UTILIZATION OF YOUTH-FRIENDLY HEALTH SERVICES BY THE YOUTH IN LUSAKA URBAN DISTRICT

BY

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STATEMENT

I hereby certify that this study is entirely the result of my own independent investigation. The various sources to which I am indebted are clearly indicated in the text and in the references.

Signed:.....

CERTIFICATE OF COMPLETION OF DISSERTATION

I Elizabeth Tshabangu Mushimba.....hereby certify that this dissertation is the product of my own work and, in submitting of my MPH program, and further attest that it has not been submitted in part or in whole to another University.

Signature:.....Date: 1st February 2005

I/We: .....having supervised and read this dissertation, am/are satisfied that this is the original work of the author under whose name is being presented. I/We confirm that the work has been completed satisfactorily and is ready for presentation to the examiners.

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APPROVAL

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DECLARATION

I, Mushinda Tshabangu Elizabeth, hereby declare that the work presented in this study for the Masters degree in Public Health is my own original work and has not been presented either wholly or partially for any other degree and is not currently being submitted for any other degree.

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DEDICATION

In remembrance of my two late sisters Evan and Dorothy Tshabangu.

ABSTRACT

Over the last decade, young peoples' health has become a subject of increasing concern throughout the World (Senderwitz, 1995). The needs of the young people are complex, diverse and demand urgent attention. This is all due to the changing patterns of behavior, combined with changing living conditions that have increased health hazards for the young people (WHO, 1992). Young people often know very little and have incorrect information or have heard rumors about sexuality and contraception. The reproductive health risks faced by young people include STIs, HIV/AIDS and unwanted pregnancies often leading to unsafe abortions and its complications (Quyed, 1998). However, insufficient information and unattractive services at the health centers has resulted in young people being reluctant to seek reproductive health services. Thus, making the "Youth Friendly Health Services"(YFHS) more available, accessible and acceptable to the young is a growing challenge for the policy makers, health providers and youths themselves.

Objectives

- To determine the number of health centers providing "youth friendly health services".
- To make a detailed analysis of the services offered at the YFHS corners.
- To determine the utilization rates of the YFHS by the young people (15-24) in both high and low density areas randomly selected in Lusaka urban district over the past four years (1999, 2000, 2001 and 2002)
- To determine the association between availability, accessibility, acceptability and the utilization of YFHS, using the Tanahashi model.

- To describe the youths' perception of the quality of services provided at the various clinics.

Study design

Cross-sectional study was carried out.

Study site

Lusaka Urban District.

Subjects and Sampling

A total of 373 youths (15-24) residing in Lusaka urban for at least the past 6 months or more were randomly selected in the residential areas of the randomly selected 4 zones using the multistage sampling method.

Main outcome measure

Utilization of the "Youth Friendly Health Services" by the youths aged 15-24 years in Lusaka urban district.

Results

The results of the study show that the age groups 15-19 years and 20-24 years were about equally presented. The persons who utilized the YFHS more (60%) tended to be older. Age was significantly associated with the utilization of the YFHS ($p = 0.0151$). The majority (75.3%) of the youths were knowledgeable about the YFHS and most of those who were knowledgeable (68%) did utilize the services. However, 24.1% were not knowledgeable about the services and denied having ever utilized them. On the source of information on YFHS, those who cited school as their source of information were 56% less likely to utilize the YFHS. However, those who cited Peer educators were two times

more likely to utilize these services as compared to those who cited other sources like church, friends, neighbors and cousins.

More than three-quarters (78.0%) had reported having had sexual intercourse 6 months prior to the study and most of these (60.5%) utilized the YFHS. There was a significant association between those with the history of having had sexual intercourse and the utilization of the YFHS ($p = 0.0006$). On multivariate analysis it was revealed that those who gave history of having had sexual intercourse 6 months prior to the survey were 67% more likely to utilize the YFHS as compared to those who had no history of sexual intercourse.

As regards to the availability of the YFHS, at the time of the study was at 95.7% while accessibility was at 66.2% due to the fact that some health centers had no offices and flexible working hours.

As for acceptability and quality of the services most of the youths (93.2%) who utilized the services described the reception given to them by the provider as welcoming, while 77.2% of them described the time spent at the corner with the provider as having had a good time. The study also revealed that more than three quarters (88.1%) said the discussion took place in the office, showing that privacy was observed. However, it is important to provide the peer educators with an office where they can carry out their duties.

Conclusion

The study revealed that youths were sexually active and yet almost one quarter of the respondents had no knowledge of the YFHS resulting in non-utilization of the YFHS. Therefore, there is need to intensify the sensitization of the young people on the YFHS available. This will improve the utilization rate of the YFHS, which in turn will help change the sexual behavior of the youth thus resulting in improved health status of the young people who are the future generation.

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OPERATIONAL DEFINITIONS

1 **Adolescent:** A person (boy or girl) aged between 10-19 years.

2 **Health Center:** Place providing health services including Reproductive health.

3 **Household:** All the people living together in a house and all depending on the same breadwinner

4 **Youth:** Refers to the young person (boy or girl) aged between 15-24 years of age

5 **Youth Friendly Corners:** Place providing reproductive and social health services to young people

6 **Young people:** A person (boy or girl) aged 10-25 years of age

7 **Peer:** One of equal standing with another – belong to the same age, sex, grade and status.

ACRONYMS

1	**AIDS:**	Acquired Immune Deficient Syndrome
2	**CBoH:**	Central Board of Health
3	**CSO:**	Central Statistics Office
4	**DHMT:**	District Health Management Team
5	**HIV:**	Human Immune Virus
6	**MOH:**	Ministry of Health
7	**NGO:**	Non-Governmental Organization
8	**STIs:**	Sexually Transmitted Infections
9	**STD:**	Sexually Transmitted Disease
10	**UNAIDS:**	United Nations Programs on HIV/AIDS
11	**WHO:**	World Health Organization
12	**YFHC:**	Youth Friendly Health Corner
13	**YFHS:**	Youth Friendly Health Services
14	**ZSHS:**	Zambia Sexual and Behavior Survey
15	**ZDHS:**	Zambia Demographic Health Survey

CHAPTER 1

1.0 INTRODUCTION

1.1 Background Information

The health of the young people is a primary element in the long-term development of a country like Zambia. Over the last decades, young peoples' health has become a subject of increasing concern throughout the world (Senderwitz, 1995). The needs of the young people are complex, diverse and demand urgent attention. This is all due to the changing patterns of behavior combined with changing living conditions that have increased health hazards for the young people (WHO, 1992). The consequences of early, unwanted and unprotected sexual activities, unwanted pregnancies sometimes resulting in unsafe abortions, as well as the high risk of Sexually Transmitted Infections (STIs), school dropouts and even deaths are disastrous for the young people, their families and the community at large.

In Zambia, a study by CARE-Participatory Learning Assessment (CARE-PLA, 1996) reported that girls as young as 8 years were already engaging in sexual activities. Urbanization and modernization are giving rise to a new pattern of sexual behavior in adolescents and the youths, including pre-marital sex which often leads to early unwanted pregnancy, induced abortions, STIs and Human-Immune-Deficiency Virus (HIV) infections. Thus, the youth have the right to Reproductive and Social health services. However, youth and adolescents are usually reluctant to use the government health services for a number of reasons. These include discomforts with young peoples' sexuality, providers' judgmental attitudes, lack of confidentiality and inconvenient clinic hours. In the past health services had not paid much attention to the reproductive health

problems affecting the adolescents and the youth and yet the young people are becoming more and more sexually active at younger ages.

The Zambian government through the Health Reforms initiated in 1991 is committed to providing equity of access to cost-effective and quality health care as close to the family as possible (MOH, 1994). This includes the provision of a basic health package for health care, including the free treatment of STIs.

In 1995, the Lusaka Urban Health Management Team (LUDHMT) and Non-Governmental Organizations (NGOs), realized through reforms and the Maternal Screening Project that young peoples' needs were not being adequately met. An assessment study (LUDHMT, 1995) was done which indicated the following factors for non-utilization of the existing health services: long waiting queues, lack of privacy, confidentiality and seats, poor reception, rushed service rendered and cost of health care. Therefore, in the quest to offer quality, easily available, accessible, acceptable, affordable appropriate and equitably distributed health care, the youth NGOs and LUDHMT health staff took up the challenge of providing a "Youth Friendly Health Services" (YFHS). These services have now been extended to Chipata, Ndola and Livingstone. The goal of the YFHS being to; promote positive health seeking behavior among young people by making the existing health services in the communities youth friendly, available and accessible through youth friendly corners.

The YFHS has the following objectives; to create a youth friendly environment at the health centers by advocating for the availability of trained health staff and peer educators to attend to

their fellow young people, to proactively motivate young people in churches, schools and communities to utilize the YFHS, while guaranteeing them privacy and confidentiality, to advocate youth participation in all health and social related activities at all levels, including planning, organizing, implementing, monitoring and evaluation, as well as to encourage community participation and ownership of the service through the involvement of the Neighborhood Health Committees (NHCs).

The activities of the YFHS include the following: basic peer counseling that is, helping someone solve his or her own problem or accept to live with it, STIs and HIV/AIDS as well as contraceptive education, referrals for treatment, for example, for those with STIs, condom promotion and distribution, conducting Focus Group Discussions on reproductive health topics of interest, Information, Education and Communication (IEC) material distribution, conducting participatory games like chess, after which peers discuss a topic on reproductive health.

