A STUDY OF ADOLESCENT DECISION-MAKING AND PREGNANCY IN ZAMBIA: THE CASE OF LUSAKA URBAN DISTRICT 1991-1998.

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APPROVAL

This dissertation by **Paul Mzumara** is approved as fulfilling part of the requirements for the award of the degree of Master of Arts in Gender Studies of the University of Zambia.

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DECLARATION

I declare that this dissertation was written and submitted in accordance with the rules and regulations governing the award of the Master of Arts Degree of the University of Zambia. I further declare that the dissertation has neither, in part nor in whole, been presented as substance for award of any degree, either to this or any other University. Where other people's other work has been drawn upon, acknowledgement has been made.

Signature of Author: 

Signature of Supervisor _____

Date: _____

ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
CAFS	Centre for African Studies
CCF	Christian Children's Fund
CSA	Census Sampling Area
CSEA	Census Statistical and Enumeration Area
CSO	Central Statistical Office
GRZ	Government of the Republic of Zambia
HIV	Human Immuno-deficiency Virus
ICPD	International Conference on Population and Development
ICCPR	International Covenant of Civil and Political Rights
IEC	Information, Education and Communication
KAP	Knowledge, Attitudes and Practice
PAI	Population Action International
PPAZ	Planned Parenthood Association of Zambia
PSU	Primary Sampling Unit
SFH	Society for Family Health
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
UN	United Nations
UNICEF	United Nations Children Emergency Fund
UNFPA	United Nations Fund for Population Activities
UTH	University Teaching Hospital
ZDHS	Zambia Demographic Health Survey

DEDICATION

In loving memory of my late young sisters Naomi and Rejoice. You were always a great joy to me.

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ABSTRACT

This study examines adolescent decision-making in matters of sexuality and pregnancy, and focuses on how adolescents decide about sex. With regard to their ability to decide freely and responsibly about sex, the underlying assumptions of the concepts of reproductive health and reproductive rights, which appear in the literature on adolescent sexuality, are used to empirically test adolescent decision-making and pregnancy. These presuppositions include:

a. The right to attain the highest standard of sexual and reproductive health, and right to service and information to make this possible and
b. The right of individuals to decide freely and responsibility if and when to have sex and/or children, and to have the information and means to enact their choices.

Further, the influence of other factors (socio-economic, political, cultural, and demographic) variables on adolescent decision-making, like family circumstances, the community and social institutions in relation to adolescent sexuality are also investigated in this research.

This study demonstrates that the majority of adolescents in Zambia are sexually active with high levels of adolescent pregnancy, and birth and that the brunt of all this heightened sexual activity is borne largely by the girls. Consequently, side by side with being sexually active, girls experience serious losses in their ability to freely and responsibly decide about sex to the extent that they are vulnerable to the whims and desires of their partners. This point is an important explanation for the rising incidence and rate of teenage pregnancy that is beginning to fuel calls for redefining adolescent sexuality and sex.

In short, the data collected reveal that a lot is wrong with the social, cultural, and economic environment within which adolescents make decisions about sex. Although adolescents indicated that the fear of diseases and the behaviour of their partner determined whether or not they would have sex, this research also demonstrates that there is a relationship between the sexual environment of adolescents, decision-making and the occurrence of pregnancy. It is also significant in this respect that most adolescents felt very strongly that adult figures in the community (parents, the clergy, teachers, etc.) disapproved of their efforts to take responsibility for their sexuality and fertility. This dilemma is partly to be explained by the inherent contradiction of Zambian society between the passion to keep adolescent sex a taboo while at the same time allowing indiscriminate and widespread sexual activity by all who can. This paradox, the study shows, robs teenagers of legitimate information flow channels and is, therefore, one of the factors that inhibits adolescents ability to freely and responsibly decide about sex.

CHAPTER ONE

Introduction

This study examines the relationship between adolescent decision-making and pregnancy in Zambia during the period 1991 to 1997. A clearer picture of the nature of this relationship will emerge through scrutiny of the incidence of adolescent pregnancy and the social context within which adolescents make decisions between choices.

Zambia has a relatively young and youthful population with 57.4 per cent of these aged under 20 (CSO, 1996:). The nature of reproductive health of the adolescent population is related to the sexual activity of this age group, the early age at first birth and the high incidence of Sexually Transmitted Infections (STIs). Most of this burden falls on female adolescents. Not only do they face problems stemming from pregnancy, with its serious health and economic ramifications, but the low status traditionally assigned to them in society compounds their situation even more. In general terms, the problems that adolescents face in Zambia appear to be similar to those encountered by adolescents in other countries. These, amongst others, involve the high incidence of pregnancy and STIs and poor access to contraception. In the Zambian context specifically, adolescent reproductive health and the concept of adolescence itself is a relatively recent phenomenon. Web (1996:) states that the emergence of a clearly recognised interim period between childhood and adulthood is the product of several decades of rapid social transition linked to urbanisation, westernization and a sustained period of widespread chronic poverty. They further point out that in Zambia the partial resistance to change is reflected in the lack of policies and social suppression of the emerging 'trends' such as increased pre-marital pregnancy and the extension of the period of formal female education. Adolescent reproductive health issues in Zambia are thus complex and sensitive.

However, the severity of the problems surrounding teenage pregnancy and STIs have induced seemingly donor driven responses in financial terms in a straight line dichotomous relationship of external pressure facilitating increased internal awareness

and activity in addressing adolescent and sexual health issues. This process has inevitably given rise to a lot of controversy and soul searching on the part of both policy-makers and society in general.

This study addresses those aspects of adolescent's sexuality that impinge directly on sexual decision-making and pregnancy. The main objective is to explain the major pitfalls and problems associated with and arising out of adolescent sexuality decision-making and pregnancy in Zambia, including the social, economic, political and cultural environments within which adolescents find themselves living. It must be stated at the outset that seven years may be too short a time frame to fully examine and understand the problems of adolescent decision-making and pregnancy. It is stressed here, therefore, that focus is primarily on observable results of the interaction between decision-making and pregnancy in the short-term.

Statement of the Problem

Adolescence is a time of change in which adolescents (13 to 19 year olds) are expected to increasingly regulate their own behaviour and to be responsible for the consequences of their actions. Adolescents confront a series of complex, yet fundamental questions concerning sexuality and pregnancy. Many adolescents make decisions that shape their experience and define issues associated with adolescent sexuality in a larger context.

These decisions entail that both male and female adolescents share responsibility for their sexual behaviour and fertility in the face of competing pressures from peers, society and their partners. This environment exposes adolescents to a high degree of vulnerability. This study essentially, therefore, focused on adolescent's decision-making ability in matters of sexuality and pregnancy and the extent to which they are able to make decisions concerning reproduction free from discrimination, coercion and violence.

Objectives of the Study

The major objective of the research effort was to investigate and examine the phenomenon of adolescent decision-making and pregnancy.

