



SCHOOL OF MEDICINE AND HEALTH SCIENCES

**BEYOND ACCESS: UNRAVELLING THE DETERMINANTS OF
FAMILY PLANNING AUTONOMY AMONG ADOLESCENTS IN
MATERO, LUSAKA**

BY

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**A Dissertation submitted to the University of Lusaka in partial fulfilment of the
requirements of a Degree in Bachelor of Science in Public Health**

DECLARATION

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I declare that this proposal is my creative work and to the best of my acquaintance has not been presented for a degree in any other institution.

Signature:  _____

Date: 21/11/2025

Supervisor Name: LUNGU ANDERSON

This dissertation has been submitted with my approval as a University of Lusaka (UNILUS) supervisor.

School of Medicine and Health Sciences, Department of Public Health

Signature:  _____

Date: 21/11/2025

DEDICATION

This work is lovingly dedicated to Mr. Moono, whose unwavering support, encouragement, and belief in me have been the greatest source of strength throughout this academic journey. Your patience, guidance, and faith in my abilities inspired me to persevere even in the most challenging moments. I will forever be grateful for your constant presence and the sacrifices you made to see me succeed. This achievement is as much yours as it is mine.

I also dedicate this dissertation to my beloved family for their endless love, prayers, and encouragement, which have carried me through every stage of my education.

Finally, I dedicate it to all my lecturers and mentors whose passion for teaching and commitment to excellence have shaped my growth and understanding of Public Health.

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LIST OF ACRONYM

AGYW	-	Adolescent Girls and Young Women
CI	-	Confidence Interval
DHS	-	Demographic and Health Survey
FP	-	Family Planning
IUD	-	Intra-Uterine Device
LAM	-	Lactation Amenorrhea Method
NGO	-	Non-Governmental Organization
NAHSP	-	National Adolescent Health Strategic Plan
SRH	-	Sexual and Reproductive Health
SRHR	-	Sexual and Reproductive Health and Rights
SPSS	-	Statistical Package for Social Science
UNFPA	-	United Nations Population Fund Agency
WHO	-	World Health Organization
YFHS	-	Youth-Friendly Health Services
ZSA	-	Zambia Statistics Agency

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ABSTRACT

This study was conducted in Matero Township of Lusaka district in Lusaka province. The general objective of the study was to investigate the determinants of family planning autonomy among adolescents in Matero. The study design used was case - control community-based cross-sectional study design with a quantitative approach to data collection. The **target** population of the study was all adolescents aged 14 – 21 years and who live in the selected study area. A total 384 participants was used as the sample size. Purposive sampling method was used to recruits participants. Adolescent boys and girls aged not above 21 years were identified by the researchers from each household, and were selected to take part with their full consent. Data collection was done using a structured questionnaire. Data analysis was done using Statistical Package for Social Science (SPSS) version 20. Descriptive statistics were used to analyze the socio-demographic characteristics and the results were presented in tables and charts. Inferential statistics were performed by Chi-square at 95% confidence interval (CI) to assess the association between the interacting variables. Outcomes $p < .05$ were considered statistically significant. The study finding revealed that the rate of family planning autonomy among adolescents in Matero was 53.7%. The utilization of different family planning methods used by the adolescents in Matero vary as the most used FP method among adolescents in Matero is condoms (40.8%), followed by implants (20.2%), Oral contraceptive pills (15.0%) and hormonal patches (12.0%). The socioeconomic and demographic factors influencing FP autonomy among adolescents in Matero are older adolescent age, female gender, low level of education, being married and occupation while the social factors influencing FP autonomy among adolescents are access to FP services, living with a contraceptive user, being in a sexual relationship and having at least 1 child.

CHAPTER ONE

1.0 INTRODUCTION

This chapter gives background of the study and an overview of family planning autonomy among adolescents by elucidating on the available modern contraception options and family planning autonomy and utilization among adolescents in Zambia. The chapter further highlights the statement of the problem to be addressed by the study, the justification of the study, the general research objective, specific research objectives and the research questions.

1.1 Background

In Zambia, modern contraception options includes female and male sterilization, intra-uterine devices (IUD), implants, injectable, oral contraceptive pills, vaginal rings, hormonal patches, male and female condoms, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal foam, jelly, cream, and sponge), lactation amenorrhea method (LAM) and emergency contraception (Ministry of Health, 2019).

The availability of different family planning options in Zambia means that users can choose the method that fits their circumstance. However, actual use of these family planning methods by many users including adolescents is still low at 48% nationwide and below the target of 58% (Zambia Statistics Agency [ZSA], & Ministry of Health, 2019). By year 2018, the country's contraception prevalence rate marginally increased from 33% in 2012 to 50% despite there being almost universal knowledge of modern contraception options among users including adolescents (WHO, 2021).

Adolescents are sexually active during their time of transition, and they have unique needs for sexual and reproductive health (SRH) (WHO, 2018; Sserwanja et al., 2019). Many adolescents have been found to engage in unsafe sex, which can lead to an unintended pregnancy, an unsafe abortion, or teenage pregnancy, which further constitutes the leading cause of preventable adolescent mortality and morbidity (Jain et al., 2021).

The low uptake of contraception has been attributed to a lack of autonomy in contraceptive decision making especially among users. Autonomy enhances one's assertiveness in dealing with sexual and reproductive health (Mangimela-Mulundano et al., 2022). Contraceptive autonomy is defined here as the factors that need to be in place in order for a person to decide

for themselves what they want in regards to contraceptive use, and then to realize that decision (Senderowicz, 2020). In being effective in preventing pregnancy, modern contraception offers users the right to decide the number, timing and spacing of children (Ghebreyesus and Kanem, 2018; Ahmed et al., 2019).

Contraceptive use plays a crucial role in reducing fertility rates, alongside other factors like marriage/sexual activity, postpartum infertility, and induced abortions. It also contributes to lowering the risk of maternal mortality per birth, particularly by preventing high-risk pregnancies, such as those in very young or older women, closely spaced births, and high-parity pregnancies (Aryanty et al., 2023). Family planning has been estimated to significantly decrease maternal mortality in various countries, ranging from 6% to 60%, with a global average of 44%. Moreover, it has a positive impact on reducing infant mortality and unsafe abortion rates (Utomo et al., 2021).

Utilization of family planning services in developing nations effectively prevents unintended pregnancies and lowers maternal and child mortality rates (Asut et al., 2018). Family planning empowers individuals, enabling informed decisions about childbirth, leading to improved maternal and child health, reduced unwanted pregnancies and unsafe abortions, and enhanced economic well-being. It also promotes women's autonomy in healthcare decisions, aligning with the United Nations' emphasis on universal access to safe family planning methods to support couples in their family planning choices, contributing to sustainable development goals (Kassim and Ndumbaro, 2022). Despite the positive effects of contraceptive use among adolescents, uptake of family planning services in this population in low and middle income countries including Zambia is low despite high universal knowledge of at least one modern contraceptive method (Chola et al., 2020).