The general expectation of the YFHS is to increase awareness and change of behavior by youths and adolescents towards the prevention of STIs, HIV/AIDS and abortions in Lusaka and Zambia at large. These YFHS are provided by peer educators and nurses, who have been trained in reproductive health, counseling skills, health education and supplying of condoms. The YFHS are provided at the Government health centers in the Youth Friendly Corners. They are run by DHMT in conjunction with organizations like UNICEF and CARE International Zambia.

1.2 Statement of the problem

The sexual behaviors of adolescents and the youth are changing rapidly in many parts of the World. In many countries, Zambia inclusive, sexual activity among adolescents is increasing. The rise in sexual activity among youths places them at greater risk for reproductive health problems like STIs, including HIV/AIDS and unwanted pregnancies often leading to unsafe abortions and its complications (Quyed, 1998).

Young people often know very little and have incorrect information about fertility and contraception and have heard rumors or have received misleading information about sexuality. The behavior-related health problems encountered by young people in Zambia appear to be similar to the health problems faced by youths and adolescents in other countries, that is, high incidence of STIs and poor access to contraception, (UNICEF, 1996). A study by UNICEF and the National Aids Program (MOH, 1997) found that adolescents make up 40 percent of the STIs clientele in outpatients department of the Government health centers.

Statistics show that 16% of the individuals tested were found to be HIV positive. The proportion of HIV positive rises with age from the level of 5% among 15-19 years to 25% in 20-34 years group before falling to the level of 17% among 45-49years (CSO ,2002).

In 1998, the Zambia Sexual Behavior Survey revealed that 50% of the adolescents did not think that consistent condom use is a way to avoid HIV infection, 17% of young men and 45% of young women did not know sources of condoms. The young people remain under-served through current health service delivery system. Further more, the

adolescents and youth remain excluded even from the guidance on sexuality and relationships within their own home environment. This could be attributed to inadequate training on adolescents' sexual and reproductive health among the health providers as well as culture of our society. Thus most of the young people depend on their peers for information on reproductive health and sexuality.

Why focus on the young people? The young people are the future generation and comprises the larger segment of the population with 606,191 being 16 years and above while 833,210 are 16 years and below out of the total population of 1,439,401 in Lusaka, (CSO, 2000). The young people are the window of hope, force for change and yet the most vulnerable to reproductive ill health. The challenge of providing "Youth Friendly Health Services" is expected to increase and improve information and services to the young people in the district through youth peer educators in the health centers (Webb, 1996).

1.3 Justification of the study

The extent of the utilization of the Youth Friendly Health Services (YFHS) is not known. Studies have been done on reproductive health services without considering each intervention program individually and so leaving YFHS in Lusaka district with inadequate information regarding its utilization and the different factors contributing either positively or negatively. This therefore, suggests the need for such a study so as to identify the gaps in this area that need emphasis and adjustment. This is important because high utilization of the YFHS would greatly improve youth and adolescents'

health. Therefore, this study sought to find out the utilization of the YFHS as well as identify any association with factors like availability, accessibility, acceptability and the quality of care.

The study was mainly done to provide information on the utilization of the YFHS and make recommendations which will be communicated to the health centers of Lusaka Urban District Health Management Team (LUDHMT), Central Board of Health (CBoH), collaborating Non-Governmental Organizations (NGOs), the community and especially the youth themselves. It is hoped that this will be of great use in the designing and re-designing of appropriate strategies that will improve the utilization of these service. It is hoped that this will in turn lead to the reduction of the reproductive and social problems faced by the young people like STIs, HIV/AIDs and unwanted pregnancies.

1.4 Objectives

1.4.1 General objective

To assess the utilization of YFHS by the young people in Lusaka Urban District.

1.4.2 Specific objectives

1. To determine the number of health centers providing the YFHS in Lusaka urban district.
2. To find out services offered at these YFHS corners.
3. To determine the utilization rate of the YFHS by young people (15-24 years) in the areas randomly selected in Lusaka urban district over the past four years.

4. To determine the association between availability, accessibility, acceptability and the utilization of YFHS, (using the Tanahashi model).

5. To describe how the youth perceive the quality of services provided at the various clinics.

1.5 Statement of hypothesis

Inadequate information among the youths on the "YFHS" has led to poor utilization of these services resulting in high prevalence of Reproductive health problems.

1.6 Analytical Framework

Health service coverage is considered as a concept expressing the extent of interaction between the service and the people for whom it is intended, that is, this interaction not being limited to a particular aspect of service provision but ranging over the whole process from resource allocation to achievement of the desired objective (Tanahashi, 1979). This transformation process involves a variety of factors such as, availability of resources, distribution of facilities, supply of logistics and peoples' attitudes to health and health care. Looking at this process from the point of view of service provision, it is possible to identify five important stages that successively lead to a desired health intervention and to define measurements of coverage appropriate to these stages.

1.6.1 First of all, some resources like manpower, facilities and drugs are always required in order to provide a service: The availability of such resources limits the maximum capacity of the service which in turn decides the amount of the service that can be made available to the target population. This coverage is called Availability Coverage.

1.6.2 Even if all the necessary resources are available, the service must be located within reasonable reach of the people who should benefit from it. The number of people who can reach and use it limits the capacity of the service. This coverage is called Accessibility Coverage.

1.6.3 Once the service is accessible, it still needs to be acceptable to the population; otherwise people may not come for it and may even seek alternative care. This "acceptability" may be influenced by such factors as the cost of the service to the user and the form of religion the user follows. The number of people who are willing to use the accessible service limits the service capacity, and the measurement of coverage based on this capacity is defined as Acceptability Coverage.

1.6.4 The next stage in the process of service provision is the actual contact between the service provider and the user. The number of people who have contacted the service is a measurement of service output. The ratio between this and the size of the target population gives a measurement of coverage that may be called Contact Coverage.

1.6.5 The contact between the service provider and the user does not always guarantee a successful intervention related to the user's health problems or an effective service. The number of people who have received satisfactory service is thus another measure of service output as it is called Effectiveness Coverage.

The investigator looked at utilization and decided to use the above theoretical framework to determine if some of the factors could be associated with the utilization of the YFHS in the district.

CHAPTER 2

2.0 LITERATURE REVIEW

2.1 Adolescents and Youth

Many young people (aged 12-24 years) perceive the period of early adulthood with much curiosity. This age group is a period of transition between childhood and adulthood during which the individual assumes his/her position as an active member of the society. It is divided into four overlapping stages; sexual awakening age group 12-15years, first sexual intercourse age group 14-17 years, gender role definition age group 16-19years and social role definition age group 18-24 years (Rwenge, 2000).

2.2 Importance of Youth Friendly Health Services

The youth age group 15-24 years are thus a great concern because with their sexual development, comes the tendency to meet sexual gratification or in search of an identity. This is usually done with inadequate knowledge and sometimes under the influence of drugs and alcohol. Thus many youth engage in unhealthy sexual behaviour which has various socio-economic and health implications for the individual. In many developing nations, the majority of young people become sexually active before the age of 20 (SANASO, 2000).

The future generation who are today's adolescents and youth will not be spared from the HIV/AIDS scourge unless all societies gather courage to develop effective preventive programs aimed at the youth who may be experimenting with sexuality and sexual activities, even selling sex to survive or having sex while under drugs (Diclement, 1984).

Thus, there is need to empower the young people with correct information for them to make accurate and wise choices. Until the young people are given accurate information, in a language they can understand and in a youth friendly manner, which promotes informed and responsible decision making in relation to their sexual health we could expect further increases in the prevalence of STIs among them. Among health problems related to sexuality, AIDS is currently, the main concern of the public authorities in Africa. Its prevalence continues to increase in most of the countries in the region with disastrous psychosocial, demographic and socio-economic repercussions (Rwenge, 2000).

The young people not only need, but have the right to reproductive and social information and services. Young people often find it easier to talk to a friend or someone closer to their age group about sexuality. The training and involvement of young people as peer educators can ensure that programs, information and services are appropriate and relevant to young peoples' concerns. Literature indicates that sexual health education for young people promotes safer practices, helps to delay first sexual intercourse and protects the young. For instance, a study in Philippines showed that though, there was very little impact the condom program helped young ones delay first sex (UNAIDS, 2000).

Sub-Saharan Africa has one of the Worlds' youngest populations. At the beginning of the 21st Century, about one out of every four people was 10-19 years old (Populations Reference Bureau, 2001). This is the largest group of young people over the region to enter adulthood. Helping African youth make a healthy transition to adulthood is critical

to the continent's development and the prosperity of its future population. Thus, making the YFHS available, accessible and acceptable is of great importance, as these services help break the silence, shame and stigma placed on young peoples' reproductive health services. However, the concern is the adolescent's knowledge and accessibility to these appropriate services. It should be noted here that those who are sexually active require interventions and access to a broad scope of reproductive health services, including a range of contraceptives, screening and treatment for STIs and other clinical services (Hughes and McCauley, 1998).

2.3 Accessibility, Availability, Acceptability and Utilization of the YFHS

A study in Senegal revealed that many young people were reluctant to seek individual information or counseling publicly, instead a few secretly requested for condoms by knocking on peer educators' windows at night. The educators believed that young people preferred services outside the neighborhood where privacy and confidentiality were more likely (Allan, 1998).

