

## CHAPTER ONE

### INTRODUCTION

“... human sexuality is just as vital. In some ways, in fact, the consequences of skipping maths are less consequential than ignorance about sexuality - the misuse of algebra is not likely to cause an unintended pregnancy...”  
Don Ardell, 2002

#### 1.0 Background

Adolescent Sexual and Reproductive Health (ASRH) has gained increased attention among researchers, public health, gender experts and policy makers over the past decades. Adolescence is a time of rapid growth and development. Major physical, cognitive, emotional, sexual and social changes that affect adolescent behaviour occur during this period. In the recent decades, adolescent pregnancy has become an important health issue in a great number of countries, i.e. in both developed and developing. However, pregnancy in adolescence is by no means a new phenomenon. Contrary to the early development theorists' notion that, adolescents are a relatively healthy group with no major physical illness (Dehne and Riedner, 2005), there is now substantial amounts of literature across the globe indicating that adolescents are faced with unique Safe motherhood (SM) and Reproductive Health (RH) challenges.

Everyday, more than quarter of a million young people become infected with a Sexually Transmitted Disease (STD) or a Sexually Transmitted Infection (STI) and more than half of all new HIV infections occur in young people. Globally, sixty (60) out of every 1,000 adolescent girls give birth each year and many of the pregnancies are unwanted (UN, 2013). Further, up to 4.4 million girls aged 15 to 19 undergo unsafe abortions (WHO, 2009).

The 1994 International Conference on Population and Development (ICPD) marked a paradigm shift by recognising that adolescents have unique special needs and vulnerabilities. Many adolescents increasingly become sexually active before the age of 20 years (Ibid, 2009) and many face difficulties in obtaining Safe motherhood (SM) and Reproductive Health Care (RHC). Also adolescents are typically poorly informed about how to protect themselves from pregnancies and Sexually Transmitted Diseases (STDs). In large regions of the world (for example, South Asia, the Middle East and North Africa), age at marriage has traditionally been low in kinship-based societies and economies. In such cases, most girls get married soon

after menarche, fertility was high, and consequently many children were born from adolescent mothers (UNFPA, 2013). Two key events during adolescence have strongly influenced the increase in teen pregnancy. The first is the changing age at menarche, with median age varying substantially among populations (ranging from about 12.5 years in contemporary Western countries to more than 15 years in poor developing countries. The second key event is increased schooling. Adolescents are less dependent on parents and family and this growing independence from parents and families, has in recent decades led to more pre-marital sexual relations and increasing numbers of adolescent pregnancies (Ibid, 2013).

Zambia is among the top five countries affected with high rates of teenage pregnancies in sub-Saharan Africa (*The Nation Newspaper*, 2013). Statistics in Zambia indicate that 13,634 teenage pregnancies were recorded in basic schools and 1,863 in secondary schools in the year 2009 (*Ibid*, 2013). It is also estimated that 28% of young females aged 15 to 19 years have begun child bearing, 22% have had a child, while 6% are pregnant with their first child (UN, 2013). With this background, it is clear that; overall, the numbers of teenage pregnancies have been increasing despite the efforts being put in place to curb the occurrence (*Ibid*, 2013).

Another study by Malibata in 1994, found out that out of fifty-one (51) boys and forty-nine (49) girls in secondary schools in Lusaka, half of both sexes 62 per cent for boys and 40 per cent for girls were involved in penetrating sexual intercourse. Thus, adolescents were more vulnerable to rape, harassment and sexual exploitation and physical and verbal abuse because they were less able to prevent or stop such manifestations of power (UNFPA, 2013). Government has also intensified awareness-raising campaigns to curb teenage pregnancies and early child marriages and has trained health staff in long-term family planning methods (Musonda, 2008).

In Musonda's study revealed that providing information and services to adolescents results in their improved health. Despite this, lack of adolescent-gender specific services has made it difficult for adolescents to access and utilise SM and RHS. Sexuality is considered a sacred topic that is not to be talked about freely. Many parents do not give their children sexuality information (Tolosi, 2004).

Researchers have explored the need to provide adolescent-friendly sexual, SM and RHS to curtail adolescents exposure to sexual health risks of unintended pregnancies, sexually transmitted infections (STIs) including HIV and AIDS, and early sexual debut (McIntyre, 2002; Dehne and Riedner, 2005). The ICPD (1994) highlighted the vulnerabilities of adolescence and called for greater recognition of adolescents as a special category with special needs. It emphasised the need to provide adolescents with SM and sexual and reproductive health information and services and for adoption of integrated and comprehensive approaches to reproductive health. Additionally, the ICPD underscored the need to remove social barriers that hinder adolescents' access to SM and RHS, and to modify policies and programmes to meet the demographic realities of the 21st century (Germain, 2000).

Thirty-eight of the participating countries from sub-Saharan Africa, Zambia included, committed themselves to a Programme of Action aimed at providing adolescents with sexual and reproductive health education, information and services. This, it was hoped, would help adolescents to understand their sexuality and protect themselves from sexual health risks (United Nations, 2005).

It is now twenty years after the endorsement of the noble call by ICPD and Zambia's commitment to the Programme of Action, adolescents in Zambia still lag behind in providing total adequate access to SM, sexual and RHS (MoH, 2009). Also, despite evidence that adolescents face sexual health risks, the perception of healthy adolescents persists. Adolescents globally access health services less frequently than expected and are more likely to seek services after sexual exposure (Hocklong et al., 2003).

Although adolescents both in the developed and developing countries face challenges in accessing SM and RHS, there exists regional differences with adolescents in developing countries facing greater challenges. Although currently, there is substantial literature about adolescent-friendly services in Zambia now even across Africa and world over, few studies have looked at the factors determining the extent to which adolescents access and fully utilise existing SM and RHS offered by government. In Zambia, SM and RHS provided by the government are offered within the Maternal and Child Health and Family Planning (MCH/FP) programmes. This makes adolescents to shy away from using the services, preferring instead to seek care from private service providers. The private sector services are expensive for adolescents who have no financial support. In context of this study, adolescent

health, gender concerns and sexuality is a global phenomenon. However, the response to efforts and interventions aimed at addressing adolescent SM and reproductive health challenges have not been applied similarly in all regions and countries. Thus, the goals of ICPD are yet to be realised fully in the days to come.

It is for this reason that the study sought to examine the factors that influence adolescents' access and use of SM and RHS in selected clinics in Lusaka urban. Specifically, the study explored whether adolescents have unique and specific-gender sexual health needs that require them to seek SM and RHS pre-exposed as opposed to post-exposed services. Additionally, the study sought to understand whether there exists SM and RHS that adolescents can use to meet their sexual and reproductive health needs, whether they access and use the services, and the challenges they encounter in so doing. Finally, suggestions for addressing identified challenges were explored to come up with policy recommendations aimed at enhancing access and utilisation of SM and RHS by the stakeholders.

### **1.1 Statement of the Problem**

Adolescent sexuality remains a global challenge particularly in developing countries such as Zambia. Although adolescents share many characteristics with adults, their health related problems and needs are different. WHO (2009), observes that although most adolescents become sexually active before the age of 20 years, the sexual contacts are generally unprotected. Adding to this challenge is the sheer magnitude of the numbers. About half of the world's population is under the age of 25 and one in every five people in the world is an adolescent (UNFPA, 2005; WHO, 2009). About 85 per cent of adolescents live in developing countries and the remainder in the industrialised countries (WHO, 2009; Dehne and Riedner, 2005). Sixteen per cent of adolescents living in developing countries live in Africa (WHO, 2009). Sexual activity among young people is not always consented and this exposes them to greater risks.

In Zambia, provision of SM and RHS for adolescents is controversial. As a result, adolescents have little knowledge about SM and reproductive health matters relating to their bodies. Consequently, they depend on their peers for information. These peers are also ill informed and have myths about sexuality. The myths are untrue and have contributed to the increase in unwanted pregnancies, consequent abortions and school dropouts as well as a rise in STIs including HIV and AIDS among adolescents. Adolescents thus, rely mainly on themselves and other ill informed sources for guidance and information on where to seek RHC and services. Although government STI and family planning programmes offer SM and

RHS in public health facilities, ethical, institutional and structural problems create access barriers to these services.

Whereas health facilities are located in open areas and public places where they can be easily accessed, this does not translate into effective use by adolescents who need the services. The highlighted challenges, inadequacies and gaps point towards the need to develop clearer policies to address adolescent SM and reproductive health problems.

Consequently, the principal purpose of this study was to fill this research gap and contribute to existing literature by investigating factors that influence adolescents' access and use of (SM and RHS) in Lusaka urban since no study has been done to this effect from the time programmes were implemented in 1994. There is need to therefore look for information that would lead to the improvement of SM and RHS.

## **1.2 Rationale of the Study**

This study was necessitated by a number of factors. The study had the potential to generate empirical data about available SM and RHS for adolescents in Lusaka urban. There is no existing data about adolescent health and gender-specific services in health centres in Lusaka urban and the rate of utilisation of SM and RHS by adolescents. This study was expected to fill the information gap and contribute to the current adolescent health and sexuality literature. The study focused on adolescents who were still in the formative stage of the life span and were vulnerable to risky behaviour that could affect their present and future reproductive health. Focusing on the factors that affected adolescents' access and utilisation of SM and RHS in Lusaka urban, the study promised to enhance measures to reduce the sexual health risks such as STIs and STDs, unwanted pregnancies and consequently maternal death facing female adolescents. In addition, the study promised to generate knowledge that was useful for policy formulation and to identify potential areas of intervention in order to ensure better access, utilisation and provision of SM and RHS for adolescents in Lusaka. It was expected to generally contribute towards the assessment of existing reproductive health policies for adolescents and the extent to which the policies affected the access and use of SM and RHS by adolescents in health centres in Zambia. This research could go a long way towards resolving and addressing gaps in policy and practice. Lastly, the study attempted to provide a better understanding of the challenges that adolescent faced in accessing and utilising SM and RHS in Lusaka urban. The study intended to provide a theoretical gender focus in understanding the factors affecting adolescents' access and use of SM and RHS in Lusaka urban clinics.

To achieve this, the study sought to answer the following research objectives and questions and achieve the set objectives;

### **1.3 Objectives of the Study**

The main objective of this study was to investigate the factors influencing access and utilisation of (SM and RHS) by adolescents in selected clinics in Lusaka urban. The specific objectives were to;

1. Examine the existing SM and RHS for adolescents in selected clinics in Lusaka district.
2. Examine the barriers and challenges that adolescents in Lusaka urban face in accessing and utilising SM and RHS.
3. Develop better ways of addressing the barriers and challenges faced by adolescents to foster increased access and use of SM and RHS among adolescents in Lusaka and in Zambia at large.

### **1.4 Research Questions**

1. What are the existing SM and RHS for adolescents in selected clinics in Lusaka district?
2. What barriers and challenges do adolescents in Lusaka urban face while accessing and utilising safe motherhood and reproductive health services?
3. In what ways can the identified barriers and challenges be addressed to improve access and utilisation of SM and RHS by adolescents in clinics in Lusaka district?

### **1.5 Definition of Terms**

Accessibility refers to the characteristics of the health service that facilities use by the potential clients. Access to quality maternity care is said to be imperative. Dever (1984) described the determinants of accessibility as follows:-

- a) **Geographical Accessibility** – the geographical accessibility relates to the location of health care facilities to that of the client. This is measured in kilometres, travel time or travel cost. In addition, the hours of obstetricians and health care providers spend to operate the facility or the time the facility remains open also influences the ability of clients to obtain care.
- b) **Affordability of Care** – this involves the cost of services and clients' ability to pay. Dever further stated that when economic barriers are removed, lower income groups considerably increase their accessibility to care. The explosive cost in the health care has disproportionately serious effects for the poor women or family who have never had access to adequate basic services. As stated in the report, prospects for sustainable human development in Zambia (1996), poverty affected females more than it did

males. Women and girl children faced significant disadvantages as a result of their gender.

- c) **Acceptability of Care** – this relates to the attitudes of both the client and the health providers. Clients may be unwilling to use available services because of the providers' attitudes or other related issues.

**2. Adolescent-** UNFPA (2011) identifies an adolescent as a person who is between childhood and before adulthood, from ages 13-19 years.

**3. Gender** – refers to a theoretical construct in the humanities and social sciences that refer to a set of social and behavioural norms that, within a specific culture are widely considered to be socially appropriate for individuals of a specific sex. It usually refers to a set of characteristics that are either seen to distinguish between male and female, one's biological sex and one's gender identity (Holmes, 2008).

**4. Safe motherhood** – is creating the circumstances within which a woman is enabled to choose whether she will become pregnant and if she does, ensuring she receives care for prevention and treatment of pregnancy complications, has access to trained birth assistance, has access to emergency obstetric care if she needed it and care after birth, so that she can avoid death or disability from complications of pregnancy and child birth (Feuerstein, 1993). The growing concern for women during pregnancy and child birth led to safe motherhood initiatives. Safe motherhood initiative when it was implemented, it was hoped it would improve the health of women and reduce mortality and morbidity. The four pillars of safe motherhood as stated by the World Health Organisation in mother and baby package (2010) are:

- (a) Family planning services for clients to plan and space pregnancies;
- (b) Antenatal care to prevent and detect complications early and treat appropriately;
- (c) To provide clean/safe deliveries by skilled attendants and adequate equipment and supplies to care for the mother and baby; and
- (d) And lastly access women to emergency obstetric care for high risk pregnancies and complications when needed.

Care of the new born child is basic to safe motherhood. The health depends to a large extent on the health of the mother during pregnancy and delivery. For the sake of the study, the

concept of SM is a broad concept and therefore the researcher only used antenatal adolescent clients for a more defined perspective.

**5. Reproductive Health Services** – reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system (ICPD, 1994).

**6. Utilisation** – put into service; make to work or to employ for a particular purpose or for its inherent or natural purpose (Oxford dictionary, 2014).

## **1.6 Structure of the Dissertation**

This dissertation is divided into six chapters. Chapter One introduces the background to the study, the statement of the problem, rationale of the study, the objectives of the study, research questions, and definition of key terms. Chapter Two reviews the literature related to the study. Chapter Three provides the research methodology which indicates the research strategy and design, sources of data, sampling procedures, sample size and characteristics of the study sites and participants and data analysis. Chapter Four presents an analysis and discussion of the findings of the study. Chapter Five considers the findings of the study based on the research questions to clearly show what the research outputs are in relation to the problem experienced from the onset. Chapter Six outlines the recommendations of the research findings as well as the research policy implications based on the findings.



## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.0 Introduction**

Literature review is a key step in the research process and refers to an extensive, exhaustive and systematic examination of publications relevant to the research project (Basavanthapa, 2007). In this study, literature was reviewed for the following reasons:

- (i) To investigate or examine what exists on the subject and determine the strength and weaknesses of the appropriate scholarly publications;
- (ii) To show the gaps in knowledge in order to generate questions for this inquiry; and
- (iii) To familiarise with methods of enquiry in earlier works including their success and shortcomings (Basavanthapa, 2007) in order to select the method appropriate for this study.

The literature review therefore, is thematised to show what is in practice on the subject. This section presents a review of literature on the general overview and history of adolescence, SM, adolescents' access and attitude to RHS in health centres. In general, this Chapter is based on SM and adolescent RHS and studies conducted in various countries including Zambia. Apart from this, issues of adolescent development stages as well as those related to adolescent sexuality and the relate traditions, practices and beliefs will also be discussed. Teenage pregnancy and child birth are associated with early biological maturity, early and activity in the absence of adequate and correct knowledge of their reproductive biology as well as each of SM/maternal and child health information.

The main issues that emerge from the literature review include basically these related broad categories; Adolescent, sexual practices, consequences of unwanted pregnancies, adolescent and reproduction health problems, adolescent and conception attitude of health care providers and adolescent utilisation of health services.

#### **2.1 The Adolescent Stage: A General Overview and History of Adolescence**

Adolescence entails a transformation of aspects of mental, physical, psychological and social organisation of one's life. Josselyn (1962), has stated that the changes that occur at puberty cause many young people to perceive the world afresh, more critically, more independently, through their own eyes, rather than the eyes of those who have nurtured them. Therefore, opportunities for social initiation and education at this stage need to be very rich and varied.

Kings (1986) reiterated that many adolescents learn about themselves by experimenting with their sexual feelings and because of this, many long-held assumptions about behaviour, many well-tried habits and customs are subject to scrutiny and are sometimes completely discarded (Ibid: 1986:22). Because adults and society begin to make new demands on them by expecting them to take up new roles and assume new responsibilities, many researchers see the years between adolescence and young adulthood as a period of considerable stress and emotional turbulence (Rayner et al., 1972).

## **2.2 Theories and Gender Perspectives of Adolescents**

This part contains the theoretical framework of the study. Adolescent health and sexuality theories that guide this study are discussed.

**Life Span Developmental Theory:** In this theory, several approaches are discussed. These include the historical perspective on the origin of adolescence, the biological or problem based notion of adolescence, the notion of healthy adolescence and the contemporary theorist's notion. The social exclusion paradigm is also reviewed and presented. Finally, the relevance of the developmental theory of adolescence and the social exclusion paradigm is provided.

### **Developmental Perspective of Adolescence: The Life-course Approach**

Different authors have used the terms life-course or life span to refer to different stages in the human life cycle. Kuh et al, (2003) noted that the concept of life span assumes that development and aging form a continuous process from birth to death. They further noted that the distinction between life span and life course is mainly a matter of scientific history. Both terms are used interchangeably in this study.

The developmental perspective considers adolescents within the context of the life span and views adolescence as a mere transition to adulthood (Millstein et al., 1993). The life-course perspective holds that there is continuity among all life phases. That is childhood, young adulthood, midlife and older adults (Merluzzi and Nairn, 1999). It also highlights the paradoxes surrounding adolescence. Firstly, adolescence is defined as the second decade of the human life cycle and a transitional period that bridges childhood and adulthood. It is also perceived as a period that is multifaceted in nature and characterised by biological, psychological and social components, as well as emotional development (Steinberg, 2001). Because of this, writers interested in adolescence have over the years addressed many

different aspects of development during this period, including biological development, cognitive development, emotional development and social development.

Secondly, adolescence is seen as one of the most fascinating and complex transitions in the life span. Kipke (1999) noted that events at this crucial formative phase can shape an individual's life course. A third view perceives adolescence as a period characterised with opposing forces. Stanley G. Hall (1844-1924) in 1904 described adolescence as the healthiest period of the life cycle and also a time of increased risk-taking, turmoil and susceptibility to behavioural problems of puberty and new concerns about reproductive health (Steinberg, 2001; King, 2004). The paradoxes surrounding adolescence and the varying definitions are best understood by examining different definitions that are relevant to this study. These are described below.

## **2.3 Origin of Adolescence: A Historical Perspective**

There are differing views about the origin of adolescence as a stage in a life course. Cultural historians suggest that adolescence was invented during the early decades of the twentieth century. The opposing sociological view suggests that adolescence was identified and institutionalised during the period when many western societies were shifting from primarily agrarian to predominantly industrial economies (Furstenberg, 2001). According to this view, the extension of schooling and the emergence of a high paying labour market, accompanied by the disappearance of employment opportunities for youth, contributed to creation of a more distinct phase between childhood and adulthood. Furstenberg (2001) noted that before the twentieth century, youth remained an obscure, ambiguous and ill-defined period including children and teenagers or even young adults who remained semi dependent well into adulthood. Furstenberg (2001) observed further that the period of adolescence was universally noted after G. Stanley Hall (1904) popularised the term that drew professional and public attention to this part of a life span. Adolescence is thus viewed as a stage in which changes and experiences occurring are biologically and socio-cultural determined.

### **2.3.1 The Notion of 'Healthy Adolescence'**

The notion of 'healthy adolescence' refutes the notion that adolescence is a troublesome, difficult or wayward phase. Instead, this notion sees adolescence as the physically healthiest developmental period in the life cycle and lacking major health problems (Perry, 2000). The proponents of the "healthy adolescents" notion believe that adolescence is not an inherently

stressful period. Rather, they assert that adolescents enjoy a particularly good state of health, and that they experience a relatively troublesome free and healthy transition to adult life. Thus, the concept of healthy adolescents (Elster and Kuznets, 1994). They also argue that the difficulties highlighted by the problem-based perceptions are grossly exaggerated (Green and Davey, 1995). Further, they argue that conflicts either within the individual or with parents or other authority figures are minimal and that the problems of a few adolescents are not characteristic of the group as a whole. The notion of healthy adolescents emerged following medical observations that adolescence stage is not characterised by chronic illness or disability. Also, observations revealed that morbidity rates for certain organic diseases like heart diseases and cancer which typically afflict adults, were historically low among adolescents. The proponents of this view further observed that the effects of health disorders that may arise during adolescence like obesity, usually cause severe health problems later in life and not during the adolescent stage.

#### **2.4 Relevance of Selected Theoretical Perspectives of Adolescence to this Study**

The life course (life span) developmental perspective is concerned with the human development process from conception to death. This study restricts itself to adolescence stage which, according to Léonie (1996), has often been ignored or neglected. The developmental perspective of adolescence is relevant to this study because it provides the intellectual and methodological tools needed to understand issues surrounding adolescent sexuality. The perspective adopts a life course approach and sees adolescent sexuality as part of the normal human growth path in which individuals develop needs and wants as they grow. The life course approach considers that adolescents have unique sexual and reproductive health needs whose gratification is determined by several socio-cultural, policy and structural factors.

The fact that reproductive health starts from childhood and that the needs of both men and women differ in each life stage is accepted. The life course perspective is relevant because it highlights the need to understand the present and future reproductive health needs of adolescents. The sexual behaviour of today's adolescents has implications for their future reproductive health. Thus providing a continuum of care is needed to meet the different reproductive health needs of individuals throughout their life span.

The contemporary view recognises the need for intervention to avert health problems that may arise during adolescence. Firstly, it recognises the “healthy adolescents” notion that

adolescents are in the healthiest stage of the life span and may lack major health problems. It however also borrows the “problem-based adolescent” view that adolescents experience stress and storm. It further asserts that a combination of biological and socio-cultural factors expose adolescents to sexual health risks. Thus there is need to intervene to provide adolescents with quality health care services. However, several factors may come into play in influencing effective intervention efforts. These are highlighted in the sociological view and the social exclusion paradigm. The social exclusion notion highlights societal, structural and institutional factors that perpetuate adolescents’ inability to take advantage of available reproductive health services to protect themselves from sexual health risks facing them. Further, societal perceptions and expectations of adolescence determine the kind of RHS that are provided to adolescents.