The government of Zambia introduced youth friendly health services (YFHS) in 1994 in selected facilities of Eastern, Lusaka, Southern and Copperbelt provinces. However, a mid-term review of this programme showed lack of standards of care for adolescents, poorly coordinated service delivery and limited access to care (national standards and guidelines for adolescent friendly health services). This further led to the national adolescent health strategic plans (NAHSP) (2011–2015, 2017–2021) that aimed for appropriate, accessible, efficient and effective adolescent friendly health services (ADFHS) (Ministry of Health, 2019).

Despite the various interventions and policies to promote modern contraceptives utilization among adolescents, the rate of uptake of family planning has remained low (Chola et al., 2020; de Vargas, 2019). However, not using modern contraceptives has been linked to various health consequences. Lack of autonomy on family planning contributes to over 90% of the annual unplanned pregnancies among adolescents in sub-Saharan Africa countries including Zambia (Sidibé et al., 2020). According to the recent studies adolescents who engage in unsafe sex are more likely to die as compared to older aged groups. This is because adolescents have immature reproductive organs (Mulugeta et al., 2019). Furthermore, the health of the newborns from adolescent mothers is also at risk of being preterm and low-birth-weight and is prone to neonatal death (Yakubu et al., 2019; Oppong et al., 2021; Gahungu et al., 2021).

When adolescents have restricted access to contraceptives, their wellbeing and autonomy could also be compromised (Yakubu et al., 2019). Adolescents who are unable to make an informed decision about their pregnancy could have a negative consequences, since they frequently lack the financial resources to care for their newborn, they dropped attending school (Oppong et al., 2021).

Despite the adverse effects of adolescent pregnancies and births, contraceptive use among adolescents in Zambia is low (Chola et al., 2020). For family planning advocates, practitioners, providers, and researchers, the main challenge has been to reduce the barriers to care, and to encourage as many people as possible to exercise family planning autonomy and take up an effective family planning method (Sieverding et al., 2018).

Promoting use of modern contraceptives among adolescents is a priority intervention that will ensure improvement of pregnancy related outcomes, however, a number of factors hinders this important target. Several factors affects family planning autonomy among sexually-active adolescent girls and young women. These factors can be grouped into individual (Casey et al., 2020) environmental (Ahinkorah, 2020; Tull, 2019) and gender-related factors (Flemming et al., 2020). Other studies also show that issues related to awareness, knowledge, decision-making power about contraception (Sharma, A. et al. 2021), fear of contraceptive side effects, contraceptive preferences and acceptability of available contraceptive methods impact contraceptive uptake by AGYW (Casey et al., 2020; Kantorova et al., 2021).

In Zambia, previous studies have explored modern contraception use in association with contraception decision-making and socio-demographic factors (Ahmed et al., 2019; WHO,

2021) but there are limited data in terms of its research and reporting on family planning autonomy among adolescents. Therefore, this study seeks to investigate the determinants of family planning autonomy among adolescents in Matero township of Lusaka.

1.2 Statement of the Problem

In Zambia, despite the government of Zambia introducing youth friendly health services (YFHS) in 1994 and the national adolescent health strategic plans (NAHSP) (2011–2015, 2017–2021) that aimed for appropriate, accessible, efficient and effective adolescent friendly health services including family planning in selected facilities of the four major provinces including Lusaka (Ministry of Health, 2022).

The uptake of family planning services among adolescents in the country is still low despite high universal knowledge of at least one modern contraceptive method (Chola et al., 2020). Evidence indicates that only around 12% of female adolescents in Zambia are using modern contraceptives (WHO & UNFP, 2024). This has led to uncontrolled childbearing among the adolescent population across different settings in the country including Matero township.

Adolescent childbearing is associated with adverse health risks such as; increased maternal mortality and morbidity such as obstetric fistulae and sexually transmitted infections (Chola et al., 2020; Sserwanja et al., 2021). Furthermore, babies born to adolescent mothers are at an increased risk of perinatal mortality because of low birth weight and problems of prematurity (Chola et al., 2020). In addition to the negative health outcomes, adolescent childbirths have been associated with adverse socio-economic consequences such as; poverty, school dropout and subsequent lower educational attainment which affects their personal development (Yakubu and Salisu, 2018; Kawuki et al., 2019).

Despite the adverse effects of adolescent pregnancies and births, there is no known study that has yet been done on the determinants of family planning autonomy among adolescents in Matero, Lusaka province. Therefore, this study will be undertaken to fill up this information gap.

1.3 Justification of the study

Carrying out this study is important because knowing the determinants of family planning autonomy among adolescents will benefit the people of Matero and the country at large because it has potential to bring about positive social change.

Given that FP is a cost-effective public health strategy with many benefits, it is imperative to have all the eligible people of Zambia, including adolescents, access the service equitably. To achieve the sustainable development goal benchmark of a CPR of at least 75% by 2030 in all countries, the majority of states, including Zambia, need to accelerate the uptake of FP (Kuria-Ndiritu, 2021).

The findings of the study will provide the much needed information on the topic which may help public health authorities and stakeholders to come up with targeted interventions in order to improve family planning uptake in this population.

Further, though there is information focusing on the general population in Zambia, none focuses on adolescents on a local setting like Matero. Analyzing the available data concentrate on this population is a cost-effective and efficient way of getting critical and relevant information. Cost-effectiveness and efficiency are crucial given the limited funding for health and particularly for public health globally.

For healthier lives, developing countries like Zambia need to develop homegrown solutions that are in line with their realities. Local research like the present study is necessary to inform priorities and national strategies and provide evidence to support program implementation. Therefore, this study provides relevant information for the FP program that will support increased FP uptake among adolescents and thus harness the benefits associated with young girls' use of contraception leading to increased uptake of FP.

Further, increased uptake of FP will prevent unintended pregnancies and the consequences thus, saving millions of dollars that are made available for other social services and economic development, thus improving the general quality of life for all (Kuria-Ndiritu, 2021).

1.3 Research objectives

1.3.1 General objective

The general objective of the research is to investigate the determinants of family planning autonomy among adolescents in Matero, Lusaka

1.3.2 Specific objectives

1. To determine the rate of family planning autonomy among adolescents in Matero township
2. To assess the utilization of various family planning services among adolescents in Matero township of Lusaka
3. To determine the socioeconomic and demographic factors influencing FP autonomy among adolescents in Matero

1.4 Research questions

1. What is the rate of family planning autonomy among adolescents in Matero?
2. How is the utilization of various family planning services among adolescents in Matero?
3. What are the socioeconomic and demographic factors influencing FP autonomy among adolescents in Matero?

CHAPTER TWO

2.0 LITERATURE REVIEW

This chapter first reviews the literature on adolescents and fertility, then highlight on family planning and adolescents on a global, regional and local perspective and then narrows to the local setting. The chapter further reviews previous studies that have been done on the topic by various scholars. The chapter then concludes by giving the theoretical framework to guide the study.