A study by Kathuria, illustrated the positive effects of the YFHS, in that it showed that peer education is an economical and potential approach in STD/HIV prevention in Zambia (Kathuria, 1994). In Zambia, young people between the ages 10 and 24 years comprise more than one third of the population and are increasingly viewed as a critical age group for targeting health messages and services. In many high STIs and HIV/AIDS prevalence countries, such services are scarce and, even if they exist young people do not know about them. In a recent study on Voluntary Counseling and Testing services in

Kenya, for example, only 11% of interested youth in Nairobi could name a service provider within their communities, more knew that testing (though not necessarily counseling) was available at a large hospital. Current best practice in youth-friendly health services shows that they should be affordable, cater to minors or unmarried adults and offer low-cost or free condoms in an atmosphere that guarantees confidentiality. In many settings, flexible opening hours for young people who work or study, will make a difference to the number of people who use such services. Russia's 'Juventa' medical center in St. Petersburg is a good example of Youth Friendly programming. It provides a range of services including HIV counseling and testing, contraception, and abortions, treatment of STIs, sexual abuse counseling and legal assistance. Consultation and other services are free to people under 18, who make up 96% of those visiting the center (UNAIDS,2002). Regular surveys are made on young peoples' satisfaction with the services and changes are made accordingly. Similar approaches, but in a very different setting, are carried out at the Youth Health Center in the Sychelles. Established with the help of the United Nations Population Fund, the center has been able to involve the young people in most areas of programming, including an extensive peer educator program (UNAIDS, 2002).

Peer education has been adopted by many preventive programs, both for young people and for other groups and is regarded as a key strategy for reaching young people who are not in school as well as those who are in school. Properly designed and implemented peer education projects can change behavior. The *Entre Nous Jeunes* Project in Nkangsamba, Cameroon, runs a peer-educator program to promote preventive behaviors regarding

sexually transmitted infection (STIs) and HIV, particularly among young people who are sexually experienced and in need of reproductive health information. A recent study of the project found that contact with peer-educator was significantly associated with stronger knowledge about contraception and the symptoms of STIs and greater use of contraceptives, including condoms. Without the peer-education, the level of contraceptive use in the community would have been significantly lower. Peer education programs for young people must pay attention to how they present gender issues. A research in South Africa underlined the importance of properly training peer educators and also creating settings in which young people of both sexes can talk openly about sexuality and relationships (UNAIDS, 2002).

In 1988 in the hope of expanding contraceptive choices, the Ethiopian Ministry of Health decided to adopt the WHO strategic approach, beginning with implementation of a nationwide assessment which covered, for example, gender equity, health-care management, quality of care, contraception method mix and adolescent reproductive health. One unexpected finding to emerge from the assessment was the discrepancy between, on one hand, young peoples' familiarity with modern contraception, and on the other, the high levels of unwanted pregnancy and unsafe abortions experienced by them. To account for this, the assessment explored such issues as unsympathetic, privacy and limited service delivery outlets as well as lack of contraception methods even at the so called youth friendly facilities (UNAIDS, 2002).

2.4 Zambian Youth Situation

In Zambia, the crucial issue for the adolescent and youth sexual and reproductive health is not so much of illness but the extremely high incidence rate of HIV and prevailing trends of STIs as stated in the previous section of the statement of the problem. The onset of sexual activity for both girls and boys is very early. The 1996, Zambia Demographic Health Survey (ZDHS), found that the median age at first intercourse was around 16 years for both boys and girls.

Youth constitute an important segment of the Zambian population, approximately 15% of all Zambians are between 13 and 19 years, inclusive while 24% is aged between 15-24 years. Approximately one out of six urban young people aged 15 - 19 of years, 62% of the boys and 50% of the girls say they have had sex. Of the young people who had had sex, 84% did not use a condom the last time they had sex. By the age of 19, only 16% of Zambian youth report that they had never had sex. Among sexually active, never married youth, 24% of boys and 13% of girls reported that they had more than one partner in the past year (ZSBS, 1998). Among the youth 64% of the girls and 70% of the boys thought that they were not at risk of contracting HIV (ZDHS, 1996).

In light of this situation, the Government of the Republic of Zambia (GRZ) has invited all interested stakeholders, NGOs and the young people themselves to implement intervention programs like YFHS, mass media to address youth and HIV/AIDS prevention (Underwood et al, 2001) so as to reduce the prevalence STIs and HIV/AIDs.

CHAPTER 3

3.0 METHODOLOGY

3.1 Variables of interest

3.1.1 Independent Variables

- Providers' attitudes
- Educational level of the youths
- Knowledge on the YFHS among the youths
- Availability of the services
- Accessibility to these services, that is, geographical.
- Acceptability of the services
- Quality of the services that is technical and as perceived by the youths.

3.1.2 Dependent Variable

Utilization of Youth Friendly Health Services.

3.2 Study design

This was a Cross-sectional study. It was both qualitative and quantitative in nature.

3.3 Study setting

The study was done in Lusaka urban district, which is the capital city of Zambia. This was done with the assistance from the Lusaka District Health Management Team (LDHMT). The district was conveniently chosen because it is the pioneer in the implementation of the YFHS intervention in Zambia. The district has 23 public health centers. These are then grouped in 8 zones with their biggest referral hospital being the University Teaching Hospital. The study sample was drawn from the households within the catchment areas of the health centers offering YFHS from the randomly selected 4 zones involving both low and high density areas.

3.4 Study population

The study population was made up of both school and non-school going youths in the age group 15-24 years residing in Lusaka urban selected residential areas, 6 months prior to the survey.

3.5 Sample size

The sample size of 384 youths was selected using the Epi-Info version 6 at 95% confidence level with acceptable frequency 50% and worst acceptable 45% based on the 198,290 households in Lusaka urban district as given by the 2000, Population Housing Census. The use of 50% was mainly due to the fact that the prevalence rate of the utilization of the YFHS was not known. Within each household the eldest youth was interviewed using a Structured Interview Schedule with both open and closed-ended questions. However, where two eldest youths were found and were agemates one was picked at random.

Criteria for selection of the youth

A youth aged between 15-24 years old and residing in the compound for not less than 6 months.

3.6 Sample selection (Multistage sampling)

Multistage sampling was used to select the study units. The district has 23 Health centers offering YFHS. These health centers fall under the 8 zones which cater for 6 to 8 compounds. Using the simple random sampling 4 zones were selected out of the 8 zones. Then the following compounds were selected conveniently, that is two from each zone: Chipata, Mandevu, Kanyama, Makeni, Kamwala, Misisi, Mtendere and Kalingalinga. In each mentioned compound the research assistants went into the center of the compound and chose a direction by spinning a bottle on the ground and choosing the direction the bottleneck indicated. Then going into the direction chosen systematically every Kth varying from 12^{th} to 30^{th} household was selected (depending on the size of the compound) up to the targeted number of households. Then, the eldest youth in the household was interviewed. For this study the final sample collected was 373 giving a non-response rate of 3% due to withdrawals as the consent gave them room do so if they wanted to do so, as well as inadequate funding.

3.7 Data collection and analysis

Data was collected systematically over a period of 6 weeks, that is from 14^{th} May to 27^{th} June 2003 using three trained research assistants. Data collection was done using the structured interview schedule administered to the eldest youth. Focus group discussions were carried out in the remaining four zones. In-depth interviews were conducted for the in-charges of the health centers. In addition a checklist for the YFHS corner or office in the health centers.

The data was then edited for completeness and accuracy. The responses were then pre-coded for easy computer entry and analysis. This data was then analyzed with the use of the Epi-info version 6 statistical tool; calculating frequencies, percentages and testing of significance using chi-square values. The step forward logistic regression analysis was conducted in order to adjust for confounding factors. A p-value of 0.05 or less was considered to be statistically significant.

3.8 Ethical considerations

Permission to conduct the study was sought from the Research Ethics Committee of the University of Zambia, the Directorate of Research and Graduate Studies of the University of Zambia as well as from the Lusaka Urban District Management Health Team. All respondents had the purpose of the study explained to them and gave consent to participate voluntarily in the study.

3.9 Pilot study

A pre-test was done to ensure that questions were clear, concise and consistent. This was done in order to yield reliable and valid data. After pre-test some questions were dropped because they did not answer the objectives.

3.10 Limitations of the study

Some of the questions were sensitive and may have had the interview process result in some respondents withdrawing from the study or not expressing themselves explicitly. Inadequate finances were another constraint as well as inadequate availability of data.

CHAPTER 4

4.0 PRESENTATION OF THE FINDINGS

4.1 Description of the sample

This is a presentation of findings as obtained from the field and is based on the responses from the youth aged 15-24 years who resided in the randomly selected communities of Lusaka urban district for six months prior to the dates of data collection.

The expected sample was 384, however, 373 youths were interviewed giving a response rate of 97.1%. This was due to the fact that some youths declined to continue with the interview as the consent allowed them to do so.

4.2 Table 1 shows that about half (50.4%) of the respondents were aged between 20-24 years and most of them (54.4%) were male. Table 1 also reveals that the majority of these youths (55.9%) had secondary level of education with a large proportion of the participants (91.4%) being Christians.

Table 1: Selected Socio-Demographic Characteristics for the youths interviewed on Utilization of the Youth Friendly Health Services (n=373)

Factor/Characteristic	Frequency	Percent
Age(years)		
15-19	185	49.6
20-24	188	50.4
Sex		
Male	203	54.4
Female	170	45.6
Educational Level		
Primary	153	41.1
Secondary	208	55.9
Higher	12	3.0
Religion		
Christian	341	91.4
Moslem	03	0.8
Not stated	29	7.8

4.3 Analysis of specific variables

Out of the 372 respondents, 290 (78.0%) had sexual intercourse 6 months prior to the current study. Table 2 shows that out of those who had history of sexual intercourse 6 months prior to the study 44.2% of them were boys while 37.8% of them were girls aged 15-19 years.