Specifically the objectives of the study were: -

(i) To determine the extent and magnitude of the problem of adolescent pregnancy in Zambia,

(ii) To determine the extent to which both female and male adolescent are able to decide freely and responsibly when to have sex and have the information to do so,

(iii) To determine the extent to which both female and male adolescent share responsibility for their sexual behaviour, fertility and well being of their partners,

(iv) To determine the factors that affect adolescent access to high standard sexual and reproductive health services and information,

(v) To examine the circumstances that impact the occurrence of pregnancy in terms of whether or not pregnancy is pre-planned, is a result of rape situations, is spontaneous, or is it a result of non-use or ineffective use of contraception, and

(vi) To outline the future course of adolescent reproductive rights and decision-making in Zambia.

Purpose of the Study

The purpose of the study was to examine adolescent sexuality decision-making and pregnancy and to develop a framework for identifying the context of adolescent reproductive rights and institutional arrangements, which can form the basis for successful prevention of adolescent pregnancy and enhance adolescent reproductive health.

Significance of the Study

The significance of this research for adolescent sexuality and reproductive health is multifaceted. At a crucial choice point in life, the social context can help to mould the adolescent into a responsible adult and guide them to a fruitful life, or it can in contrast

consign them to a truncated future, leaving them ill-equipped and poorly motivated to face the consequences of their sexuality.

Yet little is known about the social context of adolescent decision-making and pregnancy. While the consequences are a stark reality, the sources are only dimly seen and have to a large extent remained a subject of speculation. The study was, therefore, intended, first to learn how one might structure and construct interventions conducive for the prevention of adolescent pregnancy and enhancement of adolescent reproductive health. Secondly, the research was intended to find out some of the less obvious effects of peer group controls which appear to govern the lives of many adolescents and to learn how these controls may themselves be harnessed so that their effects on adolescents lives may be beneficial ones.

Definition of Concepts

Adolescent

For purposes of clarity it must be mentioned that youth, juveniles, children and adolescents are defined differently in various documents, including some GRZ/Ministry of Health publications, which refer to children and youth ranging from 6-25 years of age. Under the Juvenile Act of the Laws of Zambia the term 'juvenile' refers to a person who has not attained the age of twenty. For purposes of consistency the definition employed in this study and analysis will be that of an adolescent being a young person between the ages 13-19.

Adolescent Decision-Making

Adolescent decision-making refers to the ability and capacity of adolescents to make decisions concerning matters of sexuality and reproduction free from discrimination, coercion, and violence. The extent to which they are able to decide freely and responsibly if and when to have sex and/or children and have the information and means to enact their choices. It also refers to adolescents' choices about whether or not to become sexually active and the contextual factors that impact adolescent decision-making in relation to pregnancy.

Sexuality

The concept of sexuality is broad and all encompassing and cuts across physical, emotional and psychological dimensions of every human being. According to Fine and Alter (1996) human sexuality includes sexual behaviour and functions, as well as awareness of the body. The act of sex is only one part of sexuality, which is a complex psychological and physiological system both separate from and linked to the reproductive system.

They further stress that sexuality is a form of expression that begins and continues throughout life, involving the physical, emotional, social and intellectual aspect of every, person; that is also shaped by how a person feels about themselves. If they like themselves, feel comfortable about their body and believe in their own abilities, they are more likely to be comfortable with their own sexuality.

In further clarifying sexuality Fine and Alter (1996) point out that biological sex (female or male) is determined when we are conceived, but how any person feels about their sexuality is to some extent shaped by culture and the society in which they grow up and live. They further point out that attitudes to sexuality are strongly influenced by the way people are brought up, by what their parents think about sex, what their friends think and the sexual behaviour of those around them. Attitudes are also affected by what people think about themselves and by their belief systems and values.

Sexuality then is thus inherent in both humanity and society manifesting itself from cradle to the grave. At some point along this continuum, every person becomes an adolescent and has thus to contend with issues associated with sexuality. Choices and responsibilities concerning their bodies begin to confront them. The most challenging of these involve sexuality. Whatever choices or decisions adolescents make in this respect have particular consequences for them, their sexual partner and others. For this reason, adolescents need to know about their own sexuality and the options available to them.

Sexual Rights

1. Sexual rights, according to the ICPD (1994), embrace basic human rights and include:
   (i) Full respect for the physical integrity of the human body
   (ii) The right to the highest standard of sexual and reproductive health
   (iii) The right to necessary information and service, with full respect for confidentiality; and
   (iv) The right to make decisions concerning sexuality and reproduction free of discrimination, coercion and violence.
2. Definition and recognition of sexual rights is necessary to prevent sexual violence, coercion and discrimination against certain people in society, and to promote sexual rights for all the world's women and men. According to the ICPD (1994) recognising sexual rights will help ensure that women and girls are not subject to: unwanted sexual relations, including pregnancy and child bearing: coercive or unsafe contraception services or unsafe abortion: physical, sexual and psychological violence in the home including marital rape, battering, imprisonment and incest; unwanted medical interventions or bodily mutilations, including female genital mutilations: discrimination and violence on the basis of sexual orientation: transmission of sexually transmitted diseases (STD's) and HIV/AIDS; and systematic rape as a weapon of war.

Recognition of sexual rights is therefore important in the double sense that recognition forms the basis for prevention of sexual violence, coercion and discrimination on the one hand and the basis for promotion of sexual rights on the other.

Reproductive Rights

The concepts of reproductive health and rights are derived from the work of international women's health world-wide. Reproductive rights embrace existing human rights and include:

(i) The right to attain the highest standard of sexual and reproductive health and the right to services and information to make this possible: and

(ii) The right of individuals to decide freely and responsibly if and when to have sex and/or children, and to have the information and means to enact the choices

Reproductive rights are further defined as basic human rights like the right to life. They allow individuals both women and men as well as couples, the freedom to make decisions about the number of children they want and when to have them. Reproductive rights also imply that women, men and couples are able to act on these reproductive decisions while experiencing the highest possible standard of sexual and reproductive health care. Coercion should never be a factor (ICPD, 1994).

The United Nations Fund for Population activities (UNFPA, 1997) describes reproductive rights and their implications as follows:

(i) **The Right to Survival/Life**

This is a basic right to which we are well accustomed. In relation to women's rights it implies that women's status and health care services should be improved to reduce maternal deaths. In Zambia, according to the 1996 ZDHS, there are 649 pregnancy related deaths for every 100, 000 live births – a daily tragedy. Accomplishing this right will involve reducing early and high risk pregnancies; improving pregnant children's access to maternal care, especially pregnancy obstetric care; training providers; providing adequate supplies and equipment; managing the resources available, both human and material, to provide the best possible care; and to prevent both unwanted pregnancies and the incidence of unsafe abortion.

(ii) **The Right to Liberty and Security of Person**

This is the right to enjoy and control one's sexual and reproductive life as well as the right to informed consent when there is a medical intervention. Rape is a serious violation of this right. Using any method of family planning should not be either a criminal offence or forced upon someone.

(iii) **The Right to the Highest Attainable Standard of Health**

This implies a right to have access to health care of the highest possible quality, including care related to sexual and reproductive health, protection from harmful practices, and information and counselling to enable informed decisions.