2.1 Adolescent and fertility

Globally, adolescent fertility rate is high with their birth rate standing at 44 births per 1000 women (Sidibé et al., 2020). Global estimates show that at the age of 17, adolescents girls are 5 times more likely to conceive if they do not use contraceptives compared to those who use contraceptives at their first sexual intercourse (Dombola et al., 2021). Africa faces the highest burden of adolescent fertility with sub-Saharan Africa standing at 101 births per 1000 females (Sidibé et al., 2020; Sserwanja et al., 2022). Due to the heterogeneous nature of the sub-Saharan region, sub-regional variations exist in contraceptive use among young women (Ahinkorah et al., 2020).

2.2 Family planning uptake among adolescent

Family planning uptake among adolescents is generally low, with significant unmet need for contraception. Factors influencing this include individual-level factors like age, education, and income, as well as sociocultural factors like parental disapproval and peer pressure (Makonnen et al., 2022). In Zambia, many adolescents experience poor sexual and reproductive health and rights (SRHR) outcomes, including unintended pregnancies. Evidence indicates that 32% of adolescents aged 15–17 years and 60% of those aged 18–19 years are sexually active with studies indicating that only around 12% of female adolescents in Zambia are using modern contraceptives (WHO & UNFP, 2024).

2.3 Determinants of family planning autonomy among adolescents

A number of studies have explored the determinants of family planning uptake among adolescents. Various studies suggests that modern FP use is influenced by factors such as education level, economic status, attitude toward FP use (Imtishal et al., 2023; Oumeret al., 2020), knowledge of modern FP methods, partner's approval, couple's discussion, male

involvement in FP use decisions, desire for additional children, previous use of con-traception (Asif & Pervaiz, 2019; Kassim & Ndumbaro, 2022; Moon et al., 2021; Mulatu et al., 2020), religious affiliation, low family income, fertility preference, negative perceptions of FP, preference for unproven FP methods, limited access to reliable sources of FP information, household responsibilities, and poor male partner support on FP matters (Akamike et al., 2020; Apanga et al., 2020; Kassim & Ndumbaro, 2022). Indeed, a number of studies have reported different factors that affect adolescent contraceptive uptake in different parts of the globe (Olika et al., 2021; Ketema et al., 2018; Abebe et al., 2020). However, these studies are not consistent in terms of size, scope and geographic coverage. Additionally, varying results were stated across individual studies and these results need to be systematically collated so that easy to inform policies.

In Zambia, a study by Sserwanja et al., (2022) found that the determinants of family planning uptake among adolescents were age and having a child were common determinants of modern contraceptive use in both rural and urban settings. On the other hand, marital status, wealth index, being visited by field health worker, exposure to family planning messages and province were determinants of modern contraceptives use in rural areas but not in urban areas (Sserwanja et al., 2022). However, unlike the present study which seeks to investigate the determinants of family planning autonomy among adolescents in a single setting, the study by Sserwanja et al., (2022) was more of a comparison between the rural and the urban adolescents in this context, therefore, their findings may not be generalized.

2.4 Individual-related determinants

From seven studies that examined determinants of adolescent contraceptive uptake, educational status of adolescents was the main factor influencing the uptake of contraceptives as reported in three studies (Olika et al., 2021; Abebe et al., 2020). Adolescents whose age group is 10 – 15 years (Ketema and Erulkar, 2018), those who are not currently enrolled in school (Abebe et al., 2020), and those from low-income families were less likely to use modern contraceptive methods (Olika et al., 2021).

Other individual characteristics such as one's knowledge of contraceptive use has also been shown to be a significant determinant of family planning autonomy in different populations including adolescents. In a study on rural-urban correlates of modern contraceptives utilization among adolescents by Sserwanja et al., (2023) it was found that having knowledge of contraceptive methods and basic knowledge of SRH, and having heard about contraceptives

from media were individual knowledge related determinants of adolescent contraceptive uptake that were mentioned in three studies, and found to be positively associated with adolescent contraceptive utilization (Sserwanja et al., 2023). However, these studies were done in other countries other than Zambia, therefore, their findings may not apply to the present study setting.

2.6 Healthcare service-related factors

Healthcare service-related reasons that influence the uptake of contraceptives by adolescents were raised in some studies (Habte et al., 2022; Oliko et al., 2021). Lack of information about contraceptives during health facility visits, lack of privacy and inconvenient service hour at health facilities and not visiting health facilities were negatively associated with adolescent contraceptive utilization (Makonnen et al., 2022). Availability of youth clubs and SRH services (Habte et al., 2022; Oliko et al., 2021), inconvenient service hours for SRH, and lack of information about FP were negatively associated with adolescents' contraceptive utilization. Having knowledge of contraceptive methods and basic knowledge of SRH (Habte et al., 2022) and being informed about contraceptives through media (Abebe et al., 2020) were knowledge-related determinants of adolescents' contraceptive uptake that were mentioned in three studies and found to be positively associated with adolescents' contraceptive utilization.

