION	LEVEL OF EDUCATION					TOTAL
	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12	
Low	4 (100%)	3(13%)	2 (40%)	0 (0%)	0 (0%)	9 (18%)
Medium	0 (0%)	10 (43%)	0 (0%)	5 (46%)	2 (40%)	17 (34%)
High	0 (0%)	10 (43.4%)	3 (60%)	8 (54%)	3 (60%)	24 (48%)
TOTAL	**4 (8%)**	**23 (46%)**	**5 (10%)**	**13 (26%)**	**5 (10%)**	**50 (100%)**

All (100%) of the respondents with low knowledge on STI prevention were in grade 8, in while (13%) were in grade 9. Forty six percent (46%) of the respondents with medium knowledge on STI prevention were grade 11, while (40%) were in grade 12. Sixty percent (60%) of the respondents with high knowledge on STI prevention were in grade 10 and 12, while (43.4%) were in grade 9.

TABLE 37: LEVEL OF KNOWLEDGE ON STI PREVENTION IN RELATION TO RELIGION (n=50)

LEVEL OF KNOWLEDGE	CATHOLIC	UCZ	BIC	SDA	SALVATION ARMY	PENTECOSTAL	JEHOVAH'S WITNESS	NEW APOSTLE	CHURCH OF CHRIST	TOTAL
Low	1 (12.5%)	0 (0%)	0 (0%)	2 (14.2%)	0 (0%)	1 (20%)	2 (50%)	0 (0%)	3 (43%)	9 (18%)
Medium	4 (50%)	1 (20%)	1 (50%)	5 (36%)	0 (0%)	1 (20%)	1 (25%)	2 (67%)	2 (28.3%)	17 (34%)
High	3 (37.8%)	4 (80%)	1 (50%)	7 (50%)	2 (100%)	3 (60%)	1 (25%)	1 (33%)	2 (28.5%)	24 (48%)
TOTAL	**8 (16%)**	**5 (10%)**	**2 (4%)**	**14 (28%)**	**2 (4%)**	**5 (10%)**	**4 (8%)**	**3 (6%)**	**7 (14%)**	**50 (100%)**

Fifty percent (50%) of the respondents with low knowledge on STI prevention belonged to Jehovah's Witness church while (12.5%) belonged to Catholic church. Sixty-seven percent (67%) of the respondents with medium knowledge on STI prevention belonged to New Apostolic Church, while (20%) belonged to UCZ church. All (100%) of the respondents with high knowledge on STI prevention belonged to Salvation Army church, while (25%) belonged to Jehovah's Witness church.

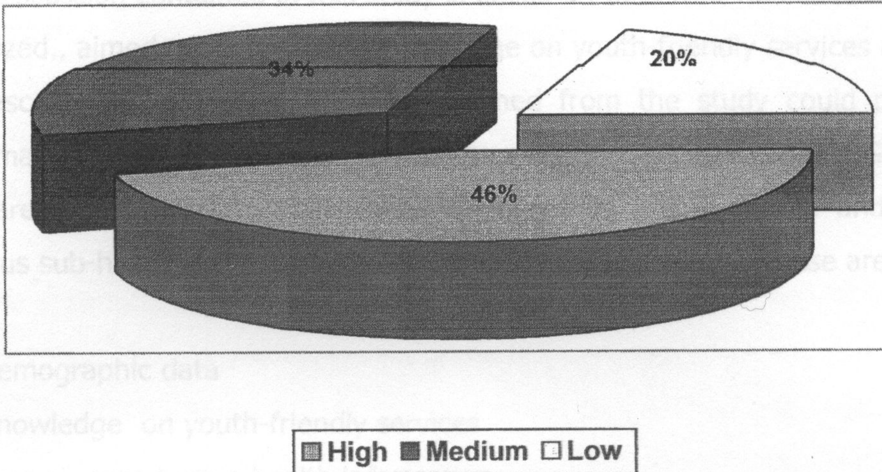
TABLE 38: SUGGESTIONS ON IMPROVEMENT BY YOUTH-FRIENDLY SERVICES (n=50)

SUGGESTIONS ON IMPROVEMENT OF YOUTH-FRIENDLY SERVICES	FREQUENCY	RELATIVE FREQUENCY (%)
Health workers to educate adolescents on youth-friendly services	25	50
Adolescents should be trained on youth-friendly services	13	26
Teachers should be trained on youth-friendly	2	4
Drama to be conducted to educate adolescents on youth-friendly services	7	14
Posters concerning youth-friendly services to be put up	3	6
No answer	3	6
Involve parents on youth-friendly services	2	4

***Multiple responses**

Fifty percent (50%) of the respondents suggested that education in youth-friendly services should be done by health workers (26%) suggested that adolescents should be trained in youth-friendly services and (20%) suggested that the youth-friendly services should be marketed so that the services can be known to the consumer other suggestions included training of teachers on youth-friendly services (4%) involving parents on issues relating to youth-friendly services, while (4%) had no suggestions on how to improve the youth-friendly services.

FIGURE 3: LEVEL OF KNOWLEDGE ON TYPE OF SERVICE RELATED INFORMATION (n=50)



Forty six percent (46%) of the respondents had high knowledge on services related information, (34%) had medium knowledge on service related information while (20%) had low knowledge on service related information.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS

5.1 INTRODUCTION

The discussion contained in this study is based on data that was collected and analyzed., aimed at determining knowledge on youth-friendly services among adolescents in Kalomo. The data obtained from the study could provide information to policy makers and health care providers as well as NGOs on the areas that need improvements. The results are discussed under the various sub-headings in line with the objectives of the study. These are:

- demographic data
- knowledge on youth-friendly services
- Sexual reproductive health information
- Knowledge on the prevention of sexually transmitted infections.