(iv) **The Right to Family Planning**

This is clear and has been accepted through various declarations since 1968. It basically refers to controlling the number of children a couple desires or the process of regulating fertility and conception as a birth control mechanism through use of various methods or modes of contraception. These methods may vary from natural to scientific ones.

(v) **The Right to Marry and Found a Family**

This implies that services for the prevention and treatment of STD's must be available, as these are a major cause of infertility.

(vi) **The Right to Privacy and Family Life**

This includes the right to make confidential choices about whether and when to have a family.

(vii) **The right to the Benefits of Scientific Progress**

This implies a right to have access to available reproductive health care technology, including family planning methods. For Zambia and most other countries this must be balanced with the cost of providing these technologies.

(viii) **Right to Education**

Fulfilment of the right to education is one of the most powerful ways of giving women knowledge, skills and self-confidence to participate fully in the development process. Female education helps to postpone the age of marriage and first pregnancy and to reduce family size.

ix) **The Right to Non-discrimination on the Basis of Sex**

This means that women must be able to make reproductive health decisions without the consent of their spouse, that girls must be able to continue their education when pregnant and that both sexes of children must be given the same chances for schooling.

(x) **The Right to Non-discrimination on the Basis of Age**

This implies that young people have the same rights to reproductive health information and services, including confidentiality, as do adults.

From the foregoing, it is now internationally recognised that sexual and reproductive rights are essential components of human rights. Without them, people are vulnerable to exploitation and oppression, and gender equality cannot be achieved.

CHAPTER TWO

Theoretical Framework

This chapter lays down the theoretical basis of the study. It is argued here that although there is no standard theoretical framework for studying adolescent decision-making and pregnancy, nevertheless, the issues involved could be adequately understood by locating within the main theories of decision-making. The purpose is to highlight how these theories of decision-making have influenced the perception of reproductive health and rights problems in society.

There are various explanations of sexual decision-making. Four theoretical perspectives are discussed here:

(i) The Malthusian approach

(ii) The social learning theory;

(iii) The cognitive behavioural perspective, and

(iv) The theory of patriarchy

(v) Post-modernism and post structuralist theories.

The Malthusian approach was based on the principle of population - the Malthusian law that population, when unchecked, increases geometrically while at most the food supply increases arithmetically - seen as a natural law about man. So far as sex is concerned, three things were important. First, he saw sex as existing in order that the earth may be peopled. Like any other instinct, it must neither be carried to excess nor used in a way contrary to its primary purpose. Human being rationale beings must regulate and direct their instincts. And, though sex is incidentally also a source of the 'exquisite gratifications' of virtuous love, its use in a way, which directly prevents it from fulfilling its primary purpose of having children, constitutes 'improper arts'.

Second, Malthus contends that sex, like all other human instincts, gives its best results through training, which implies restraint. That happiness of the married state flourishes

best on a basis of pre-marital chastity, mature choice, a long novitiate, exclusive devotion to one another of one man and one woman, and a conception of marriage looking well beyond immediate gratification (Malthus, 1958).

The third concern for Malthus is that, the responsibility for the right use of sex rests, primarily and essentially on individuals and married couples. The state may only advise, guide, or remove pressures, which might force people in the wrong direction. Malthus ideas on sex have generated much argument and debate. Humanists as well as Catholics and Protestants, who hold the catholic tradition, accept his doctrine of the natural law. But many reformed theologians, deny that the law to be read out of nature, as apart of the rulings of scripture, can be a reliable guide to right conduct on sex or anything else (Malthus, 1958).

The social learning theory lays emphasis on the fact that people learn or estimate important factors by observing the behaviour of others and then through practice, developing the skills necessary for that behaviour. In essence the social learning perspective asserts that most, if not all behaviour are a result of learning and not that of biological factors.

Tavris and Wade (1984) point out that the social theory is a product of the behaviourist school of psychology. Behaviourists emphasise observable events and their consequences rather than internal feelings or drives. They formulated a set of principles derived from simple learning skills and social behaviour. Behaviourists believe that all learning, including how people learn to make decisions, can be explained by the same basic rules. The most important learning principle is that behaviour is controlled by consequences. Thus an action that is usually followed by positive reinforcement tends to repeat itself and action that is not positively responded to tends to decrease in frequency.

In explaining sexual decision-making, Elmer (1997) using the pioneering work of Mischel (1973) and Bardura (1978: 1986) which relied on the reciprocal determinism

concept, discovered that the learning environment has to be changed for the girl to change her behaviour by getting support in the community and obtaining peer support. To change her behaviour, the learner needs behavioural capacity to perform a certain behaviour, observational learning, self-control, and expectations to anticipate outcomes of actions and self-efficiency or confidence in performing a certain behaviour.

The behaviour of the learner is crucial in the ability to learn. Learning principles articulated by Knowles (1980) also assume that learning is self-directed, tends to be problem centred and is best facilitated by doing. However, many concepts articulated by learning theorists need to be tested more thoroughly in different cultural settings. This is because different cultures and beliefs may conflict with the scientific knowledge presented.

The cognitive behavioural perspective is based on underlying assumptions that emphasise activities to personalise information about sexuality and contraception, training in decision making and assertive decision making skills and practice in applying those skills in personally difficult settings or situations. The pre-occupation of this theoretical approach is with self-image, self-confidence and locus of control. Locus of control refers to control over ones own life.

Few (1997) posits that stereotypical sexual images and contradictory messages arising from the traditional understanding of female sexuality legitimises the idea that women are passive sexually submissive objectives and thus, unable to dictate behaviours that would protect their sexual health. He thus stresses prevention strategies in terms of women's interests and the current realities of gender power imbalance. That inequality of women in heterosexual relationships must be acknowledged, women's self esteem must be bolstered to help women assume sexual decision making responsibility and efforts to bolster the sexual health of young women must include men.

To fully understand the socio-cultural implications of decision-making, the theory of patriarchy becomes important. Without doubt adolescents are influenced by the social and

cultural contexts in which they find themselves living. Gender disparities in decision-making between females and males are influenced by the socio-cultural environment in which they are nurtured and raised.

Gerda Lerner (1986), posits that patriarchy is a historic creation formed by men and women in a process which took nearly 2500 years to its completion. In its earliest form, patriarchy appeared as the archaic state. The basic unit of its organisation was the patriarchy family, which both expressed and constantly generated its rules and values. Thus through this socialisation process, the roles and behaviours deemed appropriate to the sexes were expressed in values, customs, laws, and social roles. They also, and very importantly, were expressed in leading metaphors, which become part of the cultural construct and explanatory system.

Lerner further argues that the sexuality of women, consisting of their sexual and their reproductive capacities and services, was commodified even prior to the creation of western civilization. Men-as-a-group had rights in which women-as-a-group did not have in men. Women themselves became a resource, acquired by men much as land was acquired by men. The first gender- defined social role for women was to be that of being exchanged in marriage transactions. The obverse gender role for men was to be that of those who did the exchanging or who defined the terms of the exchange (Lerner, 1986).