2.5 Socio-cultural related determinants

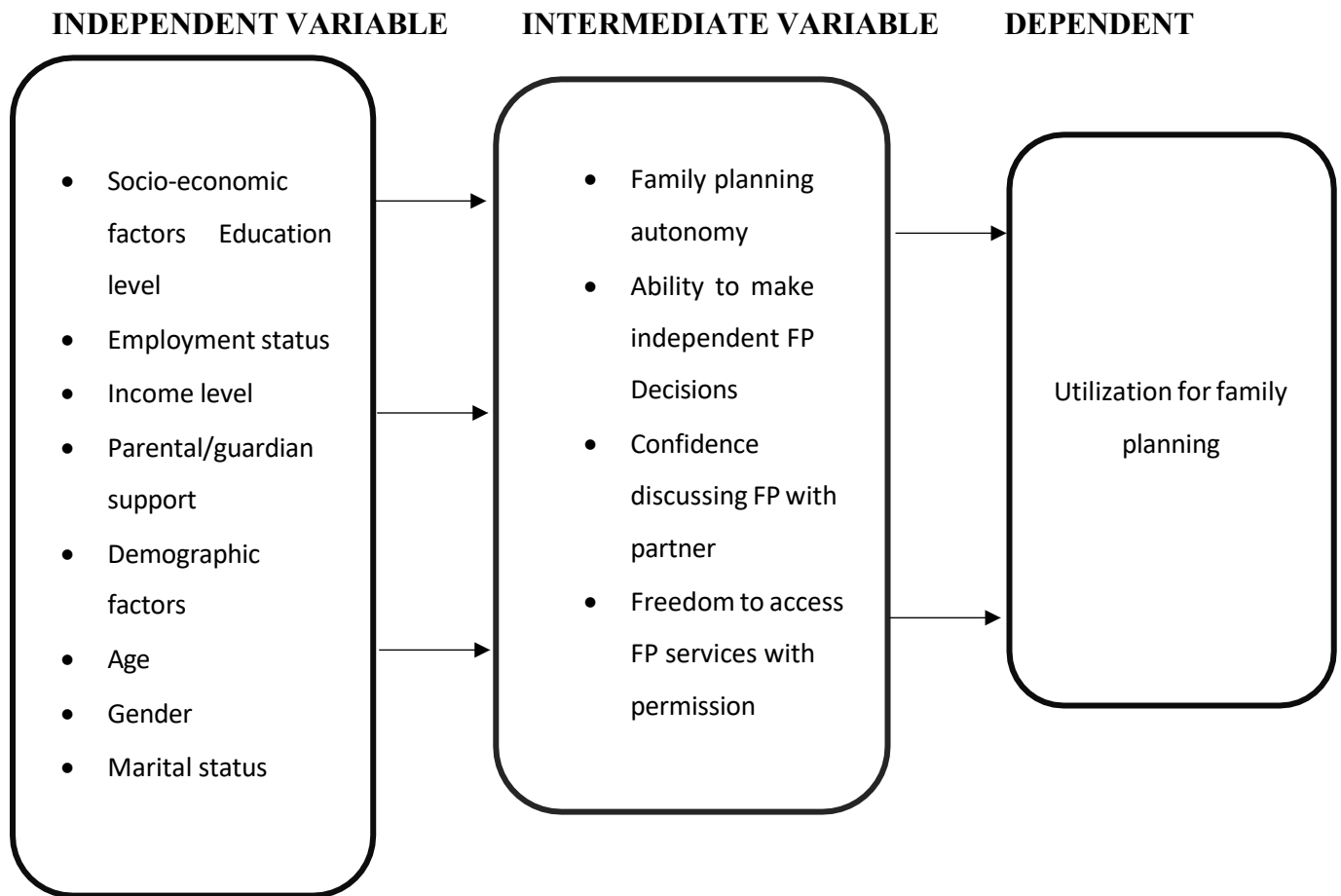
Socio-cultural related factors are the most commonly stated determinants of adolescent contraceptive uptake and are mentioned in six studies (Ketema and Erulkar, 2018; Abebe et al., 2020; Oliko et al., 2021). Discussion with family and relatives, being married (Feleke et al., 2021), arranged marriages and partner approval, parent disapproval and pressure from partners having a partner (Abebe et al., 2020), harmful traditional practices, discussion with peer groups (friends) and with sexual partners and teachers were reported as the most important determinants for adolescent contraceptive uptake (Makonnen et al., 2022). Those who are not currently enrolled in school and those from low-income families were less likely to use modern contraceptive methods (Oliko et al., 2021).

2.6 Theoretical framework

The theoretical framework that will guide this study is the Health Belief model by Davis and Blake (1956) model. The Health Belief Model provides a framework for understanding the

potential influence on an individual's decision to make use of available health services. Although the model provides a framework for understanding factors operating at the individual level to influence the decision to use reproductive health services, it does not examine factors operating beyond the individual level, nor does it include the role of community and health system characteristics in shaping this decision. Thus, previous studies on the use of sexual and reproductive health services focus largely on the barriers and facilitators involved in the decision to seek care, that is, the modifying factors taken into account in the Health Belief Model (Stephenson & Tsui, 2002; Glover et al., 2003). These studies highlighted a range of potential modifying factors in a woman's propensity to seek health care that are broadly categorized as demographic, socio-economic, cultural and health experiences characteristics. Also, previous research (Castro & Juarez, 1994) has only examined how women's roles and status influence their use of contraception and their fertility. However, although young women are seen as beneficiaries of family planning, too little attention has been paid to assessing their behavior in relation to family planning.

CONCEPTUAL FRAMEWORK



Source: compiled by the researcher.2025

CHAPTER THREE

3.0 METHODOLOGY

This chapter sets to describe the techniques and procedures that were used to carry out the study. The chapter gives the location of the study, the research design to be used, the target population, sample size, sampling procedures, data collection techniques and data analysis methods to be applied.

3.1 Study Approach

The study approach to be used was quantitative. This approach uses numerical data and statistical analysis to test hypotheses and relationships between variables.

3.2 Study design

According to Creswell & Creswell (2018), a study design is a structured framework used to guide the research process, outlining methods and procedures for data collection, analysis, and interpretation (Creswell & Creswell, 2018). A case - control community-based cross-sectional study design was used. The advantages of a cross sectional study design is that it is less costly, does not require a lot of time, and data can be collected on a large number of subjects within a given time limit. The case comprised of adolescent girl not utilizing the family planning services while the control comprised of adolescent girls utilizing the family planning services in the study area.

3.3 Study Population/Target Population

The study included all female adolescents reproductive age (14 – 21 years) who live in the selected study site (Matero Township). Both married and unmarried adolescents in this age group who had lived in the study area for at least 1 year were eligible for inclusion. Those who did not give consent were excluded from the study.

3.4 Sample size,

A total 384 participants was calculated as the sample size.

$$\text{Sample size} = \frac{(Z - \text{score}^2) \times \text{StdDev} \times (1 - \text{StdDev})}{\text{Margin of error}^2}$$

$$\frac{(1.96)^2 \times 0.5(0.5)}{}$$

$$0.05^2$$

$$(3.8416 \times .25)$$

$$0.0025$$

$$\underline{0.9604}$$

$$0.0025$$

$$=384.16$$

$$\underline{\underline{= 384}}$$

With a 95% confidence level, a standard deviation of 0.5, and a confidence interval (margin of error) of $\pm 5\%$. However, only 376 questionnaires were completed and subjected to analysis.

3.5 Sampling Procedures

Households with potential participants were identified and approached where household head present were approached for permission to have their subject take part in the study. Using purposive sampling method, adolescent boys and girls aged not above 21 years were identified by the researchers from each household, and were selected to take part with their full consent. The researchers then explained the purpose of the study to the potential participant and when given consent, the researcher proceeded with data collection.

3.6 Data collection methods

A questionnaire, designed to capture individual, household and environmental data was used as the main tool for data collection.

The individual characteristics captured on the participants included Level of education (no education, primary and post primary), age (14, 15, 16, 17, 18 and 19), marital status (married and not married), has a child or children (yes and no), working status (working and not working), exposure to family planning messages on television (TV), radio, mobile phone and newspapers as a composite variable (yes and no), being visited by a field health worker (yes and no), difficulty in seeking permission for getting healthcare (big problem and no big

problem), problems with distance to nearest health facility (big problem and no big problem) and current state of contraceptive use (yes and no).

The household characteristics captured included household wealth index (categorized into quintiles: richest, richer, middle poorer and poorest), area of residence (high, medium and low density), and gender of household head (female and male).

3.6 Data analysis

Data analysis was done using Statistical Package for Social Science (SPSS) version 20. Descriptive statistics were used to analyze the socio-demographic characteristics and the results will be presented in proportions. Inferential statistics comprising the binary logistic regression analysis for determining the predictors of FP utilization were performed. Chi-square tests at 95% confidence interval (CI) was determined to assess the association between the interacting variables. Outcomes $p < .05$ were considered statistically significant.