Table 2: History of sexual intercourse by age and sex (n=272)

Factor/Characteristic	**Male**	**Female**	**X^2 (Uncorrected)**	**P value**
Had sexual intercourse				
Age(years)				
15-19	72(44.2%)	48(37.8%)	1.20	0.274
20-24	91(55.8%)	79(62.2%)		
Total	163(100%)	127(100%)		
Had no sexual intercourse				
Age(years)				
15-19	28(70%)	35(83.3%)	2.05	0.153
20-24	12(30%)	7(16.6%)		
Total	40(100%)	42(100%)		

Table 3: Mode of transport to the nearest YFHS offering clinic (n=373)

Table 3 shows that most of the study subjects (88.5%) walked to the nearest YFHS corner.

Mode of transport	Frequency	Percent
Walk	330	88.5
By bus	27	7.2
Cycling	13	3.5
Not stated	3	0.8
Total	373	100

Table 4: Knowledge on Youth Friendly Health Services (n=373)

Table 4 shows that about three-quarters of the respondents (75.3%) were knowledgeable about the YFHS.

Knowledge on YFHS	Frequency	Percent
Yes	281	75.3
No	90	24.1
Not stated	2	0.6
Total	373	100

Table 5 shows that the major source of information on YFHS was the clinic (48.0%). About a quarter (25.6%) of the respondents sourced the information from Peer educators.

Table 5: Source of information on YFHS (n=281)

Source of information	Frequency	Percent
Clinic	135	48.0
Peer educators	72	25.6
School	40	14.2
Media	13	4.6
Friends	12	4.3
Other	7	2.5
Not stated	2	0.7
Total	281	100

Utilization of YFHS (n=281)

Overall the rate of utilization of YFHS was 51.7%. Among the 281 youth who were knowledgeable about the YFHS, 193(93.3%) indicated that they utilized the services. Table 6 shows that the majority (93.3%) of the youth who utilized the services described the reception by the provider as welcoming.

Table 6: Respondents' perception of the reception by the provider (n=193)

Reception by the provider	Frequency	Percent
Welcoming	180	93.3
Not welcoming	10	2.7
Other(not so bad, not all providers are welcoming)	3	1.9
Total	193	100

Most (88.1%) of the youth who utilized the YFHS said that the discussion with the provider took place in the office (Table 7).

Table 7: Place of discussion with the provider (n=193)

Place of discussion	Frequency	Percent
In the office	170	88.1
Out of the office	15	7.8
Classroom	7	3.6
Youth corner	1	0.5
Total	193	100

Table 8 reveals that more than three-quarters of the study subjects (77.2%) described the time spent with health providers at the YFHS corners as having had a good time.

Table 8: Respondents' description of the time spent with the provider at the YFHS (n=193)

Description of time spent at YFHS	Frequency	Percent
Good time	149	77.2
Too long	27	14.0
Too short	11	5.7
Wasted time	6	3.1
Total	193	100

Table 9 shows that most of the respondents (66.2%) described distance to the nearest YFHS corner/clinic as being near.

Table 9: Distance to the nearest YFHS corner/clinic (n = 373)

Distance to YFHS corner	Frequency	Percent
Near	247	66.2
Far	70	18.8
Very near	8	2.1
Not stated	48	12.9
Total	373	100

Table 10 shows that more than half (56.5%) of the respondents utilized the services for STIs screening and treatment, and just under a quarter (22.8) of the youth utilized antenatal clinic services at the YFHS corner/clinic.

Table 10: Services utilized at the YFHS corner/clinic (n = 193)

Services utilized at YFHS corner	Frequency	Percent
STIs screening and treatment	109	56.5
Antenatal clinic	44	22.8
Collection of IEC materials	6	3.1
Contraceptives and counseling	5	2.6
General counseling	5	2.6
STIs screening and Antenatal	5	2.6
Vedio show	2	1.0
Other	6	3.2
Not stated	11	5.7
Total	193	100

4.4 Factors associated with utilization of YFHS in bivariate analysis.

Table 11 shows that factors associated with utilization of YFHS. Age was significantly associated with utilization of YFHS (p=0.015) and the older youth (20-24 years) were more likely to have utilized the services than the younger youth (15-19 years). However, sex was not associated with the utilization of the YFHS (p=0.098). Level of education too was not associated with the utilization of these services (p=0.144) and there was no association between religion and the utilization of YFHS (p=0.669).

Table 11: Association of socio-demographic factors and utilization of YFHS.

Factor/Characteristic	Utilized n(%)	Not utilized n(%)	X^2	P-value
Age (years) n=281				
15-19	77(59.7)	52(40.3)	8.43	0.003
20-24	116(75.8)	36(24.2)		
Sex (n=281)				
Male	105(64.4)	58(35.6)	2.74	0.098
Female	87(73.7)	31(26.3)		
Level of Education (n=281)				
Primary education	69(62.7)	41(37.3)	3.88	0.144
Secondary education	115(71.0)	47(29.0)		
Higher education	8(88.9)	1(11.1)		
Religion(n=260)				
Christian	173(66.8)	86(32.2)	-	1.000
Moslem	1(100)	-		

Figure1: Knowledge on YFHS by Utilization

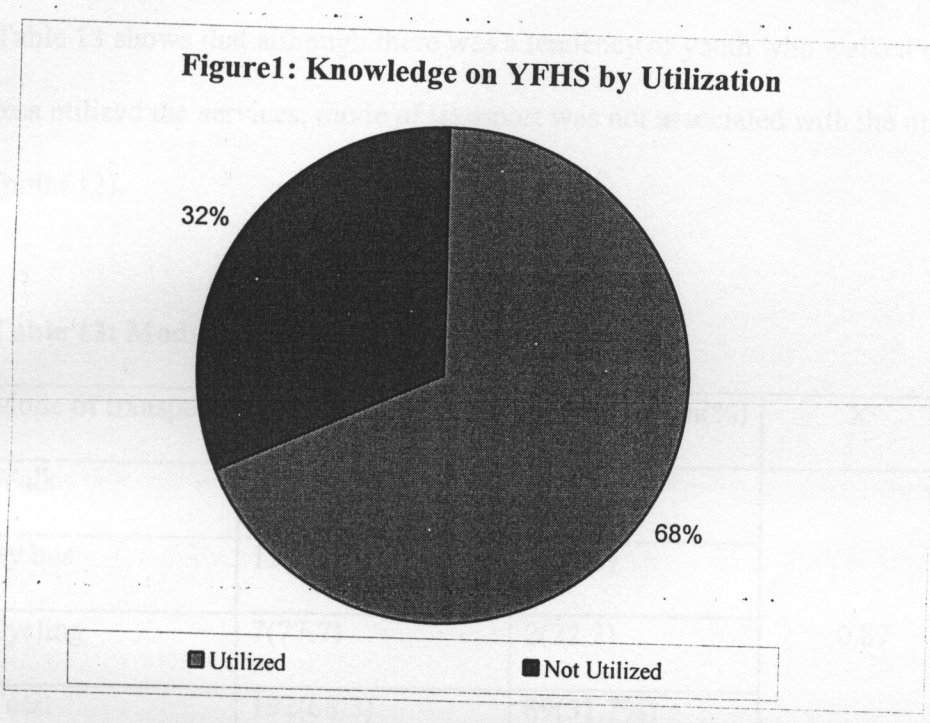


Figure 1, shows that out of 281 respondents who were knowledgeable about the YFHS, the majority of the respondents (68%) did utilize them, with only (32%) not utilizing them despite being knowledgeable about the services.

Table 12, shows that there was an association between the history of having had sexual intercourse and the utilization of the YFHS (p=0.001). The youth that had, had sexual intercourse were more likely to have utilized the YFHS.

Table 12: History of having had sexual intercourse 6 months prior to the YFHS survey 2003, by utilization (n=281)

Had sexual intercourse	Utilized n(%)	Not utilized n(%)	X^2	p-value
Yes	170(88.1)	60(68.2)	16.11	< 0.001
No	23(11.9)	28(31.8)		
Total	193(100)	88(100)		

Table 13 shows that although there was a tendency of youth who walked to YFHS corner to have less utilized the services, mode of transport was not associated with the utilization of the YFHS (p=0.612).

Table 13: Mode of transport by utilization (n=281).

Mode of transport	Utilized n(%)	Not utilized n(%)	X^2	p-value
Walk	177(67.5)	83(32.5)	0.87	0.648
By bus	13(76.5)	4(23.5)		
Cycling	7(77.7)	2(22.2)		
Total	192(68.3)	89(31.7%)		

Table 14 reveals that the major source of information (48.1%), among the users of YFHS was the clinic. Source of information on YFHS was significantly associated with the utilization of the services (p value=0.002).

Table 14: Source of information about YFHS by utilization (n=276).

Source of Information	Utilized n(%)	Not utilized n(%)	X^2	P value
Clinic	91(48.1)	43(49.4)	17.03	0.002
Peer educators	59(31.2)	12(13.8)		
School	19(10.1)	21(24.1)		
Media	10(5.3)	3(3.4)		
Others (Friends, cousins)	10(5.3)	8(9.3)		
Total	189(100)	87(100)		

4.5 Results of the multivariate analysis

All factors (age, history of sexual intercourse and source of information) that were significant on bivariate analysis at 5% were then considered in the multiple logistic regression model to control for any confounding. However, age and its significance was dropped on multivariate analysis as it may have been confounded in the history of sexual intercourse. Thus, the variables considered were the history of sexual intercourse 6 months prior to the survey and the source of information about the YFHS.