5.2 DISCUSSION OF VARIABLES

5.2.1 DEMOGRAPHIC DATA

The data was collected from 50 respondents who were both females and males. Fifty eight percent (58%) of the respondents were males while (42%) were females. Majority of the respondents (58%) were aged 17-19, (38%) were aged 13-16 while (4%) were aged 10-12 years. This means that there were few adolescents aged 10-12 in the sampled schools due to the fact that a lot of them in this age group are still in primary schools.

Although Kalomo is predominantly a Tonga speaking area, there were a lot of other tribes in the district. The majority (625) of the respondents were Tonga, (12%) Bemba, (6%) were Ngoni, (62%) were Lozi. Fourteen percent (14%) accounted for other tribes such as Luvale, Chokwe, Kaonde and Namwanga. This shows there has been a lot of migration from other districts of Zambia. All the respondents (100%) were Christians, although they

belonged to various religious denominations. This was expected because the majority of the denominations in Zambia are Christians, some cases of Moslems, Hindus and cults can be found but usually are of foreign nationality. Besides this, Zambia was declared a Christian nation by the former, second Republican President of Zambia, Dr. F. J. T. Chiluba. This could probably explain why most Zambians are Christians. In this study, most respondents belonged to SDA (28%) while (14%) belonged to catholic church. This may be due to the fact that the SDA church in Zambia started at Rusangu, in Southern Province, hence many people in the area belong to this religious affiliation.

All the respondents were school going pupils. Forty·six percent (46%) were in grade 9, (26%) grade 11, (10%) grade 8, (10%) grade 12 and (8%) grade 10. The grades in secondary schools were chosen because most youths reach adolescence while in these grades. According to Malibata, C (1994) the adolescents initiate sexual behaviour in secondary/basic school grades and tend to acquire a lot of knowledge related to issues of sexual behaviours hence the need to know their level of knowledge on youth friendly services.

Most of the adolescents (66%) lived with parents though a good number of them were looked after by relatives and friends. Eight (18%) were ;looked after by uncles and aunties, (10%) by sisters and brothers, (4%) by grand parents while (2%) by friends. This shows the close family ties that exist in the Zambian society. The extended family plays and important role in looking after each other's siblings and this is part of the Zambian culture. There is a probability that some have lost their parents and relatives took responsibility to look after them.

5.2.2 KNOWLEDGE ON YOUTH-FRIENDLY SERVICES

According to findings of the study as in Table 2 (76%) of the respondents were aware of the existence of youth friendly services in their communities. Forty two percent (42%) of the respondents who were aware of the existence

of youth-friendly services learnt about these services from friends, (32%) from teachers while (18%) learnt of the services from health workers. This shows that adolescents get information more from their peers than any other source. According to Bennett, B. and Schuetler, J. (2000) youth-friendly services can be free standing clinics that provide a full range of services and information to young people. The services help in preventing HIV/AIDS and other STIs through distribution of condoms, voluntary couunselling and testing for HIV. Adolescents are supposed to be the sole owners of youth-friendly services and should be actively involved in the programme design and service delivery.

The youth-friendly services were generally accessible to adolescents for (37%) of the respondents spent less than 15 minutes to reach the services while (18%) had to walk for more than one hour to reach the services.

Despite the adolescents being aware of the youth-friendly services, only (40%) of the respondents had ever utilized the services. The results showed that (60%) of the respondents had never used youth-friendly services, (Table 5). Most of the respondents (54%) did not know the type of services offered at youth-friendly services. The findings are in agreement with the CboH (2003) Reproductive Health report that stated that adolescents are aware of youth-friendly services but do not utilize them efficiently.

Fifty eight percent (58%) of the respondents did not utilize the youth-friendly services because they lacked information on the services. The youth-friendly services were however accessible to adolescents because only (7%) did not use youth-friendly services due to distance. The CBoH (2003) Reproductive Health report stated that the adolescents were not utilizing the services due to the services not sufficiently publicized in the community; as a result, many adolescents lack knowledge on youth-friendly services.

The results revealed that most of the respondents (58%) had medium knowledge on youth-friendly services (36%) had low knowledge while (6%)

had high knowledge on youth friendly services, (Figure 1). There were more male respondents (70%) with medium knowledge as compared to (29%) among female subjects (Table 9). The respondents with high knowledge on youth-friendly services were all males. Seventy-five percent (75%) of the respondents with low knowledge on youth-friendly services were female respondents while (25%) were males.

This may be due to the cultural influence that encourages males to take initiative and be bold in finding out new things, unlike girls who are expected to be more reserved and passive especially on issues relating to sexual behaviour.

The findings revealed that (58%) of the respondents with medium knowledge were aged 17-19, (Table 10) and all the respondents with high knowledge with high knowledge on youth-friendly services were in the same age group Table 17-19. Thirty nine percent (39%) of the respondents with medium knowledge were aged 13-16 and (50%) of the same age group had low knowledge on youth friendly services. Hence it is suggestive that the effect of age on the level of knowledge is that the latter increases with age. However, due to the limited sample size, this cannot be concluded.