3.7 Ethical considerations

Ethical approval was sought and obtained from the University of Lusaka Ethics Committee. During data collection, informed consent of the prospective participants was also sought by explaining the objectives of the research to the potential participants so that they willingly give their consent to participate in the study.

Confidentiality of the participants were guaranteed and the participants remained anonymous throughout the study in order for privacy purposes. Also, the researcher ensured maximum confidentiality of the responses from the participants is guaranteed and the collected information will not be used for any other purposes than for what they are intended to be used.

CHAPTER FOUR

4.0 PRESENTATION OF FINDINGS

In this results section, graphical and statistical presentations are used to present major findings from the study. Bar and pie charts are used to depict the results. In addition, statistical tests by chi-square are used to investigate relationships between dependent and independent variables.

4.1. Response rate

4.1.1 Socio-demographic characteristics of the study sample

The following presents the socio-demographic characteristics of participants in the study. The socio-demographic characteristics presented include distribution of participants by age, gender, marital status, level of education attained, distribution of participants by religious affiliation

Table 1: Distribution of participants by age group (n = 376)

Age (Years)	Frequency	Percentage (%)
14 – 16	50	13.3
17 – 19	86	22.9
20 – 21	240	63.8
Total	376	100%

Table 1 shows that 13.3% of the participants in the study were aged between 14 – 16 years, 22.9% were aged between 17 – 19 years and majority 63.8% were aged between 20 – 24 years. The majority 63.8% of the participants aged 20 – 24 years indicates that late adolescence ages of 20 – 24 years are sexually active.

Table 2: Distribution of participants by gender

Gender	Frequency	Percentage (%)
Male	136	36.2
Female	240	63.8
Total	376	100%

The table shows that 36.2% of the participants in the study were male and 63.8% were female. The majority 63.8% female participants indicates that the female adolescents are the most affected gender when it comes to family planning autonomy.

Table 3: Distribution of participants by Level of Education

Level of Education	Frequency	Percentage (%)
None / Primary	36	9.6
Junior secondary	160	42.6
Senior Secondary	120	31.9
College / University	60	15.9
Total	376	100%

The table above shows that 9.6% of the participants in the study had none to primary level of education, 42.6% had junior secondary education, 31.9% had senior secondary education and 15.9 had tertiary level of education. The majority 42.6% of the participants having attained only up to junior secondary education indicates that majority of the adolescents in Matero are school going.

Table 4: Distribution of participants by current occupation

Occupation	Frequency	Percentage (%)
Formally working	54	14.4
Part – time jobs	122	32.4
Business	40	10.6
Jobless	160	42.6
Total	376	100%

The table shows that 14.4% of the participants in the study were formally working, 32.4% in were part-time jobs, 10.6% in business and 42.6% were jobless. The majority 42.6% jobless indicates that most of the adolescents in Matero are dependents.

Table 5: Distribution of participants by role in the community

Age (Years)	Frequency	Percentage (%)
Christians	240	63.8
Muslims	86	22.9
Others	50	13.3
Total	376	100%

Table 1 shows that 63.8% of the participants in the study were Christians, 22.9% were Muslims and 13.3% belonged to other religions. The majority 63.8% of the participants being Christians indicates Christianity is a dominant religion in the area.

4.1.2 Family Planning Autonomy

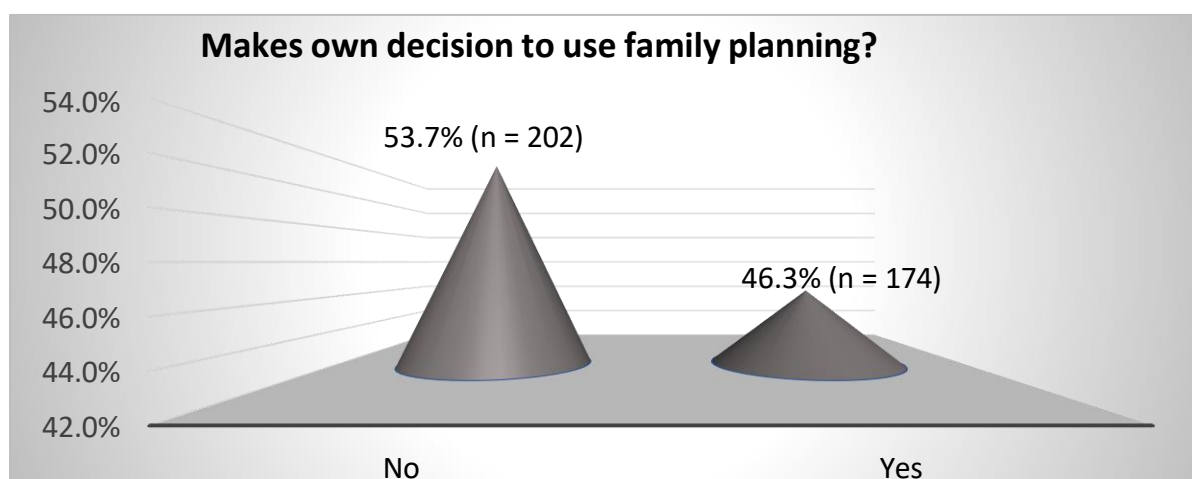


Figure 1: Rate of family planning autonomy among adolescents in Matero township (Source: Field data 2025).

Participants were asked to state whether they make own decisions whether to use family planning or not. From the 376 (100%) that participated, 202 (53.7%) were found to enjoy “family planning autonomy” while 174 (46.3%) were not, making the rate of family planning autonomy among adolescents in Matero township to be 46.3%.

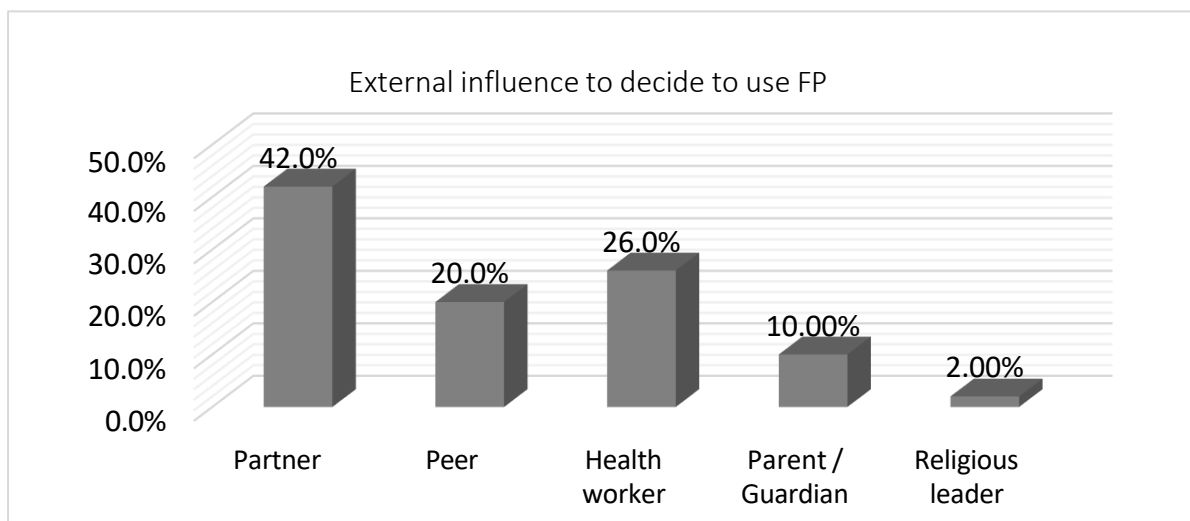


Figure 2: External influence to use FP among participants with no FP autonomy

Participants were asked to indicate who influences them to utilize FP services. The finding shows that 42.0% of the participants were influenced their partner, 20.0% by their peer, 26.0% by their health care provider, 10.0% by their parent / guardian and 2.0% by their religious leaders.