## **2.5 Adolescent Sexual and Reproductive Health Concepts and Issues**

This part presents selected concepts of adolescent sexual and reproductive health (ASRH). They include sexual and reproductive health, reproductive health care, and reproductive health. These include policy issues, ambivalence and controversies about adolescence and ASRH service related aspects.

## **2.6 Adolescent Sexual and Reproductive Health Concepts**

### **2.6.1 Sexual and Reproductive Health (SRH)**

The UNFPA (2013) observes that concerns about reproductive health starts from childhood and last throughout the human life-cycle. However, the needs of both men and women differ in each life stage. Women bear the greatest burden of reproductive health problems. Research has shown that reproductive health problems account for approximately 36 per cent of the total disease burden among women of reproductive age (15-44 years) compared to an estimated 12.5 per cent in men in developing countries (World Bank, 1993).

Sexual and reproductive health means more than just the reproductive organs and reproduction. The need to understand reproductive health within the context of relationships between men and women, communities and society is underscored. This is because reproductive and sexual health status of individuals is affected by a complex web of factors ranging from sexual behaviour and attitudes, societal factors, biological and genetic predisposition and economic, cultural and psychosocial determinants (Cook and Dickens,

2000). Sexual health can also be influenced by mental health, acute and chronic illnesses and violence (Butler, 2004). The ICPD plan of action thus defined reproductive health as:

“A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes” (DFID, 2004; United Nations, 1995)

Harding and Taylor (2002) observed that health cannot be defined merely as absence of disease. Rather, social psychological elements are equally important. Sexual health, although an integral part of reproductive health, goes beyond reproductive health. It encompasses problems of STIs including HIV and AIDS, unwanted pregnancies and abortion, infertility and cancer resulting from STIs, and sexual dysfunction. Reproductive health embraces certain human rights (United Nations, 1995).

Then British Medical Association (BMA, 2003), noted that at its simplest, sexual health is compromised when sex is forced or unwanted and/or it has undesirable health or reproductive consequences such as the transmission of an STI or the conception of an unwanted pregnancy. WHO (2009) recognises that successful promotion of sexual health requires a comprehensive programme of activities, encompassing the health and education sectors as well as the broader political, economic and legal domains. In each area, action is needed to remove challenges to sexual health and to promote factors that support it. WHO (2009) further suggests that, addressing sexual health at individual, family, community or health system level requires integrated interventions by trained health providers and a functioning referral system. It also requires a legal, policy and regulatory environment where the sexual rights of all people are upheld.

### **2.6.2 Reproductive Health Care (RHC)**

In terms of care, it is argued that reproductive health requires that a continuum of care be provided to meet the health needs of individuals throughout their life span. Hence, the ICPD defined reproductive health care as: the constellation of methods, techniques and services that contribute to reproductive and sexual health and wellbeing by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counselling and care related to

reproduction and sexually transmitted diseases (DFID, 2004; Girard, 1999). It is argued that effective reproductive health care addresses these problems from birth with appropriate and culturally sensitive education and health care programmes (WHO, 2009). For example, sexually active adolescents, who lack accurate knowledge about reproductive health and lack access to RHS, including contraception, cannot protect themselves from pregnancy and STI/HIV (WHO, 2009).

In relation to care, health has been defined as the extent to which an individual or group is able on one hand to realise aspirations and satisfy needs and on the other hand to change or cope with the environment. Health is therefore seen as the resource for everyday life and not the object of living. Health is a positive concept emphasising social and personal resources as well as physical capacities. The assumption that the definition makes is that, individuals or groups of people often know their health needs and therefore have to negotiate or access means of satisfying them. This may however often not be the case particularly on issues of sexual and reproductive health. Unless individuals know their needs, and are able to define them within the social and cultural settings, they are unlikely to address them.

## **2.7 Issues Surrounding Adolescent Sexual Reproductive Health (ASRH)**

There are a range of factors that influence adolescents' use of reproductive health services. Strategies to improve access and use to RHC for adolescents can be assessed using several criteria. That is, services should be available, visible (convenient and recognisable), quality based, confidential, affordable, flexible (meeting diverse needs), and co-ordinated (Cohen, 2002). Challenges to access and use of SM and RHS by adolescents may include lack of privacy and confidentiality, insensitive staff, threatening environments, an inability to afford services and the fact that services do not often cater for the needs of unaccompanied minors, or are restricted to married adults (UNAIDS, 2001).

Neckermann (2002) observed that finding out what keeps young people from using existing public health services reveals exactly what should be done to make the services attractive to the young people. The reasons for avoidance of public sexual and reproductive health (SRH) services by adolescents could include the following factors:

### **2.7.1 Service Availability**

Accessibility to reproductive health services is considered as an essential component in fulfilment of an individuals' right to health in all its forms and at all levels. Accessibility to health facilities and health services is determined by components such as non-discrimination, physical accessibility, affordability and access to information (Hogerzeil, 2003). Theoretical models that describe access view it as a fit between predisposing factors on one side, and enabling and health system factors on the other. Predisposing factors include individual perceptions of an illness, population specific cultures as well as social and epidemiological factors. Enabling factors refer to the means available to individuals for using health services.

Health systems factors refer to resources, structures, institutions, procedures and regulations. According to Klein et al. (2001), access to SM and RHS could increase healthy habits and in turn minimise behavioural risks that adolescents are exposed to. However, the potential for alleviating health problems by targeting young people has been largely ignored (Goodburn and Ross, 2000). Regrettably, the risky behaviour of adolescents tends to increase while their participation in health care tends to decrease (Cohen, 2002).

### **2.7.2 Quality of Reproductive Health Care and Service Environment**

Alderman and Lavy (1996) emphasised the need to look at the quality of health services. They noted that, in deciding whether to seek health care and which health provider to consult, households base their choice on many factors, such as availability of drugs, doctors, hours and clinical service, the adequacy of equipment and the physical condition of health care facilities. Despite the widespread agreement on the value of providing health services of adequate quality, the health care available to adolescents in the developing world is far from satisfactory. Counselling and access to sexual and reproductive health information and services for adolescents are still inadequate or are lacking. Also adolescents' right to privacy, confidentiality, respect and informed consent is often not considered (United Nations, 1999). Utilisation of health services has to do with quantity and procedure of health care services. Documented operational factors that affect use of sexual and reproductive health services include the following: high cost of care and services, inconvenient hours of operation, affordable transportation, travel time and opportunity costs linked to it, perceived quality of care and provider behaviour (Hocklong et al., 2003). Operational constraints also present challenges for service providers, even when there is willingness to provide care. Neckermann



(2002) observed that if public health facilities are not able to deliver basic health services to the general population, it would be hard to make them youth-friendly.

Among the factors which have been cited as reasons for under-utilisation of reproductive health services include poor relationships between health care professionals and their clients, long waits, administrative red tape, lack of emotional support and privacy, differences in language and culture between health professionals and their clients, rude medical staff, and the often-expected ‘gift’ for medical attention (Naré, Katz and Tolley, 1997).

While quoting Mensch (1993), Naré, Katz and Tolley observed that interpersonal process is the vehicle by which health care is implemented and on which its success depends. Thus, the relationship between the patient and health care provider should be characterised by privacy, confidentiality, informed choice, concern, empathy, honesty, tact [and] sensitivity. Mensch further observed that the dimension of health infrastructure cannot be ignored and that there is need to focus on such elements as equipment and facilities, staff and training, supervision, record-keeping and supplies. However, according to Mensch, few studies have looked at the infrastructure to determine the quality of care being provided, and that there are few studies on the quality of care of fixed facilities.

### **2.7.3 Addressing Inequalities in Adolescents’ Sexual and Reproductive Health Care**

Reduction in social inequalities in health is viewed as an important way of addressing social exclusion (Santana, 2002). However, most programmes and approaches do not consider the particular vulnerabilities of adolescents and are not tailored to meet the special needs of adolescents. Instead they tend to be directed towards meeting the needs of adults or children (WHO, 2000; United Nations, 2000). Santana (2002) argued that, assuming that disadvantaged groups present more health needs than the general population, it is important to know in more detail not only their health service utilisation patterns but also their satisfaction with health services. In Kamau’s study revealed that adolescents may encounter embarrassment at needing or wanting reproductive services and experience discomfort in using the services. This is particularly because of the belief that the services are not intended for adolescents. Adolescents may be ashamed to use services especially if the visits follow coercion or abuse. They may also have fears of medical procedures and contraceptive methods including side effects and get concerned over lack of privacy and confidentiality.

Thus, as Hogerzeil (2003) observed, health facilities and services must be respectful of medical ethics, and culturally appropriate and sensitive to gender and life cycle requirements. Therefore addressing these challenges called for clear policies and guidelines. The policies would indicate the commitment of governments to address reproductive health matters and concerns of adolescents. It is important therefore to understand the nature and type of existing adolescent reproductive health policies. This study sought to understand how the above challenges, among other factors, influence access to SM and RHS by adolescents in Lusaka.

#### **2.7.4 Adolescent Sexual Practice**

During adolescence between 10 to 19 years old according to WHO (2006), a lot of development takes place in the bodies and minds of the teenagers. At this age, teenagers seek to establish their own social identity and want to experiment in a lot of things. The one thing they want to experiment in is sex, especially with influence from peers. These practices expose adolescents to STIs, HIV and AIDS. Often the teenagers also become vulnerable to unwanted pregnancies which are quite common even among 12 year olds due to the reduced age at which girls attain their menses. Furthermore, Henshaw (1990) states that girls of school going age and unmarried try to get round this problem by consulting their peers on how to abort pregnancies on their own or take desperate measures in order to carry out abortions.

SAFAIDS (1999), reported that statistics were showed that adolescents were not always making safe choices while adolescents may be forced to sell themselves for affection and emotional closeness. This also is a risky activity which threatens the spread of AIDS. In addition, most adolescents do not know what condoms are and how to use them and have almost no access to health care facilities. While adolescents may be found to be selling themselves to adults, they look to one another for affection and emotional closeness. This too is a risky activity which threatens the spread of AIDS. Sexual behaviour has a bearing on the risk of unwanted pregnancies and contraction of STIs.

#### **2.7.5 Adolescent Utilisation of Health Services in Health Centres**

The idea that girls and boys should remain health, not to be sexually active and not to get pregnant should be encouraged. However, that is not the reality of what is happening in this group. The socio-economic condition of a school girl and an adolescent school drop-out

pushes them to be sexually active. According to the Zambia Central Statistics Office (CSO, 1996) which states that, this idea appears to contribute to substantial numbers of self-included abortions. One solution can be to change the attitudes of young people towards safe sex and use of contraceptives. According to MoH (September, 2007), in a needs' assessment carried out in June, it was found out that:

1. Young people feel uncomfortable attending clinics at the same time as adults especially for RH concerns.
2. Youths would like separate clinic facilities or time for reproductive health care.
3. Adolescents would prefer to have same health care providers.
4. Young people would like adolescent services to be coupled with literacy training and recreation.

Youth friendly clinics were open as a pilot project in Lusaka. It is hoped that youths will attend these clinics if they feel that they are welcome. Despite a huge number of young people who initiate sexual activity and child bearing at an early stage, young people are often marginalised from the current service delivery system.

It was concluded by Kelly (2001) that, there was need to initiate measures to maintain and improve the health of women as has been recognised both at international and national levels. This is a positive step towards ensuring quality RH and safe motherhood. Furthermore, WHO (2009) stated that teenagers needed to develop the self-esteem and awareness that are integral to making health choices. Youths require access to contraceptive and other RH services so that those who are sexually active can protect themselves from pregnancies, STI and HIV. Accurate information on abstinence, alternatives of sexual intercourse and contraceptive should be given to inform young people about available options. Adolescent need to know exactly what they must do to protect themselves sexually and this must be communicated directly.

Araoye and Fekeye (2003) suggested that, comprehensive sexual and RH services for adolescent may be offered in hospitals, schools, community-based health facilities gynaecological exams, physical exams for males, contraceptive services, pregnancies testing, testing for STIs including HIV and treatment, these classes should be included in these services for youths. The most effective services are teen-friendly guarantee

confidentiality and offer accessible homes (including walk-in-appointments at convenient locations.

### **2.7.6 Importance of Adolescent Reproductive Health**

The health of young people becomes a subject of increasing importance throughout the world because of a better understanding of this age group to public health and changing conditions which are combined with changing patterns of behaviour. This is especially true with regards to sexual and reproductive health. The nature of reproductive health of the adolescent population is related to the sexual activity of this age group, the early age of first births and the high incidences of STIs especially HIV. These factors combine to have an important impact on the country's human resources for years to come. It is therefore important to put in place to provide for sound adolescent reproductive health.

The burden of reproductive health probably falls largely on female adolescents. They face problems stemming from pregnancy with its famous health and economic ramifications but there is also evidence that older men seek young girls as sexual partners (Flykers et al., 1995). This increases the risks of contracting STIs and HIV which can lead to infertility and death. Generally, the behaviour related health problems faced by adolescents are similar worldwide, for example, the high incidences of STIs and poor access to contraceptives.

However, in the Zambian scenario, low status of women, fraction of early pregnancy and high incidence of HIV and AIDS make adolescent RH complex and sensitive in current decade, population growth in developing countries, urbanisation, early marriages combined with delayed marriages and the decline in family authority, have all given rise to new patterns of sexual behaviour taking place at earlier ages and thus giving rise to problems of early pregnancies and child bearing. But also leads to induced abortions, STIs and HIV which in turn leads to AIDS (WHO/ADH, 2003). According to WHO 2009, the worldwide population of young people aged 10 to 24 years old is projected at 450 million by the year 2025. The number of women in the ages 15-19 years old who experience pregnancy is expected to increase by nearly 25 per cent from 1995 to 2020 (Reproduction Health News - December, 1997). The annual population growth rate of 3.2 per cent in Africa will have doubled by the year 2025. The majority of this population is below 15 years of age (Bambra, 1999).

In Zambia 57.4 per cent of the population are people under 20 years old. Adolescents account for 24 per cent of the total population with 28 per cent of the Copperbelt's populations made up of adolescent (CSO,1996). NASTILY reports that, more new cases of STI including HIV are found in young women than in any other group, therefore, adolescents urgently need to learn how to keep away from becoming infected with STIs.

### **2.7.7 Adolescent Reproductive Health Services**

Adolescents' knowledge of RH must be accompanied with availability of and accessibility to appropriate reproductive health centres. In order to make health decisions about illness, it is important to see a trained reproductive service provider. Programmes have identified the need to develop specialised approaches that provide youths with services that are of high quality, medically sound and safe. The foundation of initial knowledge should start at grass level. In this situation, it is the family from where adolescents originate from. Health care provider managers and researchers have to realise that in order to increase young people's utilisation of RHS, these services should be youth friendly. These services can be provided in a health facility such as a clinic, hospital, schools or through community outreach by peer education. The services should include STI screening and treatment, antenatal and childcare counselling and contraceptive services (for the sexually active). In view of encouraging abstinence, regardless of the venue, services must be attractive or user friendly and be able to retain the young people in order to be effective.

### **2.7.8 Adolescents Access to Reproductive Health Services**

Adolescence and youth age ranges are times of discovery, emerging feelings and exploration of new behaviour and relationships. Sexual behaviour can involve risks. At the same time, young people get mixed messages. They are confronted with media images of sex, smoking and drinking as glamourising and risk free. They are helped to be abstinent but they are exposed to the beverage of advertisement using sex to sell a good. They are often faced with double standards calling for virginity in girls, long and early active sexual behaviour in boys (SAFAIDS December, 1998).

Young people do not only need the right to reproductive information but have a right to RHS. Those that are sexually active require interactions to access a broad scope of

RH including a range of contraceptive screening and treatment of STIs and other clinical services (Hughes and Macaulay, 1998).

In Burkina Faso after 18 months of operation of RHS 12,000 young people visited the centre and many students residing in the surrounding neighbourhood came to learn and discuss RH topics with centre staff and for RHC. Services utilised were diagnosis and treatment of STI and contraceptive services. On the contrary, young people in Senegal were reluctant to seek individual enforcement or counselling publicly, although a few secretly requested for condoms by knocking on peer educators' window at night. The educators believed that the young people preferred services outside their neighbourhood where confidentiality and privacy were more likely to be experienced (AGI, 1998).

Adolescents' knowledge of RHS, although half the young women and men in most developing countries report that they have learned of at least one modern contraceptive method. Many do not know where to get these methods or how to use them (AGI, 1998). A similar finding was obtained from the CARE PLA study (Ibid, 1998). They found out low utilisation of sexual and RHS especially among adolescent resources for low utilization were lack of knowledge about the services available (Passages Act, 1997).

In Tanzania, a study on adolescents' sexual reproductive and RH revealed that young people lacked knowledge about sex despite being sexually active. The study further revealed that young people had many unmet needs.

## **2.8 Adolescents and the HIV and AIDS Crisis**

Adolescence is a stage when behaviour which had been appropriate in childhood suddenly is over looked or discarded and because it is also a reward of great sexual simulation and experimentation, many adolescents are likely to engage in risk sexual activities that may have negative repercussion on their health. Kelly (1998) states that, "in our AIDS scared world, sexual and HIV and AIDS education are a pre-requisite for individual survival". This is true for young people especially girls between the ages of 15-24 years. Despite the vulnerability, some parents and religious leaders or the young people themselves are still opposed to programmes that teach or discuss adolescents' sexual health. This is because they believe that such issues are taboos as they may promote promiscuity among adolescents or are simply too embarrassing to be discussed publicly. Reports from WHO/UNAIDS (2007) indicate that young people in developing countries

are shouldering the main brunt of the HIV and AIDS pandemic because of poor social and economic infrastructure over the notion that young people aged below 15-19 years worldwide are infected with HIV and AIDS (UNAIDS, 2007). Ninety per cent of these are in developing countries of the sub-Saharan Africa, Latin America and the Caribbean. Hardest hit are the youths in the sub-Saharan African region where about two thirds of all new HIV and AIDS infections worldwide occur (Ibid, 2007).

According to Kelly (1998) the gender imbalance in many African countries have put girls and women at a higher risk of contracting HIV and AIDS. The higher levels of HIV and AIDS infections among young women are due to a combination of factors which to a large extent are beyond their own control. Traditional practices, lack of economical and educational opportunities. In many Africa societies women and young girls are more vulnerable to HIV and AIDS infections.

According to Davis and Gibson (1968), “sex education is a type of education that relate to people’s sexual and reproductive functions. That is to say, the anatomical and physical development of a person’s sexual organised functions that enabling them to reproduce another human being (Ibid, p. 61). Other scholars like Kelly (1998) have however extended this option by stating that, sex education goes beyond a person’s biological ability to reproduce and extends to other aspects of human behaviour such as sexual norms, values, beliefs and skills to cope with sexual pressure. Sex education is therefore both a biological and social contrast. Although the biological elements may be universal, the social elements may vary from one culture to another. In many traditional Zambian societies, sex education has been existence for a long time. Focus on young people (2000) has stated that traditional and culture are two major contextual factors that help to shape and influence young people’s social lives.

Usually traditional sex education in Zambia takes the form of the various instructions that many young people are given are not always clean because most of it is characterised by myths, taboos, threats and has usually given information on tales and proverbs. Snelson (1974) also state that historically sex education was a significant part of a traditional education which follows a concentrated cause of instruction given to young people. It is a slow process of teaching young people according to perceived maturity and proximity to marriage. In many societies, girls are subjected to more sexual taboos than boys because of the anticipated rules of life. Mothers taught girls to pull their

labia minora. Because sexual norms are always undergoing change, there is great need to discuss factual questions regarding sex and other major psychological implications with adolescents.

The key concept of school-based sex education is therefore expected to include SM and reproductive health anatomy, relationships with family and members of the opposite sex. It may also include personal skills such as values in decision making, communication and negotiation. Sexual health behaviour may involve lessons on abstinence sexual risks and contraception. SM, STIs and HIV and AIDS are now a major and predominant part of sex education because of the negative effects that these diseases have had on adolescents' social, academic and economic well-being (Kirby, 2000).

The Zambian government through the Ministry of Education has also recognised the need for schools to influence the behaviour and attitudes of young people especially with the advent of the HIV and AIDS pandemic. However, Zambia unlike other countries in the sub region like Zimbabwe, Botswana and South Africa, still lacks a clear policy on sex education for primary and secondary schools. A research by PPAZ (2003) indicated that, during its research undertaken among secondary schools on the Copperbelt, most respondents knew very little about the existence of sex education in schools. What becomes clear from many head teachers is that, nobody is aware of any national curriculum guidelines on sex education. This is despite the fact that many adolescents in primary and especially secondary schools were faced with increased peer pressure and as result were likely to be forced into risk sexual behaviours. Southern Africa HIV Action (2003) indicates that quality sex education programmes in schools have proved to be an effective tool in delaying the onset of sexually active young people already sexually active young people to seek protection against STIs, HIV and AIDS and unplanned pregnancies. Kelly (1998) also concepts that schools must seek influence behaviour and inculcate good values in young people. Chanda (1988) has argued that, "while many fine world countries have pre-occupied themselves with trying to provide education to a growing number of adolescents while many have neglected curriculum innovations aimed at bringing more relevance to education, (Ibid, p. 88). Behaviour is not shaped or changed overnight and Beazley, L. and Knejp (1996) have reiterated that in any society, outside the education potential of even the most resourceful family, there must be a whole area of serious and systematic initiation



into adulthood with some form of communally organised education to be provided to its young people (Ibid, p. 204).

### **2.8.1 Consequences of Unwanted Pregnancies**

Unplanned birth is likely to be emotionally distressing and it may place heavy financial burden on the parents of the adolescents. According to UNICEF (1997), reports on early child bearing and unmarried adolescents who fall pregnant in many countries, face disapproval and rejection from family members or spouses. Low use of contraceptives may not necessarily arouse serious health hazards.

However, WHO (2004) reports that there are factors that elevate the risks of abortion, maternal and child deaths which are major public health problems with far reaching consequences for women and their families. An estimated 75,600 deaths are due to unsafe abortions that occur each year in the world and 33,000 of these deaths occur in African countries accounting for one third of the total deaths.