Table 15: Results of the multivariate analysis

VARIABLE	OR	(95%CI)
History of sexual intercourse		
Yes	1.77	(1.36, 2.55)
No	1	
Source of Information		
Media	1.61	(0.54, 4.82)
Clinic	0.91	(0.56, 1.48)
School	0.44	(0.24, 0.82)
Peer educator	2.09	(1.12, 3.90)
Others(Friend, church, cousin)	1	

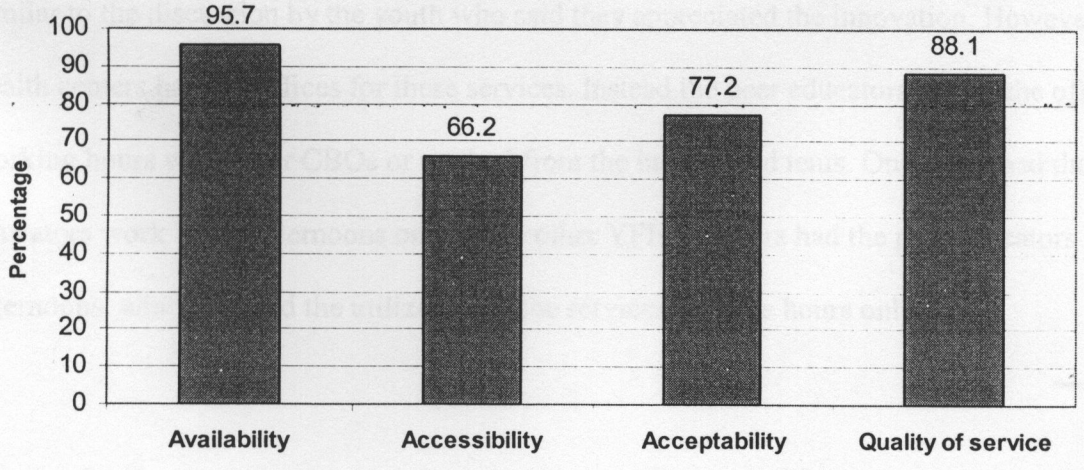
Table 15 shows that respondents who gave history of having had sexual intercourse 6 months prior to the survey were 77% more likely to utilize the Youth Friendly Health Services as compared to those who had no history of sexual intercourse.

On the source of information about the YFHS, those who cited school as their source of information were 56% less likely to utilize the YFHS. However, those who cited Peer educators were two (2) times more likely to utilize these services as compared to those who cited others like friend, church, neighbor and cousin.

Figure 2: Graph on Availability, Accessibility, Acceptability and Quality of YFHS.

Figure 2 shows that availability of the YFHS was at 95.7% and yet accessibility was still at 66.2%.

Figure 2: Graph on Availability, Accessibility, Acceptability,and Quality of YFHS in Lusaka Urban District



4.6 Qualitative Data Results

Focus Group Discussion

The four Focus Group Discussions that comprised of 10 youth of both sex, revealed that some of the youth were aware of the YFHS and the Peer educator. However, they expressed the fact that they preferred attending the YFHS corner in the clinics outside their area for privacy as the issues discussed were very sensitive. During the discussions the youth said they appreciated the innovation though they said sometimes it was difficult for them to access the services as they opened when most of them were either in school or at work. This was made worse by the fact that these YFHS corners never opened on weekends.

The Checklist

The checklist showed that 22 out of 23 health centers were offering the YFHS through established YFHS corners. However, data was not complete due to poor record keeping especially for the years 1999 and 2000 with some improvement in the year 2001 and 2002. From the data available there was some steady increase in the utilization of the services.

In-depth interview with the Health Center-in-charges

This revealed that the innovation of YFHS was well accepted by the young people and this was similar to the discussion by the youth who said they appreciated the innovation. However, not all health centers had the offices for these services. Instead the peer educators shared the office working hours with other CBOs or worked from the improvised tents. One clinic had the peer educators work in the afternoons only while other YFHS corners had the peer educators in the afternoons, which limited the utilization of the services to those hours only.

CHAPTER 5

5.0 DISCUSSION

5.1 Introduction

The study sought to determine the utilization of the "Youth Friendly Health Services" offered by the trained peer educators/counselors and the trained health providers in Lusaka urban district. This chapter now discusses the main findings.

5.2 Demographic characteristics of the youths interviewed

The results of the study show that the age groups 15-19 years and 20-24 years were about equally represented in the sample. The persons who utilized YFHS more tended to be older. Age was significantly associated with the utilization of the YFHS on bivariate analysis. However its significance was dropped on multivariate analysis. It may have been confounded in the history of sexual intercourse.

More than half of the respondents (54.4%) were males and most (64.4%) of these did utilize the YFHS while (45.6%) of these respondents were females of whom 73.7% utilized the services. However, sex was not associated with the utilization of the YFHS.

Most of these respondents (55.9%) had attained secondary level of education followed by those who had attained primary education level (41.1%). However, level of education was not associated with the utilization of the YFHS.

Most of the respondents (91.4%) were Christians and the majority (66.8%) of these Christians did utilize the services despite the fact that this religion does not encourage premarital sex. However, 0.6% of the respondents were Muslim and 100% of them did utilize the service. Religion was not associated with the utilization of the YFHS.

5.3 Proportion of respondents who had sexual intercourse 6 months prior to the YFHS survey 2003.

Majority of the respondents (78.0%) said they had, had sexual intercourse 6 months prior to the survey. Out of these 44.2% of the boys and 37.8% of the girls aged 15-19 years said they had sex. Altogether only 22% of the youth reported no history of having had sex. This showed some improvement as compared to the ZSBS (1998) findings that among 15-19 years, 62% of the boys and 50% of the girls said they had had sex, and only 16% of the Zambian youth reported that they had had no sex. There was a significant association between having had sexual intercourse and the utilization of the YFHS. The common reasons given by the youth for practicing sexual intercourse were as follows: to have children, to express sexual feelings, due to negligence by the parents, to strengthen a relationship and to cope with the modern life style.

On multivariate analysis it was noted that those who had the history of having had sexual intercourse 6 months prior to the survey were 67% more likely to utilize the YFHS than those who had no history of sexual intercourse. Thus the need to sensitize them on the services even before they become active as these services are meant for the young people both those who are sexually active as well as those who are not. In the long run young peoples' reproductive health education programs should be linked into the societal influences on sexual behaviors and not only the physiological aspects. Young people engage in behavior that has been learned in their environment (Webb et al, 1996).

5.4 Knowledge on "Youth Friendly Health Services".

In Zambia, young people in the age group 15-24 years comprise more than one third of the population and are increasingly viewed as a critical age group for targeting health messages and services. In many high STIs and HIV/AIDS prevalence countries such services are scarce and even if they exist young people do not know about them. In a recent study of voluntary counseling and testing services in Kenya, for example, only 11% of the youths in Nairobi could name a service provider within their community (UNAIDS, 2002). However, the present YFHS survey revealed that the majority of the respondents (75.3%) were knowledgeable about the YFHS while 24.1% were not. Those who were not knowledgeable about the services denied having ever utilized them. However, out of those knowledgeable, the majority (68%) did utilize the services. Those knowledgeable about the services cited different sources of information. The current survey revealed that those who cited school as the source of information were 56% less likely to utilize the YFHS. However, those who cited Peer educators were two (2) times more likely to utilize these services as compared to those who cited other sources like church, friends, neighbors and cousins. This tells us the need to have YFHS even in schools so as to make it easy for those in schools to use them.

5.5 Availability, Accessibility, Acceptability and Quality of service of the YFHS

5.5.1 Availability

At the time of the YFHS survey (2003), 95.7%, that is 22 out of the 23 public clinics in Lusaka urban district were providing the services through the trained peer educators with the health center trained health providers. However, the in-depth interview with the clinic in-charges and the checklist revealed that not all health centers had offices for these services. This meant that the peer educators shared offices' working hours with other CBOs or worked from improvised tents. One clinic had the peer educators work in the afternoons only while others worked in the mornings which limited the utilization of the services to those times only. However, most of the centers had the services offered every working day with the shift depending on individual clinic. During FGD the youth expressed the difficulties that they sometimes faced when being referred from one department to another as quite uncomfortable.

However, the providers said they always tried to have both a female and male peer educator on each day as some youth preferred to talk to someone of their own sex. This was in line with the literature references, which said peer education must pay attention to how they present gender issues. A research in South Africa underlined the importance of properly trained peer educators and also creating settings in which young people of both sexes can talk openly about sexuality and relationships (UNAIDS, 2002). Thus the investigator feels it is very important to improve the referral system and availability of the resources that are youth friendly.

5.5.2 Accessibility

Even if all necessary resources are available, the service must be located within reasonable reach of the people who should benefit from it. Among the young people who were interviewed 78.0% of them said they had had sexual intercourse 6 months prior to the YFHS survey. Those who are sexually active require interventions and access to broad scope of reproductive health services, including a range of contraceptives, screening and treatment for STIs and other clinical services (Hughes and McCauley, 1998). The majority (66.2%) of the respondents stated distance to the nearest YFHS corner/clinic as near, with the majority (88.5%) of them saying they walked to these corners. The present study revealed that more than three quarters (89.6%) of those who walked to these centers did utilize the YFHS. Statistically mode of transport to the YFHS was not associated with their utilization. However, during FGD most youths said it was difficult to access these services as they opened when most of them were either in school or at work and these corners were never open on weekends. Thus it was noted that it is important to have flexible opening hours for young people who study and work.

During FGD, the youths said they sometimes preferred visiting a YFHS corner outside their compounds and this made them feel that privacy was better maintained that way as they said the things discussed were very sensitive. Most of them said they would prefer having the peer educators work from their compounds. This finding was similar to the findings of a study done in Senegal which revealed that young people were reluctant to seek individual information or counseling publicly, instead a few secretly requested for condoms by knocking on peer educators' windows at night. The peer educators believed

that young people preferred services outside the neighborhood, where privacy and confidentiality were more likely (Allan, 1998).