4.1.3 Trends of family planning utilization

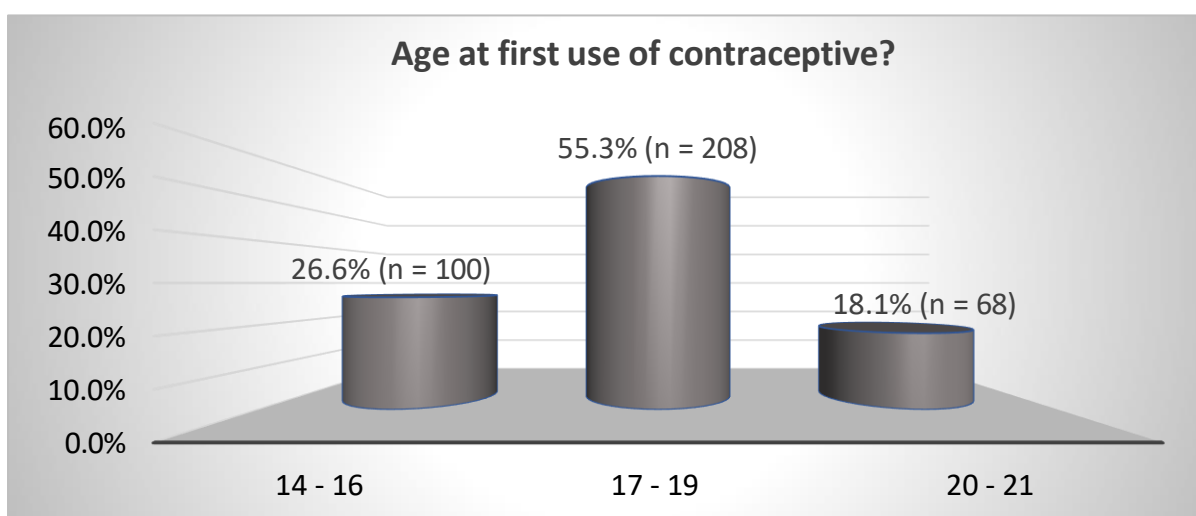


Figure 3: Age at first ever contraceptive use by participants (Source: Field data 2025).

Participants were asked to indicate how old they were when they first ever used a contraceptive. From the 376 (100%) that participated, 100 (26.6%) were found to have been between 14 – 16 years when they first used a contraceptive, 208 (55.3%) were between 17 – 19 years and 68 (18.1%) were aged 20 – 21 years when they first used a contraceptive. This shows that contraceptive use among adolescents usually starts in their late teens.

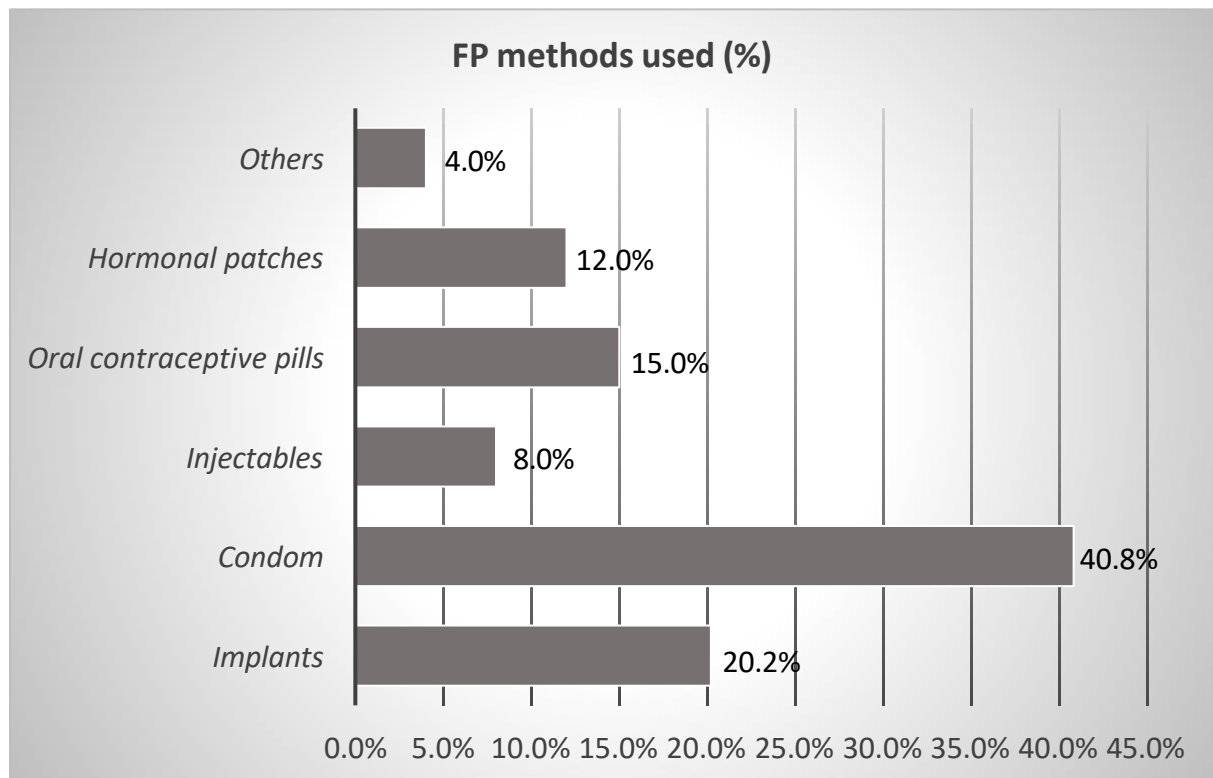


Figure 4: Types of family planning methods used by the adolescents in Matero (Source: Field data 2025).

Participants were asked to indicate what family planning methods they have or were currently using. The finding shows that the most used FP method among adolescents in Matero is condoms (40.8%), followed by implants (20.2%), Oral contraceptive pills (15.0%), hormonal patches (12.0%) and other methods were used by only 4.0%. This shows that condoms, implants and oral contraceptive pills are the common FP methods used by adolescents in Matero.