Procter (1997) estimated that 3.7 million unsafe abortions occurred in Africa each year and the abortion mortality ratio was over 80 per 100,000 live births. Teenagers are at a greater risk of severe complications of abortion because they often waited until the second trimester. The complications that may arise include pelvic infections, haemorrhage, uterine perforation and tetanus. If complications are left untreated, they may result in sterility and structural damage to the reproductive organs or even lead to death.

Cal (1998), states that teenage pregnancy is a major concern because of the psychological, social and economic sequence of child bearing and it is mostly associated with unplanned or unwanted pregnancies. A pregnant teenage is confronted with maternal ambivalence or rejection which has been acknowledged as a major element in the development of mental or physical illness. However, according to Manrizo (2000), abortion rates among teenagers aged 15 – 19 years have stabilised in recent years in most developed countries. An act from human costs in terms of mortality, morbidity and suffering, unwanted pregnancy can place a heavy burden on the health resources of poor countries when women seek abortion services are neither not available or not met. WHO (1993) states that, in Tanzania a study on women hospitalised with various diagnoses were the most common reasons for admission to gynaecological wards accounting for between 34 per cent and 57 per cent of all admissions. In developing countries, many a pregnancy is terminated in clandestine or otherwise unsafe

conditions. Unwanted pregnancies result not only from not using contraceptives but also from the use of less effective methods of contraceptives.

### **2.8.2 Contraceptive Use: Prevalence and Trends**

WHO (2002), states that, although records of attempts to avoid contraception date back to as early as 1850 BC, fertility regulation on a large scale is a phenomenon of this century. Over the last three decades in particular, there has been an impressive rise in the use of contraceptives all over the world and this is expected to continue during the rest of the decade. According to WHO (1996), in 1990 it was estimated that up to 57 per cent of all married women of reproductive age had husbands using a method of contraception. This represented an increase of 6 per cent points over the prevalence in 1983.

Furthermore, WHO (2004) reported that it was particularly noteworthy that principally, a rise in contraceptive usage in developing countries (8%) accounted for this increase. In the more developed regions of the world, contraception prevalence was already 70 per cent in 1983 and by 1990 it had increased to 72 per cent. Many young people are eager to develop skills necessary to postpone sexual intercourse. Abstinence should be presented as a viable option, particularly to those who are younger or those not yet sexually active. WHO (2007) generally recommend that if young people are to be helped, it would be through the spirit of girls getting involved actively rather than passively. Many strategies to prevent pregnancies have been employed, for instance, resistance skills training options approaches, education and acquisition of knowledge and parent child communication. According to MOH (2007), Zambia has taken a step forward to introduce adolescent clinics known as youth-friendly clinics like the ones in Lusaka and on the Copperbelt where counselling services by CARE are provided. It is most likely that if more of such clinics were established, they would go a long way in preventing adolescents from HIV and AIDS, abortions and the risk factors of early child bearing. However, there is need to evaluate the effectiveness of such services.

### **2.8.3 Attitude of Family Planning Care Providers**

Adolescents are neither children nor adults, though they share some of the characteristics of both groups. The need is for effective health information and services geared specifically towards adolescents at particular stages of development. With the inception of youth-friendly clinics, we hope to see a scenario where youths provide information and a listening ear to their peers. Seats (2000), stated that peer educators tackled issues ranging from information

and worries about pregnancy, to communication with adolescents on issues of sexuality and contraceptives with confidence. Winnet (1994) reported that the need to initiate measures to maintain and improve the health of women has been recognised both at national and international levels. This is a positive step towards ensuring quality reproductive health and SM. Health care providers are urged to have positive receptive attitudes towards adolescents who wish to utilise antenatal, post natal and family planning clinics.

#### **2.8.4 Knowledge about Safe Motherhood**

Mpangile (2004) revealed in a study carried out in Tanzania that issues such as pregnancy complications, danger signs, antenatal and postnatal care, birth preparedness, the importance of a skilled attendant during delivery and post-abortion care are almost unknown to the pupils because they are never taught in school. The components of birth preparedness such as saving money, food and arrangement of transport are not known to most children because these are common problems in communities. This is a good sign showing that early and effective interventions can have greater potential to influence and promote utilisation of skilled birth attendants for safer motherhood. Interestingly, boys are found to be more knowledgeable than girls in many aspects of reproductive health and SM. This suggests that boys have more access to health information than girls do, or there is more information sharing among boys and between boys and adults than there is among girls or between girls and adults. In this regard, if boys are targeted earlier, they can be potential partners in promoting SM and RHS. Generally, the above problems appear to be associated with an overall weakness of school health education in general and reproductive health education in particular. School teachers and key informants expressed the urgency for culturally sensitive reproductive health education in schools especially for children who are above 10 years of age.

#### **2.8.5 Conclusion**

Adolescent sexual activity possess serious economic social, cultural, religious, health and moral problems. Not only do they question the moral fabric of society but they also predispose teenagers to risks of unwanted pregnancies and related consequences as well as infection with STIs including HIV and AIDS. Great efforts are needed to encourage abstinence throughout school and encourage postponing sex until when married.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.0 Introduction**

This Chapter presents the methodology used in the study and is organised under the following sections: research strategy and design, research site, population, sampling and sample size, research instruments, data collection procedures and data analysis.

#### **3.1 Research Strategy and Design**

According to Parahoo (2006), a design selected for research should be the one most suited so as to achieve an answer to the proposed research question. Qualitative research methods are utilized in order to study people in their natural social settings (naturalism), with the focus of research being on the meanings and understandings what individuals and social groups attach to their social world. In this study, qualitative research methods have been employed in evaluating the implementation of an intervention in lack of access to SM services and reproductive health facilities specifically in terms of assessing its impact on the subjective health beliefs, health knowledge and behaviour of the target population.

Qualitative methods are generally utilised in order to generate hypotheses rather than with the testing of hypotheses. Given that the social world is an open rather than a closed entity, qualitative methods cannot (nor should not attempt to) limit the range of variables being investigated. Such approaches produce rich and complex data, which presents both a challenge and opportunity for the interpretative analytical techniques that are generally utilised in qualitative research (Burns and Grove, 2009).

A cross sectional qualitative research design informed by the abductive research strategy incorporating a quantitative research approach was chosen to ground this study. According to Blaikie (2000), this is a research strategy that embraces interpretivism and constructivism. Noting that the ontological assumptions of the abductive research strategy are different from those of induction and deduction, scholars such as Dilthey, Simmel and Weber who once used abduction, maintained that the human sciences (*geisteswissenschaft*) were fundamentally different from the natural sciences (*naturwissenschaft*) and as such could not be studied in the same manner (Erickson, 1986). Recognising that the ontological assumptions of abductive strategy stem from the inner world of beings and those human beings do not behave in the same manner (constructing or interpreting social action) and assign meaning to situations differently, exploratory qualitative research was therefore

befitting. The interpretivists' and constructivists' model of human beings carries with it the notion of choice, free will and individualism. Human beings are seen as active agents capable of monitoring their own behaviour and using their speech to make comment on their performance and plan ahead. Further, human beings are purposive, active and involved with life experiences about things (Cohen et al., 2007). The things have meaning (at least to a very large extent) in virtue of the fact that people ascribe meaning to them. These ascriptions can be diverse and numerous and can display a multitude of perspectives, motives and biases (Smelser and Baltes, 2001).

Recognising that meanings for the interpretivists and constructivists are not static and that the researcher wanted to show lived experiences adolescents as they constantly created life and conceptions of motherhood alongside the roles of their husbands or partners. An exploratory and descriptive design employing a qualitative approach therefore was best suited to elicit the lived experiences of antenatal mothers regarding access to safe motherhood services specifically antenatal care. Kerlinger (1969) in Kombo (2006) explains that descriptive research is predominantly exploratory because it takes a case study approach. Descriptive studies involve giving a detailed account of events and the cultural setting where the phenomena are happening (White, 2005).

### **3.2 Research Site**

Data was collected over a period of two months from December 2013 to January 2014. This data was collected from three health centres in Lusaka district, namely Chelstone, Chipata and Ng'ombe clinics as well as the Ministry of Health. Lusaka province has the highest number of health facilities distributed across urban, peri-urban and rural areas and most of them are in the urban areas. (ZDHS, 2007)

Lusaka has the highest number of reported cases of adolescent pregnancies and hence the choice of this site for the study. It was also convenient for the researcher to see what was actually happening on the ground. As such, it was thought to be research prudent to explore the views of adolescents in Lusaka urban reported cases of adolescent's motherhood. (Ibid, 2007)

For this study, the researcher desired to have view points from adolescents in the urban places and as such, Chelstone, Chipata and Ng'ombe health centres were enlisted purposefully from among health centres to represent urban places. The health centres chosen were all within Lusaka with accessible roads and transport. All health centres provide basic emergency

obstetric care including antenatal, delivery and postnatal care services. (MOH, 2007) These clinics were chosen also selected because they represent a diverse social economic and ethnic characteristics representative of Lusaka urban and was also convenient for researcher.

### **3.3 Study Population**

According to White (2005), a study population refers to a collection of objects, events or individuals having some common characteristics that the researcher is interested in studying. In this study, the population comprised mothers attending antenatal and postnatal care services at the location of the clinics in Lusaka Urban.

### **3.4 Sampling Techniques**

The researcher used purposive sampling technique in selecting location of clinics as study focal points as well as study participants. The selection of these centres was based on sampling three clinics with large catchment areas among the many in Lusaka urban. Further, the three facilities cater for diverse social economic cultures and populations and this ensured a comparison and applicability of the research findings to create typical phenomena that could be explored further in future. Recruitment of participants was done through locally acceptable procedures as follows:

- (a) Permission to conduct research was sought from the Ministry of Health Headquarters, and from Lusaka District Health Office as well as the participants themselves; and
- (b) The officers in charge of the three clinics were consulted as entry points into the health facilities. The approval and cooperation of the officers in charge of the health centres allowed greater trust by participants in the three purposively sampled health facilities.

The researcher was helped by staff to draw sample elements from mothers cutting across the two groups (antenatal and postnatal mothers). This is because the staff knew who was in the two phases and when such clinics took place. Both antenatal and postnatal mothers were the best of the safe motherhood groups because the mothers who were interviewed were the only group that had a recent experience with antenatal care, labour and or were attending postnatal care. Antenatal mothers in this case were used because they represented the first step to accessing safe motherhood care services.

MacNealy (1999) gives advice on purposive sampling and submits that a researcher who desires to have sampling units that are necessary and specific to answer questions about a

certain matter or product should consider this type of sampling technique. To recruit mothers for in-depth interviews, the researcher employed a theoretical sampling technique as one variant of purposive sampling in selecting sample units or searching for cases or individuals until saturation was attained to cover the spectrum of views and perspectives sought by the research questions.

The theoretical sample is a “well-defined sample” according to Barton (2001: 324,325) and “that is systematically aimed at reaching saturation and not representativeness”. The process of sampling was such that when data from one interview were analysed, before conducting the next interview, a grounded theory approach of data analysis was employed to see what categories were emerging. These categories were used as building blocks for the next round of inquiries. Once the categories kept on emerging in subsequent interview discussions, the researcher recruited additional participants or conducted interview discussions as points of saturation. This is what Glaser (1978) and Strauss and Corbin (1990) consider as theoretical sampling. This kind of sampling was interleaved with maximum variation sampling, where cases were selected serially, with each adding a different contrasting element to the overall sample.

### **3.4.1 Sample Size**

A total of 40 participants participated in the study. The sample included the Ministry of Health Headquarters and three health centres. These facilities and the key informants were purposefully selected. The clinics that participated in the study were Chelston, Chipata and Ngo'mbe clinic. The thirty six (36) participants who participated in the study were adolescents seeking a Safe Motherhood or Reproductive Health Service. The participants were categorised as follows; two (02) adolescent girls accompanied by their partners (boys) in total four (04) adolescents. These boys were identified through the antenatal clinic where they had escorted their partners. The other twenty-eight (28) participants were pregnant adolescent girls who were also captured from the antenatal clinic. But this group of participants was not accompanied by their partners. The remaining four (04) boys were identified in the circumcision class that they were attending.

On average, interviews took thirty to forty minutes to explore phenomena around mothering and access to services and facilities. These two methods were appropriate for exploratory and descriptive research questions that were designed rather than for the formal testing of hypotheses as argued by Stewart and Shamdasani (1990), Peters, (1993) and Rigge (1994).

One (1) key informant from the Ministry of Health and three (3) Health Care Providers were purposively sampled to have in-depth interviews. In total there were forty (40) participants that participated in the study.

### **3.5 Data Collection Instruments**

Semi-structured questionnaires were used by the adolescents aged 13-19 years. The questionnaire comprised of both close-ended and open-ended questions. The open-ended questions were meant to give adolescents an opportunity to give detailed information about the subject of investigation. The information obtained helped in understanding or making connections with the information given by the adolescents. Interview guides were used by the key informants to collect valuable information about the subject under investigation.

### **3.6 Data collection**

In –depth interview were conducted with thirty-six (36) three (3) Health Care Providers from the health centres and one (1) key informant from Ministry of Health and (MOH).

#### **3.6.1 Interview Process**

The researcher introduced herself and the purpose of the study. Thereafter, and depending on the literacy level of a prospective participant, the researcher either gave her the consent form to read and sign or read the consent form to her for verbal consent. Thereafter, the researcher requested the participant to introduce herself including her age, number of children, number of previous pregnancies, marital status, education, religion, and source of income. Once a participant had introduced herself and demographic information recorded, the researcher welcomed the participant and began the interview.

The researcher emphasised confidentiality and the voluntariness of participation in the study and sought the participant's permission to use the voice recorder on condition that the recorded voices would be used for research purposes only.

The researcher then led the participant through a series of exploratory and descriptive research questions that had been designed while constantly ensuring a conducive atmosphere that enabled optimum participation of the participant throughout the interview process. At the end of every interview, the researcher thanked the participant for cooperating and participating in the study.



### **3.7 Data Analysis**

According to Burns and Grove (1999) qualitative data analysis occurs in three phases: description, analysis and interpretation. The researcher transcribed the interviews verbatim and analysis of the transcripts that were carried out by the researcher while utilising Colaizzi's (1978) seven step approach to descriptive data analysis seven step process to data analysis. As the researcher intended to only have one round of interviews, Colaizzi's seventh step would not apply. However, the researcher sought clarification on any issues at the time of interviewing. In order to achieve complete data saturation, thorough reading and re-reading was necessary to ensure identification of all recurring information and variations and this would be achieved only when no new information is obtained (Holloway and Wheeler, 2002 and Polit and Beck, 2008). Volumes of data were gathered throughout the data collection process which required the researcher to complete a reduction in data through categorising and identifying similar themes. This process allowed the researcher to interpret findings more easily. Data analysis started once all the data had been collected. The qualitative data was manually analysed, coded and processed using emerging themes. The conversation highlights major theme topics and responses. According to (Zoppi and Espstein 2002), coding is a short phrase, letter or word that symbolically assigns a summative salient, essence-capturing and/or evocative attribute for a language-based or visual data. In this study the researcher coded the adolescents by using their sex, age and the clinic they were representing for easier identification; i.e. an adolescent from Ng'ombe was coded as adolescent 3, [F19, N], to represent that the adolescent was interviewed number three (3), and was a female aged 19 years and from Ng'ombe clinic [N]. In the same vein Chelston was coded as [C1] and Chipata was coded as [C2] and as such the same was applied to the health care providers; i.e. [P1, N] for Ng'ombe clinic, [P2, C1] for Chelston clinic and [P3, C2] for Chipata clinic.

### **3.8 Pilot Study**

A pilot study was used to assist in further development of a larger study that it would be used in order to test study measures, estimation of interviews, testing validity of tools and estimation of outcome variables (Arain et al., 2010). Researchers benefit from carrying out a pilot study prior to the main study as it allowed for the identification of any weaknesses in the plans and allowed time to rectify any necessary amendments before carrying out the remainder of the study. In most cases, it was recommended that a pilot study be carried out prior to the main research using 10 per cent of the actual sample, meaning from research data (Polit and Beck, 2008). Data analysis was an ongoing process. The study was a qualitative

study with and so participants could not be determined priori; however only four participants from the Chainama Clinic were sampled. Chainama clinic was used because of because it also has a diverse social economic and ethnic characteristics representative of Lusaka. The social economic diversity and culture of its clientele and represent five major large major catchment areas in Lusaka namely, Presidential Housing Initiative (PHI), Mtendere and Kaunda Square stages one (1) and two (2) and Munali/Great East Road residents. The pilot study was used to test the tools and frameworks trustworthiness, reliability and also the interview location, audio recording sound and time frames. This pilot study was used as a method to discover any flaws in the current data collection plan, while also allowing enough time to rectify these before the main research took place.

### **3.9 Ethical Consideration**

Ethical clearance was obtained from the Research Ethical Committee of the University of Zambia. Permission was sought to enter into the research sites by way of an introductory letter from the University of Zambia. Clearance to enter the health centres was given by the Lusaka District Community Health office. The study sites included three clinics namely, Chipata, Chelstone and Ng'ombe.

#### **3.9.1 Informed consent**

Informed consent was obtained from the participants. The participants were informed that the interviews would be audio-recorded and notes were to be taken. It was explained that audio-recording was going to help to listen to the interview afterwards and that this would help in easily transcribing the interview. Permission was then sought to audio-record the interviews. Where participants agreed to have their interviews audio-recorded or where participants expressed discomfort on audio-recording and opted for interview notes to be taken, all views were respected.

In obtaining the participants' informed consent, their individual rights were first explained orally. It was explained that participants were free to participate in the study and that there was no financial gains or any material rewards for their participation. They were also informed that they were free to withdraw their participation at any time without giving any reasons. It was also explained that the information obtained from the participants was for academic purposes only and no names would be published in the report. The oral explanation of their rights was followed by individual letters of consent signed by the participants and the researcher to guarantee indemnity of the participants (see Appendix A)

### **3.9.2 Limitations**

This study had three limitations. The first limitation was the non-availability of sufficient participants at a given single time for a focus group discussion. Morgan (1998) and Bryman, (2008) sets the focus group discussion size to be between '*six to ten members*'. The officers in-charges that were availing participants for the study could not assemble six participants or above at once due to other participants being in the antenatal room at the time when others were being interviewed. Because of this limitation, no focus group discussion was undertaken. Instead, thirty six personal interviews were conducted. The second limitation was the inadequacy of information obtained from the participants themselves shying away to give sensitive information. This hindered the researcher from getting important information.

The small population sample size caused findings to only be relevant within the hospital or clinic from where it was taken from and could not be generalised outside of this study. In addition, it was predicted that findings would benefit nurses, doctors, other health assistants and adolescents themselves as a result of the knowledge gained and shared. Qualitative research is not completely precise and complete objectivity and neutrality is impossible to achieve and thus, this limits the accuracy of the study's findings (Holloway and Wheeler, 2002).

## CHAPTER FOUR

### PRESENTATION OF RESEARCH FINDINGS

#### 4.0 Introduction

This Chapter presents the data collected on themes focusing on the key research questions:

1. Sexual health concerns of adolescents in their lived experiences.
2. Existing SM and RHS for adolescents in selected clinics in Lusaka District.
3. Barriers and challenges adolescents in clinics of Lusaka district face in accessing and utilising SM and RHS.

In presenting the findings, the researcher takes a naturalistic point of view. As a model of qualitative research, *naturalism* focuses on the factual characteristics of the object under study (Guba and Lincoln, 1994). The observations and narratives are intended to reflect on what the researcher saw and heard in the real world of adolescents' lived experiences on accessing and utilising SM and RHS. In this section, the researcher is describing an experience or events and has selected only what is critical to describe what the research questions were demanding and in the process features certain aspects of what is critical. The researcher presents a personal interactive view and in a number of places uses double hermeneutic phenomenology to transform the experience or event by contextualising it. A double hermeneutic phenomenology necessarily forms part and parcel of *verstehen*. The first hermeneutics that will be presented is Husserlian in nature. This is the original description of phenomena as lived by the social actors and can be called as original meaning. The second hermeneutics is existential in nature. This is because according to Hans Gadamer (1989), there are no original meanings but only original meaning ascriptions which tend to be personalised and may include the researcher's observations and interpretations. To use a double hermeneutics so as to show the results clearly, the researcher does this by citing past research and adds a personal interpretation. Although no description is free of interpretation, basic or fundamental qualitative description, as opposed to, for example, Husserlian phenomenological or grounded theory description, which is the approach used in this section, entails a kind of interpretation that is low to moderate inference, or likely to result in easier consensus among researchers. This approach borrows heavily from Pearce (1971) and Wolcott (1994). As a rule, demographic characteristics of the respondents are discussed before the main findings. The results of the interviews conducted among the sampled adolescents. The Chapter is based on data obtained from 36 interviews with adolescents.

Although the study intended to obtain equal samples of adolescents in the various clinics, the adolescents who participated in the research were 36 yielding to a response rate of 89%. In addition, time constraints hindered completion of six planned interviews three in Chipata and the other two in Chelstone and one in Ng'ombe clinics whereas two interviews yielded poor information and were discarded. The response rate of 89% is nonetheless ideal to permit analysis and data reliability. These are cases where there was no response, or the interviewee broke down in tears and withdrew from the interview.

#### **4.1 Demographic Characteristics of the Participants**

Data on the demographic characteristics of the adolescents was obtained during the interviews. About 36 adolescents were sampled from three clinics and of these 30 were girls while 6 were boys. The average age of the respondents was 16 years and 19 years for girls and boys respectively. The youngest was 13 years old and the oldest 19 years old. Of the total respondents, three-quarters of the adolescents (76%) lived with both parents whereas quarter (24%) lived with a single parent or relatives. In addition 3 key informants and also 3 health care providers were purposively sampled.