5.2.3 SEXUAL AND REPRODUCTIVE HEALTH INFORMATION

Information on sexual and reproductive health is vital to enable adolescents make informed choices and responsible decisions in their life. In this study, sexual and reproductive health information was assessed to know the respondents' level of knowledge on SRH.

The findings showed that majority (94%) of the respondents have been taught on SRH and (60%) got this information from teachers, (32%) from health workers, while the least (13%) got the information from parents (Table 19). The teachers have been the major source of SRH probably due to the inclusion of this topic in the school curriculum. On the other hand,

parents are the least source of information on SRH because it is a taboo in our culture for parents to discuss sexuality issues with their children. The people who play this role are anties, uncles, grandparents, cousins and other elderly people in the society like Alangizi (marriage counselors). This is in support with Daka's findings that only (40%) of parents communicated sexuality issues to their children , and this was because it was taboo for parents to discuss SRH with children (Daka, D. 2003). This implies that parents are not yet free to discuss all topics of sexuality issues with their children.

Topics that were taught on SRH included puberty and growing up, human reproduction, contraceptive and condom use and personal hygiene. Abortion, counseling and drug abuse were not part of the topics that were taught (Table 15). This gave suggestive information that the information a adolescents had on SRH was limited for them to make informed choices and responsible decisions.

The preferred person to respondents to teach SRH was the health worker (50%) though others preferred people such as teachers (26%) , friends (16%) and the least preferred were parents (4%). This shows that the adolescents had more confidence in information from health workers. Probably adolescents think that health workers are more knowledgeable on sexual and reproductive health information than any other source.

The findings revealed that (46%) of the respondents were involved in girl/boy friend relationship, while (52%) were not (Table 20). This is a normal developmental process because change is the hallmark of adolescence which happens to be a transition stage from childhood to adulthood. Change is in form of physical emotional, mental and social characteristic. They usually move towards independence from parents and elders and establish new interests and relationships (Bennette B. and Schueller, J. 2000). Dating is normal, it gives them an opportunity to get to know the opposite sex.

Sixty two percent (62%) of the respondents had already indulged in sexual intercourse and (38%) were abstaining (Table 20). Sometimes the adolescents indulge in sexual intercourse out of curiosity, to please a peer group they belong to show 'maturity' and for financial purposes. Findings revealed that (36%) indulged in sexual intercourse due to peer pressure, (20%) due to curiosity and (6%) due to financial reasons.

Without being aware of the consequences the adolescents engage in sexual relationship and end up getting pregnant, or with an STI/HIV/AIDS (CBoH, 2001). Early sexual activity poses health risks for young women and men (adolescents). Most adolescents having sex for the first time do not use contraception and therefore end up with unplanned pregnancies. Others are usually unaware of the dangers of unprotected sex, therefore contracting HIV/AIDS and other sexually transmitted infections.

In Zambia, between 1994 and 1998, a Demographic Health Survey (DHS) revealed that (61%) of adolescents had already indulged in sex before the age of 15. (Population Review Bureau, 2001). These actions usually end in contracting STI/HIV infections , unplanned pregnancies and incomplete abortions. Instead of enjoying their youth, such adolescents youthful period is marred by misery and ill health. If they continue being sexually active, they infect a large proportion of their age group and elderly partners.

For adolescents who are abstaining, they need to be encouraged to delay the initiation of sexual intercourse. This group is very vulnerable because adolescents tend to listen more to each other and influence each other than they can be influenced by adults.

Findings showed that while (42%) of the respondents had sex with regular partners (20%) did so with casual partners. This exposes them to risks of contracting HIV/AIDS. Faithfulness to one partner, has been encouraged in

HIV/AIDS campaigns, but some adolescents are still engaged in risky sexual behaviour.

The majority (36%) of the respondents who indulge in sex, did so out of peer pressure. The fact that peer influence is a major contributor to adolescents sexual behaviour is acknowledged by a lot of organizations. Organizations are seeking ways to turn this influence around to a desired behaviour. UNAIDS (1999) explained that although young people's understanding of life is influenced by parents and adults,. It is developed both with and among peers. These groups of close friends shape the adolescents understanding of social relationship. With encouragement, such influence can channel correct information on HIV/AIDS and sexual behaviour.

Thirty eight percent (38%) of the respondents had only one sexual partner, while (20%) had two to five partners and (4%) had more than 5 partners. The majority (38%) who had one sexual partner showed a degree of stability in sexual relationships, though it is not known whether this was the beginning of their sexual relationship or if it had been like this for along time. Adolescents need to be responsible for their sexual behaviour especially that their sexual behaviour can affect many people including their lives. For instance, if that act results into contracting HIV/AIDS, parents will be involved in their care, financially, emotionally, physically and socially, which makes it a major concern to everybody (UNADIS, 2000).

Findings of the study revealed that (30%) of the adolescents were always using condoms during sex while (16%) never did so (Table 20). Condom use has always been advised to the adolescents who cannot abstain. While the majority of the respondents who indulge in sex used condoms, some did not, which puts them at risk of contracting STIs including HIV/AIDS. The reasons for not using condoms included (14%), of the respondents believed condoms not being hundred percent safe, (16%) said partners not being cooperative where condom use was concerned. In agreement with this,

UNAIDS (1999), report indicated that in the year 1994, a group of NGOs in Lusaka realized that the existing of primary health care was not meeting the health needs of adolescents, so they joined with the MoH and the District Council in organizing an informal working group to identify these health needs and developed a strategic plan. This led to the birth of youth-friendly services in 1996.

The majority (44%) of the respondents who were using condoms stated that they did so for protection. This could be as a result of the many television and radio campaigns on condom use.