4.1.4 Determinants of FP autonomy

Table 6: Association between participants' socio-demographic factors and FP autonomy

Variable	Categories	Freq.	FP Autonomy		p-Value
			No n (%)	Yes n (%)	
Age (Years)	14 – 16	50	20 (5.3)	30 (8.0%)	0.022
	17 – 19	86	50 (13.3)	36 (9.6%)	
	20 – 24	240	104 (27.7)	136 (36.2)	
Gender	Female	240	124 (33.0)	116 (30.9)	0.011
	Male	136	50 (13.3)	86 (22.9)	
Level of Education	None / Primary	36	34 (9.0)	02 (0.5)	0.000
	Junior secondary	160	102 (27.1)	58 (15.4)	
	Senior secondary	120	30 (8.0)	90 (23.9)	
	Tertiary	60	08 (2.1)	52 (13.8)	
Marital status	Single	134	104 (27.7)	30 (8.0)	0.021
	Married	70	20 (5.3)	50 (13.3)	
	Divorced / separated	50	40 (10.6)	10 (2.7)	
Occupation	Formally working	54	10 (2.7)	44 (11.7)	0.033
	Part – time jobs	122	52 (13.8)	70 (18.6)	
	Business	40	14 (3.7)	26 (6.9)	
	Jobless	160	98 (26.1)	62 (16.5)	

Chi-square tests were computed to test for the association between the dependent variable (FP autonomy) and the independent variables (age, gender, education, home living arrangement and occupation). The results show that there was a significant association between FP autonomy and age ($P=0.022$), Gender ($p=0.011$), level of education ($p=0.000$), marital status and occupation ($p=0.033$).

Table 7: Association between social factors and FP autonomy among adolescents

Variable	Categories	Freq.	FP Autonomy		P – Value
			No n (%)	No n (%)	
Access to FP services	Yes	154	142 (37.8)	12 (3.2)	0.062
	No	222	32 (8.5)	190 (50.5)	
Lived with a contraceptive user	Yes	198	150 (39.9)	48 (12.8)	0.011
	No	178	24 (6.4)	154 (50.0)	
Presently in a sexual relationship	Yes	100	74 (19.7)	26 (6.9)	0.001
	No	276	150 (39.9)	176 (46.8)	
Has at least 1 child at present	Yes	114	26 (6.9)	88 (23.4)	0.062
	No	262	148 (39.4)	114 (30.0)	

Chi-square tests were computed to test for the association between the dependent variable (FP autonomy) and social factors. The results show that there was a significant association between FP autonomy and access to FP services ($p=0.011$), living with a contraceptive user ($p=0.001$), being in a sexual relationship ($p=0.000$) and having at least 1 child ($p=0.062$) and living arrangement ($p=0.000$).

CHAPTER 5

5.0 DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This chapter discusses the findings of the study. The discussions are mainly based on the findings from the data collected. In addition, the same was equally referenced with secondary information documented on the topic.

5.2 Discussion

This study sought to determine the rate of family planning autonomy, the utilization of family planning services and to determine the socioeconomic and demographic factors influencing FP autonomy among adolescents in Matero.

It was found that majority (53.7%) of the adolescents in Matero had “family planning autonomy”. For participants that were found not to enjoy FP autonomy, the external influences on the utilization of FP services were ones partner (40.0%), their peers (26.0%) and their health care provider (10.0%). This finding agrees with various other studies that family planning uptake among adolescents is influenced by various factors including partner’s approval, (Asif and Pervaiz, 2019) health care provider’s advice (Kassim and Ndumbaro, 2022) and peers (Moon et al., 2021; Mulatu et al., 2020).

On the utilization of different family planning methods used by the adolescents in Matero, it was found that the most used FP method among adolescents in Matero is condoms (40.8%), followed by implants (20.2%), Oral contraceptive pills (15.0%), hormonal patches (12.0%) and other methods were used by only 4.0%. This shows that condoms, implants and oral contraceptive pills are the common FP methods used by adolescents in Matero. The finding confirms what was reported that in Zambia, modern contraception options includes male and female condoms, implants, injectable, oral contraceptive pills, hormonal patches and others (Ministry of Health, 2019).

On the determinants of FP autonomy among adolescents in Matero, it was found from the Chi-square tests computed there was a significant association between FP autonomy and age ($P=0.022$), Gender ($p=0.011$), level of education ($p=0.000$), marital status and occupation ($p=0.033$). Various studies have also explored the determinants of family planning uptake among adolescents with various studies outcomes suggesting that modern FP use is influenced by factors such as education level (Imtishal et al., 2023) gender (Oumeret al., 2020), marital status and occupation (Moon et al., 2021; Mulatu et al., 2020). Being married pressure from

partners having a partner may make an individual to five in to either use or not use the FP services available (Feleke et al., 2021).

On the association between social factors and FP autonomy among adolescents in Matero, it was found from the Chi-square tests computed that there was a significant association between FP autonomy and access to FP services ($p=0.011$), living with a contraceptive user ($p=0.001$), being in a sexual relationship ($p=0.000$) and having at least 1 child ($p=0.062$) and living arrangement ($p=0.000$). Similar findings have also been reported in similar other studies that socio-cultural related factors are the most commonly stated determinants of adolescent contraceptive uptake (Abebe et al., 2020; Olika et al., 2021). Some scholar have further contented that discussion with family and relatives, harmful traditional practices, discussion with peer groups (friends) and with sexual partners are some of the most important determinants for adolescent contraceptive uptake (Makonnen et al., 2022).

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

This chapter concludes the study findings in line with the set objectives. The conclusion is mainly based on the findings from the data analysis as the study sought to determine the rate of family planning autonomy, the utilization of family planning services and to determine the socioeconomic and demographic factors influencing FP autonomy among adolescents in Matero.

6.1 Conclusion

The rate of family planning autonomy among adolescents in Matero was 53.7%, the utilization of different family planning methods used by the adolescents in Matero vary as it was found that the most used FP method among adolescents in Matero is condoms (40.8%), followed by implants (20.2%), Oral contraceptive pills (15.0%) and hormonal patches (12.0%).

The socioeconomic and demographic factors influencing FP autonomy among adolescents in Matero are older adolescent age, female gender, low level of education, being married and occupation while the social factors influencing FP autonomy among adolescents are access to FP services, living with a contraceptive user, being in a sexual relationship and having at least 1 child.

6.2 Recommendation

Further study should be undertaken to assess factors influencing the choice of contraceptives among adolescents in Matero.