The majority (92.2%), of those who utilized the services said they did not pay anything for the services, while 7.8% said they paid something. However, during FGD the youth said they only paid for the book to record of problems and treatment received where necessary and also were asked to buy the prescribed drugs if they were not in stock at the health center. Their request was that the health centers should have most of the drugs, especially drugs for the treatment of STIs. Current best practices in youth-friendly health services show that they should be affordable, cater for minors or unmarried adults and offer low-cost or free condoms in an atmosphere that guarantees confidentiality (UNAIDS, 2002).

5.5.3 Acceptability/Quality of service

The young people not only need but also have a right to quality reproductive information and service. Once the service is accessible, it needs to be acceptable to the population; otherwise people may not use it and may seek alternative care. This acceptability may be influenced by factors like, cost and religion (Tanahashi, 1979). Studies on health seeking behavior patterns in relation to STIs among the youth in Lusaka indicated that 59% of the youth resorted to using government clinics only after first attempting to get treatment from various other sources like traditional healers, private practitioners and street vendors (Webb et al, 1995; Zambezi, 1996). However, this study revealed that most of the youth (93.3%) who utilized the services described the reception given to them by the providers

as welcoming, while 77.2% described the time spent at the YFHS corner as having had a good time. During the FGD the youth said they appreciated the innovation and this was in agreement with the responses from the in-charges. This should be encouraged as it showed some great improvement in comparison to the (LUDHMT, 1995) report that had poor reception as one of the contributing factors to poor utilization of the existing health centers.

The study also revealed that the majority (88.1%) of those who utilized the services said the discussion with the provider took place in the office. This showed that privacy was encouraged. This is very important, as the youth perceived quality of service as maintenance of privacy or confidentiality.

The researcher feels there is still need to intensify the awareness campaigns so as to sensitize the young people about these YFHS. Also need to make youth friendly health services to be more and more accessible and acceptable so as to attract young people to use them.

5.5.4 Utilization of the "Youth Friendly Health Services"

Health service coverage is considered as a concept expressing the extent of interaction between the service and the people for whom it is intended. This interaction not being limited to a particular aspect of service provision ranging over the whole process, from allocation of resources to achievement of desired objective (Tanahashi, 1979). Utilization of any service is dependent on its availability, accessibility, affordability, acceptability

and quality of service. From the 281 youth who were knowledgeable about the YFHS, 193(68.4%) indicated that they utilized the services.

5.5.5 The shortfall in the sample size

Post adhoc using a utilization rate that was found in the study of 51.7% the sample size should have been 383. The study had a sample size of 373, an indication that the level of Confidence achieved by the study was 90%.

The shortfall in the sample was due to the fact that some respondents declined to continue with the interview as the consent allowed them to do so.

CHAPTER 6

6.0 CONCLUSION

The study sought to determine the utilization of the "Youth Friendly health Services" in Lusaka urban district by the youth aged 15-24 years. The results show that the majority of the youth were knowledgeable about the YFHS and two thirds of those who were knowledgeable did utilize the services. Youth with a history of having sexual intercourse were more likely to utilize the YFHS as compared to those with no history of sexual intercourse. On source of information, the youth who cited school as source of information were less likely to utilize the YFHS. However, those who cited peer educators were more likely to utilize the services as compared to those who cited other sources like the church, friend, neighbor and cousin.

As regards to the availability of the YFHS at the time of the study almost all health centers were offering these services with the trained peer educators/counselors. Most of the youth said that they walked to the nearest YFHS corner as these were near. The services received at the YFHS corner were virtually free making them affordable and accessible. Most of the respondents who utilized the YFHS described the reception given to them at the YFHS corner as welcoming and the discussion took place in an office ensuring privacy.

6.1 RECOMMENDATIONS

1. Almost one quarter of the youth who were not knowledgeable of the YFHS did not utilize these services. This shows that the young people need to be knowledgeable about the service for them to utilize them. Thus, there is need to increase sensitization of the young people in the community, schools, churches and any other social gatherings on the YFH services and what they offer. There is also need to advocate for these services to the parents, guardians, teachers and health providers so as to create a conducive environment for the young people to deal with their sexual and reproductive health.
2. There is need to improve accessibility from 66.2% to 95% by having flexible working hours especially over the weekends for the YFHS, that is, when most of the young people are neither at school or at work.
3. The DHMTs need to make sure that the office and essential drugs are available at these centers if they are to be attract young people to utilize the YFHS instead of other sources like the traditional healers and street vendors. This will in turn reduce the number of STIs and HIV/AIDs.
4. There is need to train all health providers on young peoples' reproductive health so as to improve the referral system within different departments and thus improve on the utilization of the services which will result in the reduction of the prevalence of STIs, HIV/AIDs and unwanted pregnancies.
5. Due to poor monitoring and reporting format there is need to review the HMIS to improve on the monitoring and reporting formats so as to categorize youth data and thus be able to measure the extent of the utilization of the YFHS.

6. To reduce gender disparity in the utilization of the YFHS there is need to train more peer educators of both sex so as to encourage the youth of either sex to feel free to attend the YFHS knowing that they will always find someone of their sex to see.

7. Post adhoc using a utilization rate that was found in the study of 51.7% the sample size should have been 383. The study had a sample size of 373, indicating that the confidence achieved by the study was 90% and so there is a need for larger study in order to achieve a better confidence level of 95%.

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APPENDIX I

INTERVIEW SCHEDULE

UTILIZATION OF YOUTH FRIENDLY HEALTH SERVICES

Respondent's Identification No.:.....

Study Location:.....

Interview Date:..... Interviewer:..... (Initials only)

INSTRUCTIONS

1. Always greet and introduce yourself.
2. Explain the purpose of the study and ask for permission to do the interview.
3. Make the respondent sign the consent before you start or use the thumb print for those who cannot sign.
4. Assure the respondent of maximum confidentiality.
5. Explain that the respondents have a choice to participate and the option to withdraw. If the respondent is unwilling to take part, do not force them.
6. Do not write name of respondent on the questionnaire.
7. Write appropriate response in the box or lines provided.
8. Thank the respondent at the end of the interview.

CONSENT FORM

INFORMED CONSENT

Dear Participant,

I am Elizabeth Tshabangu Mushinda a Postgraduate (MPH) student at the University of Zambia, conducting a study on Youth Friendly Health Services (YFHS) and their utilization in Lusaka Urban District. This is mainly to assess how effective these services have been in the prevention of sexually transmitted infections and unwanted pregnancies, which result in pregnancy wastage.

Youth Friendly Health Services are designed to provide basic peer education on reproductive health, counseling, screening and treatment of STIs as well as the supply of contraceptives.

So this is to inform you that I will be collecting information from the youths (15 to 24 years) that are in the reproductive age. The data required from you, is your knowledge about YFHs, whether you utilize them or not, and if you know any reasons why it is difficult or easy to use them.

RISK/BENEFITS

To participate, you will be required to give information through the questionnaire I will give you. This has no risks or disadvantages or harm to you, though you will be required to spend some of your precious time with me.

As for the benefits, there is no direct or monetary benefit to you; however, your participation will help in strengthening your knowledge on these services STIs, HIV and their prevention. This will help in improving the health of the young people and thus a better future for the nation.

CONFIDENTIALITY

All information will be confidential and privacy will be highly maintained. During the interview and we will make sure that you are not identified by anybody, as anonymity will be maintained.

PARTICIPATION

Is voluntary and you are free to withdraw at any stage if you so wish and will not affect the standard of caregiver to you when you attend these YFHs.

ACCEPTABILITY

By now the reasons for the study and its probable implication should be well understood by you. So if you wish to participate in the study, please sign or put the thumbprint.

I ..... hereby called participant understand the guidelines and reasons of this study, and I am willing to be interviewed. I hereby consent to participation.

Signed/Thumbprint..... Date: .....
(Participant)

Signed: ..... Date: .....
(Witness)

1. How old are you? _____

2. Sex: 1. Male 2. Female

3. Place of Residence_____

4. Distance to the nearest YFHS: _____

5. What is your Religion? _____

8. Who do you live with? _____

(i) Parents
(ii) Friends
(iii) Husband/wife
(iv) Boy friend/girl friend
(v) Guardians (Specify)_____

9. How do you get to the YFHS corner/clinic

(a) Walk
(b) By bus
(c) Cycling
(d) Others, specify_____

10. Educational level:

(i) Primary education
(ii) Secondary education
(iii) College/University

11. Do you know of any Youth Friendly Health services?

(i) Yes
(ii) No

12. If yes, where did you hear about these services?

(a) Media
(b) Clinic
(c) School
(d) Peer educator
(e) Others, Specify_____

13. Do you use these services?

(i) Yes ☐
(ii) No ☐

14. If NO, why don't you use them?_____

15. If yes, what services have you utilised?

(i) STIs screening and treatment ☐
(ii) Antenatal clinic ☐
(iii) Contraceptive counselling ☐
(iv) Other, specify_____