Thus from the foregoing, patriarchy is unambiguously understood to be the manifestation and institutionalisation of male dominance over women and children in the family and the extension of male dominance in society in general. It implies that men hold power (including sexual decision-making power), in all the important institutions of society and that women are either totally powerless or totally deprived of rights, influence, and resources.

But Learner also notes that a system of patriarchy can function only with cooperation of women. This cooperation is secured by a variety of means: gender indocrination; educational deprivation; the denial to women of knowledge of their history; the dividing of women, one from the other, by defining '"respectability" and "deviance" according to women's sexual activities; by restraints and outright coercion; by discrimination in access

to economic resources and political power; and by awarding class privileges to conforming women (Lerner, 1986).

Inevitably, adolescents as a social group live under this socio-cultural construct of patriarchy which consequentially shapes their lives and the way they act under the covering and tutelage of patriarchy. Patriarchy then undergirds the whole continuum of socialising agents through which adolescents are socialised. The result is that adolescents internalise and begin to act out their respective roles as either female or male as a direct reflection and mirror of the roles generally accepted and allocated to adult females and males in society. Relationships are thus reduced to and played out within the parameters and confines of male dominance and superiority and female subordination and inferiority. This then, also becomes the dynamic that shapes, influences and constrains decision-making even in matters of sex.

While the historical explanation of patriarchy traces the origins of women's subordination, the materialist approach to the study of patriarchy seeks to elaborate an explanation of how patriarchy works in terms of the different activities of women and men in society. The materialists have been influenced by Marxist theory and focus on demonstrating the relationship or lack of one between patriarchy and capitalism. They also try to debate the roles of capitalism and patriarchy in the reproduction of women's oppression. (Stacy, 1993). Other materialists like Sylvia Walby have attempted to produce the structures of patriarchal society. Her argument is based on what she calls the six structures of patriarchal society: employment; household production; the state; sexuality; violence; and culture. Her account escapes the criticisms of universalism and essentialism so often levelled at generalise theories of patriarchy, by offering a model of patriarchy which identifies historically specific forms in particular periods. (Stacy, 1993).

Psychoanalytic theory has also been used to explain the deep rootedness of patriarchy through an understanding of the unconscious. Rather than seeing patriarch solely as a set of social structures or institutions which oppress women, psychoanalytic theory analyses the operations of patriarchy on a psychic, as well as a social, level. The use of psychoanalysis to produce feminist theories of patriarchy has been criticised for its

ahistoricism and universlism. Questions have been raise as to the general applicability of the psychoanalytic model, developed as it was on the basis of Freud's white, middle-class Viennese patients growing up in patriarchal families at the end of the nineteenth century. It should be noted that the three explanations of patriarchy presented above, the historical, materialist and psychoanalytic, produce generalised explanations of the subordination of women.

Briefly, the above theoretical perspectives have informed much of the debate on sexual decision-making. The Malthusian approach stresses restraint, discipline and responsibility in matters of sex. The social learning approach possesses clear strengths in pointing out the importance of environmental factors as they affect decision-making. The cognitive behavioural approach on the other hand, has revealed the significance of bolstering self-image and other confidence building measures. The theory of patriarchy in turn points out the importance of understanding the socio-cultural constructs of society as the underlying dynamic that determines relationships between males and females. Nevertheless, none of these five approaches can singly adequately explain adolescent sexual decision-making, let alone find correct solutions in the Zambian context. This study, while noting the essential differences between the five approaches discussed here tried to build on the useful insights provided by each of them, in order to advance a more comprehensive understanding of adolescent sexual decision-making and pregnancy in Zambia. In this sense, the study was eclectic in its approach.

CHAPTER THREE

Review of Literature

In the literature presented here, much concern has been shown over the need to prevent adolescent pregnancy. Much of that concern has stemmed from findings, which indicate that families formed as a result of adolescent parenthood are often poor and dependent. Much of the research on adolescent childbearing implies that having a child disadvantages adolescents in terms of future life options. While this has certainly been found to be so, these studies have mainly concentrated on the after effects of adolescent pregnancy without delving into the contextual factors that impinge on adolescents' actions and choices (i.e. decisions) to engage in sex in the first place. Additionally, studies that have been done on adolescent pregnancy in Zambia do not adequately address rights of adolescents as individual participants in decision-making in matters of sexuality. While the literature presented here aims at highlighting Zambia's adolescent pregnancy and decision-making problem, it is nonetheless, placed within the wider context of the problem of adolescent pregnancy and decision-making world-wide.

The Global Context of Adolescent Pregnancy

A recent study by Population Action International (PAI) of 118 countries containing 94% of the world's population indicates that the health risks to women resulting from sexual activity and maternity vary tremendously from country to country. "The lifetime risk of death causes related to pregnancy and child birth ranged from 1in 17,000 in Italy to 1in 17 in Zaire. In 55 countries, the risk exceeded 1 in 100 (PAI) (1996:). Thirty-two of the 46 countries in the high or very high-risk categories are in Africa. They exhibited "high rates of adolescent pregnancy, low contraceptive prevalence, medium to high levels of HIV infection, high rates of sexually transmitted diseases and lack of care during pregnancy and abortion are among factors (PAI) (1996:).

A compilation of data from 44 developing and five developed countries, covering 75% of the world population, documented divergent trends in adolescent pregnancy. "World-wide, approximately 15 million births occur to females 10-19 years of age each year, representing slightly more than 10% of total births. About 35% of young women in Latin

America and the Caribean and 50-60% in Sub-Sahara Africa have their first child before age 20 years. In most Latin America and Sub-Saharan African countries, 15-20% of all births involve women 15-19 years of age (Tunick, 1996). They report further highlight the fact that early child bearing brings with it an increased risk of inadequate prenatal care, prolonged or obstructed labour, and increased maternal and infant mortality.

Adolescent Pregnancy in Developed Countries

Of all Developed countries the United States has the highest rate of adolescent pregnancy at 2-5 times higher than in other developed countries. In 1992, 12.7% of live births occurred in mothers under 20 years of age in that country (Plouffe and White, 1996:). In their study, Plouffe and White linked teenage pregnancy to early onset of menarche, earlier initiation of sexual activity, and ineffective use of contraception. They found that sexually active adolescents are more likely to engage in general risk behaviours and to come from families where parental education status is poor. Another study also found that "adolescent child bearing increased in families with low human financial or social capital (Sucoff, 1995). The high rates of adolescent pregnancies in the United States have also been attributed partly to unwillingness among adults to discuss sexuality issues with adolescents and provide them with contraception. Studies have clearly shown that teens are interested in sexuality and would like to discuss issues with physicians. Physicians are, however, not readily available to discuss these matters with teens due to constraints of time and the predominant socio-cultural ideology of treating sex and sexuality as a taboo subject. Teens are often concrete thinkers focused upon their physical appearance and dedicated to taking risks (Nelson, 1996). Adolescent pregnancy is a serious problem in the United States with one million teenagers getting pregnant and half a million having babies each year (Luker, 1996).

In Switzerland a survey found that 5% of 1726 sexually active adolescents in a group of 3993, 15-20 years olds, in institutions of learning, had been pregnant at least once. The factors associated with adolescent pregnancy in Switzerland were found to be non-use of contraception at first intercourse, having four or more sex partners, use of less effective

contraceptive methods, stress and perceiving a lack of future prospects (Narring, et al, 1996).