**Table 4.1.1 Shows the Distribution of the Adolescents by Gender & age**

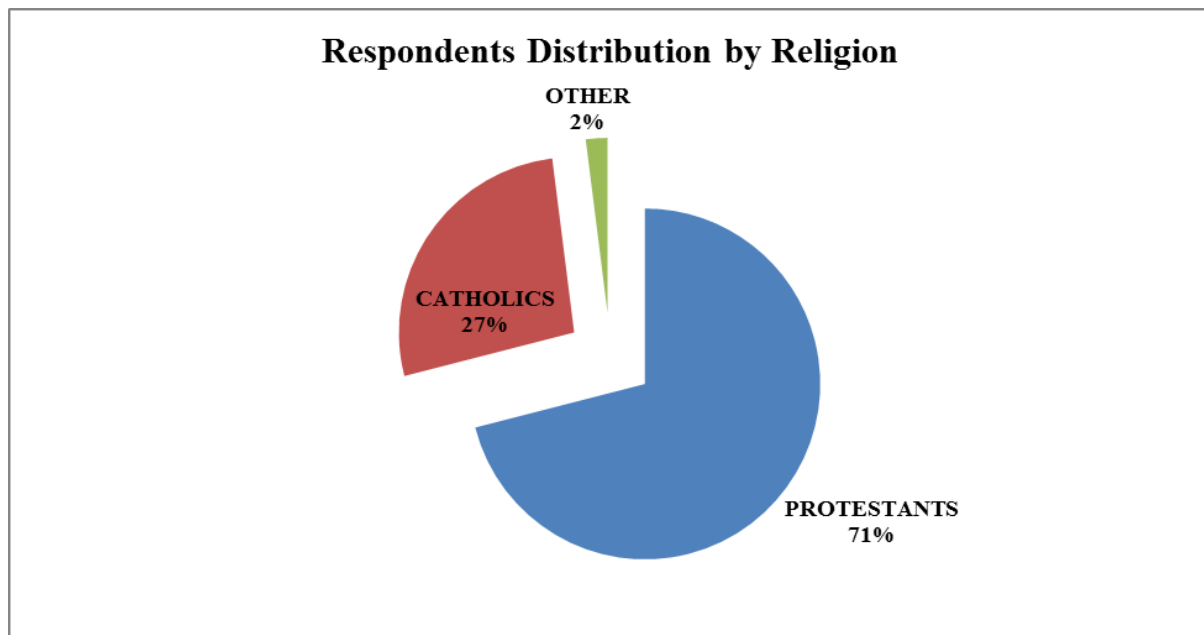
<b>Mean Age</b>	<b>Gender</b>	<b>Frequency</b>	<b>Percent (%)</b>
16	Girls	30	83
19	Boys	6	17
<b>Total</b>		<b>36</b>	<b>100</b>

The average age of the adolescents was 16.7 years. The youngest was 14 years old from Ngombe and the oldest 19 years old representing from all the three clinics.

#### **Table 4.1.2 Religious Affiliation**

Close to three-quarters of the adolescents 26 (71%) were Protestants and belonged to Pentecostal and Evangelical churches, quarter 10 (27%) were Catholics and 1 (2%) belonged to other religious groups

**Figure 4.1.3**



#### **4.2 Theme I: Sexual Health Concerns among the Adolescents**

The adolescents were asked about their main health concerns. The aim was to find out whether they had specific reproductive health concerns that would require them to seek SM or and reproductive health care. Adolescents had multiple health concerns. They raised health concerns on the following aspects: sexual behavioural concerns, psychosocial and emotional concerns, maturation and developmental concerns, interpersonal concerns, concerns about drug use and abuse, and societal-related concerns.

The results are summarised. Most of the adolescents, 30 (84.2%) raised sexual behavioural concerns. Out of the 36 adolescents, 17 (47.2%) expressed fear of contracting HIV and AIDS, 11 (30.6%) had fear of contracting STDs whereas 8 (22.2%) had concerns about teenage pregnancy. These included three boys who raised concern about causing pregnancy or about their siblings getting pregnant. Of these adolescents, 27 (75%) worried about sex experimentation among adolescents.

About half of the adolescents 19 (52.8%) had psychosocial and emotional concerns. Of the 36 adolescents, 27 (75%) were concerned about negative peer influence that made adolescents to engage in early sex or other risky behaviours. Another 26 (72.2%) of adolescents were concerned about relationships with the opposite sex. They indicated that they experienced increased attraction to the opposite sex and desire to form relationships. About 10 (27.8%) adolescents also indicated that they experienced loneliness and mood swings. In addition,

they indicated feeling like outcasts and feared being alienated by their friends if they did not have girlfriends or boyfriends. Half of the adolescents, 18 (50%) raised maturation and developmental concerns. Also 2 (5.6%) of the adolescents, particularly the boys had concerns about the increased sexual desires and having pains in the genitalia.

Close to half of the adolescents, 16 (43.9%) had interpersonal concerns. About 31 (86.1%) adolescents were concerned of relating with their parents, teachers and friends. They reported having fear and difficulties in sharing their problems with their parents, teachers, siblings and friends. They feared that if they shared their problems with their parents, their parents would suspect them of having indulged in sex. They also expressed lack of trust of their health providers and friends and feared that their problems would be disclosed or shared with other people. Only 4 adolescents (11.1%) expressed concerns about drug use and substance abuse. They mentioned alcohol, cigarettes, cannabis and hard drugs like cocaine as common substances that were abused mainly by boys. Among the respondents 5 (13.9%) adolescents were also concerned about increased rape incidences, the negative effects of using contraceptives. The results of specific health concerns of the adolescents are summarised in Table 4.2.1.

**Table 4.2.1 Specific Health Concerns Raised by the Adolescents in the Study**  
(Results of Multiple Responses)

	<b>Frequency</b>	<b>Percent (%)</b>
Sexual Behaviour	30	83.3
Contracting HIV/AIDS	17	47.2
Contracting STDs	11	30.6
Teen Pregnancy	8	22.2
Experimenting Sex	27	75
Psychosocial & Emotional	19	52.8
Negative Peer influence	27	75
Relationships	26	72.2
Loneliness & Moods	10	27.8
Maturation & Developmental	18	50
Sexual desire & Genital Pain	2	5.6
Interpersonal Issues	16	44.4
Family & Friend Relations	31	86.1
Drug & Substance Abuse	4	11.1
Rape Incidence	5	13.9

### 4.2.2 Response to Adolescents Health Concerns

Another aim of this study was to find out whether there were efforts being made to address the health concerns raised by the adolescents. Adolescents were asked about their awareness about efforts by the government, NGOs or other agencies to address their reproductive health concerns. 8 (22.2%) of the adolescents indicated that the government through the Ministry of Health had made efforts to respond to their reproductive health concerns, 17 (47.2%) cited interventions by schools and 13 (36.1%) interventions by religious organisations mainly the churches. Another 8 (22.2%) cited interventions by the media and 7 (19.4%) cited NGOs, individual counsellors and People Living with AIDS (PLWAs). The other 4 (11.1%) of the adolescents thought that there were no efforts being made to address their concerns. They cited high levels of teenage pregnancy, laxity by the government to curb sexual exploitation of girls and failure to deal with prostitution as reasons. They noted that inaction by the government impeded provision of good role models for adolescents. The adolescents also noted that they lacked a forum through which they could share their concerns. They felt that the Ministry of Health assumed that adolescents were always healthy and lacked major health complications. A few also thought that efforts by NGOs to provide condoms were inappropriate. They observed that they received inadequate information about condom effectiveness and that such efforts failed to address the real issues and concerns raised by the adolescents. The results of adolescents' views in institutional response to their health concerns are summarised in table 4.2.3.

**Table 4.2.3 Adolescents' Views on Institutional Response to their Health Concerns**  
(Results of Multiple Responses)

	Frequency	Percent
Government	8	22.2
Schools	17	47.2
Religious Organisation	13	36.1
Media	8	22.2
NGOs & Individuals	7	19.4
No Efforts	4	11.1



### **4.3 Theme II: Existing Safe Motherhood and Reproductive Health Services for Adolescents**

#### **4.3.1 Availability of (SM) and Reproductive Health Services (RHS)**

The other aim of this study was to generate data on whether there existed any reproductive health services for adolescents. Adolescents were asked to: (a) indicate whether they had knowledge of organisations that offered reproductive health services in Lusaka; (b) indicate their source of knowledge about these organisations; and (c) describe the kind of reproductive health services that were offered by the mentioned organisations assuming that all health facilities provided the services.

Adolescents were then asked whether they had knowledge about institutions that specifically provided SM and RHS for adolescents in their respective clinics and to indicate the kind of services that were provided. The aim was to understand whether there were specific services available for adolescents in Lusaka. Half of the adolescents indicated having awareness of organisations that provided health services for adolescents. They however, noted that these services did not specifically target adolescents. Rather that, adolescents who needed to use the services could obtain them through public health services. The other half of the adolescents indicated lack of awareness about specific reproductive health services that adolescents could use in the Lusaka local clinics. They indicated that they lacked knowledge about the district health services. Of the adolescents who indicated having awareness of organisations offering services for adolescents in the district, 33% mentioned government health facilities like Voluntary Counselling and Testing (VCT) centre, 12% CBOs like New Start Centres and individual counsellors. Another 6% named church youth seminars. The adolescents also named youth-friendly corners, VCT centres.

#### **4.3.2 Nature of Available Reproductive Health Services in Lusaka**

A higher proportion of the adolescents (35%) cited provision of information and awareness creation about HIV and AIDS, condoms distribution and HIV testing and counselling as the major services offered by the named organisations. About 21% of the adolescents mentioned that the organisations provided counselling and advice services on the dangers of early sexual initiation, STDs, unplanned pregnancies, abortions, contraceptives, drug abuse and advice about relating with parents. Another 8% of the adolescents cited treatment of diseases like STDs and 3% mentioned other services such as financial support of organisations offering awareness and education about HIV and AIDS, conducting pregnancy tests.

Regarding the type of RHS offered by the cited organisations to adolescents, 36.8% of the adolescents mentioned information, talks and video shows on HIV and AIDS, HIV testing and counselling services, and information about condoms. Another 16.7% named treatment of diseases like STDs and referral services, whereas 14.0% mentioned youth guidance and counselling seminars on sexuality issues like unwanted pregnancies, appropriate dressing and dangers of drug abuse. A few of the adolescents 7.9% named other services like supporting organisations offering awareness and education about HIV and AIDS, supporting AIDS orphans, providing sanitary pads and maternity services.

#### **4.3.3 Adolescents Need for RHS**

Views of adolescents were sought on their need for sexual health services. Adolescents were asked to indicate their desired services and to identify the service needs of boys and girls. All adolescents expressed overwhelming desire to be offered preventive reproductive health services. About a third of the adolescents observed that, if there were adolescents health services, they would get informed about their general health (31.5%), what to expect during adolescence (29.2%), and where they could obtain services (20.2%). Another 20.2% of the adolescents observed that they would be informed about the dangers of sex experimentation or what some termed as “doing bad things”, and 13.5% on how to avoid contracting HIV and AIDS. The adolescents also felt that having adolescent specific services would help them learn how to prevent STDs (10.1%) and unwanted pregnancies (6.7%), and how to avoid bad company (negative peer pressure) which exposed them to doing “bad things” like going to Discos (7.9%). Further, they felt that this would also enable them to freely share their sexual health problems with the health providers (15.7%) and that they would learn of the dangers of drug abuse (5.6%). A few adolescents (5.6%) stressed that their parents and teachers would also have a chance to provide them with sexual health information, whereas 3.4% felt that they would learn about condom efficacy and what to do if raped.

#### **4.3.4 The Types of Services Needed**

Adolescents were asked to specify the services they wished to be provided with. They indicated having basic and special needs to be addressed. About 31% wished to be educated on the dangers of HIV and AIDS. They also expressed the need for VCT services in their communities. They added that persons found to be HIV positive should be advised on how to live positively and how to prevent further infections and that those found to be negative

should be advised on how to avoid getting infected. The adolescents also wished to be informed on how to relate with the opposite sex and how to avoid peer influence. They wished to be provided with individualised guidance and counselling. Further, they noted that those offering guidance should openly share (straight talk) with them sexual health issues and be willing to solve the problems affecting adolescents. They further observed that they could learn more if they were provided with books on sexuality issues. Adolescents had other unique service needs. The girls wished to be informed of the dangers of pre-marital sex and how to avoid them and what to do if and when raped. A few girls felt that boys abused drugs and that they should be advised against this. The girls also wished that seminars could be organised to teach them about growth and development. They wished to be informed early about menstruation so that this did not come to them as a surprise. They noted that some girls cried when they begun to menstruate due to lack of prior knowledge. They also wished to be informed about how to deal with painful and irregular menses. The lack of interaction between adolescents and their parents was noted. The girls indicated that they often shared menstruation related problems with friends and even with boys but did not share such problems with their parents. They wished to be informed about the personal hygiene and cleanliness and for the sanitary pads to be provided to girls who lacked them. Additionally, the girls wished to be informed about STDs and how to deal with unintended pregnancies. They noted that girls felt guilty when they got pregnant leading to failure to seek antenatal care and complicated child delivery. They further suggested that girls should be educated on the dangers of abortion. Guidance and counselling should be provided to those who became pregnant. A few of the girls also felt that girls should be advised against the use of contraceptives and that the government should intervene to stop early marriages and protect girls against violence.

The boys wished to be advised on how to overcome sexual desires, to deal with homosexuality tendencies, to be informed about the effects of drugs like cigarettes and alcohol and how to avoid them. A few of the boys thought that sexual health services should be provided to girls because the girls unlike the boys have sexuality problems. They also felt that boys should be informed on how to report rape cases.

#### **4.3.5 Use of Safe Motherhood and Reproductive Health Services by Adolescents**

The adolescents were asked whether they had used any reproductive health services. The aim was to assess whether adolescents' knowledge on available services resulted in their use of the services. They were asked (a) to describe the services they had used; (b) to indicate where they accessed the services and reasons for the choice of the services; (c) whether they were accompanied to the services; and (d) whether the services were accessible and affordable. Adolescents were also asked what they liked about the services in order to establish their level of satisfaction with the services. Adolescents were also asked to suggest areas of improving access and utilisation of SM and RH.

#### **4.3.6. Types of Services Used**

About 10 (27.8%) of the adolescents reported having used reproductive health services. Out of these, 13 (36.1%) adolescents indicated that they had accessed the sought services in other communities. Adolescents indicated having used the following services: health facilities which included government health facilities, private hospitals and clinics; VCT services, services from the Community Based Organisations (CBOs) and individual counsellors, and the church youth seminars. A few adolescents cited information from the mass media and some indicated that they had consulted their parents and teachers. Adolescents had also used school guidance and counselling services which were often compulsory.

A higher proportion of the adolescents who had used services rated guidance and counselling as a highly utilised service. They received guidance and counselling especially for the antenatal clients in the following areas: general health; birth preparedness, danger signs (during pregnancy, during labour, mother and baby), after delivery, nutrition, malaria/fancider, deworming/vermox tablets, what to do when sick in pregnancy, hygiene, Preventive Mother to Child Transmission (PMTCT)/breast feeding, STIs in pregnancy, exercising during pregnancy, first level hospital delivery referrals, family planning, birth preparedness/birth certificates, in reproductive health; how to prevent HIV and AIDS, STDs, and early sexual engagement; how to exercise self-control, relating with parents and peers, about condoms use, as well as advise on drug use and abuse. The adolescents cited other services received as HIV and AIDS counselling and testing services, treatment of diseases STDs/STIs through circumcision services for the boys like.

#### **4.3.7 Reasons for Choice of Service Provider**

The reasons cited by adolescents for their choice and use of the services were as follows:

- (a) Learning how to avoid problems that occur in adolescence and to be informed about health issues in general e.g. STDs;
- (b) The services being near their homes, schools or churches and easily accessible;
- (c) Being required by schools to undergo medical check-ups before being admitted to Form One or Grade 8;
- (d) Being required to seek services like VCT by their parents;
- (e) They liked the facility because the staff were nice, welcoming, friendly, ‘motherly’ and not rude; and
- (f) To get circumcision services or because they preferred the clinics.

#### **4.3.8 Accessibility and Affordability of Services**

The adolescents were asked whether they faced difficulties in locating the health services. All the adolescents who had used the services indicated having had no difficulties in locating the services. They indicated that the in-school services were accessible because the teachers, the school matron or nurse were available within the school and the guest counsellors came to their schools. Adolescents also indicated having had no difficulties in locating the non-school services. Twenty-seven adolescents indicated that the facilities were near their homes or school. Two indicated that their parents accompanied them to the facilities while the other two were accompanied by a friend and encountered no problems in locating the services. Adolescents were further asked whether they paid for the health services. The aim was to establish whether they faced financial barriers. They indicated that in-school services such as guidance and counselling and church youth seminars were offered for free. Sixteen adolescents having had paid for the services. The service charges ranged from K20 to K40. The highest paid fee was for the institutionalised laboratory testing services. Five adolescents described the fees as being affordable and the other five felt that the fees were expensive particularly for the laboratory services and institutionalised circumcision. Adolescents also felt that membership fee for the HIV and AIDS club although small was prohibitive. Six adolescents were not sure of the amount paid because their parents had paid for the services.

#### **4.3.9 Satisfaction with Used Services**

Adolescents were asked to indicate what they liked about the services they received. Out of 36 adolescents who responded to the question, 27 indicated that they were happy because

they received the services they needed like treatment, laboratory tests or pre-HIV test counselling. Also 17 adolescents reported that they were satisfied with the services because the health providers and counsellors were welcoming, friendly and open; and that they received information and counselling about HIV and AIDS, menses, relationships with the opposite sex and how to avoid unintended pregnancies. About 7 adolescents said clean and organised facilities, enhanced privacy and confidentiality, short waiting time, free services and being attended on first-come first-served basis as reasons for their satisfaction. Twelve adolescents cited other reasons as being equipped with guidance and counselling skills. They observed that they could use the skills to counsel their peers and that the group sessions enabled them to learn from each other. Another reason cited for satisfaction was being awarded peer counsellor certificates.

A few adolescents expressed dissatisfaction with the services. They cited their reasons such as not being provided with enough information on STIs and relating with the opposite sex, being forced by parents to undergo HIV testing from a VCT centre and not being offered pre- and post-test counselling.

#### **4.3.9.0 Reasons for Non-use of Safe Motherhood and Reproductive Health Services**

About 17 of the adolescents who had not used reproductive health services were asked why they had not used reproductive health services. The aim was to understand the reasons for non-use of RHS among the adolescents. The adolescents cited having had no need for the services (40.5%), lack of awareness on the reproductive health services available (13.9%), a feeling that reproductive health services were for adults and not for adolescents (5.1%) and fear that health providers would judge them as being too young and unmarried to use adult services. Adolescents indicated that they were embarrassed to use services (3.8%) especially when they had to explain to the doctors or nurses their problems before receiving services. Regarding the non-use of VCT services, 10.1% of the adolescents cited lack of time to go to the VCT centres, and 10% indicated being certain of their negative HIV status and that they did not need the tests. A further 6.3% feared that HIV results might be positive and that they would not know how to handle it. Other cited reasons for non-use of VTC services included not having been taken to the centres by their parents (3.8%) and consulting friends or praying when they had problems (6.8%).

#### **4.9.1 Unmet Reproductive Health Needs**

Adolescents were asked whether they had ever had reproductive health needs but did not know where to get information or seek help from. The aim was to find out whether the adolescents had unmet sexual health needs that required them to access and use RHS. The adolescents who responded to this question were 28. Of these, about 11 (39.3%) indicated having had unmet sexual health needs, whereas 20 (71.4%) indicated not having unmet needs. The girls who indicated having unmet needs cited painful menses, vaginal discharge and itching and lack of sanitary napkins or pads. The boys cited unmet sexual health needs as increased sexual desires, pain in the genitals and bleeding after circumcision. Adolescents also cited challenges in relating with the opposite sex as another unmet need. They indicated that they experienced increased desire to establish relationships or wanted to end them. The girls wondered why boys pressurised them to establish relationships. The boys wondered why girls were not receptive to their advances. A few indicated having emotional imbalances and anger.

#### **4.4 Theme III: Barriers to Access and Utilisation of Safe Motherhood and Reproductive Health Services by Adolescents**

Another purpose of this study was to find out about the barriers and challenges that adolescents faced in accessing and utilising SM and RHS. This study was based on the premise that effective access and utilisation of preventive reproductive health services by adolescents should ensure that, (a) health information and services are available, accessible, acceptable and affordable (MoH, 2003); (b) privacy and confidentiality to be enhanced; (c) staff are sympathetic to the needs and circumstances of adolescents, have knowledge and experience in serving adolescents and the willingness to offer correct and complete information about existing services to adolescents and to provide them with needed services; and (d) that services should demonstrate acceptance and respect of adolescents (Heaven, 1996). This objective presents the study findings on the perspectives of the adolescents, the health providers and the key informants about the barriers and challenges faced by adolescents in accessing and utilising preventive reproductive services. The identified barriers include lack of adolescent health services, adolescents' lack of awareness about available services, psychosocial barriers, ethical, institutional and structural barriers. The implications for improving access and utilisation of preventive reproductive health services by adolescents are discussed and proposals for tackling the identified barriers made.

#### 4.4.1 Lack of Adolescent-gender Specific Services

Adolescents lacked access to adolescent-gender friendly services. Those who needed reproductive health services used the same services as those provided for adults, for example, MCH/FP services and curative services. Adolescents also felt that the limited VCT centres in Lusaka denied them access to sexual health information. Adolescents expressed feelings of being neglected and marginalised from health services. They felt that, unlike the adults and children, they were neglected, uncared for, and excluded from services. Many adolescents felt that efforts by the government, NGOs and CBOs to address their health concerns were inadequate. They expressed the need to be offered separate services from adults and parents.