Findings of the study indicated that alcohol and substance abuse prior to sex was not common with only (2%) of the respondents being involved. The use of such substances compromise the ability to make responsible choices like negotiation for safe sex or even the practical aspect of safe sex. This makes one failing to use discretion and ends up taking unnecessary risks. The majority of the respondents were not using drugs and alcohol due to the fact that an anti drug/substance abuse club exists in schools. The clubs may be very active and effective.

The findings revealed that (58%) of the respondents who were abstaining were females while (26%) were males. Forty eight percent (48%) of the respondents who were indulging in risky sexual behaviour were males and (16%) were females. Boys and men are generally believed to be less in control of their sexual urges than girls and women. According to Rwenge, M. 2000, he stated that girls were particularly likely to engage in risky sex for economic reasons than boys, which negatively influence their power to use condoms during sexual intercourse. However, the picture was different in this study which could be that girls were not involved with older men where they could have difficulties to negotiate for safer sex. Many female respondents were abstaining and it could be due to massive campaign on the need of a girl child to say 'No' to sex and be able to keep her virginity until marriage.

Findings also revealed that (60%) of the respondents who practiced risky sexual behaviour were in grade 12, while (75%) of the respondents who were abstaining were in grade 8 (Table 23). This shows that adolescents in the higher grades are more sexually active than those in the lower grades.

The study showed that (80%) of the respondents who were practicing abstinence belonged to the Pentecostal church while (21%) belonged to SDA church. Forty three percent (43%) of the respondents who were practicing risky sexual behaviour belonged to SDA while (20%) belonged to Pentecostal church (Table 24). As much as the churches have been encouraged to include sexual behaviours in their preaching only a few churches have been involved in doing so. The Pentecostal churches have tried to teach its members to be morally right. However, the church generally has done little in educating adolescents on sexual behaviour. The churches should consider empowering the adolescents with knowledge on issues relating to sexuality, so as to protect its members from contracting STIs including HIV/AIDS..

5.2.4 SERVICE RELATED INFORMATION

In recognition of the need to empower adolescents with knowledge on health related information, health workers are trying to make contacts with the schools. Sixty eight parent (68%) of the respondents indicated that their school have been visited by health workers while (32%) indicated that their schools had not been visited by health workers (Table 25). The role of the health workers in information dissemination is further acknowledged by (50%) of the respondents preferring them to be their source of SRH (Table 27). This may be a reflection of a need for adequate and accurate information by adolescents which can reliably be given by the health workers.

However, (2%) of the respondents indicated that their school was visited by health workers that month, (2%) that term, (28%) the previous year and (32%) had not been visited by health workers (Table 26). This could be attributed to the shortage of staff in hospitals and clinics leading to inadequate visitation to the schools. According to Nchima, C. M. 2001, the shortage of human and financial resources lead to less schools being visited by health workers.

The majority of respondents (76%) were aware of the health centre being the main source of STI prevention. However,(12%) of the respondents did not know the source for STI prevention. Despite the adolescents being aware of the source for STI prevention, (82%) did not utilize the services (Table 28). The reasons that were given for not visiting the health centre included being too young, and were practicing abstinence (38%) (14%) felt condoms and family planning were not safe, while (12%) did not visit the health centre because of the poor attitude of health workers.

This is in line with Nchima, C. M. (2001), study on attitude and practices of adolescents towards sexually transmitted infection, where adolescents were not visiting sexual and reproductive health services due to poor attitude of health care providers and because some were abstaining. The high rate of abstinence among adolescents would be as a result of the social marketing strategy of abstinence promotion in the campaign against HIV/AIDS.

Among the adolescents who had gone to the health centre for SRH services (22%) had been welcomed and assisted. This implies that the services are user friendly to adolescents. A similar situation was found in Chikankata where (52%) of adolescents described the nurses as friendly (Ndele, T. T. 1998). On the other hand, (40%) of the respondents parents approved of their adolescent children's use of condoms to prevent STIs, while (60%) disapproved the use of condoms. Parents do not usually support condom use to their adolescent children because they don't want to seem to encourage

promiscuity to their children. The parents may fear that the message may encourage the adolescents to practice sex. Parents' attitude towards sexuality issues may also be due to the belief that adolescents are still young and the information on sexuality my lead them to experiment sexual intercourse, thus they will be promiscuous. Some parents may have limited knowledge on family planning, teenage pregnancies, abortion and SIT, as such they will reject any information on reproductive health .

According to Daka, D. (2003) in a study to determine parents' attitude and practice towards sexuality of adolescent, parents misconception about sexuality issues was due to the limited knowledge on family planning, teenage pregnancies and STIs. In the study, findings showed that sharing information about condom use among adolescents was highly rejected and condemned by the parents. This implies that parents do not support use of condoms as a way of preventing HIV/AIDS and STIs. On the other hand, negative attitudes harboured by parents on sexuality topics such as family planning, pregnancy ad drug abuse, inhibit the implementation of behavioural change and making informed choices among adolescents.