APPENDICES

Appendix 1: Questionnaire

SECTION A: Demographic Information

1. Age: _____years
2. Sex:
 - Male
 - Female
 - Other (please specify): _____
3. Marital status:
 - Single
 - Married
 - Divorced/Separated
 - Widowed
4. Educational level:
 - No formal education
 - Primary
 - Secondary
 - Tertiary
5. Religious affiliation:
 - Christian
 - Muslim
 - Other (please specify): _____
6. Ethnic group: _____
7. Household size: _____persons

8. Who do you currently live with?

- Parents
- Guardians
- Alone
- Spouse
- Friends
- Other (specify): _____
-

SECTION B: Socioeconomic Characteristics

9. Are you currently employed?

- Yes
- No

10. If yes, what type of employment?

- Formal
- Informal
- Self-employed

11. Do you receive any form of income/support?

- Yes
- No

12. What is your estimated monthly income (if applicable)?

- Less than k500
- K500–K999
- K1,000–K1,999
- K2,000 or more

13. Who is the main financial provider in your household?

- Self
 - Parent(s)
 - Guardian
 - Spouse/Partner
 - Other: _____
14. Do your parents/guardians support you in making health decisions?
- Yes
 - No
 - Sometimes

SECTION C: Family Planning Autonomy

15. Have you ever made an independent decision about using family planning?
- Yes
 - No
16. Who usually influences your decision on whether to use family planning?
(Check all that apply)
- Self
 - Partner
 - Parent/Guardian
 - Health worker
 - Peers
 - Religious leader
17. Do you feel you have the right to choose whether or not to use family planning?
- Yes
 - No
 - Not sure
18. Are you confident discussing family planning with your partner?
- Yes
 - No

- Not applicable
19. Have you ever been denied family planning services because of your age?
- Yes
 - No
 - Not sure
20. Do you feel free to visit a clinic or health center for family planning services without needing permission?
- Yes
 - No

SECTION D: Utilization of Family Planning Services

21. Have you ever used any family planning method?
- Yes
 - No
22. If yes, which method(s) have you used? (Check all that apply)
- Condoms
 - Pills
 - Injectable
 - Implant
 - Emergency contraceptive
 - Other: _____
23. How often do you use family planning methods?
- Always
 - Sometimes
 - Rarely
 - Never

24. Where do you usually access family planning services?

- Government health center
- Private clinic
- Pharmacy
- NGO
- Other: _____

25. What challenges do you face in accessing family planning services? (Check all that apply)

- Cost
- Distance to health facility
- Stigma or fear of judgment
- Lack of information
- Parental disapproval
- Religious beliefs
- Other: _____

26. Have you received any information about family planning in the last 12 months?

- Yes
- No

27. If yes, where did you get the information from?

- School
- Health worker
- Media (radio, TV, internet)
- Peers
- Other: _____

Appendix 2: WORK PLAN / GANTT CHART

Activities	2025 March	2025 April	2025 May	2025 Aug	2025 Sept	2025 Oct	2025 Nov
Chapter 1							
Chapter 2 Literature Review							
Chapter 3 Methodology							
Proposal Submission							
Data Collection							
Data Analysis and discussion							
Dissertation Writing							
Final Submission							

Appendix 3: BUDGET

The following is going to be the budget for this study

S/N	DESCRIPTION	QTY	UNIT PRICE	TOTAL (ZMK)
1	(Typing and Printing) of Proposal	1	300	300
2.	Ethical letter fee			500
3.	Ream of paper	1	120	120
4.	Transport	-	300	300
5.	Lunch/Refreshments	5	50	250
6.	Pack of pens	1	50	50
7.	(Typing and Printing) of Research final Report	2	300	600
8.	Assistants Allowances	2	100	200
9.	Typing and Printing Questionnaires	384	6	2,304
			GRAND TOTAL	K4,624

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NATIONAL HEALTH RESEARCH AUTHORITY

Lot No. 18961/M, off Kasama Road, Chalala, P.O. Box 30075, LUSAKA
Tell: +260211 250309 | Email: znhrasec@nhra.org.zm | www.nhra.org.zm

NHRA11085/10/10/2025

15th October 2025

The Principal Investigator,
Dorcas chikunda,
University of Lusaka,
Lusaka

Dear Dorcas chikunda,

Re: Request for Authority to Conduct Research

The National Health Research Authority Is in Receipt of Your Request for Authority to Conduct Research Titled **“Beyond Access: unravelling the determinants of family planning autonomy among adolescents in matero, Lusaka”**

I wish to inform you that following submission of your request to the Authority, our review of the same and in view of the ethical clearance, this study has been **approved** on condition that:

1. The relevant Provincial and District Medical Officers where the study is being conducted are fully appraised.
2. Progress updates are provided to NHRA bi-annually from the date of commencement of the study.
3. The final study report is cleared by the NHRA before any publication or dissemination within or outside the country.
4. After clearance for publication or dissemination by the NHRA, the final study report is shared with all relevant Provincial and District Directors of Health where the study was being conducted, University leadership, and all key respondents.

Yours sincerely,

National Health Research Authority

Prof Victor Chalwe,
Director and Chief Executive Officer



UNIVERSITY of LUSAKA

Passion for Quality Education: Our Driving Force

UNIVERSITY OF LUSAKA RESEARCH ETHICS COMMITTEE (UNILUS-REC)

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UNILUS-RESEARCH ETHICS COMMITTEE

Ref no: FWA00033228-1002(08)/(08)/{2024}

Date: 15 August 2025

STUDENT NAME: **Ms. Dorcas Chikunda**

Beyond Access Unraveling the Determinants of Family Planning Autonomy Among Adolescents

The above research was submitted to the research ethics committee for review. The study has no major ethical problems and is approved subject to the following:

1. The study cannot be changed without express permission of the UNILUS research ethics committee.
2. Approval from the necessary authority should be sought.



Professor Kasonde Bowa

MSc(Glasgow),M.Med(UNZA),FRCS(Glasgow),FACS,FCS,DPH(LSTMH),MPH(UCL)

Chairman- UNILUS REC

Professor of Urology and Consultant Urologist

Deputy Vice-Chancellor – Research and Innovation

Executive Dean - School of Medicine and Health Sciences

Dorcas Chikunda
University of Lusaka
School of Medicine and Health Sciences
Email: chikundadorcas@gmail.com
Phone: +260 976 514 644

Date: 28th October, 2025

To:

The ~~Matro~~ ward councillor
Lusaka matero

Kapwepwe ward

Subject: Request for Permission to Conduct Research study

Dear Sir/Madam,

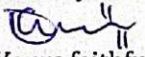
I am writing to request permission to carry out my research in your ward. I am a student at the university of Lusaka , currently conducting a study titled " Beyond Access: unravelling the determinants of family planning autonomy among adolescents in matero, Lusaka"

This study is being undertaken as part of the requirements for the award of a Bachelor of Science in Public Health at the University of Lusaka. The research will involve the collection of quantitative data using structured questionnaires administered to adolescents aged 14–21 years residing in Matero Township.

The purpose of this study is to explore the social, cultural, and economic factors that influence adolescents' autonomy in making family planning decisions. The research will be conducted in accordance with ethical standards, ensuring voluntary participation, informed consent, and confidentiality of all participants.

Your permission and support to conduct this research in your ward will be highly appreciated.

Thank you for your time and consideration.


Yours faithfully,

Dorcas Chikunda
(Student, BSc Public Health)
University of Lusaka
Student ID: BSPH212483285