**Interviewer:** As far as you know, is anything being done to address these concerns?

**Adolescent 4[M18, C1]:** *‘The government is not doing anything. The NGOs they deal with adults and children and leave us aside. We feel like we are just left behind ... I have never seen anything for adolescents but maybe there is’.*

**Interviewer:** Is there any additional information that you would like to share with me ...?

**Adolescent 5[F19C2]:** *‘Adolescents should be provided with regular counselling by NGOs. These provide free education and they are good ... they should come specifically to the youths... [tizipunzisiwa teka noti na makolo] “We should be taught alone without the parents”.*

The health providers and key informants concurred with the adolescents’ views. Similarly, their views denoted the continued social exclusion of adolescents from SM and reproductive health services. For example, the health providers noted that public forums were targeted at adults, like the HIV and AIDS awareness campaigns including education through schools and churches, did not effectively reach adolescents. Consequently, adolescents are less likely to access and utilise services that do not provide adolescent-gearred information and services. They continue to face sexual health risks with their needs remaining largely unmet. The findings of this study indicate the existence of a reproductive health service gap within the Zambian health care system that hinders adolescents the access to and utilisation of SM and



RHS. Accordingly, adolescents are not guaranteed access to comprehensive RHS across their life span. The findings correspond with previous studies that highlighted the importance of adolescent-specific and friendly services. Dehne and Riedner (2005) noted the lack of adolescent-friendly services in Africa. They observed that efforts to establish adolescent friendly reproductive health services in Africa were recent. These findings imply the need to establish adolescent-friendly services in Zambia, to wholesomely address SM and reproductive health needs of adolescents, and to offer adolescent-focused services.

#### **4.4.2 Adolescents Ignorance about Available Services**

Adolescents lacked adequate awareness about existing preventive reproductive health services. Lack of adequate awareness compounded with lack of adolescent-specific services posed a big challenge to adolescents when accessing and utilising PRHS. This also implied that adolescents have no appropriate forum for sharing their sexual and reproductive health concerns. Although access to services and information is not a privilege but a right (UNDP, 2003), the findings of this study suggest that adolescents do not enjoy this right and are not accorded their right to access sexual and reproductive health information and services. Further study findings showed that adolescents were unlikely to access SM and RHS from the mainstream RHS because of lack of adequate awareness about available services. They also lacked the necessary knowledge about service provision procedures and processes. The key informants made similar observations.

**Key informant 1:** *‘... even as the communities are claiming not to move out of the traditional way, there is no forum where adolescents can sit and discuss sexuality matters. In the end the child discovers and gets information from wrong people’.*

Most of the adolescents in this study felt that they received inadequate information regarding available preventive reproductive health services. This finding corresponded with the finding that showed unwillingness among the health providers to inform adolescents about existing SM and RHS. This was due to the feeling that adolescents were too young to use such services. Some providers offered selective information regarding existing services for adolescents, despite being aware of the need to provide adolescents with full-range of information and services. Selective provision of information heightened adolescents’

ignorance about available SM and RHS. Consequently, they failed to access and use the services.

**Interviewer:** Can you please tell me about the existing government policies on reproductive health care in Zambia?

**Provider [C1]:** *'Presently there are no restrictions. We give them FP services ... But we tell them the contraceptives are not good because they may interfere with their hormones and this can make them fail to get pregnant when they want ... adolescents are not told that the services are provided in public. But we are told when we go for seminars that we should give them services if they come seeking the services.'*

The adolescents expressed the need for more and up-to-date information on available adolescent health services and to be informed about what to expect during service provision. The findings of this study concurred with that of Hocklong et al. (2003). Hocklong et al. (2003) observed that the barriers impeding adolescents' access to sexual and reproductive health services could be addressed by a common set of strategies falling under the rubric of "youth-friendly environments". They further argued that youths may delay in seeking services if they have inadequate or incorrect information regarding the location of services and their eligibility for care, if they are not planning to have intercourse, or if they have easy access to condoms. Naré, Katz and Tolley (1997) in a study conducted in Senegal also identified lack of information about the location of family planning services as one of the factors inhibiting adolescents' access to reproductive health and family planning services. They observed that, some of the adolescents did not know how to find the services and they were uncomfortable and embarrassed to ask for directions.

The findings of this study also corresponded with the previous studies in supporting the view that adolescents have to know of the services to use them. The UNFPA (2013) observed that despite the increased awareness of adolescents' sexual and reproductive health needs, adolescents lacked information about the available services. Leslie et al. (2002) in an Action research conducted in Burkina Faso and Senegal (West Africa) on adolescent sexuality and reproductive health made similar observations. They found out that adolescents lacked adequate awareness about facilities in their communities which offered medical care and counselling specifically for adolescents. Despite the observations, there are striking

differences between the findings in this study and that of Leslie et al. Whereas the West African study showed that adolescents considered traditional healers as an alternative to formal health care system, adolescents in this study showed greater preference to access services in the formal health care system including the VCT services. When asked what they would do if they had a sexual health need, a higher proportion of the adolescents (39.5%) indicated that they would seek help from health professionals. The varying preferences among the adolescents reflected the prevailing socio-cultural differences in health care seeking patterns in different regions and communities. Nonetheless, the findings indicated that adolescents were eager to interact with health care providers and to be offered services. The findings contrast the notion that adolescents arrogant and not keen on being advised by the adults and the health care providers. On the contrary, adolescents demonstrated desire for health professionals, school authorities, parents, counsellors, People Living With Aids (PLWAs) and older peers like university students to offer them SM and reproductive health information and services. They however expressed the need for confidentiality and to be served by health care providers who did not know them. The lack of awareness among adolescents on the available services was also due to the non-involvement in their sexual health matters. The respondents noted the need to effectively engage adolescents and their peers in their health matters and to inform them about available services. They further noted the need to engage adolescents in giving health talks and in planning for their health services. This would help them to learn the positive aspects from their peers and their peers' mistakes and therefore make right decisions.

**Interviewer:** In your opinion, how best can these challenges be resolved?

**Provider [N]:** *'the fellow youths should be involved so much. Those who have been taking drugs and those who have been infected. These ones should be invited to talk to the youths. When a youth tells them, "I am already positive and I know what it is, so my fellow youths please do 1, 2 and 3". This time they even fear because it is their colleague who has stood there and tells them he/she is already infected. But if an old person like me stands there and tells them, they will say, "(bana sobela kudala)"– these people have enjoyed life, now they are*

*telling us not to enjoy life”. For example... when our students [nursing students] talk to the adolescents, we normally see that they listen. And they ask questions, but if I as an older person stand, there is a difference. They are also role models to the adolescents. We should have other youths who are trained to go and talk to the adolescents. A fellow youth will have a lot of impact than someone older like me.’*

Effective provision of adolescent reproductive services requires involvement of not only the providers but also of the users of the services. Adolescents are partners and stakeholders in their own health and should be informed about available SM and RHS. They should also be involved in deciding and planning for their reproductive health services. Understanding the needs of adolescents’ calls to work with them and not in isolation, the health care providers noted that adolescents rebelled and engaged in risky behaviour because they were often left to be on their own and were not involved in the planning for their reproductive health. The findings imply the need to give adolescents the right information at the right time to help them make right decisions, know their rights and become aware of the available services and where to seek them from. The government needed to continuously engage adolescents in decision-making regarding their sexual health matters. Consequently, adolescents would seek SM and RHS and open up about their health concerns.

**Interviewer:** Is there any additional information that you would like to share with me?

**Provider [C2]:** *‘It is time we went to everybody, that is, the professionals, the administration and all the stakeholders to realise that we are in a new world and that adolescents need to get the information they need and the right information at the right time so that they make the right decisions. Adolescents need to be involved more so that they know their rights, where they can get information. This is a challenge to us all ... because we are not giving a lot of emphasis to adolescent activities ... people sometimes think that they*

*[adolescents] are rebelling to what we are trying to tell them ...'*

The lack of institutionalisation of adolescent reproductive health implies that the concept of adolescent sexual and reproductive health is not common knowledge in the communities. Information regarding adolescent-friendly services is foreign at the community level and it is unlikely that adolescents, particularly those living in the rural areas, would be aware of such services. The bureaucratic red tape that regulates and vets CBOs activities restricts adolescents' access to information about the available SM and RHS. The findings of this study suggest the need to adopt a multi-sectoral approach to create awareness about adolescent-friendly services. The findings also imply the need for community education to create awareness about available health services. One health provider observed that, "there is actually a gap between what we have and what the community knows that we have". The findings imply the need to educate adolescents, parents, health care providers, CBOs and religious based organisations about the need for adolescents to access and use SM and RHS. Different forums can be used to inform communities about the available PRHS for adolescents. For instance, the provincial administration and the schools could play an important role in disseminating information through the community and parents-teachers meetings respectively. Community education is also needed to correct the perception that health facilities are only centres for treating diseases.

#### **4.4.3 Psycho-social and Interpersonal Barriers**

This study has identified psychosocial barriers that affected the level of access and utilisation of preventive reproductive health services by adolescents. The adolescents exhibited interpersonal fears of sharing sexual health problems with their parents, sharing services with adults and fear of being served by familiar health care providers. The adolescents were ashamed and embarrassed to use SM and RHS. They exhibited lack of trust of the health care givers and fear of breach of confidentiality. This hindered their access and utilisation of SM and RHS.

#### **4.4.4 Fear of Suspicion and Sharing Problems with Parents**

This study has established that communication problems experienced at the family level affected adolescents' ability to openly access and utilise SM and RHS. The adolescents generally preferred to remain with their unmet sexual health needs rather than inform or

involve their parents because of fear of being suspected of being sexually active. The adolescents preferred to share their sexual health concerns with unfamiliar persons. It was observed that ‘most adolescents fear telling their parents information about sex’. It was also observed that one could not share with parents but with someone else who did not know them. The lack of openness on sexuality matters between adolescents and their parents deepened adolescents’ fear of accessing and utilising SM and RHS. The adolescents felt that informing their parents, and even health providers, teachers and caregivers, about their need to access and utilise SM and RHS would lead to suspicion that they were sexually active. Consequently, they feared to express their need to access and utilise SM and RHS.

**Interviewer:** ... is there any time that you had a sexual health need but you did not know where to get information, advice or service?

**Adolescent 7[F17, C2]:** *‘... itching when I have periods. I have not told anyone. If I tell my friends they may start back-biting me that I have had sex. If I go to the school nurse she may tell the teachers who are her friends. If I tell my mother she may think that I have had sex. I am afraid that the doctor may also tell me that I have had sex, they start asking me many questions to arrive at this. Because of this, I have not gone to see a doctor. It has remained a problem to me. We sometimes talk among friends and they say one should apply Vaseline and powder. But this does not work with me. I also find it difficult to talk to the guidance and counselling teacher or a health care provider because even them they may think ... that I have had sex and ask my parents.’*

The findings suggested that the lack of close interaction between parents and adolescents created obstacles for adolescents in sharing their sexual health concerns. Adolescents expressed the need for parents to be open with them and to discuss sexuality issues with them. The findings imply the need to bridge communication gap between adolescents and parents regarding sexuality matters.

#### 4.4.5 Fear of Sharing Services with Adults

The adolescents feared sharing reproductive health services with adults. This study has established that there were no separate SM and RHS for adults and adolescents. Sharing of services with the adults hindered adolescents' access and use of SM and RHS. Adolescents were likely to avoid services if they felt that the services were not meant for them. The adolescents indicated that they disliked waiting and queuing for services with adults and avoided services in facilities where they were likely to meet their parents and relatives. They feared that being seen at the health facilities might raise suspicions and questioning about their reasons for seeking health care services, and were anxious that their parents might know that they had sought RHC services.

**Interviewer:** Can you tell me what some of the health care services that you feel should be provided for adolescent boys?

**Adolescent 3[M 17, N]:** *‘... it’s good to have services for different ages. If an older person finds you at the VCT, they will wonder what you are doing there and would bring the information home –[“Siti mafuna ku onewa na makolo muno mu komboni chifukwa banga uza ma makolo batu futi”] Adolescents do not want to be seen by other parents in the community because they may tell your parents. They will also wonder what you are doing there because it is thought that someone goes to VCT to be tested only for HIV but that is not the case – [“Chifukwa muntu anga yenda kwinangu kwamena ninga kambe na kufunsa muntu pali umoyo nama nkalildwe” ] ‘Someone can also go to a VCT to be counselled and guided on how to live.’*

The findings of this study corresponded with those of Moya (2002). Moya observed that young people did not want to run into family members and neighbours when entering, utilising or leaving sexual health facilities. This study established that the fear among the adolescents of suspicions and uneasiness in mixing and sharing reproductive health care services with the adults emanated from their feelings that they might be seeking “wrong” health care services which their parents might not approve of. It also emerged because of the

invisibility of adolescent health problems. Often, adolescents may lack outward physical signs and symptoms depicting their nature of illness or health problems. This gave rise to suspicions and questioning from the adults and also their peers about their reasons for seeking services. However, even if adolescents have outward physical signs like pregnancy which suggested the type of reproductive health care services needed, they may encounter discomfort in using the same services together with adults as being young and unmarried compounded the problem because reproductive health care services were seen as specifically for women and the old people. Accordingly, adolescents are not expected to seek reproductive health services. Adolescents felt that provision of separate SM and RHS would counter this problem and enhance privacy, anonymity and confidentiality in seeking care.

**Interviewer:** If you have never used the services, why is this so?

**Adolescent 11: [F19, C1];** *'If you go to hospital to seek information, someone might think that you have a disease [STD] then they will start to gossip. People may say that I am a bit too small [young] to visit these organisations. Some people associate these medical clinics as being for married women and elders.'*

The findings of this study pointed to the lack of understanding about adolescent sexual and reproductive health and about the role of SM and RHS. This also demonstrated that ambivalence and misconception about adolescent reproductive health needs leading to stigmatisation of services and social exclusion of adolescents from services. The findings entrenched the behavioural theorists' perception of 'healthy adolescents' (Perry, 2000). This also implied the need to have separate reproductive health care services for adolescents in order to curtail the psychosocial and interpersonal barriers barring adolescents from accessing and utilising available SM and RHS. Adolescents needed to be provided with services they can identify with to enhance their access and utilisation of SM and RHC services. This as a result, created an environment that encouraged adolescents to openly share their sexual and reproductive health concerns. The findings further showed a service gap in the life span where services were planned and availed to the adults and children, leaving out the adolescents. This situation needed to be corrected to ensure completeness of access and utilisation of services throughout an individual's life span. This requires firstly, an understanding that sexual and other health needs differ across the life span. Secondly, an



appreciation of the need to provide services to adolescents to meet their unique sexual and reproductive health needs and thirdly, the provision of appropriate services for them. This should be supported with public awareness and sensitisation on the need to integrate adolescents in health care delivery system.

#### **4.4.6 Fear to be served by Familiar Health Providers**

The adolescents feared being served by health providers and health professionals known to them. They feared that the health providers might negatively perceive them negatively or tell their parents that they had sought preventive reproductive health services. On the contrary, the adolescents showed confidence in sharing with people who did not know their sexual health concerns. This could be because sexual matters were private. Adolescents seemed comfortable to share their sexual health concerns with strangers who they were likely to have little interaction with in future; and who might not remember them even if they met later on. This phenomenon highlighted the complexities of dealing with adolescents' sexuality matters. This study terms this phenomenon as stranger confidence versus familiarity anxiety. The health providers made similar observations. They noted that adolescents avoided going to them if they knew their parents, or if they had served in the same facility for long and therefore had known the adolescents since childhood. The providers associated adolescents' preference for private clinics as opposed to government health facilities, if they had sexual health needs, with shame and familiarity anxiety.

**Provider [N]:** *'the youths do not feel free to come and tell us their problems. They feel ashamed to present their problems. May be it is because we have been here for a long time and they would not want us to know their problems. Not many come to present reproductive health problems like seeking family planning services and information, or even when they get raped, they do not come to report. We don't know why they do not come.'*

Despite the above observations, the health providers were opposed to the view that they should not serve in communities where they are known or in the same facility for too long. Instead, they stressed the need for providers to have the right skills to enable them serve adolescents effectively. Hence, the health providers felt that someone who was known would serve and understand the community better than an outsider. The findings implied the need

for adolescents to understand that they can obtain health information and advice and that they can ask questions about their sexual health concerns from the mainstream health facilities.

#### **4.4.7 Staff Shortage and Heavy Workload**

Staff shortage and lack of adequate space hampered the health care providers' ability to enhance confidentiality. Despite being sensitised on the need to offer individualised services in one room, during a single visit and under an environment that provided privacy and confidentiality to clients. The health providers indicated that they sometimes attended to patients together in one room to save time. The health care providers in-charge of MCH/FP clinics noted, for example, that they sometimes served clients together in one room because of staff shortages, heavy workload and inadequate consulting rooms.

Interviewer: What challenges do you face when providing services to adolescents?

**Provider [C1]:** *'... privacy at the clinic is still not optimum. Due to the large number of patients who come to the clinic, we are forced to take two patients in one room at the same time ... if there was enough room and health personnel, one would be seen alone in a room. This way the patient or the adolescent would tell you more .... This becomes a challenge particularly to the adolescents who may fear that someone may follow them. The queue is not the best .... It would be best if one would come in a way that nobody knows what one is doing.'*

#### **4.4.8 Suggestions for Improving Adolescents' Access and Utilisation of SM and RHS**

Adolescents were asked to suggest ways for improving their access and utilisation of preventive reproductive health services. The aim was to elicit proposals and recommendations for strengthening use of SM and RHS for adolescents. Adolescents indicated the need for improvement of school health services, the public sector adolescents' health services and to target communities and the parents through the religious organisations.

#### **4.4.9 Suggestions for Improving Clinic-based SM and RHS for Adolescents**

Most adolescents suggested that clinics for VCT counselling services should be improved. They suggested that health centres should have regular, intensive and programmed guidance and counselling services. They also wanted schools to establish family groups, growth groups

and academic families and the HIV and AIDS clubs to be open to all adolescents. They reported that they needed adequate information about HIV and AIDS, STDs, drug use and abuse, menstruation, relationships with the opposite sex and on condom efficacy. In addition, the adolescents reported the need to be provided with handbooks, magazines and pamphlets containing sexuality information, especially on topics that the health care providers found difficult to handle. They also expressed the need for their health care providers to have and follow to diversify the counselling topics to make them interesting.

Adolescents also suggested that they should be provided with individualised counselling services because they found it difficult to share or raise some problems in the group counselling. They also suggested that clinics should have separate guidance and counselling offices to ensure privacy.

#### **4.4.9.0 Provide Specific Guidance and Counselling on HIV and AIDS, STDs**

##### **Suggestions for Improving Public Sector Adolescent SM and RHS**

Adolescents highlighted areas for intervention by the government to improve their access and utilisation of SM and RHS. They wanted conditions at the public sector health facilities improved. They suggested that the government should provide separate services and establish health centres for adolescents, including circumcision services for boys; and ensure that adolescents did not share or wait for services with adults. They also suggested that the government should organise regular education seminars and camps to inform them about sexuality issues.

The adolescents also observed that the health providers should be sensitive to their needs, particularly when asking sensitive questions about their sexuality; that health providers should show interest in serving adolescents, and assure them that the equipment used (especially for circumcision) were safe. They also observed that staffing conditions should be improved and that the government should employ trained counsellors and other professionals to serve adolescents. Adolescents also called for government involvement of stakeholders working on adolescent health issues and to involve university students in the provision of services to adolescents. Adolescents further suggested the need to consider age and gender of the health providers serving them. The girls had greater preference for female health providers and the boys for male health providers. Adolescents generally preferred younger health care providers. However, a few expressed that age and gender of the health provider

was not an issue. They noted the importance of ensuring that health professionals serving adolescents were persons whom adolescents were comfortable to talk, with whom they could freely share their problems, and who could provide solutions to their problems. They however stressed that the health facilities should have both male and female staff to take care of their needs.

Finally, adolescents expressed gratitude for the study. They indicated that they had benefited from it and that it gave them a chance to share their concerns. They noted that they lacked someone to freely talk to and wished that such forums would be regular and involve many adolescents. They also requested to be informed about the study results.

## **CHAPTER FIVE**

### **DISCUSSION OF FINDINGS**

#### **5.0 Introduction**

This study has established that adolescents had sexual health concerns that required them to use sexual health services. Many adolescents had fears of contracting HIV and AIDS and STDs. They also had concerns about early pregnancies and early exposure to sexual debuts. Further, they had psychosocial and interpersonal concerns. The findings suggest that there is need for adolescents to adequately access and utilise SM and RHS. Despite the evidence that adolescents have sexual health needs and concerns, this study found out that adolescents did not know how to deal with these concerns. Evidence from the study showed that adolescents feared to share their sexual health problems with their parents and/or guardians, that they did not know where to seek care and were afraid that health providers would be unsympathetic to their needs. The findings also showed that many adolescents had unmet sexual health needs. For example, 44 per cent of the adolescents indicated having had reproductive health needs but did not know where to seek care from. The lack of understanding about maturation and developmental changes was a key unmet need among adolescents. The findings from this study showed gender differences in the health concerns of boys and girls. The girls worried about unwanted pregnancies and menarche-related problems. The boys had greater concerns about increased sexual desires. They lacked understanding about why they experienced increased sexual desires and why they were attracted to girls. Some boys associated this to male circumcision, which is a cultural practice undertaken during the adolescence period. Ahlberg et al. (1998) made similar observations in a study conducted on ‘breaking the silence on adolescent sexuality for prevention of HIV and AIDS in Zambia. The authors observed that adolescents link secondary sexual characteristics to circumcision. They further noted that this was not surprising because the operation was performed at the age of sperm ache, when there is a physiological increase in the production of male sexual hormones resulting in increased sexual desire. The above findings implied that adolescents were less likely to take appropriate action concerning their sexual health needs (i.e. to access and utilise services) because of lack of understanding of their sexuality. The findings point to the need to adequately educate adolescents about maturation, growth and developmental processes across the life span. This would equip them with necessary awareness about their sexual health needs and limit the negative reactions such as being embarrassed about seeking care or

assuming that they are the only ones experiencing sexual health challenges. The findings of gender differences in the concerns of boys and girls concurred with the observation by Dehne and Riedner (2005). Dehne and Riedner noted that adolescent girls were often far more concerned about preventing unintended pregnancy and menstrual problems than about STI symptoms while for boys sexual health concerns often outweighed reproductive health ones. The findings of this study imply the need to engender adolescent sexual and reproductive health services.

## **5.1 What the study found**

### **Do Adolescents then Need Sexual Reproductive Health Services?**

The study findings show great need for sexual health services for adolescents. All the adolescents, the health care providers and the key informants concurred with the need for adolescent SM and RHS as well as PRHS. The views obtained implied that adolescents have for long been ‘forgotten’ and excluded from reproductive health services, and that they were often left to do things on their own.