16. Did you pay anything for the services

(a) Yes ☐
(b) No ☐

17. How did the provider receive you;

(i) Welcoming ☐
(ii) Not welcoming ☐
(iii) Other, specify_____

18. Did you enjoy the discussions with the provider?

(a) Yes ☐
(b) No ☐

19. If no, why? _____

20. Did the provider allow you to ask questions?

(a) Yes ☐
(b) No ☐

21. If yes, did the provider respond to the questions asked?

(a) Yes ☐
(b) No ☐

19 How was the provider's explanation?

(a) Not clear and difficult to understand
(b) Easy to understand
(c) Do not know

22. Where did you have the discussion with the provider?

(a) Outside the office
(b) In the office
(c) Others, specify _____

21. Did the discussion take place in front of other people?

(a) Yes
(b) No

22. If yes, did this make you feel uncomfortable?

(a) Yes
(b) No

23. How easy was it to get to the YFHS Corner? _____
_____

24. Did you meet people you know us you were trying to get to the YFHS Corner?

(a) Yes
(b) No

25. If yes, what was the relationship?

(c) Neighbour
(d) Relative
(e) Friends
(f) Parents
(g) Others, specify _____

26. From the YFHS Corner were you referred to another department in the health centre?

(a) Yes
(b) No

27. If yes, did the other staff also help you in a friendly way?

(a) Yes
(b) No

28. At the end of the day were you given the assistance you needed?

(a) Yes
(b) No

29. If yes, were you happy with the services?

(a) Yes
(b) No

30. If no, what where you not happy with?

(a) No supplies given
(b) Told to go and buy
(c) Others, specify_____

31. What do you think of the time spent with the provider?

(a) Wasted time
(b) Good time
(c) Too long
(d) Too short

32. Did you get any education or education material on topics like:-

(a) HIV/AIDS
(b) STIs
(c) Sexuality and contraception
(d) Pregnancy
(e) Others, specify_____

33. Have you have had sexual intercourse?

(a) Yes
(b) No

34. Indicate reasons why you are practicing sexual intercourse?

_____

35. How many partners do you have? _____

36. What are your recommendations to the improvement of the YFHS.

_____

_____

_____

THANK YOU FOR PARTICIPATING

APPENDIX II

CHECK LIST

NAME OF NEAREST YOUTH FRIENDLY HEALTH SERVICE:_____

ZONE:_____ DATE:_____

1. When was the youth friendly health service corner established? _____

2. Does the YFHS corner have a peer educator everyday, that is Monday to Friday?

   (a) Yes
   (b) No
   If no, how often is he/she available? _____

3 How many are they_____ Females_____ Males_____

   Check if any time-table or not?_____

4 Attendances per year, 1999, 2000, 2001 and 2002

	Total	Rate
1999	_____	_____
2000	_____	_____
2001	_____	_____
2002	_____	_____

5 Types of reproductive health services did youths and adolescents receive in the last 12 months?

_____

_____

_____

6 Type of services the youths/adolescents mainly come for?

_____

_____

_____

7 Type of services the youths/adolescents do not mainly come for?

_____

_____

_____

8 Observe if they have a record to confirm if the clients are attended to or not when referred to other departments ? _____

- Any register for the YFHS Corner? _____
- How complete are these registers? _____
- Do the YFHS clients have personal files? _____

9 Who utilizes the services more than the other?

(a) Boys/Girls _____
(b) Older youths or youth adolescents? _____
(c) School going or out of school youths? _____
(d) Those aware of the services or those just referred to you without their knowledge? _____
(e) Those from the zonal residential area or those from outside? _____

10 Do you always have enough supplies of materials like condoms, education material etc.

_____

11 How is your relationship as a peer educator with the health center members of staff?

_____

_____

12 Training received by peer educators? _____

_____

13 Is the Peer Educator a resident of the area he is serving or not? _____

14 Observe if sex of the Peer Educator does affect the client flow or not? _____

APPENDIX III
LETTER OF CONCENT

The University o f Zambia
School of Medicine
Department of Community Medicine
PO Box 50110, LUSAKA

2nd April 2003

The Director
Lusaka Urban DHMT
PO Box 50827
LUSKA

UFS: The Head
Department of community Medicine

Dear Sir/Madam

I am a student undertaking a Masters Degree in Public Health at the University of Zambia, School of Medicine. In order to fulfil my requirements for this program, I am supposed to carry out a research study.

I hereby seek permission to carry out a study on "Utilisation of Youth Friendly Health Services in your district.

I would be very grateful if I could be allowed to carry this study.

Thanking you in anticipation of your favourable response.

Yours faithfully

Elizabeth Tshabangu Mushinda
MPH STUDENT

FOCUS GROUP DISCUSSION

Name of the zone: _____ **Date:**_____

Instructions to Moderator:

1. Introduce self and recorder
2. Explain the purpose of the discussion and topic in general
3. Give assurance of confidentiality
4. Encourage participants to discuss subject matter
5. Let participants introduce themselves
6. Rule: Participants should listen to each other, respect each others' opinion if possible, only one person should speak at a time.

UTILIZATION OF YFHS

1. What do you understand by the term youth friendly health services?
2. What youth friendly health services are offered at your nearest health centres.
3. How did you come to know about the YFHS?
4. Have you ever used these YFHS? If yes:
5. What services have you utilised?
6. Where you satisfied with the services offered?
7. If not, why (observe for factors like availability, accessibility, acceptability, appropriateness and quality of care).
8. What are your recommendations towards the improvement of these services?

APPENDIX IV

IN DEPTH INTERVIEW GUIDE FOR MANAGERS OF HEALTH CENTRES

STUDY TOPIC: UTILISATION OF YOUTH FRIENDLY HEALTH SERVICES.

NAME OF FACILITY: _____

PERIOD INTERVIEWED: _____ DATE _____

1. What are Youth Friendly Health Services (YFHS)?
   .....
   .....
   .....

2. What type of services does YFHS offer at this Health Centre?
   .....
   .....
   .....

3. Do these YFHS have a separate office/room to provide their services?
   .....
   .....

4. How do you ensure privacy for the clients?
   .....
   .....
   .....
   .....

5. Do you have trained peer educators working at these corners all the time? And what is the total number these?
   .....
   .....
   .....

6. How many days per week are Youth Friendly Services offered?
   .....
   .....

7. What materials do you have displayed at these YFHS corners?

.....

.....

.....

8. Do these peer educators or health providers working in these corners have any guidelines to follow?

.....

.....

9. How are the clients referred from YFHS corners to other departments like FP, ANC, PNC, STD etc?.....

.....

.....

10. Are there any outreach activities? If yes, what services are provided through this?

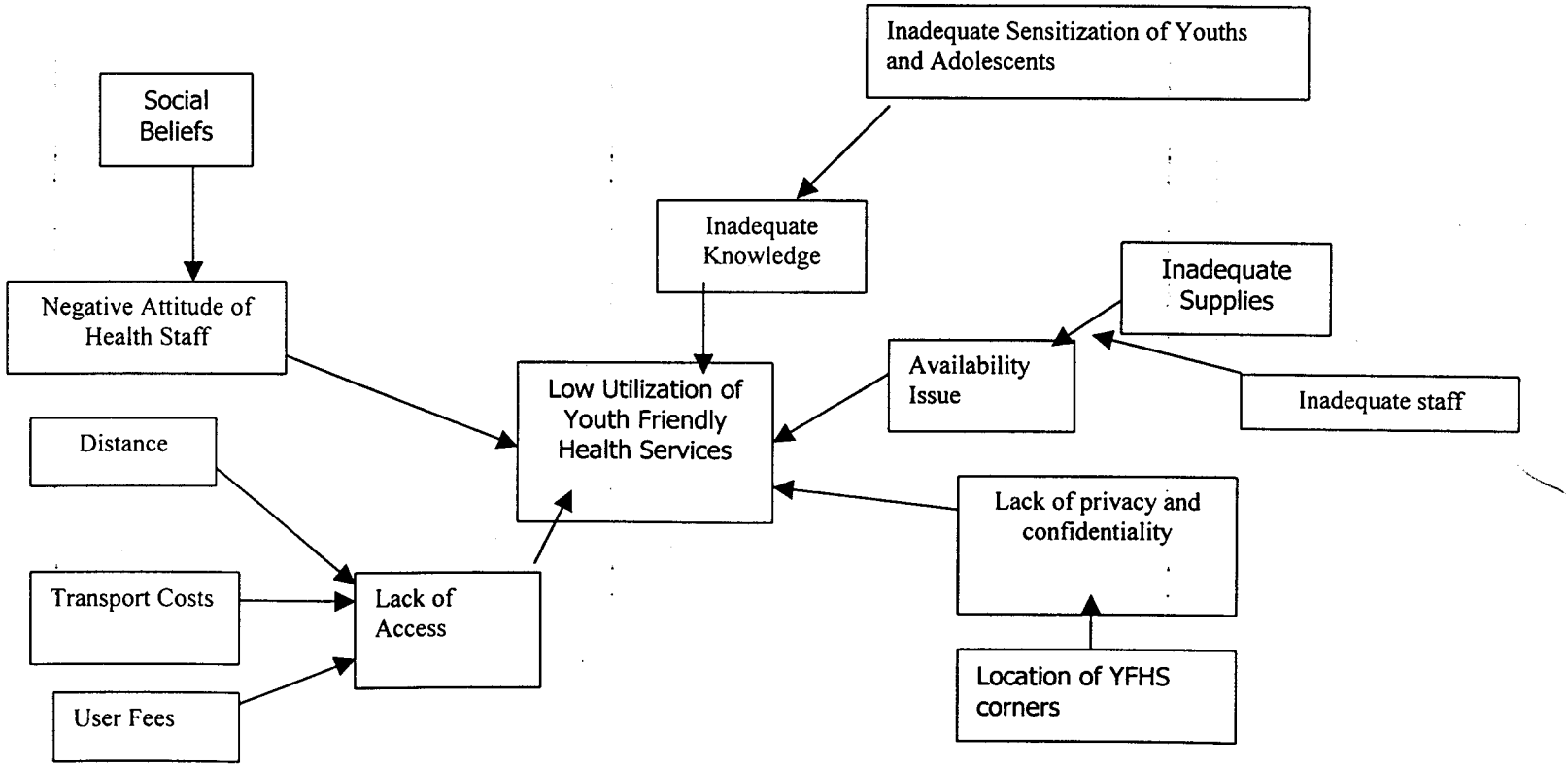
.....