Adolescent Pregnancy in Developing Countries

An overview of current trends in adolescent fertility and adolescent reproductive health in developing countries, records the dramatic effect of urbanisation on patterns of adolescent fertility with a breakdown in rites of passage resulting in high extramarital birth rate. In Latin America and the Caribbean 20-60% of births to young women were unwanted in 1990. Adolescents were found to be a high-risk group for HIV/AIDS and other sexually transmitted diseases. The report also notes that 20% of persons with AIDS contracted the disease in their teens (Mohamud, 1996).

In Nigeria, Abia State, it was found that sexual activity among female adolescents began quite early, knowledge about family planning methods was low, and among girls who knew these methods family planning use was low. He thus found that the rates of out-of-wedlock pregnancies, of abortion and of maternal mortality among adolescent females were high (Ogbu, 1995).

In another study conducted in the Cameroon in 1995 by the Centre for African Family Studies (CAFS) and the Cameroon National Association for Family Welfare it was determined that adolescent mothers in Cameroon became sexually active early in life and had many sex partners with almost 60% of adolescents becoming sexually active before age 16 years. It was found that 20% of the 1302 adolescent mothers interviewed, had used abortion an method and least 14% had had a least one abortion. Further, it was observed that despite having a good knowledge of contraceptive methods and having multiple sex partners, the respondents rarely used any method. Although a high level of knowledge about AIDS and how it is transmitted was evident, only 20% of the women used condoms. It was also revealed that pregnant adolescents in school were either expelled or ridiculed, while employed adolescents lost their jobs (CAFS, 1996).

In the South African context, the incidence and prevalence of pregnancy among black teenagers had far reaching consequences including dropping out of school or interrupted education, abortion, social ostracism, social neglect and abandonment, school adjustment problems for children born to teenage mothers, adoption, the lack of social security, poverty, repeat pregnancies before age 20, and negative effects upon domestic life. The general state of poverty amongst South African blacks has not helped the situation with many pregnant girls being left vulnerable to crime and participation in it (Cunningham, Boult, 1996).

Generally, in relation to sexual and reproductive health, the World Bank Report (1993) states that approximately one-third of diseases in women of reproductive age from developing countries are linked to health problems related to pregnancy, child birth, abortion, (HIV) and reproductive tract infections, including STD's and infections associated with medical and other procedures. Reproductive health problems thus have a tremendous impact on human capital in developing countries.

Sexual and reproductive health is influenced by many factors. The ability or capacity of adolescent women to maintain reproductive health is influenced by their ability to protect themselves from unwanted pregnancy and sexually transmitted diseases and the accessibility of appropriate health care information and services. In Zambia, the relatively poor status of reproductive health undermines both human capital and national development potential.

Adolescent Decision-Making and Pregnancy in Zambia

In terms of fertility, a UNICEF report (1995) shows that the total fertility rate has not declined significantly since independence in Zambia. After rising from 6.6 (1960) to 7.1 (1980) it has declined again to 6.4 (1991) with fertility rates remaining higher for rural women and for those less educated. Adolescent pregnancy has also been shown to be very common, with two-thirds of women having a child by the time they are 19 years of age.

Size of the Adolescent Population in Zambia

The size of the adolescent population in Zambia varies with the overall birth rate. Demographic data based on the national Census of 1990 estimate the present population of Zambia to be 9.37 million with growth annualised at 2.7 percent. Twenty six (26) percent of the total population, approximately 2.03 million are aged between 10-19 (GRZ/UN, 1996).

According to Voydanoff and Donnelley (1990) the size of the adolescent population needs to be taken into account when examining figures on adolescent sexual activity, pregnancy and child bearing, because numbers of adolescent pregnancies, births and abortions are likely to be higher when the size of the adolescent populations is large. Thus in most cases it is more meaningful to look at rates rather than absolute numbers. Comparing percentages at different times takes into account variations in the size of the adolescent population.

Adolescence Sexual Activity in Zambia

Voydanoff and Donnelly (1990) point out that the first question that arises in the process of adolescent childbearing is whether or not to become sexually active. An adolescent is considered sexually active when he or she experiences sexual intercourse at least once. The Demographic Health Survey ((1992) found that 88% of Adolescents in Zambia had had intercourse by age 20. Overall the median age at first intercourse is 16.3 years.

In 1996, 21.7% of teenage girls aged 15 were sexually active, while 39.3% of teenage boys of the same age were sexually active (ZDHS: 1996). Thus at age 15 boys are more likely to be sexually active than girls. According to the ZDHS (1996), three of ten teenagers in Zambia have either already had a child (24%), or are pregnant with their first child (7%). There is some variation between provinces. While in most provinces, one in four teenagers has become a mother, the proportion in Luapula is 17% of the adolescent population and in north-western almost twice as high (31%). Although most teenage

women who have started child bearing have given birth only once, a small proportion have had two births. Overall, three in four have not given birth, one in five has had one child, and 4% have two or more children. Table 2.1 below shows the distribution of women age 15-19 by number of children ever born.

TABLE 2.1 CHILDREN BORN TO ADOLESCENT MOTHERS

Percentage distribution of women 15-19 by number of children ever born (CEB), according to single years of age, Zambia 1996

	Number of Children ever born			Total	Mean Number of CEB	Number of Women
Age	0	1	2plus			
15	98.1	1.9	0.0	100.0	0.02	398
16	89.3	10.4	0.3	100.0	0.11	419
17	79.7	19.4	0.9	100.0	0.21	379
18	65.6	30.3	4.1	100.0	0.39	406
19	47.9	36.9	15.1	100.0	0.69	401
Total	76.1	19.8	4.1	100.0	0.28	2,003

Source: ZDHS, 1996

Recent Trends in Percentage Sexually Active

Assuming non-use of contraception, the likelihood of pregnancy is directly related to the frequency of intercourse. The percentage adolescent women who report being sexually active in Zambia generally has decreased over the last five years. The figure for women aged 15-19 decreased from 55.7% in 1992 to 26.9% in 1996. Although there are no reported figures for adolescent men for 1992, the 1996 ZDHS report shows that in age group 15-19, 27.9% were sexually active. The higher figure for boys can be attributed to higher levels of sexual activity among 15-19 year olds, as shown in the 1996 ZDHS.

In the Zambian context, pertinent factors to take into account when discussing adolescent's sexuality are urbanisation and the transition to modern culture. These have

given rise to new patterns, induced abortion, STD's and HIV infection. Adolescents themselves express lack of information and understanding about their own sexuality (Likwa, 1993).

Fertility among teenagers has become an increasingly important concern in Zambia. Table 2.2 in the appendix shows the percentage of women age 15-19 years who have become mothers or are pregnant with their first child. It shows the variations between provinces with North-Western exhibiting the highest ratios of almost 31 percent and Luapula registering the lowest proportion at 17%. The ZDHS report does not however take into account the age group lower than 15 years which group the present study is also interested in and discusses in later chapters.