**Key Informant 1:** *‘... it’s only a day like today when you have come. You have even made us to think about the adolescents, the issues that they are facing and that they are a special group that needs special attention. That is an issue that does not normally come in. We do not have that kind of a forum ... it’s not that we have forgotten them [adolescents]. We can remember them but because of financial constraints, you feel that “let me leave that issue. It has its own people”.’*

Whilst acknowledging the lack of adolescent specific services, the adolescents came up with recommendations to improve access and utilisation of their services. These included the need to be offered individualised guidance and counselling. Adolescents suggested the need for open sharing and to be provided with information and advice on sexuality matters, about general health and maturation, and how to relate with peers of both sexes. They further noted the need for adequate access to information about available RHS for adolescents including information about voluntary counselling and testing services (VCTs); to be provided with Information, Education and Communication (IEC) materials and circumcision services for

boys. Adolescents also proposed the incorporation of parental guidance and counselling in adolescent health services.

### **5.1.1 Efforts to Address Adolescents' Sexual Health Concerns**

The study findings show that marginal efforts were made to address the sexual health concerns raised by adolescents. The government through the Ministry of Health also focused on the dangers of performing illegal abortions and of drug use and abuse. In addition, fellow peer adolescents' educators showcased SM and RHS through drama and plays. Outside of the clinics, the response efforts targeted the entire population. There were no gender-specific tailor-made response programmes targeting adolescents. For example, the HIV and +AIDS and VCT programmes served all people. Although there were efforts to respond to adolescents' health concerns, further study findings showed that such efforts did not provide comprehensive reproductive services that would effectively address the sexual and reproductive health needs of adolescents. The emerging views portray lack of government commitment to target and engender adolescent services. Many adolescents and health providers blamed the government for the persistent problems of unplanned and unintended pregnancies among adolescents and the lack of adequate information regarding sexual health matters.

### **5.1.2 Summary**

The above findings show that adolescents had sexual health concerns that required them to access and utilise SM and RHS. However, they did not know how to effectively deal with these concerns. Adolescents feared to share their concerns with their parents. They feared unsympathetic and judgemental health providers. They further lacked adequate awareness about where to seek care from. There were significant gender differences between the health care needs and concerns of boys and girls. Boys had greater concerns about increased sexual desires whereas the girls worried about unwanted pregnancies and menarche-related problems. Despite these concerns, adolescents have generally been "forgotten" and left to do things on their own. There are no comprehensive efforts to deal with broad sexual and reproductive health needs of adolescents. Attempts to respond to preventive reproductive health needs of adolescents have been inadequate. To improve access and utilisation of adolescent services, the following needed to be embraced:

- (i) Provision of adequate access to preventive reproductive health services;

- (ii) Increased awareness and education of adolescents about maturation, growth and development; and
- (iii) Engendering reproductive health services for adolescents.

### **5.1.3 Available Reproductive Health Services for Adolescents**

The study findings show lack of “adequate” adolescent-friendly services in Lusaka district. Two-thirds of the adolescents (65%) indicated being aware of organisations that offered reproductive health services in the Zambia - mainly VCT centres, health facilities, schools, religious organisations, CBOs, NGOs and the media.

However, many of the adolescents expressed concern about the lack of adequate adolescent-gender-specific services in their locations where they resided. Overall, adolescents considered the health facilities as key sources of SM and reproductive health services. Interestingly, more than a third of the adolescents (38%) thought that reproductive health services could be obtained from VCT centres. The above findings imply the need for greater interaction between the health care providers and the adolescents. The findings also imply that VCT centres services are an invaluable source of reproductive health services for adolescents. The findings nonetheless demonstrate the need to integrate SM and reproductive health services for adolescents with VCT services. This would ensure that all adolescents, including the ‘minors’, can benefit from VCT services.

### **5.1.3 Reasons for Lack of “Adequate” Adolescent-friendly Reproductive Health Services**

Several factors were associated with the lack of adolescent-friendly and specific services in Lusaka district. These included lack of planning for adolescent services thus creating a service gap, failure to prioritise adolescent health issues, lack of adequate data on adolescents’ sexual health situation. These factors are discussed further in detail.

### **5.1.4 Lack of Planning and Prioritisation of Adolescent Health Services**

The government policy is to improve adolescents’ access to information and reproductive health services following its commitment to the Cairo Programme of Action. However, the current health care model depicts exclusion and marginalisation of adolescents from sexual and RHS. The feeling among the adolescents, the health providers and the key informants was that the government had not done enough to address the reproductive health needs of



adolescents. The optimism expressed by some health providers about government plans to establish adolescent-friendly services in Lusaka's clinics was regarded by many as inadequate. The findings suggest that the government response programmes were often triggered by emerging public health challenges such as HIV and AIDS and not merely because of the need to address the sexual and reproductive health needs of adolescents. Claims by the government that adolescents need special services were thus perceived as mere rhetoric. The respondents echoed the need for the government to include adolescents as a special category in service delivery and to set-up reproductive health services for them.

**Provider [C1]:** *'Because of the impact of AIDS, the youth group is under threat. This is however still at the level of talk. It is mere rhetoric that adolescents need special services. There is, however, no historical evidence of isolating youth as a special category in service delivery. This could be because of lack of facilities, lack of training, the current training programmes have also not included adolescent component in their training.'*

The lack of prioritisation of adolescent health was associated with government's neglect of adolescent health. The respondents blamed the government for neglecting the health of adolescents whilst concentrating on competing health problems like fighting polio, TB and Malaria. The assumption that adolescents were healthy, that they lacked major illnesses and had no immediate health threats make their health issues to be pushed to the periphery when setting health programme priorities. This finding aligns with the developmental theorists' notion of 'healthy adolescents' which asserts that adolescents experience a relatively troublesome free and healthy transition to adult life. The findings of this study suggest that adolescents have been forgotten since the inception of health care services in Lusaka.

**Provider [N]:** *'... it's actually this time of HIV that we are now thinking of the adolescent and even thinking of protecting them. I think from the inception of health care, the adolescent was actually a forgotten person basically because they do not get sick so often. They are in their prime time and very healthy people. It is expected that they do not even get pregnant so they will*

*not need MCH and they are not expected to be sexually active. Somehow somebody did not articulate how to tackle the issue of the adolescent until now because of the epidemic that we realise that so many youths are dying even when giving birth. That means that they have been engaging in sexual intercourse. It's now we are trying to tackle their issues.'*

## **5.2 Meaning of the Study**

### **5.2.1 Lack of Baseline Data on Adolescent Reproductive Health Status**

The lack of baseline data on the sexual and reproductive health status of adolescents and lumping of adolescent health needs with the needs of adults and children, contributed to the lack of planning for adolescent SM and RHS. This also heightened the assumption that adolescents had no health needs. A further research was needed to ascertain the health situation of adolescents and to help in proper planning. The Ministry of Health, through its network of health facilities should undertake continuous monitoring of adolescent sexual and reproductive health. Further, the Ministry of Education should address sexual and reproductive health needs of the in-school adolescents. The two ministries (Health and Education) should collaborate with other government departments [Early learning department, the Ministry of Gender, Ministry of Mother, Child and Community Development and other departments like Culture and Social Services in ministries like Tourism, and Ministry of Chiefs and Traditional Affairs] to closely monitor sexual health related school drop-outs as well other reproductive health outcomes of adolescents. The gathered data should be disaggregated according to age and gender and shared with relevant departments that deal with adolescent health issues to facilitate directed planning.

The findings of this study correspond with previous studies. Kolip and Schmidt (1999) observed the need to disaggregate all health statistics by sex. They observed that sex and gender are important variables within the whole health process and that health reporting should be differentiated according to gender. Further, they argued that “without detailed information about gender-specific aspects of health, it is difficult to implement effective practices and policies” and that “sex-specific health statistics allow appropriate conclusions to be drawn for improving the health system for girls and boys”. Singh and Darroch (1999) also noted that effective policy and legal framework needed to be backed up with data.

Likewise, formulation of policies and development of programmes on ASRH required up-to-date information on levels and trends of teenage sexual activity.

The Planned Parenthood Association of Zambia (PPAZ) (2003), similarly noted the need to disaggregate data according to regions, age and marital status. They observed that the lack of data on adolescent health and sexuality implied that many adolescent policies were based on premises that the lives of adolescents in developing countries were like those of adolescents in western countries. That is, mainly living at home with families, not working, in school and unmarried. The Population Council argued that experiences of married and unmarried adolescents were different, for example, on their knowledge levels about information on contraceptive use. Thus, lumping married and unmarried adolescents together presents problems because the two groups significantly represented different populations and had varying levels of knowledge about sexuality matters. It also led to failure to address the unique needs of the married and the unmarried adolescents (PPAZ, 2003).

**Provider [C2]:** *‘we would recommend that the government should come up with a department entirely to handle the issues of the adolescents. That way, there will be somebody responsible. Just as there have been gender issues in the Ministry of Health. Just as they are concerned with the children under 18, they even have a policy for them. But for the adolescents, there is nobody taking care of them.’*

A second view was opposed to the setting up of adolescent departments. They instead suggested that existing departments and ‘youth’ programmes, like the Youth programme within the Ministry of Sports, should be strengthened and their capacities expanded to accommodate adolescent health issues. Moreover, setting up new departments may lead to duplication of services and overstretch the capacity of the already understaffed departments as implied below.

Whereas the findings emphasised the need to incorporate adolescent health issues in the existing health structures, the limitations that entail setting up new departments were noted. The findings suggest that most health facilities lacked the financial and institutional capacity to establish and equip adolescent health centres. An ideal adolescent-friendly centre should have space and be equipped with television, videos and IEC materials. Thus, the lack of

space, furniture and shortage of trained staff created further challenges. Despite the divergent opinions, the findings demonstrate the need to coordinate adolescent health programmes in the Lusaka. The findings suggest the need to establish a national coordination body or committee to monitor adolescent health issues in Zambia generally.

### **5.2.2 Variations in Knowledge about Available Services**

Adolescents had different levels of awareness about available reproductive health services. The difference related to their levels of exposure to sexuality matters as well as residential differences. The findings show that adolescents lacked basic information about available reproductive health services in the clinics in Lusaka. They also suggest that adolescents living in the low density areas had higher levels of awareness about SM and RHS than their counterparts in the high densely populated areas. For example, adolescents from low density areas had more awareness about where they could seek VCT services from mainly because of exposure to the media and literacy levels. To the contrary, many of the adolescents from within Lusaka district indicated having heard of clinics that offered VCTs that offered reproductive health services in the district but did not know about their operations. Some even wondered what VCTs were.

The health providers and the key informants concurred with this finding. They noted that adolescents in the high densely populated areas exhibited less awareness about sexuality issues, for example, about HIV and AIDS than their same age counterparts in the urban areas. The findings imply the need to tailor adolescent health services to the individual needs of adolescents, taking into account age and regional differences. Leslie et al. (2002) in a study conducted in Burkina Faso and Senegal made similar observations. Leslie et al. noted that there existed notable differences among urban, semi-urban and rural populations of adolescents regarding sexual and reproductive health knowledge, attitudes and behaviour. Further, they suggested the need for policy makers to recognise diverse needs of youth in these areas and to tailor programmes accordingly. The United Nations (2005) also observed that adolescents had a right to sex education and to access reproductive health services that are tailored for their needs.

### 5.2.3 Parental Neglect and Ignorance about Adolescent Health Matters

Parental ignorance and neglect about adolescent reproductive health and sexuality contributed to the ignorance among adolescents about available services. The study findings showed lack of parental involvement in adolescent health matters and expressed that talking about sex matters with parents was a taboo in our African set up. Accordingly, adolescents had no one to inform them about existing RHS and the need to use them. Parental neglect has its roots in the shift in the socio-cultural practices.

Traditionally, for example, among adolescents, they were taught sexuality matters by their grandparents and guardians and never a parent, it was either the mother's sister or cousin who talked to them about sexual issues and not on the father's side. With changes in traditional practices, there emerged a gap because no systems were put in place to replace the traditional teaching methods. As a result, many parents were in a dilemma and found it difficult to openly share sexuality matters with their children. Consequently, adolescents depended on their peers for information. The situation was perpetuated by the changing social-economic patterns and community structures whereby parents spent most of their time working for their families' upkeep. They thus had little time to understand the health challenges facing their adolescent children.

**Key Informant 1 :** *'... the community structures or family set-ups the way they are now, we may not have the time or the opportunity to communicate as well as we would or as it used to happen with the adolescents. You find that they fall into a lot of problems and sometimes they do not know who to go to... most of the people ... the parents may not even know that there is a problem of drugs consumption among their children until when it is very late.*

This study concurs with the observations made by previous scholars that, parents relegated the responsibility of advising adolescents to the schools and institutions like churches. Mutati (1998) observed that adolescent ignorance about sexual and reproductive behaviour was compounded by the reluctance among parents and teachers to impart relevant information. Tolosi (2004) similarly noted the tendency by parents to offer adolescents information in response to negative events. In that study conducted, it was observed that parents did not talk

with their adolescent children about sexual and reproductive health; and that when they did, this was often triggered by a wedding, a birth or the first menstrual cycle. They further noted that even then, the information given by parents to adolescents was often vague and inadequate. Leslie et al. further noted that some parents were opposed to adolescents' access to sexual and reproductive health services due to fears that adolescents were too young and that such services would promote promiscuity and early sexual relations. The findings further suggested the need for parents to take greater parenting roles since some of the problems faced by adolescents started from home and could be identified, prevented and dealt with at the family and household level. Although clinics could deal with some of the problems facing adolescents like control of drug in-take, they were only complementing agencies and not 'rehabilitation centres'. Their focus was more on providing health services to its communities rather than counselling services. There is therefore a need for parents to be educated on the challenges experienced by adolescents so that they were not strangers to their adolescent children. The findings further imply the need to educate parents about sexual and reproductive health matters. The health providers and the key informants observed the need to educate parents not only about adolescent sexual and reproductive health but reproductive health issues in general. They observed that some parents did not understand their own reproductive health needs. Accordingly, it would be difficult for them to advise their adolescent children. The adolescents made similar proposals. Most of them felt that their parents and even some of their teachers for those who were in schools felt that they did not understand them. They proposed the need for parents' guidance and counselling to expose them to adolescent health issues.

#### **5.2.4 Summary**

The study findings showed lack of "adequate" adolescent-gender and specific services in Lusaka district. Adolescents considered health facilities as key sources of SM and reproductive health services. The lack of adequate adolescent-friendly services in Lusaka district was associated with lack of planning for adolescent services, failure to prioritise adolescent health, lack of reliable data about adolescents' sexual health status. The findings also showed that Lusaka was still lagging behind in developing viable adolescent health services and outreach programmes. There was need for baseline data to assess and ascertain the reproductive health situation of adolescents in Lusaka district. Lessons drawn from the data should be used to devise adolescent gender-specific friendly policies and help planning for adolescent health programmes. The findings further suggest the need to establish a

national coordinating body to monitor and coordinate adolescent health issues. There was also need for more engagement strengthening of departments handling adolescent health issues, NGOs and CBOs focusing on adolescent health; and to initiate health education and counselling programmes targeting parents.

### **5.2.5 Clinic Health Services**

The findings from this study show that health centres had made efforts to address adolescents reproductive health needs. Clinics offered SM services, counselling services, and had integrated (infused) HIV and AIDS. The findings show that clinics have caregivers who attend to the health needs of adolescents and offer them curative services. They also offer referral health services to adolescents who need additional care to the nearest health facilities. The caregivers included resident or non-resident school nurse, or resident matron or cateress.

This study identified several weaknesses in the health services such as firstly, the lack of confidential and individualised services. It was discovered that the counselling services were not individualised or confined, these were offered publicly or in groups. Adolescents were not free to openly share their sexual health concerns with their counsellors, thus creating a communication barrier. The adolescents feared that their peers might tease them if they openly shared their concerns. The findings showed lack of trust and suspicion between adolescents and the caregivers. Many adolescents seemed unhappy with the way their health problems were handled. The adolescents portrayed their caregivers as unfriendly, disinterested, uncaring, rude, intrusive and unwilling to help. They lacked understanding about how to handle adolescent health problems. Adolescents cited difficulties in sharing their health problems with school caregivers as observed in one of the interviews below:

**Interviewer:** *Does this clinic provide you with information and services that can help you meet these concerns?*

**Adolescent 12[F15, C1]:** *‘... nurses can also help when one has a problem. But some are not so friendly. So even when you have a problem you will not go there. Yet they are the only ones who can give permission to go to be referred elsewhere.’*

The lack of openness, compounded by lack of trust of their health provider and fear of breach of confidentiality resulted in ineffectiveness in meeting individual sexual health needs of

adolescents. Although they aimed at narrowing the communication gap between adolescents as well as enhance open sharing, the findings suggested that adolescents should share with their care givers what they perceived as morally appropriate. Some deconstructed their real problems and asked questions indirectly pretending that they were asking on behalf of friends or that they had heard a rumour. The findings also showed lack of consistency and uniformity in the clinics' sexual health services lack of consistency, uniformity and continuity creating levels of marginalisation among the adolescents in the accessing SM and reproductive health information and services. The above findings pointed to the need for clinics to provide confidential individualised reproductive health services to adolescents. This would foster open sharing, enhance professionalism in service delivery and would in turn boost access and utilisation of reproductive health services by adolescents. The findings implied the need for clinics to have separate counselling office space. There is also an indication for the need for regular, planned and coordinated guidance and counselling.

Furthermore, the findings imply the need to involve adolescents in designing and planning the counselling sessions to make them more appealing and relevant to their needs. The schools, in conjunction with the Ministry of Education and the Ministry of Health, needed to work together to develop a common or standard curriculum or programme for adolescent reproductive health to be followed by schools and health centres. As much as possible, the counsellors and health providers should follow a set counselling curriculum to avoid repetitiveness. They should also allocate adequate time to allow adolescents to ask questions regarding their sexual health concerns. In addition, provide adolescents with information packs about sexuality issues have follow-up programmes and hold the sessions regularly and not in response to crisis like when there were cases of unwanted pregnancies. Consequently, adolescents trust and confidence in their health providers and response efforts would be enhanced. The fact that reproductive health starts from childhood and that the needs of both men and women differ in each life stage is accepted. The life course perspective is relevant because it highlights the need to understand the present and future reproductive health needs of adolescents. The sexual behaviour of today's adolescents has implications for their future reproductive health. Thus providing a continuum of care is needed to meet the different reproductive health needs of individuals throughout their life span.

The findings of this study showed lack of complete and comprehensive SM and RHS. Ideally SM and RHS health services should encompass promotion of positive health behaviours among adolescents, management of health problems like STIs, health in pregnancy,



counselling and referral services to meet individual needs of adolescents, reinforcement of health instruction with an emphasis on health promotion and prevention of STIs including HIV and provision of health screenings (WHO, 2006). This study has established that the lack of comprehensive SM and RHS and the lengthy referral procedures created obstacles for adolescents in meeting their sexual health needs.

### **5.2.6 Utilisation of SM and Reproductive Health Services by Adolescents**

Adolescents did not adequately utilise available SM and reproductive health services. Only about a third of the adolescents (31.6%) had used SM and reproductive health services. Two interpretations could be derived from this finding. One was that, adolescents were healthy and did not need to access and/or utilise the health services as implied by the notion of ‘health adolescents’. This was also implied by about a third of the adolescents (40.5%) who indicated failure to use health services because they had no sexual health need. The second interpretation was that, adolescents had sexual and reproductive health needs but did not have access to utilise the services in order to meet these needs. Evidence from this study greatly supported the latter view. The findings showed that adolescents had sexual health needs and that they desired to access and utilise SM and RHS. The low utilisation of services by adolescent was associated with adolescents’ failure to go to health care facilities. The health providers observed that adolescents had needs but did not physically seek the health services. The providers felt that this was a social issue that required ‘breaking the bridges between the adults and the adolescents’ to understand the thinking and perceptions of adolescents. A few providers expressed hope that VCT services would help to open up the ‘bridges’ between adolescents and the health care systems. Others, however, noted that VCTs may not provide optimal solution to the challenges faced by many adolescents because of policy barriers that restrict access to VCT services for adolescents below 18 years (Section 6.2.1). The health providers indicated that adolescents did not seek SM and reproductive health services even when in need.

**Interviewer:** What are the main services that adolescents seek from this clinic?

**Provider [N]:** *“When they come here for the first time, they come for antenatal. They often come when they are pregnant ... when we take their profile, we find that some have STIs and some even have HIV and AIDS...”*

**Provider [C1]:** *‘...the youths do not feel free to come and tell us their problems ... maybe it is because we have been here for a long time, and they would not want us to know their problems. Not many come to present reproductive health problems like seeking family planning services and information. Or even when they get raped, they do not come to report.’*

This study has established that adolescents visited health care facilities to seek post-exposure reproductive health services. These included antenatal (ANC) services, post-abortion care, curative services for STDs or even HIV infections. Adolescents faced specific challenges that affected their level of access and utilisation of SM and reproductive health services. The findings also showed that the lack of laboratory services, negative attitude towards services and delay in recognising STIs especially among girls, made adolescents to delay seeking care. Further study findings suggest that there existed gender differences among adolescents in accessing and utilising SM and RHS. Two out of three health providers observed that more girls than boys used SM and reproductive health services. The services used by the girls were cited as: ANC, MCH/FP and treatment for severe menstrual pains. They observed that most of the adolescents who sought ANC and MCH/FP were married. The services used by the boys were cited as: to obtain condoms, occasional treatment for STI. The health providers indicated that STI cases among adolescents were few and had declined over time. They associated this to the success of HIV and AIDS awareness programmes. They however noted that the few STI cases were mainly among girls largely because of their physiological make-up and that, boys preferred to seek services from the private health facilities. The fact that reproductive health starts from childhood and that the needs of both men and women differ in each life stage is accepted. The life course perspective is relevant because it highlights the need to understand the present and future reproductive health needs of adolescents. The sexual behaviour of today's adolescents has implications for their future reproductive health. Thus providing a continuum of care is needed to meet the different reproductive health needs of individuals throughout their life span.