.....

.....

.....

PROBLEM ANALYSIS



APPENDIX IV
LETTER OF CONCENT

The University o f Zambia
School of Medicine
Department of Community Medicine
PO Box 50110, LUSAKA

2nd April 2003

The Director
Lusaka Urban DHMT
PO Box 50827
LUSKA

HEAD COMMUNITY MEDICINE
SCHOOL OF MEDICINE
UNIVERSITY OF ZAMBIA
P.O. BOX 50110, LUSAKA.

UFS: The Head
Department of community Medicine

Dear Sir/Madam

I am a student undertaking a Masters Degree in Public Health at the University of Zambia, School of Medicine. In order to fulfil my requirements for this program, I am supposed to carry out a research study.

I hereby seek permission to carry out a study on "Utilisation of Youth Friendly Health Services in your district.

I would be very grateful if I could be allowed to carry this study.

Thanking you in anticipation of your favourable response.

Yours faithfully

Elizabeth Tshabangu Mushinda
MPH STUDENT

P O Box 50827
Lusaka
Tel: 235554
Fax 236429

In reply please quote
No.....

MINISTRY OF HEALTH
LUSAKA DISTRICT HEALTH MANAGEMENT BOARD

23rd April, 2003

The Head
Department of Community Medicine
UNZA
P.o. Box 50110
LUSAKA

RE: RESEARCH UNDERTAKING – MS ELIZABETH T. MUSHINDA

Be informed that authority has been granted to the above mentioned student to carry out a study on " Utilization of Youth Friendly Health Services in the District".

However this is subject to her presenting a report on the findings to this office for our perusal.

By copy of this letter the Youth Friendly Services Co-ordinator is informed forthwith.

Yours faithfully.

DR. M. KABASO
CLINICAL CARE EXPERT
FOR DISTRICT DIRECTOR OF HEALTH

c.c. Youth friendly services coordinator

THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE

RESEARCH ETHICS COMMITTEE

Telephone: 256067
Telegrams: UNZA, LUSAKA
Telex: UNZALU ZA 44370
Fax: + 260-1-250753

Dean's Office
P.O. Box 50110
Lusaka, Zambia

Assurance No. FWA00000338
IRB00001131 of IOR G0000774

Ref: 007-01-03
26 March 2003

Ms Elizabeth Tshabangu Mushinda
Department of Community Medicine
School of Medicine
University of Zambia
LUSAKA

Dear Ms Mushinda,

RE: SUBMITTED RESEARCH PROPOSAL

The following research proposal was presented to the Research Ethics Committee Meeting on 29 January 2003. where changes were recommended. We would like to acknowledge receipt of the corrected version. The proposal has been approved. Congratulations!

Title of proposal: 'Utilisation of youth friendly Health Services in Lusaka Urban District'

Conditions:

- This approval is based strictly on your submitted proposal. Should there be need for you to modify or change the study design or methodology, you will need to seek clearance from the Research Ethics Committee.
- If you have need for further clarification please consult the Research Ethics Committee. Please note that it is mandatory that you submit a detailed progress report of your study to this committee every six months and a final copy of your report at the end of the study.

Yours sincerely

Prof. J. T. Karashani, M.B., Ch.B, Ph.D
CHAIRMAN
RESEARCH ETHICS COMMITTEE

Date of approval: 26 March, 2003
Date of Expiry: 25 March, 2004
Please note that when your approval expires, you will need to request for renewal. The request should be accompanied by a progress report.

The University of Zambia

DIRECTORATE OF RESEARCH AND GRADUATE STUDIES

Telephone: 290258/291777
Telegrams: UNZA LUSAKA
Telex: UNZALU ZA 44370
Fax: + 260 - 1 - 290258/253952
E-mail DirectorPostgrad@postgrad.unza.zm

P O Box 32379
Lusaka, Zambia

Your Ref:
Our Ref:

7 May 2003

Ms Elizabeth Tsabangu Mushinda
C/O Department of Community Medicine
School of Medicine
UNZA

Dear Ms Mushinda

RE: MASTER OF PUBLIC HEALTH (MPH) RESEARCH PROPOSAL

Your research proposal for the Master of Public Health (MPH) entitled: ***"Utilization of youth friendly Health Services in Lusaka Urban District"*** was presented at the 78th meeting of the Board of Graduate Studies held on 2nd May 2003.

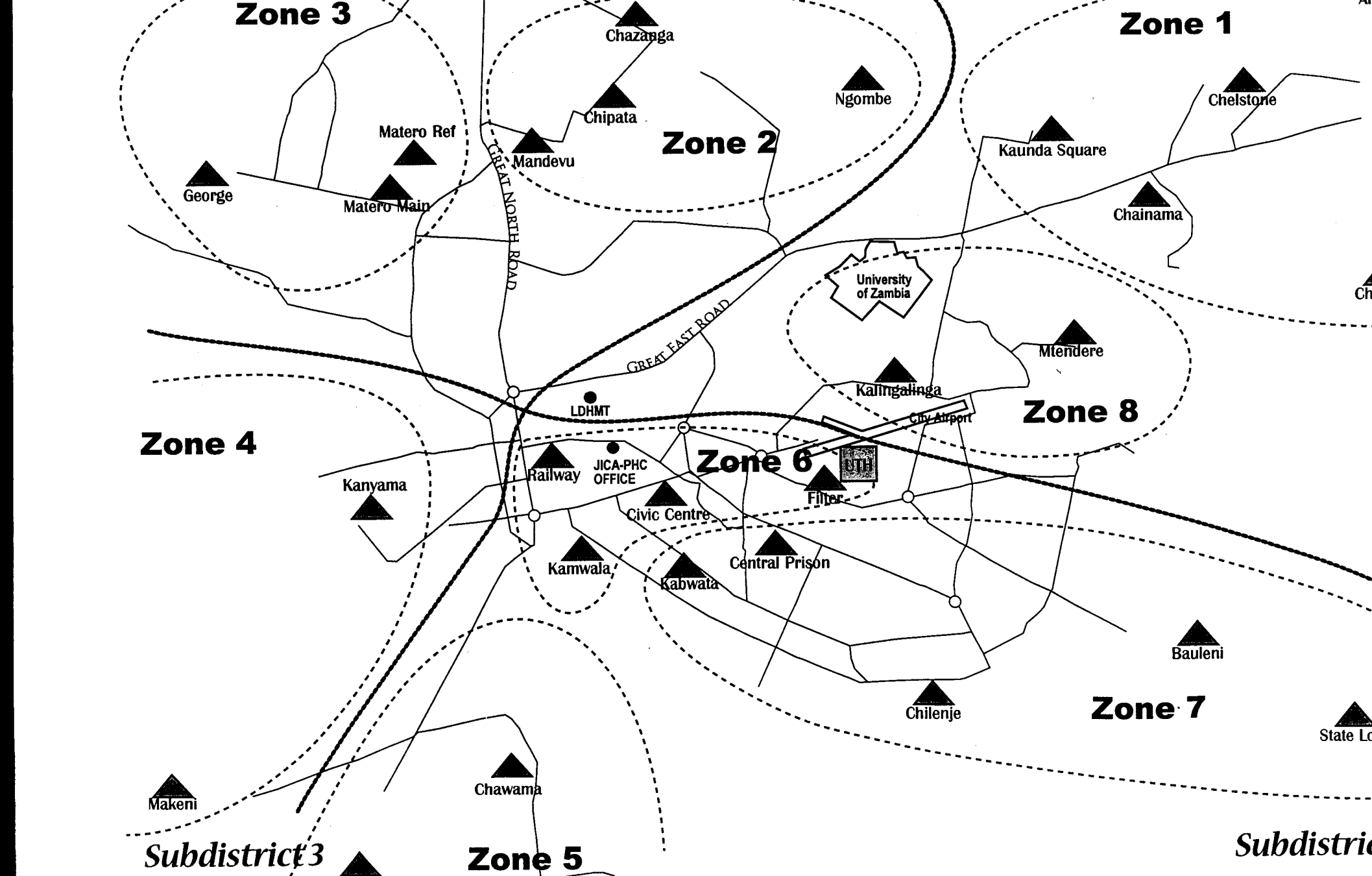
I am pleased to inform you that the proposal was approved by the Board. You can proceed to Part II of the programme and your Supervisor is Dr D. De Coyere and your Co-supervisor is Dr S Nzala.

I wish you every success in your studies.

Yours sincerely

Dr S B Kanyanga
ACTING DIRECTOR

cc Dean, School of Medicine
Head, Department of Community Medicine
Assistant Dean (PG), School of Medicine
Dr D. De Coyere, School of Medicine
Dr S. Nzala, School of Medicine


Zone 3
Zone 1
Zone 2
Zone 4
Zone 6
Zone 8
Zone 7
Zone 5
Chazanga
Ngombe
Chipata
Matero Ref
Mandevu
George
Matero Main
GREAT NORTH ROAD
Chelstone
Kaunda Square
Chainama
University of Zambia
GREAT EAST ROAD
Mtendere
Kalingalinga
LDHMT
City Airport
UTH
Railway
JICA-PHC OFFICE
Filter
Kanyama
Civic Centre
Kamwala
Kabwata
Central Prison
Bauleni
Chilenje
Makeni
Chawama
Subdistrict 3
Subdistric