From table 2.2, it can be seen that adolescent girls form an increasing proportion of reproductive women in Zambia. Currently around 22% of births are in the 15-19 age group, and indications are that this is rising (UNICEF, 1995:). From an alternative perspective, two thirds of girls have had a baby before their 19th birthday (UNICEF, 1995, Likwa, 1993). Forty percent had had a baby by the age of 18, and 80% by the age of 20 (UNICEF, 1995:).

According to a UNICEF technical report (1993) teenage pregnancy carries with it health risks for the mother and baby. Mothers in the 15-19 age group have shorter median birth intervals than older mothers, in a situation where a birth interval of less than two years is a major indication in infant mortality. Early teenage pregnancy is more risky than later, with the 12 to 15 year old group suffering from serious obstetric complications. It has also been shown that maternal deaths are high in Zambia at 649 per 100, 000 and mortality is highest in the under-twenty group and those with more than 5 children (Mudenda, 1992)

According to the 1996 ZDHS, maternal mortality is a high as 800 per 100, 000 live births in some remote rural areas. The major causes of this high mortality rate include young

age at first pregnancy, high fertility rate with current average being 6.1 children per woman ; closely spaced pregnancies; lack of knowledge of high risk pregnancies; abortions; high number of deliveries at home (53%) and only 47% at hospital; poor general health and nutrition status of women; heavy workload; inadequate rest and limited access to health services. Other principal causes of maternal mortality cited include – anaemia, STD's (including HIV infection) toxaemia, hypertension, high blood pressure, malaria and complications of pregnancy and delivery. The low socio-economic status of women also contributes to high maternal mortality.

The problems associated with teenage pregnancies have different social implications in the urban and rural areas. In the rural areas, a greater proportion (68%) of younger women will be settled with their partners, as against 56%. Urban girls will have finished their education prior to pregnancy. A larger proportion of urban teenage mothers leave their babies in their parents or families care (15%, as opposed to 8% rural mothers). This is mainly because they had no intention of getting pregnant in the first place but it all happened as an accident. The other reason is that urban girls are more likely to go back to school after delivery. Rural adolescent girls are more likely to have wanted to become pregnant (73% versus 37%) and their parents are less likely to refuse responsibility for the pregnancy, by a factor of 50% (Castle, Likwa, 1990:).

These disparities in urban/rural management of adolescent pregnancies could be attributed to a contrast in beliefs, attitudes and practices as they have evolved within the specific confines of the urban/rural social, economic, cultural and political settings. These specific settings could have given rise to a number of beliefs and stereotypes, which have in turn affected sexual activity and behaviour amongst adolescents. This combination of belief and practice constrains social responses to adolescent pregnancies.

Like in most other countries adolescent sexuality and pregnancy is a big problem in Zambia. The (ZDHS, 1992) report shows that in Zambia the majority of women become mothers before they are 20 years old and that child bearing before age 15 is not

uncommon. It was also found that more than 40% of women aged 25-49 years had their first birth by age 20. The proportion of women who begin childbearing in their teens was also found to show a decline from 76% and of women age 20-49 it was found to be 18.6. By age 17, one third of women were found to have began child bearing; by age 18, one half of women, and by 19, two thirds have. Early child bearing was found to particularly characterise rural women and those without school education.

In terms of family planning, the usage of these services was found to be low (ZDHS: 1992: 1996). The 1992 ZDHS study estimated the number of women using contraception on a continuous basis at only 15%. Of these, 9 percent were said to be using modern, while 6 percent were using traditional methods. The 1996 ZDHS findings estimated contraceptive use in Zambia at about 26 percent.

This slow prevalence of family planning usage in Zambia has serious implications on adolescent sexual practice and pregnancy. It increases the risk of pregnancy for sexually active adolescents. In a recent survey the Christian Children's Fund (CCF), a non-governmental organisation working in a compound in Kafue, found that many girls dropped out of school in lower secondary and 75% of these dropouts were due to pregnancy. This was a direct result of non-use of contraception by the girls involved (CCF, 1997). Although the study attributes these pregnancies to non-use of contraception, the study does not explain the reasons that caused the 75% affected girls to decide not to use contraceptives. It only describes the consequences of the girl's actions and completely ignores the causal factors of non-use. The present study delves into these causal dynamics and factors.

A study done by Siyanga (1996) found that the problem of pregnancy was compounded by the fact that relative to boys, girls are more often expected to fend for themselves at a young age in terms of producing income and finding a way to fund their education. Many young girls are therefore compelled into early sexual activity with multiple sex partners in exchange for financial reward. In doing so, these girls are at considerable risk of

unwanted pregnancy and sexually transmitted diseases. It was also found that teenagers also tend to have unprotected sexual intercourse and young girls face a high risk of death and complications from pregnancy and childbirth. Young female sex workers were found to be particularly at risk. Siyanga isolates financial reward as being at the root of adolescent pregnancy. However, his emphasis on this one factor does not give a complete picture of the context and complete dynamics of adolescent sexual decision-making. While it is an important consideration for most girls, the present study will subsequently demonstrate that the motivating and compelling factors on adolescent sexual choices are varied and many.

During a study of pregnant women from July 1993 to June 1994 done at Mansa General Hospital, it was revealed that adolescent females were significantly more likely to have a uterine rapture than all women delivering (Nkata, 1996). In 71% of the cases mortality was associated with adolescence. While these statistics are ominous they do not in themselves shed light on the socio-economic and other factors that are responsible for sending teenagers to maternity in the first place. The study simply describes the tragedies and consequences of early childbearing merely as a clinical and medical curiosity. It does not concern itself with the wider issues of the causes of early childbearing in the first place.

In a recent research carried out in Lusaka, Kasonde (1997) found that unwanted pregnancy was a serious problem and affected all socio-economic sectors, but poorer out of school girls were more likely to have an unplanned and early pregnancy. She found that girls as young as 12 got pregnant; that girls were often in unequal relationships with boys or men where they were unable to say no; that traditional barriers and sanctions were deteriorating and that adolescents were reluctant to use services that have been traditionally on offer.

Kasonde also found that adolescent pregnancy was a problem for a number of reasons. Women under 18 were less likely to seek antenatal care and their pregnancies were more

likely to be high risk. Obstetric outcomes were poorer, that is the babies were more likely to die. She also revealed that adolescents were more likely to present at delivery with enclampsia, to have untreated anaemia and to deliver by caesarean section. While adolescents made up only 20% of Kasonde's study population, they accounted for almost half of the cases of enclampsia. She concluded that most adolescent pregnancies end up as complications or tragedies. Although she brings out the fact that girls are more often in unequal relationships with boys or men, she does not explore the reason for this further to account for the unequal relationships that are occurring. In this sense her findings remain largely descriptive. The present study overcomes this by examining the social context within which adolescents live and make decisions about sex.