**Interviewer:** What are the main services that adolescents seek from here?

**Provider [C2]:** *“... no boys come to the clinic. It is only the girls. Maybe if there was an adolescent clinic, we would include adolescent counselling and this would probably attract the boys. As for now, we do not have adolescent counselling nor as a specific service ... The number of girls seen at the clinic is higher than that of the boys. This is because most of the girls come here asking questions about their reproductive health and antenatal issues. Others come with complaints about STDs. The boys don't come here when they have STDs. They go to private clinics”.*

The findings of this study aligned with previous studies that indicated that girls face greater reproductive health challenges than boys (Leslie et al. 2002; MoH, 2004). The femininity and masculinity theory could also explain the observed gender differences in access and utilisation of SM and reproductive health services among adolescents. Kolip and Schmidt (1999) noted that ‘boys were the “weaker sex” up to puberty since they were more often sick and present to a doctor’ and that ‘this health-related gender ratio was reversed in adolescence’.

### **5.3 Summary**

The above findings indicated low use of SM and RHS by adolescents. Although the theory of ‘health adolescents’ could explain why few adolescents had used services. There was compelling evidence to suggest that adolescents had sexual and reproductive health needs and that they desired to access and utilise a SM and or a RHS. However, a multiplication of factors prohibited their use of services. Evidence showed that adolescents did not go to the health facilities even when they had sexual health needs and were therefore not physically accessible to the health providers. Thus, the health providers lacked an opportunity to provide them with preventive reproductive health services. The findings also suggested that adolescents sought post-exposure reproductive health services as opposed to preventive reproductive health services. The findings have also shown the gender differences in accessing and utilising SM and reproductive health services.

## **CHAPTER SIX**

### **CONCLUSION, RECOMMENDATIONS AND POLICY IMPLICATIONS**

This section presents the overall study conclusions and the implications of the study findings. It provides concrete proposals on what needs to be done to address identified barriers that hinder effective provision, access and utilisation of SM and RHS for adolescents. It further presents proposals for improving access and utilisation of SM and RHS by adolescents and for informing policy.

#### **6.0 Study Conclusions**

This study sought to establish the factors influencing the access and utilisation of SM and reproductive health services by adolescents in Zambia. The study was expected to gain an understanding of the challenges facing adolescents in their pursuit to access and utilise SM and RHS in Lusaka urban.

The study findings showed that adolescents had sexual and reproductive health concerns that required them to access and utilise SM and RHS. The adolescents expressed behavioural, psychosocial, maturation and developmental and societal-related concerns. The main sexual health concerns of adolescents included fear of contracting STIs including HIV and AIDS, concerns about early pregnancies and about early exposure to sexual debuts. The findings also showed that adolescents lacked adequate knowledge about maturation and body changes. There existed gender differences in the concerns of boys and girls. Whereas boys showed greater concern about increased sexual desires, girls worried about unintended pregnancies and menarche-related problems. The findings further showed that adolescents had psychosocial and societal related concerns. Despite the notable concerns, adolescents feared to share their concerns with parents, health providers and caregivers. They feared being suspected as sexually active and to consult health providers they perceived as judgemental and unsympathetic. They also lacked awareness about available services and the service provision procedures. The findings showed that efforts by the government, schools, NGOs, CBOs and Faith Based Organisations (FBOs) to address sexual and reproductive health concerns of adolescents were inadequate and incomprehensive. Adolescents were socially excluded from SM and RHS and were left with no one to advise them. As a result, their needs

remained unmet. Many adolescents turned to their peers for advice who might also be inadequately or incorrectly informed.

This study provided ample evidence to support the contemporary theorists' notion that adolescents faced sexual health risks that justify their need to access and utilise sexual and reproductive health services. The contemporary view recognises the need for intervention to avert health problems that may arise during adolescence. Firstly, it recognises the "healthy adolescents" notion that adolescents are in the healthiest stage of the life span and may lack major health problems. It however also borrows the "problem-based adolescent" view that adolescents experience stress and storm. It further asserts that a combination of biological and socio-cultural factors expose adolescents to sexual health risks. Thus there is need to intervene to provide adolescents with quality health care services. However, several factors may come into play in influencing effective intervention efforts. These are highlighted in the sociological view and the social exclusion paradigm. The social exclusion notion highlights societal, structural and institutional factors that perpetuate adolescents' inability to take advantage of available SM and RHS to protect themselves from sexual health risks facing them. Further, societal perceptions and expectations of adolescence determine the kind of reproductive health services that are provided to adolescents.

Despite this, the level of use of SM and RHS by adolescents was low. The health providers could not effectively reach and serve adolescents because adolescents did not go to health facilities and did not want to be served by familiar health providers. The study shows prevailing gender differences in access and use of SM and RHS. The health providers revealed that more girls than boys sought SM and RHS. However, adolescents generally sought post-exposure as opposed to pre-exposure SM and RHS. The study highlighted the need to engender adolescent reproductive health services taking into account the social confinements of adolescents. The study established additional barriers that significantly hampered adolescents' access and utilisation of preventive reproductive health services summarised as follows:

## **6.1 RECOMMENDATIONS AND POLICY IMPLICATIONS**

This study has the following specific recommendations and policy implications that need to be considered. They include the following:

### **6.1.1 Intensify Efforts to Provide Adolescent-friendly and Gender-specific SM and RHS**

The findings that there were no adolescents-friendly and specific services in Lusaka district implied the need for the government to intensify efforts to establish adolescent centres in Zambia. The aim should be to ensure adolescents equal access to information and services. Although this study restricted itself to one district, the findings reflect the general situation in most districts of Zambia. As a first step, the government, schools, NGOs, CBOs and FBOs need to formally acknowledge that adolescents have sexual and reproductive health (SRH) needs and concerns and that they need to access and utilise SM and RHS. This should be followed with provision of the services to adolescents. Further, there is need to engender adolescents' sexual and reproductive health services. This should ensure that adolescent health programmes and interventions target the unique and individual needs of boys and girls. Efforts to respond to adolescents' health concerns should consider the socio-cultural confinements of boys and girls regarding sexual health matters. The services should address diverse SRH needs of adolescent boys and girls that encompass prevention, protection, health promotion and care. They should also enhance adolescents' access to factual SRH information and education, to confidential guidance and counselling services and to curative and referral services. To accomplish this, the government needs to do the following:

1. The government (through the MoH) needs to establish comprehensive freestanding or integrated adolescent friendly-services in Lusaka and other districts in the whole country. It should ensure that adolescents were provided with accessible, acceptable, confidential, flexible and friendly health services that adolescents can identify with.
2. Allocate a budget and provide enough funds for establishment of adolescent clinics countrywide and for equipping them with videos and IEC materials suitable for adolescents.
3. Establish voluntary counselling and testing (VCT) centres in Lusaka district and other rural areas. As much as possible, VCT services should be integrated into adolescent-friendly and SM and RHS. The aim should be to ensure that VCT services are available for adolescents who need to access and use them.

4. Provide information, advice, education and counselling to adolescents about maturation, growth and development across the life span, relating with peers, parents and adults, personal hygiene and cleanliness and dealing with rape.
5. Provide promotive and preventive reproductive health services. These should include preventive care such as counselling and testing services for pregnancies and STDs; provision of contraceptives (including condoms); intervention, treatment and referral services; provision of delivery services including pre- and post-natal care, pre- and post-abortion care, and rehabilitation services to address drug use related problems as well as services promoting abstinence.

### **6.1.2 Standardising Adolescents' RHS and Programmes**

This study has shown lack of uniformity in the adolescent health services. The government in partnership with policy makers, programme planners and health providers need to harmonise and standardise adolescent health programmes in Zambia. There is need for stakeholders' consensus about the content, depth and quality of adolescent SM and RHS package. The aim should be to ensure adolescents have access to reasonable, comprehensive, and uncensored sexual and reproductive health information and services; and to ensure uniformity and accuracy of information provided to adolescents. Although the study findings show overwhelming need for adolescent SM and RHS, they also show lack of consensus on the type of services that should be provided to adolescents. Divergent views persisted among health providers and key informants on whether to offer SM and RHS to adolescents, especially contraceptives. The NGOs and CBOs need to be actively engaged in developing an adolescent SM and RHS package. This would reduce the need to censor and vet school-based sexuality services. Further, there is need to develop a checklist for periodic monitoring and evaluation of adolescent SM and RHS. The checklist should form the starting point for monitoring the reproductive health status and outcomes of adolescents. It should also be enforced and used as reference documents for ensuring that all adolescents, irrespective of gender, age, marital status or locality, have access to full range of SM and RHS. Also the content and quality of services offered to adolescents need to be continuously monitored and evaluated.

### **6.1.3 Prioritising Pre-exposure SM and RHS and Enhancing Outreach Programmes**

This study has established that existing SM and RHS and policies largely address post-exposure reproductive health needs. Accordingly, adolescents seek post-exposure services like ANC, post-abortion care or treatment for STIs as opposed to pre-exposure services. The government, in collaboration with strategic stakeholders like the MoH, MoE, NGOs, CBOs and FBOs need to strengthen and boost availability of pre-exposure SM and RHS for adolescents. To achieve this, the government needs to do the following:

1. Encourage adolescents to seek pre-exposure SM and RHS and not just post-exposure services. This can be achieved by educating adolescents on the available PRHS for them and by addressing barriers that hinder their access and use of the services.
2. The government should adopt and enforce policies that promote provision of SM and RHS to adolescents. Adolescents' access to SM and RHS should be enhanced and provided through the public and private health facilities, schools, NGOs, CBOs, FBOs and appropriate community forums. The government should also intensify community awareness about the benefits of early access and utilisation of SM and RHS by adolescents. This would help to de-stigmatise SM and RHS.
3. Strengthen and scale-up SM and RHS and outreach programmes for adolescents - the government should support health providers and/or caregivers to provide PRHS to adolescents within and outside of the health care facilities, in communities and places most frequented by adolescents. The government needs to designate specific staff to coordinate and oversee implementation of SM and RHS and outreach programmes for adolescents. It should also provide health care providers with adequate and reliable means of transport to enable them effectively reach adolescents.
4. There is need to assess and improve health institutions' capacity (human and technical) to provide comprehensive and confidential SM and RHS. Further, there is need to address staff shortages and enhance equitable distribution of staff in all regions. The government needs to train more staff to specifically serve adolescents and reduce or limit staff transfers. Further, it should continuously assess and evaluate the training needs of health professionals serving adolescents and constantly update them on global reproductive health issues of adolescents.





Picture from the internet

## References

- AGE (1998). Adolescents, sexuality and the socio-economic and cultural change: Impact on reproductive health in an African setting' in Stolen K. A. (ed) Gender, Culture and Power in Developing Countries University of Oslo, Vol II.
- Ahlberg, Beth M. et al. (1998). 'Male circumcision: practice and implication for transmission and prevention of STD/HIV in Central Kenya' in Becker C. et al. (eds) Experiencing And Understanding AIDS In Africa Codesria: Karthala & IRD pp599-612.
- Alderman and lavy (1996). Culture, gender and change: Reflections on challenges on equal sexual and reproductive rights for women and men' Presented On A Q Web Seminar, November 2000 available at <http://www.qweb.kvinnoforum.se/choiceandpower/papers.html> [accessed 2012, March 22]
- Araoye and Fekaye (2003). Gendered construction of sexual risks: implications for safer sex among young people in Kenya and Sweden'. Reproductive Health Matters 9 (17): 67 – 77.
- Bassett, Mary T. (2000). What They Don't Know Can Hurt Them: How School-Based Reproductive Health Programmes Can Help Adolescents Lead Healthy Reproductive Lives Adolescent and Reproductive Health Project of the Training and Research (TARSC).
- Bambra D, (1999). Do young women in tropical regions constitute a recognized social category?' Acta Tropica 62: 201 - 207.
- Barton, E. (2001). Design in observational research on the discourse of medicine: toward disciplined interdisciplinarity. Journal of Business and Technical Communication, 15, 309 – 332.
- Beazley L. and Knejp, (1996). Pre-budget analysis of the education sector' in IPAR A Pre-Budget Outlook of the Kenyan Economy Institute of Policy Analysis and Research Policy Quarterly Issue 1.
- Blaikie, N. 2000. Designing Social Research: The Logic of Anticipation. Polity Press. Cambridge.
- Bornemann, Reinhard (2006). Personal communication [accessed 2013 February 28].
- Bossert, W. D'Ambrosio and Peragine, V. (2005). Deprivation And Social Exclusion Centre for Household Income, Labour and Demographic Economics, CHILD Working Papers 03/2005.

- British Medical Association (2003). Adolescent health. British Medical Association, Board of Science and Education:
- Basavanthappa, B.T. (2007). Nursing Research. 2<sup>nd</sup> ed. Jaypee Brothers, Medical Publishers: New Delhi.
- Butler, Patricia A. (2004). 'Sexual health - a new focus for WHO'. Progress in Reproductive Health Research. UNDP/UNFPA/WHO/World Bank Special Programme Of Research, Development And Research Training In Human Reproduction (HRP). World Health Organization, Geneva: Progress 67.
- Burns and Grove (2009). Choosing research methods: Data collection for development workers. Oxford UK Information Press, Eynsham, Development Guidelines No. 7.
- Cal S. K, (1998). The International Encyclopedia of Sexuality, New York: Continuum publishing company, Volume I – III.
- Central Statistical Office (CSO) [Zambia] and Macro International Inc. 2009.
- Chanda K, (1988). Country Cooperation Strategy: Zambia: 2002–2005. World Health Organization, Regional Office for Africa Brazzaville
- Charmaz K, (2002). 'Grounded theory: Methodology and theory construction' International Encyclopaedia of the Social & Behavioural Sciences Elsevier Science Ltd. pp 6396 – 6399.
- Cohen M, (2002). 'Adolescence: 11 – 21 Years' in Green Morris and Palfrey Judith (eds) Bright Futures: Guidelines For Health Supervision Of Infants, Children And Adolescents. National Centre For Education In Maternal And Child Health Georgetown University. Second Edition, Revised.
- Conrad, P. (2002). 'Qualitative health research' International Encyclopaedia of the Social & Behavioural Sciences Elsevier Science Ltd. pp 6608 – 6612 Cook, Rebecca J. and Dickens,
- Bernard M. (2000). Considerations For Formulating Reproductive Health Laws World Health Organization (WHO), 2nd Edition, WHO/RHR/001.
- Corbett, Elizabeth et al. (2002). 'HIV-1/AIDS and the control of other infectious diseases in Africa'. The LANCET 359 (9324): 2177 - 87.
- Davies and Gibson (1968). Integrating STI Management Into Family Planning Services: Occasional Paper 1
- Dehne, Karl and Riedner, Gabriele (2005). Sexually Transmitted Infections Among Adolescents: The Need For Adequate Health Services World Health Organization and Deutsche Gesellschaft fuer Technische Zusammenarbeit (GTZ) GmbH.

- Department for International Development (2004). Sexual And Reproductive Health And Rights A position paper: DFID.
- Dever J, (1984). 'Life course: sociological aspects' International Encyclopedia of the Social & Behavioral Sciences. Elsevier Science Ltd. pp 8817 – 8821.
- Dick, Bob (2002). 'Grounded theory: a thumbnail sketch' available at <http://www.scu.edu.au/schools/gcm/ar/arp/grounded.html> [accessed 2012, February 15].
- Dickens, B.M. and Cook, R.J. (2005). 'Adolescents and consent to treatment'. International Journal Of Gynaecology And Obstetrics 89 (2): 179 -184.
- Elster, Arthur B. and Kuznets, N.J. (1994). AMA Guidelines For Adolescent Preventive Services (GAPS): Recommendations And Rationale Baltimore: American Medical Association, Williams and Wilkins.
- Erikson, F. (1986). Qualitative methods in research on teaching. In: Wittrock M.C. (ed.) Handbook of research on teaching (PP. 119 – 161). Macmillan: New York
- Eschborn (2002). 'Sexual and reproductive health of young People: Experiences from technical cooperation projects' in Neckermann Christina (ed) Deutsche Gesellschaft Für Family Health International (2000). Programs For Adolescents: Encouraging Youth- Friendly Clinics Network 20 (3): FHI.
- Feuerstein, Jane G. (1993) Health And Population. Supraregional Project Innovative Approaches In Reproductive Health Revised Edition
- Flykers Charles .K (1995). 'Hand into Glove: The grounded theory approach and social work practice research' in Edmund Sherman and Reid. J. Willian (eds) Qualitative Research In Social Work New York: Columbia University Press
- Focus on young people (2000). Barriers And Benefits Of Managed Care For Low-Income Women. Centre for Health Policy Research, UCLA Policy Brief.
- Furstenberg, F. (2001). 'Adolescence: sociology of' International Encyclopedia of the Social & Behavioral Sciences Elsevier Science Ltd. pp 94 - 97.
- Germain, Adrienne (2000). 'Population and reproductive health: Where Do We Go Next?' American Journal Of Public Health 90 (12): 1845 -1847.
- Girard, Françoise (1999). 'Cairo + Five: Reviewing progress for women five years after the International Conference on Population and Development'. Journal of Women's Health and Law 1 (1).

- Glaser, B.G. and Strauss, A.L. (1978). *The Discovery Of Grounded Theory: Strategies For Qualitative Research* Chicago: Aldine. Glaser, Barney (1992). *Emergence Vs. Forcing: Basics Of Grounded Theory Analysis* Mill Valley: Sociology Press.
- Goodburn, Elizabeth A. and Ross A. David (2000). 'Young people's health in developing countries: a neglected problem and opportunity'. *Health Policy And Planning* 15 (2): 137–144.
- Green and Davey, (1995). 'Qualitative evidence on adolescents: views of sexual and reproductive health in Sub-Saharan Africa'. Occasional Report 16, New York: The Alan Guttmacher Institute.
- Guba, E.G. & Lincoln, Y.S. 1994. Competing paradigms in qualitative research. In Denzin N.K. & Lincoln Y.S. (eds.) *Handbook of qualitative research* (pp. 105-117). Sage: Thousand Oaks, CA.
- Guest, Greg; Bunce Arwen and Johnson Laura (2006). 'How many interviews are enough? An experiment with data saturation and variability'. *Field Methods* 18 (1): 59 - 82.
- Häggström-Nordin, E. (2005). *Worlds Apart? Sexual Behavioural, Contraceptive Use, And Pornography Consumption Among Young Women And Men* Dissertation: Uppsala Univesitet, Uppsala Dissertations from the Faculty of Medicine 6.
- Harding, G. and Taylor, K. (2002). 'Social dimensions of pharmacy: Health, illness and seeking health care'. *The Pharmaceutical Journal* 269: 526 - 528.
- Heaven, Patrick C.L. (1996). *Adolescent Health. The Role Of The Individual Differences* New York & London: Routledge Publishers. Heller, Daliah;
- Henshaw (1996) 'Behavior change evaluation of a culturally consistent reproductive health program for young Kenyans'. *International Family Planning Perspectives* 30 (2): 58 - 67.
- McCoy, Kate and Cunningham, Chinazo (2004). 'An invisible barrier to integrating HIV primary care with harm reduction services: Philosophical Clashes between the Harm Reduction and Medical Models'. *Public Health Reports* 119:32 - 39.
- Hocklong, Linda et al. (2003). 'Access to adolescent reproductive health services: Financial and structural barriers to care'. *Perspectives On Sexual And Reproductive Health* 35 (3): 144 - 147.
- Hogerzeil, Hans (2003). 'Access to essential medicines as a human right'. *Essential Drugs Monitor* 33.
- Holmes A, (2008). Qualitative content analysis'. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research* 1 (2).

- Hurrelmann, K. (1990). 'Health promotion for adolescents: Preventive and corrective strategies against problem behaviour'. *Journal Of Adolescence* 13: 231 - 50.
- International Conference on Population and Development ICPD, 1994. Programme of Action, Chapter VII: Reproductive Rights and Reproductive Health 7.8. P.48. Cairo, 5-13 September 1994. United Nations Population Fund.
- Institute of Economic Affairs (2002). *The Little Fact Book: The Socio Economic & Political Profiles Of Kenya's Districts* Nairobi: IEA. Inter Press News Service (1996). 'Kenya population: Church burns condoms and AIDS materials' Inter Press News Service (IPS), 5 September 1996.
- International Women's Health Coalition (1994). 'Challenging the culture of silence: Building alliances to end reproductive tract infections' IWHC: New York available at <http://www.users.interport.net/i/w/iwhc/sfa.html> [accessed 2013, January 12].
- IntraHealth International (ca. 2004). *Improving The Performance Of Primary Providers In Family Planning And Reproductive Health: Results And Lessons Learned From The PRIME II Project, 1999-2004* Chapel Hill, NC.
- Jejeebhoy, Shireen J. (1998). 'Adolescent sexual and reproductive behavior: A review of the evidence from India'. *Soc. Sci. Med.* 46 (10): 1275 -1290.
- Josselyn (1962) *Children And Young People In A World Of AIDS*. Joint United Nations Programme on HIV/AIDS, UNAIDS/0156
- Kelly (1998-2001) *Origins of Development*. National Academy Press. Washington D.C
- Kerlinger, F. 1969. *Foundations of behavioural research*. Holt Rinehart & Winston: London.
- Kirby D. K. (2000). 'Improving adolescent preventive care in community health centers'. *Pediatrics* 107 (2): 318-327.
- King, Rosalyn M. (2004). 'Adolescence: Overview, history, theories' King's Psychology Network available at <http://www.psyking.net/id183.htm> [accessed 2006, March 22].
- Kipke, D. Michele (Ed) (1999). *Risks And Opportunities. Synthesis Of Studies On Adolescence* Washington D.C: National Academy Press.
- Kings (2004) 'Contraceptive use among high school students in Zambia'. *International Family Planning Perspectives*, 21(3).
- Kolencherry, Shuby (2004). *Sexual And Reproductive Health Needs Of Young People: A Study Examining The Fit Between Needs And Current Programming Responses In India* Dissertation: School of Public Health, University of Bielefeld.