Findings revealed that (67%) of the respondents with high knowledge on STI prevention were males compared to (33%) females (Table 34). Fifty six percent (56%) of the respondents with low knowledge on STI prevention were females. These findings further highlight the inquisitiveness of boys being more adventurous thus increasing their level of knowledge, even in issues of sexuality. The study also revealed that (75%) of the respondents with high knowledge on STI prevention were aged 17-19, (56%) with low knowledge were aged 13-16. Studies from Ghana, on condom use among youth people stated that initiation of sexual activity and knowledge on sexuality is higher among older adolescents, (Ankomah, A, 1998).
The adolescents who had knowledge on STI prevention were from all grades apart from grade 8 (Table 36). This could mean that adolescents have heard messages of safer sex. Despite the adolescents having heard messages of

safe sex (32%) are still involved in risky sexual behaviour (Table 22). This implies that knowledge on sexuality does not have a positive impact on sexual behaviour of adolescents. Fetters, T. et al (1999), study on testing community based approached for improving adolescents reproductive health, also concluded that while knowledge and awareness of HIV/AIDS was generally high, risky sexual behaviours among adolescents remained common.

The study revealed that (22%) of the respondents said that their churches did not allow the teaching of condom use among adolescents. Among the adolescents whose churches did not allow the teaching of condom use among adolescents (18%) believed that the discussion of condoms would promote immorality, (4%) believed that sex should reserved for married people and (34%) did not respond to whether their church approved or disapproved condom use among adolescents. Despite the churches trying to teach adolescents on prevention of HIV/AIDS and other STIs including condom use, there is still a lot more to be done as far as teaching on condom use and sexual behavious of adolescents is concerned.

5.3 IMPLICATIONS TO THE HEALTH SYSTEM

The results of the study have shown that adolescents are aware of the existence of youth friendly services in the community but majority have not utilized the services. There is need for the health institutions to work with the youth-friendly services in the community, schools and other NGOs, like Mumuni centre to inform, educate and communicate with adolescents on their sexual and reproductive health. There is also need to market the youth-friendly services so that the adolescents can utilize and appreciate the services.

The results have also shown the desire by adolescents to be given adequate information on SRH by health workers who have not been able to carry out frequent visits to the schools. Despite the shortage of staff, the health workers have an obligation to meet the need for information and counseling

especially to vulnerable groups like the adolescents. The nation's health system should provide logistics to make it possible for such activities to be sustainable.

The study showed that majority of parents have not taken an active role in educating adolescents on SRH. The nation's health system recognizes parents as partners in adolescent reproductive health, hence forums to assist parents break the cultural barriers that hinder the promotion of adolescent SRH should be held regularly until such a time when parents will be able to discuss such matters with their children freely.

The study has also shown that most times adolescents turn to colleagues for information. The informants are not knowledgeable leading to misinformation. This results in adolescents getting wrong information which puts them at risk of making wrong decisions where SRH is concerned. This result in many adolescents getting HIV infection and other STIs. The infected adolescents, due to embarrassment and uncertainty, do not seek medical attention in good time, but in the process continue to infect many others. The end result is that the health care system becomes congested and the depleting medical supplies run out. Besides this, the treatment of opportunistic infections resulting from HIV infection is very expensive, putting considerable strain on the delivery of quality health services in Zambia. Congestion ad overcrowding are common features facilitating cross infection to patients and staff, therefore compromising care.

5.4 CONCLUSION

The assessment of knowledge on youth-friendly services among adolescents in Kalomo was worthwhile in providing baseline data for programme formulation in fighting HIV/AIDS and positive behavioural change.

While (58%) of the respondents had medium knowledge on youth-friendly services, (60%) were not utilizing the services, implying that the knowledge

the adolescents have is not enough to make therm appreciate the services offered by youth friendly services. However, it was found that a lot of factors affect adolescent's knowledge on youth-friendly services in Kalomo. Some adolescents lack service factor information, that is, type of service available for adolescents like family planning, condom distribution, voluntary counseling and testing, adolescent parents not discuss SRH with them, while other's religious cultural beliefs prevent adolescents from accessing youth-friendly services. From the suggestions of the respondents, it was found that adolescents wanted to be provided with adequate information on abstinence, contraceptive use for safer sex and on dangers of unprotected sex. They also suggested that adolescents and teachers should be trained so that they can disseminated pertinent information on sexual and reproductive health including youth-friendly services. Adolescents suggested that civic education of youth-friendly should be done by health workers so that all the adolescents in the community can access the services.

5.5 RECOMMENDATIONS

In view of the findings the following recommendations have been made:

5.5.1 TO THE MINISTRY OF HEALTH

The health care providers should intensify the school health services outreach programme and be consistent in their programmmes so that health education on sexual behaviour and other reproductive health issues can be given to make more adolescents be aware of youth-friendly services. The health care provider should sensitize adolescents on youth-friendly services so that the services will be utilized to the fullest. Health workers who deal with adolescents need to be trained on counseling skills so that they can meet the health needs of young people.

5.5.2 THE MINISTRY OF EDUCATION

The Ministry of education need to put a deliberate policy that will reinforce the education of adolescents on reproductive health, so that the spread of

HIV/AIDS and other sexually transmitted infections can be prevented. The policy should be revisited which empower the teacher to instill discipline and promote high moral behaviours to school going adolescents.

The Ministry of Education through the District Education Office should train teachers in counseling skills so that they can be able to counsel the adolescents without waiting for health care providers to do the counseling and give health education talks.

5.5.3 SCHOOLS

The school authorities would ensure that they intensify information, education and communication on issues relating to adolescents sexuality so that the spread of HIV/AIDS and other STIs can be prevented.

The school authorities should encourage adolescents to maintain and promote high morals. The emphasise should be on behavioural change and voluntary counseling and testing. Fellow pupils need to be trained so that they can be peer educators.