Other studies that have been done in Zambia on adolescent reproductive behaviour indicate worrisome trends. A study by Care Zambia, done in Lusaka compounds, revealed that adolescents start having sexual relations as early as 10 years for girls and 12 for boys. This is despite that fact that their information about health is often incomplete and incorrect and the sources of information are frequently unreliable ones. They also found that young people seldom used clinics (Care Zambia, 1996). The study fails to explain why kids at such a tender age are having sex in Lusaka compounds and therefore does not shed much light on the factors that are causing infants to decide to have sex.

Another study by the Planned Parenthood Association of Zambia Reproductive Health Programs (PPAZ, 1997) to assess the needs of adolescents revealed that young people feel uncomfortable attending clinics at the same time as adults, especially for reproductive health concerns and that adolescents would prefer to have same sex providers. This is undoubtedly one of the major reasons that forces adolescents to forego the use of contraception and settle for decisions to engage in unprotected sex thereby risking pregnancy. Free access to high standard sexual and reproductive services and information remains a major impediment to responsible sexual decision making for most adolescents.

Research conducted by Likwa (1996) reveals that 80 percent of the women who were admitted to hospitals with induced abortion-related complications were younger than 19. Young women are more likely than older women to undergo illegal unsafe abortion. The report also indicates that an examination of socio-demographic differences between 199 women who obtained legal abortions and 65 who were hospitalised with complications after illegal abortions revealed that women who succeeded in obtaining legal abortions tended to be between 20 and 29 (55 percent), had some secondary education (60 percent), and had children (71 percent). Most women undergoing illegal abortions between ages 15 and 19 (60) percent), had some secondary education (55 percent), were unmarried (80 percent) and had no prior pregnancies (63 percent). Of those who resorted to illegal abortions, 18 percent were students who wanted to continue their education. The study adequately gives the reasons for the abortions and highlights the fact that 60% of the women undergoing abortions were teenagers between 15 and 19. It does not however address the pre-abortion sex dynamics and environment that sucks teens into the sex vortex in the first place.

According to Castle et al (1990) despite the relatively lower risk of abortion early in pregnancy, many adolescents and women of lower socio-economic status delayed abortion procedures until the second trimester. This may be a result of lack of information, fear or hesitation on religious grounds. For young girls, this could also be failure to recognise signs of pregnancy, refusal to face the situation, or hope for spontaneous abortion.

Contraception

There are various issues, which arise when examining contraception use amongst adolescents, and in Zambia in particular, the moral debate is particularly fierce, despite the self-evident sexual activity of teenagers. There are two compelling reasons for which contraception is necessary in Zambia – the prevention of unwanted pregnancy and of STD's especially AIDS. The latter of course requires the use of condoms, whereas the former includes pills, injections and other "discrete" forms more in control of the women.

In the adolescent age group, there are people living both high and low risk lifestyles and it is, therefore, necessary to offer a variety of family planning and contraceptive services.

Reported use of contraception amongst adolescents is quite low, with the lowest rates of consistent use amongst women of reproductive age in the 15 to 19 age group (Likwa, 1993). Rates are very low, with few as 8.7% of married women under 20 using contraception (Castle, Likwa, Whittaker, 1990:). This makes pregnancy even more likely to occur.

A survey of 2000 adolescents of 19 years and less in both urban and rural areas showed that 40% could not name a way of preventing pregnancy, although 51% had had sex at least once. Those who could name a means of preventing pregnancy mentioned condoms, diaphragms and pills (UNICEF, 1994:).

There is, therefore, no reliable conclusion to be drawn concerning adolescent awareness and use of contraception, as different studies have produced such varying results. It is safe only, however to conclude that adolescent's knowledge of contraception is not complete and not adequate for meeting the needs presented by sexual activity.

Abortion

Abortions, both legal and illegal exist in Zambia. Legal abortions have been available since 1972, a rare situation in Africa. It is, however, very difficult for many women to obtain legal abortion in Zambia. To comply with the Law, consent for the operation must be given by three doctors, one of whom must be a specialist obstetrician/gynaecologist. This of course is unfeasible in many places, particularly in rural areas where there are very few doctors. Added to this, awareness levels of availability of legal abortion appear to be very low.

In considering illegal abortion, one must distinguish between non-medical practitioners offering abortion services and self-induced abortion, carried out by pregnant women

using a variety of agents such as herbs and roots, chloroquin and aspirin tablets and the use of sharp instruments. People appear to be aware of the fact that illegal abortions are not permitted and this knowledge can deter girl's complications seeking assistance until their condition becomes desperate.

Record keeping as concerns abortion cases, rates, and figures is very poor. In fact in many cases it is grossly inadequate. An easier abortion procedure has, however, been adopted at the University Teaching Hospital (UTH), which requires less sedation. This expanded access to legal termination which currently runs at 50 cases per month, also caters for patients outside Lusaka requesting services (Siamwiza, 1994:). Self induced abortion represents up to 30% of maternal mortalities and 25% of these deaths are in under 18 year olds (Castle, Likwa, and Whittaker, 1990:).

There are more cases of self-induced abortions amongst young girls 19 and under with older women either able to request legal termination or to accept the consequences of pregnancy (UNICEF, 1995: Sampule et al, 1993:). With the paucity of detailed figures of abortion in Zambia it is difficult to get a complete and clear picture of the extent and seriousness of the teenage abortion situation in Zambia. It is however fair comment that from the approximately 50 cases presenting every month at UTH alone, that this problem could be more widespread in both legal an illegal sites in the country. It is in fact a less discussed and seemingly unpalatable dimension of the problem of teenage pregnancy in Zambia. At UTH and Chainama hospitals we found that most of the adolescent girls gave studying as the reasons for their request for abortion. It was also easily indicated from hospital records that the social background of the girls was representative of all strata of society.

From the foregoing review, it can be seen that the overriding concern of almost all the studies that have been conducted so far is with the after effects and consequences of adolescent pregnancy. Little and mostly no effort has been made to delve into the

contextual and environmental factors (societal, peer pressure, media images, family, etc.) that cause adolescents to decide to have sex in the first place. The present study broke with this pattern and practice and instead took it as its point of departure to conduct a study that uncovers how adolescents decide about sex. In this respect the thrust was to try and explain and understand the underlying factors and dynamics of adolescents decisions to engage in sex in the first place.

The present study, therefore, was mainly concerned with how adolescents decide about sex. How do adolescents decide to have sex? With whom? At what age? and at what stage of a relationship? When and how do adolescents say "No" to sex? Does their position as adolescents in society have a role to play in making these decisions? The study was additionally concerned with the reproductive rights milieu of adolescents and looked at adolescents experience of sexual decision making from the view point of adolescents and aimed to discover how knowing about adolescent sexuality decision making would help promote adolescent reproductive rights and thus enable better development of adolescent pregnancy prevention strategies.

CHAPTER FOUR

We interviewed 86 (25 male: 61 female) respondents in Lusaka in two high-density residential areas of Chawama and Matero. Maternal Health Centres in these two areas were also covered. We also interviewed 85 respondents (24 male: 61 female) in two low-density residential areas of Woodlands and d Roma. Maternal Health Centres within this perimeter were also covered. In total 171 adolescents were captured in the study. In addition 20 government officials and politicians were interviewed. From the actual sample of adolescents, 122 were female (pregnant, mothering and non-pregnant), while 49 were male. The sample constituted more females because the focus of the study was more on decision-making and pregnancy, which is primarily a female concern. Therefore, there was more inclusion of girls in an effort to comprehensively and in a more detailed manner study the dynamics of the girl's ability, in particular, to freely and responsibly decide in matters of sex and pregnancy. Lusaka was chosen because it was easily accessible to the researcher and could easily be covered within the limited budgetary resources available.