- Kolip, Petra and Schmidt, Bettina (1999). 'Gender and health in adolescence' European Health 21 Target 4 (13) World Health Organization (WHO) Health policy for children and adolescents (HEPCA) series No. 1.
- Kuh, D. et al. (2003). 'Life course epidemiology'. J. Epidemiol. Community Health 5: 778-783. Kuria, George T. (1992). 'Facts of File' Encyclopaedia of the Third World, Fourth Edition, New York: Vol. iii: 970 – 971.
- Kombo & Tromp, L.A. 2006. Proposal and thesis writing: An introduction. Paulines Publications Africa: Nairobi
- Léonie, Sugarman (1996). 'Lifespan development' in Aitken Y and Jellicoe (eds) Behavioural Sciences For Health Professionals Development, London: Saunders Company Ltd.
- Leslie, Joanne et al. (2002). Youth Sexuality: Action Research From Burkina Faso And Senegal Los Angeles: Pacific Institute for Women's Health.
- Library of Congress (2005). 'Country profile: Kenya' Federal Research Division (FRD), United States available at <http://lcweb2.loc.gov/frd/cs/profiles/Kenya.pdf> [accessed 2012, March 23].
- MacNealy, M.S. (1999). Strategies for empirical research in writing. Addison Wesley Longman: New York.
- Malibaliti 1994 Rural life and internet accessibility: A partnership of exclusion?' Tangentium 2 (1).
- Marshall, Catherine and Rossmann, Gretchen (1995). Designing Qualitative Research. California: Second Edition, Sage Publications Inc.
- McCarry, Melanie and Baxter, Louise (2004). 'The school for policy studies study skills manual' University Of Bristol available at [http://www.bris.ac.uk/sps/downloads/study\\_skills/13.pdf](http://www.bris.ac.uk/sps/downloads/study_skills/13.pdf) [accessed 2012, July 12].
- McCauley, A. P. and Salter, C. (1995). 'Meeting the needs of young adults'. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Population Reports, Series J 41: 1-39.
- McCormick, Dorothy and Schmitz, Hubert (2001). Manual For Value Chain Research On Homeworkers In The Garment Industry Institute for Development Studies, University of Nairobi and Institute of Development Studies, University of Sussex.
- McIntyre Peter (2002). 'Adolescent friendly health services: An agenda for change' World Health Organisation (WHO) Publication, WHO/FCH/CAH/02.14 available at

[http://www.who.int/child-adolescent-health/publications/ADH/WHO\\_FCH\\_CAH\\_02.14.htm](http://www.who.int/child-adolescent-health/publications/ADH/WHO_FCH_CAH_02.14.htm) [accessed 2013, September 03].

Merluzzi and Nairn,(1999). Guidelines For Ethical Evaluation Of Medical Research Involving Human Subjects: The Policy And Organisation Of Research Ethics In Sweden,

Ministry of Health (1999c) 1999 Population Census Ministry of Planning and National Development, Lusaka. Ministry of Health (1997). Sessional Paper No. 4 of 1997 on AIDS In Zambia Ministry of Health, Zambia: Lusaka and MOH.

Ministry of Health (2005a). AIDS Zambia In: Background, Projections, Impact, Interventions, Policy Ministry of Health, Sixth Edition, Lusaka and MOH.

Ministry of Health (2006b). National Condom Policy And Strategy 2001 – 2005. Ministry of Health in Collaboration with the National AIDS Control Council (NACC), Lusaka: and MOH.

Ministry of Health (2004). National Profile: The Status Of Children's Environmental Health Republic of Kenya, Nairobi: MOH.

Ministry of Health (MoH) 2009. 'Health services availability and utilization' Government Of Zambia, MoH available at <http://www.health.go.zm/> [accessed 2013, January 03].

Ministry of Health (2007c). National Guidelines For Voluntary Counselling And Testing. Ministry of Health, National AIDS and STD Control Programme (NASCOP) & National AIDS Council (NAC), Lusaka: and MOH.

Ministry of Health (2008d). Quality Health Care To All Zambians: First National Congress On Quality Improvement In Health Care, Medical Research And Traditional Medicine Final Congress Report, Lusaka: Zambia and MOH.

Ministry of Health (2009). AIDS In Kenya: Trends, Interventions And Impact, National AIDS and STI Control Programme (NASCOP), Lusaka: and MOH 7th edition.

Mpangile M, (2004). 2003/4-2007/8 Strategic Plan For National Statistical System Ministry of Planning and National Development, Tanzania:

Mensch P. (1993). 'A Review of the Regulatory Framework for Private Healthcare Services in Kenya'. Social Sector Division, Kenya Institute for Public Policy Research and Analysis, KIPPRA Discussion Paper 35.

Millstein, Susan G. et al. (1993). 'Adolescents health promotion: rationale, goals, and objectives' in Susan G. Millstein, Petersen A.C, Nightingale E.O (eds) Promoting The Health Of Adolescents: New Directions For The Twenty-First Century.



- Moya, Cecilia (2002). *Creating Youth-Friendly Sexual Health Services In Sub-Saharan Africa: Issues At A Glance* Washington, DC: Advocates for Youth.
- Musonda 2008 Predicting household poverty: A methodological note with a Zambian example'. Social Sector Division Zambia Institute for Public Policy Research and Analysis. Discussion Paper Series 12.
- Mutati C. (1998). *Adolescents and Reproductive Health in Ndola*. University of Zambia.
- Naré, Christine, Katz, Karen and Tolley, Elizabeth (1997). 'Adolescents access to reproductive health and family planning services in Dakar (Senegal)'. In Okonofua F. and Snow (Editors), *African Journal Of Reproductive Health*. Women's Health and Action Research Centre 1 (2).
- National AIDS Council (2002-2005). *Mainstreaming Gender Into The Zambia National HIV/AIDS Strategic Plan 2000 - 2005 The Gender and HIV /AIDS Technical Sub-Committee of the National AIDS Council (NAC)*, Zambia, Lusaka: NAC.
- Neckermann, Christina (2002). 'Promotion of reproductive health in health services' *Hands On! A Manual for Working with Youth on SRH* Deutsche Gesellschaft fuer Technische Zusammenarbeit (GTZ) GmbH.
- Oxford Dictionary (2014) Oxford. Oxford press. 2013
- Passages Act (1997). *Barriers And Opportunities For Integration Of STD/HIV And MCH/FP Services In Tanzania* unpublished report, London: London School of Hygiene and Tropical Medicine.
- Parahoo V.V.F (2006). 'Perspectives of adolescent boys on the risks of unwanted pregnancy and sexually transmitted infections: Burundi'. *Reproductive Health Matters* 9 (17): 57- 66.
- Pearce, J.C. 1971. *The crack in the cosmic egg: challenging constructs of mind and reality*. Washington Square Press New: York.
- Perry, L. C. (2000). 'Preadolescent and adolescent influence on health' in B.D. Smedley and S. L. Syme (ed) *Promoting Health: Intervention Strategies From Social And Behavioural Research* Washington D.C: National Academy Press.
- Peters, D.A. 1993. Improving quality requires consumer input: using focus groups. *Journal of Nursing Care Quality*, 7, 34-41.
- Planned Parenthood Association of Zambia (2003). *Facts About Adolescents From The Demographic And Health Survey – Statistical Tables For Programme Planning: Zambia 2003* New York:

- Procter A.(1\1997). Capacity-Building Resources In Youth Sexual And Reproductive Health: Pack 3: Youth-Friendly Health Services Program for Appropriate Technology in Health and NGO Networks for Health, Washington DC:
- PATH. RCAP (1994). 'Fact Sheets about AIDS/STD issues: Preventing HIV/STD among adolescents'. Rural Center for AIDS/STD Prevention [RCAP], Fact Sheets 1.
- Polit, D.F. & Beck, C.T. 2008. Nursing research: principles & methods. 7<sup>th</sup> ed. Lippincott Williams & Wilkins: Philadelphia.
- Rayner (1972). Adolescent Reproductive Health & Development Policy National Council for Population and Development (NCPD), Ministry of Planning and National Development, and Division of Reproductive Health.
- Raymond C. (1999). 'Adulthood and aging: Transitions in health and health cognition' in Thomas L. Whitman, Merluzzi V. Thomas and White D. Robert (eds) Life-Span Perspectives On Health And Illness London: Lawrence Erlbaum Associates Publishers pp 189-206.
- Reproductive Health News 1997, Living covers tory: from boys to men' Daily Nation Newspaper Zambia [accessed 2014 May, 20]
- Rigge, M. 1994. Involving patients in clinical audit. Quality in Health Care, 3 (supply), S2-S5.
- Rowntree, et al. (2000). 'Diversity amid globalization' 1995-2000 Prentice-Hall Inc: A Pearson Company available at <http://cwx.prenhall.com/bookbind/pubbooks/rowntree/chapter6/> [accesses 2014, March 03].
- Southern Africa HIV Action (2003)Report on teenage sexuality and their understanding of STDS/HIV in Zambia'. African Population Studies 2 (12).
- Sandelowski, Margaret (2000). 'Focus on research methods: Whatever happened to qualitative research'. Research In Nursing And Health 23 (4): 334 – 340. John Wiley and Sons, Inc.
- Santana, P. (2002). 'Poverty, social exclusion and health in Portugal'. Social Science & Medicine 55: 33–45.
- Seats E, (2000). Contraception in adolescence' in Issues In Adolescent Health And Development Discussion Papers on Adolescence:
- Singh, Susheela and Darroch, Jacqueline E. (1999). 'Trends in sexual activity among adolescent American women: 1982-1995'. Family Planning Perspective 31 (5): 212-219.

- Erikson, F. 1986. Qualitative methods in research on teaching. In: Wittrock M.C. (ed.) Handbook of research on teaching (PP. 119 – 161). Macmillan: New York
- Snelson K, (1974). ‘Zambia health profile’: WHO available at <http://www.who.int/countries/zm/co/> [accessed 2013, February 09].
- Stanley G. Hall (1844-1924). ‘How do the youth in two communities make decisions about using condoms?’ Centre for Social Science Research. CSSR Working Paper No. 2
- Steinberg, L. (2001). ‘Adolescent development: theories of’ International Encyclopedia of the Social & Behavioral Sciences Elsevier Science Ltd. pp 102 – 105
- Stewart, D.W. and Shamdasani, P.N. 1990. Focus Groups: Theory and practice. Sage Publications: Newbury Park.
- Stone, Nicole and Ingham, Roger (2002). ‘Factors affecting British teenagers' contraceptive use at first intercourse: The importance of partner communication. Perspectives On Sexual And Reproductive Health 34 (4): 191 – 197.
- Stone, Nicole and Ingham, Roger (2003). ‘When and why do young people in the United Kingdom first use sexual health services?’ Perspectives On Sexual And Reproductive Health 35 (3): 114 – 120.
- Strauss, A.L. and Corbin, J. (1990). Basics Of Qualitative Research: Grounded Theory Procedures And Techniques Newbury Park: CA, Sage.
- Sustainable Human Development in Zambia(1996).Report on Development And Research Training In Human Reproduction (Fourth Edition) Geneva:
- The Nation Newspaper. Teenage pregnancy on the rise. 2013, [accessed July 31<sup>st</sup>.Lusaka].
- Thomas, David R. (2002). ‘Qualitative research methods: data gathering and data analysis’ Health Research Methods Advisory Service Department Of Community Health. University Of Auckland available at <http://www.health.auckland.ac.nz/hrmas/resources/Qualit2002.pdf> [accessed 2013, January 10].
- Trochim, William M. (2004). ‘The research methods knowledge base’ 2nd Edition available at <http://trochim.human.cornell.edu/kb/index.htm> [accessed 2014, March 03].
- Tolosi M, (2004) Adolescents and sexuality. University of Zambia.
- U.S. Agency for International Development (2002-2003). ‘New voluntary counseling and testing sites reach growing numbers’ Success Stories: HIV/AIDS Bureau for Global Health: USAID.

- United Nations (1999a). Links Throughout The Life Cycle: Women's Empowerment And Reproductive Health United Nations Population Fund, Pacific Institute for Women's Health, Los Angeles: UNFPA.
- United Nations (2005). 'Platform for action and the Beijing declaration' Fourth World Conference on Women, Beijing, China. 4 - 15 September 2005.
- United Nations Children's Fund (1997) Health And Family Planning Overview Bureau for Africa, Office of Sustainable Development ,UNFPA [accessed 2014,January,23]
- United Nations Department of Public Information. United Nations (1999). Follow-up to the fourth world conference on women: Implementation of strategic objectives and action in the critical areas of concern: Thematic issues before the commission on the status of women Report of the Secretary-General, Economic and Social Council, E/CN.6/1999/4.
- United Nations Population Fund (2000b). Reproductive Health: Meeting People's Needs. United Nations Population Fund, Annual Report: UNFPA.
- United Nations Population Fund (2003a). Making 1 Billion Count: Investing In Adolescents' Health And Rights. State of World Population, 2003: UNFPA.
- United Nations Population Fund (2003b). Adolescent Reproductive Health: Working To End Gender Inequity Population Issue 3: UNFPA.
- United Nations Population Fund (2005a). The Promise Of Equality. Gender Equity, Reproductive Health & The MDGS. The State of World Population, 2005: UNFPA.
- United Nations Population Fund (2005b). 'International Conference On Population And Development, ICPD At Ten' The World Reaffirms Cairo: Official Outcomes of the ICPD at Ten Review: UNFPA.
- United Nations Population Fund (2005). 'Programme priorities: Adolescent reproductive health' UNFPA Annual Report 2005: UNFPA available at <http://www.unfpa.org/about/report/report97/adolesce.htm> [accessed 2013, January 19].
- United Nations Development Programme (2013). Third Zambia Human Development Report: Participatory Governance For Human Development, UNDP.
- United Nations Population Fund (2005). 'Programme priorities: Adolescent reproductive health' UNFPA Annual Report 2005: UNFPA available at <http://www.unfpa.org/about/report/report97/adolesce.htm> [accessed 2013, January 10].
- United Nations Population Fund (2013). Youth: At Risk And In Need Of Information And Services The State of World Population, News Feature: UNFPA.

- United States Agency for International Development (2001). 'Africa overview: Zambia' USAID: Budget Justification FY 2001 available at <http://www.usaid.gov/pubs/bj2001/afr/ke/> [accessed 2012, March 23].
- Vivian, Green and Basiro, Davey (1995). 'Adolescent development and risk taking' in Basiro Davey (ed) *Birth To Old Age: Health In Transition* Open University Press, pp 92 - 109.
- Wamboldt, D. Barbara (1992). 'Content analysis: method, applications and issues' *Health Care For Women International* 13: 313 – 321. Webb, S [Ed], (1998). *Insights From Adolescent Project Experience 1992-1997* Watertown: Pathfinder International.
- Wilbon, Matisa (2005). *Sex 'N The Hood. The Interrelationships Among Neighbourhood Characteristics, Parental Behaviour, Peer Networks, And Adolescent Transition To First Sex*. Dissertation: Ohio State University.
- Winnet(1994) *Reproductive Health Strategy To Accelerate Progress Towards The Attainment Of International Development Goals And Targets* Geneva: WHO.
- White C.J. 2005. *Research: A practical guide*. Prentice Hall Inc: Pretoria.
- World Bank (1993) *World Development Report 1993: Investing In Health*. Oxford University Press: The World Bank's World Development Report.
- World Bank (2003). *Sexually Transmitted Diseases: Policies and Principles for Prevention and Care* UNAIDS Best Practice Collection, Key Material:
- World Health Organisation (1993-1997). *The Status of School Health* Geneva: WHO.
- World Health Organisation (2003-2004). *The Second Decade: Improving Adolescent Health And Development: Adolescent Health And Development Programme Family And Reproductive Health*: WHO/FRH/ADH/98.18, Geneva: WHO.
- World Health Organisation (2005-2006a). 'Strengthening the provision of adolescent-friendly services to meet the health and development needs of adolescents in Africa' A Consensus Statement Emanating From A Regional Consultation On Strengthening The Provision Of Adolescent-Friendly Services To Meet The Health And Development Needs Of Adolescents In Africa Harare Zimbabwe: WHO.
- World Health Organisation (2007-2008b). *Reproductive Health During Conflict And Displacement. A Guide For Programme Managers* SHR Department of Reproductive Health and Research, World Health Organisation (WHO/RHR/00.13), Geneva: WHO.
- World Health Organisation (2009-2010a). 'Country health indicators: Zambia' Statistical InformationSystem:WHOavailableat <http://www3.who.int/whosis/country/indicators.cfm?country=ken> [accessed 2012 March 29].

World Health Organisation (2011-2012a). 'Adolescents sexual and reproductive health' Child And Adolescent Health And Development: WHO available at <http://www.who.int/child-adolescent-health/asrh.htm> [accessed 2013, August 07].

World Health Organisation (2013b). 'Special programme of research, development and research training in human reproduction guidelines for research on reproductive health involving adolescents' in Preparing A Research Project Proposal: Guidelines And Forms UNDP/UNFPA/WHO/World Bank Special Programme Of Research;WHO.

World Health Organisation (2013a). 'Contraception in adolescence' in Issues In Adolescent Health And Development Discussion Papers on Adolescence: WHO

Zambia Demographic and Health Survey 2007: Key Findings. CSO and Macro International Inc: Calverton, Maryland, USA

## APPENDICES

### Appendix A: Data Collection Instruments

#### STUDY ON HEALTH SERVICES FOR ADOLESCENTS IN LUSAKA

#### THE UNIVERSITY ZAMBIA

**Researcher: Chuma Simbyakula, School of Humanities and Social Sciences, University of Zambia, Tel: +260 977 424280 or +260 966 424280. Email: [chuma.nyirenda@gmail.com](mailto:chuma.nyirenda@gmail.com)**

**Dear Participant,**

My name is **Chuma Simbyakula**, a postgraduate student in the department of Gender Studies at the University of Zambia in the School of Humanities and Social Sciences conducting a study on the above topic.

You have been purposively selected to take part in the study. Your participation is purely voluntary and you reserve the right to withdraw any time without any explanations. Even when you agree to participate, you are free to refuse to answer certain questions you are not comfortable with.

## ADOLESCENTS INTERVIEW QUESTIONNAIRE

### Bio data:

1. Name: .....
2. Can you please tell me your age? .....
3. Please tell me whether you live with your parents? (both, one, other) .....
4. What is the occupation of your parents? .....
5. Can you please tell me your religious affiliation? .....

Young people like you, experience body and emotional changes as they grow up. They also have needs and concerns about their health and they sometimes wish that they can get someone to talk to and share these concerns. I would like to ask you some questions about your main health concerns and how you try to cope or deal with them. Please feel free to ask any questions or seek clarifications or ask me to translate into vernacular if you are not clear with the question. The information that you will provide will be treated with utmost confidentiality and will not be used for any other purpose other than this study. Participation in this research is voluntary and you are free to withdraw your participation at any time.

### Reproductive Health Services:

6. Now X ..... what do you think are the major health problems facing adolescents in Lusaka today?
7. As far as you know, is anything being done by the government, NGOs or other organisations to address these concerns? Please explain.
8. Please tell me, does this clinic provide you with information and services that can help you to meet these concerns? Please explain.
9. In your opinion, do you think that it is necessary for adolescents like yourself to be provided with sexual health services? Please explain.
10. (For girls, if boy go to Question No. 11). Can you tell me what some of the services are that you feel should be provided for adolescent girls?



11. (For boys, if girl go to Question No. 12) Can you tell me what are some of the services that you feel should be provided for adolescent boys?

**Use of Services:**

12. Please tell me if you have ever received services that you have mentioned above? (If No go to Question No. 30)
13. If Yes, what kind of services did you received?
14. Why did you choose to use the service in particular?
15. Can you tell me whether anyone prompted you to go to these health centres?
16. Can you tell me whether anyone accompanied you to receive these services?
17. Please tell me whether you had to pay to receive the services. (If No go to Question No. 26)
18. If yes, did you find the services affordable? Please explain
19. Please tell me some of the things that you liked about the service that you received?
20. What are some of the things that you felt could have been done better?
21. Please tell me, whether you were satisfied with the services that you received?
22. Did you receive additional information about sexual health matters, for example, how you can protect yourself or someone else from getting sexually related illnesses, pregnancy and HIV/AIDS? Please explain. (Go to Question No. 30)

**Never Used the Service:**

23. If you have never used the services, why is this so?
24. Do you know of someone else who has used the services mentioned above? Please explain (If No go to Question No. 30)
25. Please tell me the extent to which they were satisfied with the services that they received.

26. Please tell me, is there any time that you had a sexual health need but you did not know where to get information, advice or service? Please explain
27. Is there any additional information that you would like to share with me about other services or information that are necessary for adolescents?

**Thank you for your time - END**

## STUDY ON HEALTH SERVICES FOR ADOLESCENTS IN LUSAKA

### THE UNIVERSITY OF ZAMBIA

**Researcher: Chuma Simbyakula, School of Humanities and Social Sciences, University of Zambia, Tel: +260 977424280 or +260 966424280. Email: [chuma.nyirenda@gmail.com](mailto:chuma.nyirenda@gmail.com)**

Dear Participant,

My name is **Chuma Simbyakula**, a postgraduate student in the Department of Gender Studies at the University of Zambia in the School of Humanities and Social Sciences conducting a study on the above topic.

You have been purposively selected to take part in the study. Your participation is purely voluntary and you reserve the right to withdraw any time without any explanations. Even when you agree to participate, you are free to refuse to answer certain questions you are not comfortable with.

### HEALTH PROVIDERS' INTERVIEW SCHEDULE

#### Bio-data:

1. Name of the organisation:.....
2. Name of the expert:.....
3. Position in the organisation:.....

As the ..... at this institution, I am sure that you have a wealth of experience in reproductive health matters. I would like you to share this information with me. At this juncture, I would like to ask you a number of questions. My first question to you is:

4. What do you think are the major health concerns/challenges facing adolescents in Zambia and in Lusaka district today?
5. As far as you know, is anything being done by the government or other agencies to address these issues or concerns?

6. Please tell me about the reproductive health services that are offered at this institution/in the district etc.
7. Among the services that you have mentioned, which ones are offered especially for adolescents?
8. Can you tell me how your institution/organisation is involved in provision of reproductive health services to adolescents in Lusaka?
9. What are some of the challenges that you or your institution/organisation face in offering reproductive health services in general?
10. Do you or your institution/organisation face any specific challenges when offering reproductive health services to adolescents?
11. In your opinion, how best can these challenges be resolved?
12. In your opinion, how do these policies influence provision and utilisation of reproductive health services by adolescents?
13. In your opinion, how best can these challenges be addressed?
14. Can you tell me about the reproductive health services that are most sought by the adolescents at your health centre/ facility?
15. About how many boys/girls seek reproductive health services from your health centre/ facility per day
16. Are the services offered in the same setting as those for the adults?
17. Is there any additional information that you would like to share with me?

**Thank you for your time – END**