The school authorities should encourage teachers to train as counsellors so that they can counsel the pupils on good sexual behaviour and encourage utilization of youth-friendly services. The school authorities need to work hand in hand with health care providers in order to intensify and promote anti-AIDS clubs in schools. The school authorities should also work with the youth-friendly services so that there can be coordination of activities between the two parties.

5.5.4 PARENTS

Parents should acknowledge the fact that some adolescents are sexually active and hence need not keep quite especially in this era of HIV/AIDS. Parents should play a big role in educating and counseling of their children. The parents need to intensify their authoritarian role to instill discipline and

promote good morals to their children. Parents should lead by example so that the children will have role models especially where sexual behaviour is concerned.

5.5.5 CHURCHES

The problem of HIV/AIDS sexually transmitted infections and unwanted pregnancies is real, the church therefore need to start teaching adolescents on sexual and reproductive health. The church should encourage adolescents to be involved in groups or organizations like youth-friendly services where they can lean a lot on issues relating to sexual behaviours. The churches should know that a lot of adolescents find difficulties to abstain from sex, hence there is need to consider condoms as an alternative for adolescents who cannot abstain.

The churches to continue promoting good morals among members and to involve adolescents in activities that promote good behaviour.

5.5.6 NON-GOVERNMENTAL ORGANIZATIONS (NGOs)

There is need for NGOs to work hand in hand with Ministry of Education and Health to design programmes that will promote the health of adolescents. Monitoring and evaluation of these programmes is important for effectiveness purposes.

NGOs should involve adolescents in their programmes, so they can participate fully in issues of health. This will make them more responsible over their health and be able to impact a positive change to others.

5.5.7 RECOMMENDATIONS FOR FURTHER STUDY

There is need to research further on the information adolescents receive from various sources, because despite the information given adolescents, they still remain sexually active. Adolescents still have apathy on services, such as youth-friendly services, that deal with their health.

There is need to conduct a large scale study on knowledge on youth-friendly services in Kalomo to enable generalization of findings.

Research in rural areas should be promoted so that views and problems of the adolescents in such areas can also be researched and findings to be disseminated so that they can be helped accordingly.

5.6 PLANS FOR DISSEMINATION OF FINDIGNS

The results will be disseminated to the authorities such as District Education Office and MoH. One copy of the research will remain in the Department of Post Basic Nursing, medical library for use as reference to other researchers. The sponsors, Central Board of Health will also remain with a copy which can be used in policy formulation. Executive summaries of research findings will be sent to Kalomo District Health Management Board, Kalomo District Education Office, and the coordinator for youth-friendly services in Kalomo including NGOs who have adolescents at heart like Mumuni centre. Seminars and workshops will be held for adolescents in schools and churches in relation to the research findings.

5.7 LIMITATIONS OF THE STUDY

The sample size was small due to limited time for the study. Funding for the research was not adequate which made if difficult to finish the study on time for the researcher had to wait for her salary to successfully complete the study.

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APPENDIX I

THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

QUESTIONNAIRE FOR A STUDY ON KNOWLEDGE ON YOUTH-FRIENDLY SERVICES AMONG ADOLESCENTS

QUESTIONNAIRE NUMBER...

DATE OF ADMINISTRATION...

PLACE...

INSTRUCTIONS FOR RESEARCHER

1. Introduce yourself to the respondent
2. Explain the purpose of study
3. Seek respondents' consent to participate in the research
4. Information given must be kept confidential
5. No names should appear on the questionnaire
6. Respondent should tick against appropriate answers in the provided spaces
7. Ensure the questionnaire is complete
8. Thank the respondent for participating in the research

SECTION A: SOCIAL DEMOGRAPHIC DATA

FOR OFFICIAL USE ONLY

1. Sex
   (a) Male [ ]
   (b) Female [ ]
2. What is your age according to your last birthday?
   (a) 10 -12 [ ]
   (b) 13 – 16 [ ]
   (c) 17 – 19 [ ]
   (d) 20 – 24 [ ]
3. What is your tribe?
   (a) Ngoni [ ]
   (b) Bemba [ ]
   (c) Lozi [ ]
   (d) Tonga [ ]
   (e) Others, specify...
4. What is your religious denomination?
   (a) Catholic [ ]
   (b) UCZ [ ]
   (c) RCZ [ ]
   (d) SDA [ ]
   (e) Others, specify...
5. In what grade are you?
   (a) Grade 8 [ ]
   (b) Grade 9 [ ]
   (c) Grade 10 [ ]
   (d) Grade 11 [ ]
   (e) Grade 12 [ ]
6. Whom do you live with?
   (a) Parents [ ]
   (b) Sister/brother [ ]
   (c) Grandparents [ ]
   (d) Aunt/uncle [ ]
   (e) Others, specify...

7. Who pays for your school expenses?

(a) Parent [ ]

(b) Guardian [ ]

(c) Others, specify...

FOR OFFICIAL USE ONLY

SECTION B: KNOWLEDGE

8. Do you know of any youth-friendly services in your community?

(a) Yes [ ]

(b) No [ ]

9. If 'Yes' to question 8, who informed you about these services?

(a) Friend [ ]

(b) Parent [ ]

(c) Teacher [ ]

(d) Health worker [ ]

(e) Others, specify...

10. How far is the nearest youth-friendly corner/centre?

(a) Less than 15 minutes walk [ ]

(b) About 30 minutes walk [ ]

(c) About 45 minutes walk [ ]

(d) More than one hour walk [ ]

11. Have you ever used the youth-friendly services available in your community?

(a) Yes [ ]

(b) No [ ]

12. If the answer to question 11 is 'Yes', what services are offered at the youth-friendly centre?

(a) Family planning [ ]

(b) Condom distribution [ ]

(c) Health education [ ]

(d) Others, specify...

13. If answer to question 11 is 'No', please explain.

....

....

....

FOR OFFICIAL USE ONLY

14. Have you ever been taught about sexual and reproductive health?

(a) Yes [ ]

(b) No [ ]

15. If 'Yes' to question 14, from whom did you learn about sexual and reproductive health?

(a) Friends [ ]

(b) Parents [ ]

(c) Grandparents [ ]

(d) Teacher [ ]

(e) Health workers [ ]

(f) Radio/TV/books [ ]

(g) Others, specify...

16. What topics were included in the lesson?

(a) Personal hygiene [ ]

(b) Puberty and growing up [ ]

(c) Human reproduction [ ]

(d) Contraceptives including condom use [ ]

(e) Other, specify...

17. Who would you like to teach you about sexual and reproductive health?

(a) Friends [ ]

(b) Parents [ ]

(c) Health worker [ ]

(d) Teachers [ ]

(e) Others, specify...

SECTION C: SEXUAL BEHAVIOUR

FOR OFFICIAL USE ONLY

18. Are you currently dating?
    (a) Yes [ ]
    (b) No [ ]
19. Have you ever had sexual intercourse?
    (a) Yes [ ]
    (b) No [ ]
20. If 'Yes' to question 19, whom did you have sex with?
    (a) Regular partner [ ]
    (b) Casual partner [ ]
    (c) Others, specify...
21. Why did you engage in sexual intercourse?
    (a) For financial reasons [ ]
    (b) Under peer pressure [ ]
    (c) Out of curiosity [ ]
    (d) Others, specify..
22. How many sexual partners have you had?
    (a) None [ ]
    (b) One [ ]
    (c) Two to five [ ]
    (d) More than five [ ]
23. How often do you use condoms when having sex?
    (a) Always [ ]
    (b) Sometimes [ ]
    (c) Never [ ]
24. If 'Yes' to question 23, why do you use condoms?
    (a) To protect self [ ]
    (b) To please partner [ ]
    (c) They are readily available [ ]
    (d) Friends taught me to use them [ ]
    (e) Others, specify..

25. If "No' to question 24, please explain.

....

....

....

FOR OFFICIAL USE ONLY

26. Have you and your partner ever used drugs or alcohol before indulging in sex?

(a) Yes [ ]

(b) No [ ]

27. If 'Yes' to question 26, please explain why?

....

....

....

SECTION D:SERVICE RELATED INFORMATION

28. Has a health worker ever visited your school to give a talk on sexual and reproductive health?

(a) Yes [ ]

(b) No [ ]

29. If "Yes' to question 28, when was the last time the health worker visited your school?

(a) This month [ ]

(b) This term [ ]

(c) This year [ ]

(d) Last year [ ]

(e) Others, specify...

30. Where can you get services on STI prevention?

....

31. Have you ever gone to the clinic to ask for condoms or and family planning?

(a) Yes [ ]

(b) No [ ]

FOR OFFICIAL USE ONLY

32. If 'No' to question 31, please explain.

....

....

....

33. If 'Yes' to question 31, did the health worker welcome and assist you with the services?

(a) Yes [ ]

(b) No [ ]

34. Do your parents or guardian support condom use?

(a) Yes [ ]

(b) No [ ]

35. Does your religion encourage education on sexual and reproductive health?

(a) Yes [ ]

(c) No [ ]

(c) I don't know [ ]

36. If the answer to question 35 is "No' please explain.

....

....

....

37. Any suggestions on how to improve on provision of knowledge on youth-friendly services in your community?

....

....

....

****THANK YOU FOR YOUR PARTICIPATION****

APPENDIX II: WORK SCHEDULE

TASK OF PERFORMED	RESPONSIBLE PERSON	DATES	DAYS
Literature review	Researcher	Continuous June 2004 – April 2005	Continuous
Finalizing Research Proposal	Researcher	June 7th – August 23rd	65 days
Clearance from the facilitator – PBN	Researcher/ Facilitator	25th Aug. – 30th Aug	5 days
Pilot study	Researcher	06th Sept. – 8th Sept.	2 days
Data Collection and Tool Amendment	Researcher	9th Sept. 11th Sept.	2 days
Data Collection	Researcher	13th Sept. 23rd Sept.	10 days
Data Analysis	Researcher	25th Sept. – 1st Nov.	30 days
Report Writing	Researcher	2nd Nov – 22nd Nov	20 days
Submission of Draft Report to PBN	Researcher facilitator	23rd Nov. – 5th Dec.	12 days
Finalizing Report	Researcher	Dec. 7th – Jan. 17th	40 days
Submission of final report to PBN	Researcher	Jan. 18th – Jan. 28th	10 days
Dissemination of Results and Evaluation	Researcher	March 31st – 5th April	5 days

APPENDIX III: GANTT CHART

TASK	KEY PERSON	JUNE 2004	JULY 2004	AUGUST 2004	SEPT. 2004	OCT. 2004	NOV. 2004	DEC. 2004	JAN. 2004	FEB. 2004	MARCH 2004
Literature review	Researcher										
Finalizing Research Proposal	Researcher										
Clearance from the facilitator – PBN	Researcher										
Pilot study	Researcher										
Data Collection and Tool Amendment	Researcher										
Data Collection	Researcher										
Data Analysis	Researcher										
Report Writing	Researcher										
Submission of Draft Report	Researcher/ Facilitator/ supervisor										
Finalizing Report	Researcher										
Submission of final report	Researcher										
Dissemination of Results and Evaluation	Researcher										

APPENDIX IV: BUDGET

DESCRIPTION	QUANTITY	UNIT PRICE (K)	TOTAL (K)
Stationery			
Reams of paper	4 reams	25,000.00	100,000.00
Pens	5	1,000.00	5,000.00
Diskettes	1	5,000.00	5,000.00
Markers	5	3,000.00	15,000.00
Rubber	1	1,000.00	1,000.00
Tippex	2	8,000.00	16,000.00
Pencils	2	500.00	1,000.00
Flip chart	1	40,000.00	40,000.00
Manila paper	2	2,000.00	4,000.00
Manila folders	6	2,000.00	12,000.00
Subtotal			**199,000.00**
SECRETARIAL REQUIRMENTS			
Typing			
Research Proposal	80 pages	3,500.00	280,000.00
Research Report	100 pages	3,500.00	350,000.00
Questionnaire	7 pages	3,500.00	240,500.00
Photocopying			
Research Proposal	80	500.00	40,000.00
Research Report	400	500.00	200,000.00
Questionnaire	(65 x 10 pages) = 650	500.00	325,000.00
Bindings			
Research Proposal	2	10,000.00	20,000.00
Research Report	4	60,000.00	240,000.00
Subtotal			**1,784,500.00**

DESCRIPTION	QUANTITY	UNIT PRICE (K)	TOTAL 9K)
Emoluments Transport Meals	 To and from 1 x 10 days	 125,000 50,000.00	 250,000.00 100,000.00
Total			**350,000.00**
Subtotal			**2,354,000.00**
Contingency	10% of total cost		**235,400.00**
GRAND TOTAL			**2,589,400.00**

BUDGET JUSTIFICATION

The budget prepared is supposed to cater for the costs of the project.

STATIONERY

The reams of paper were used to write, print and photocopy the proposal, questionnaires and the reports. The pens and pencils were used for writing the proposal and data collection. Diskettes were used to store information. Tipex and rubbers were used for corrections in the proposal and report. Markers and flip chart were used for writing during dissemination of information. Manila paper was used for binding and Manila folders for filing papers and questionnaires.

SECRETARIAL SERVICES

Money was required for typing the proposal, photocopying report and for binding all the copies. Two copies of the proposal were needed, one for the facilitator and one to the investigator. Money was required to type one questionnaire and photocopying sixty questionnaires and to type one report and bind four reports. One report would be sent to the Department of Post

Basic Nursing, one to the Medical Library, to the sponsor and the other to the researcher.

EMOLUMENTS

Transport money was required for the researcher to move to and from the research setting (from Lusaka to Kalomo and back). The researcher needed money for lunch as she travels to and from the research setting.

CONTINGENCY

The contingency money was required for unseen costs.

P. O. Box 620085
KALOMO

17th August, 2004

The District Education Officer
P. O. Box
KALOMO

UFS: The Head of Department
Department of Post Basic Nursing
School of Medicine, UNZA
P. O. Box 50110
LUSAKA

Dear Sir/Madam,

Re: PERMISSION TO CONDUCT A PILOT STUDY IN YOUR SCHOOL

I am a fourth year student in the School of Medicine doing B.Sc. in Nursing at the above mentioned department.

In fulfillment of the programme, I am required to carry out a research project. My topic of study is "knowledge on youth-friendly services among adolescents in Kalomo".

It is in this respect that I am seeking your permission to undertake a pilot study at Namwianga Secondary School to test my data collection tool and technique prior to the actual study.

Your assistance in this matter will be highly appreciated.

Thanking you in advance.

Yours faithfully,

Juliana M. Hakaloba

c.c. Headmaster, Namwianga Secondary School

P. O. Box 620085
KALOMO

17th August, 2004

The District Education Officer
P. O. Box
KALOMO

Hambwe

UFS: The Head of Department
Department of Post Basic Nursing
School of Medicine, UNZA
P. O. Box 50110
LUSAKA

Dear Sir/Madam,

Re: PERMISSION TO CONDUCT A RESEARCH STUDY IN YOUR SCHOOLS

I am a fourth year student in the School of Medicine doing B.Sc. in Nursing at the above mentioned department.

As part of the fulfillment to the programme to complete the training, I am required to conduct a research study. My topic of study is "knowledge on youth-friendly services among adolescents in Kalomo".

In this respect, I seek for your permission to collect data and conduct the research in your schools in Kalomo Central.

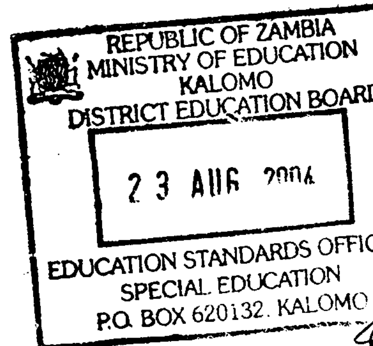
Your assistance in this matter will be highly appreciated. Looking forward to your quick and favourable response.

Yours faithfully,

She passed through the District Education Board Office kindly allow her to carry out her research.

Hakaloba
Juliana M. Hakaloba

G.S. Muleya
for/ DEBS
KALOMO



c.c. Headmasters of specific schools

c.c. Kalomo District Health Office