In-depth Interviews

Twenty-four (24) pregnant and mothering adolescents were purposefully selected for in-depth interviews from the wide sample of 122 female adolescents. Interviews were conducted to enable members of this group to describe their reproductive decision making process. The interviews had three major objectives. First, respondents described and evaluated in their own words, key socio-economic, cultural and other factors that impinged on their decision-making process. Second their responses were important in our exploration and assessment of the underlying factors of adolescent pregnancy. Third, data from in-depth interviews were important for comparison purposes with those from the survey. Interviews were conducted with the 20 government officials and politicians. These interviews intended mainly to assess government's position and thinking on adolescent reproductive health.

Survey

Methodology

This chapter basically deals with methodological issues. To study a sensitive area such as adolescent pregnancy and decision-making required the use of both qualitative and quantitative research techniques. The study was thus based on both qualitative and quantitative methods and stressed the importance of context and the participants frame of reference. The study was interested not only in estimating the problem of adolescent pregnancy and decision-making. The qualitative aspect of the methodologies employed assisted in confirming (triangulating) quantitative data.

Research Design

The target population was defined as pregnant and mothering adolescents and adolescent males and females. Adolescents were operationally defined as those between ages 13-19. It was important in defining sample size, to balance the values of increased information and the costs involved in terms of money and time. In view of these concerns a sample of 200 respondents was chosen. Eighty (80) were pregnant and mothering adolescents, 25 were non-pregnant adolescents, 75 were male adolescents and the remaining 20 were key government officials and politicians drawn as follows:

Number of Participants	Ministry
5	Ministry of Health (reproductive health unit and central board of health officials)
4	Ministry of Legal Affairs officials
3	Gender Division officials
3	Police Service officials
5	Members of Parliament

The study involved person-to-person interviews in a two-stage cross-section sample survey design.

Stage 1

The aim was to draw out primary sampling units (PSUs) i.e. institutions and communities to be included in the survey at this stage. All schools are listed at the Ministry of Education. All communities are listed in the CSA maps at the Central Statistical Office (CSO) and Maternal Health Centres are listed at the Ministry of Health. These documents constituted our sampling frame. In the first stage of our sampling, probability samples were not utilised. We instead used purposive sampling. The reason for this is that we wanted to concentrate on institutions and communities with large populations (i.e. those that exhibited large numbers of adolescents).

In total 47 adolescents were involved in the survey. Of these 17 were male adolescents and 30 were non-pregnant female adolescents. The sample size for the survey was small because it was used in combination with the other two data gathering methods of in-depth interviews and focus group discussion. This compensated for the small sample survey as triangulation is readily afforded by the other approaches.

Stage 2

The aim was to come up with actual lists of adolescents to be interviewed. Our sampling frame consisted of:

(i) Registers at schools
(ii) Registers at health centres and
(iii) CSO, CSEA maps

We used simple random sampling procedures (SRS) to determine the size of the sample of the adolescents, to specify the chances of inclusion of each adolescent in the institution and community in our sample. We effected SRS procedure by using a Table of Random numbers.

Focus Group Discussions

In total 12 focus group discussion were conducted each lasting between 45 and 60 minutes. A facilitator was present with each group, which had between 8-9 participants. The groups were not tape-recorded but the recorder followed a discussion guide.

This is shown in Table 1.1 below

TABLE 1.1 FOCUS GROUPS SAMPLES BY SITE

SITE	BOYS	GIRLS	PREGNANT	TOTAL
CHAWAMA	8	8	9	25
WOODLANDS	8	8	9	25
ROMA	8	9	8	25
MATERO	8	9	8	25
TOTAL	32	34	34	100

Groups were arranged and organised by the researcher and adolescents were contacted using clinic-based contacts, youth groups, and school based contacts. The groups met informally at schools, market places and in spare rooms at clinics. Although the sex of the facilitator and recorder did not match that of the female groups, the gender mis-match did not in any way inhibit the groups' freedom to discuss issues openly.

Data Collection

Pre-test

A pre-test is extremely important in a study of this nature. Items on the questionnaire had to carry the same meaning for those answering as for ourselves. To establish this was the case, a pilot study of about 20 cases was carried out in Kalundu and Ngombe residential areas. A few maternal health centres were also included in the sample. This enabled us discover major flaws in the study instruments.

Three methodologies were used to collect data: in-depth interviews, focus group discussions and a survey in Matero, Chawama, Roma and Woodlands. Out of the actual sample of 191, 47 were subjected to a survey and 24 including the 20 government officials and politicians had in-depth interviews administered to them. The research relied heavily on in-depth interviews and focus group interviews as the primary method of data collection.

Recording and Management

To keep data complete, organised and easily accessible, data transcription and organisation were performed in a single operation. Observational notes, KAP notes and responses to in-depth interviews and focus group discussions were recorded in hard-backed notebooks that could be held in the lap. This made it easy to organise data while making it easy to retrieve and manipulate.

Data Analysis

The computer was used to analyse the data using the SPSS and Word Perfect software packages. This was done after editing necessary to make field notes retrievable had been performed. Since the computer was used, it was combined with interpretational analysis in order to uncover themes, patterns and constructs to enhance the ability to describe and explain the phenomenon of adolescent sexual decision-making and pregnancy.

Limitations of the Study

The field instruments for the in-depth interviews i.e. interview schedules were designed to gather data on adolescents reports of their own behaviour and actions. This meant that the research relied on adolescents reports of their own behaviour and actions. Two important drawbacks of this approach of data collection were that adolescents may have forgotten aspects of their behaviour and they may have over-emphasised certain others.

Structure of the Dissertation (Organisation of the Work)

The study consists of the following five main chapters and is organised as follows:

Chapter One lays down the theoretical basis of the study. It is argued here that although there is no standard theoretical framework for studying adolescent decision-making and pregnancy, nevertheless, the issues involved could be adequately understood by locating them within the main theories of decision-making such as the Malthusian approach, the social learning theory, the cognitive behavioural perspective and the theory of patriarchy. The purpose is to highlight how these theories of decision-making have influenced the perception of reproductive health and rights problems in society.

Chapter Two reviews the literature and presents the ultimate justification of the study.

Chapter Three discusses and highlights the details of the methodology and research design.

Chapter four and **five** constitutes the presentation, discussion and analysis of the research findings.

Chapter six comprises the conclusions and recommendations.

CHAPTER FIVE

The Extent to Which Adolescents Freely and Responsibly Decide on Matters of Sex

Introduction

The extent and magnitude of the problem of adolescent pregnancy in Zambia reviewed in the earlier chapters, also manifests itself in the form of adolescents ability to decide freely and responsibly when to have sex and have the information to do so. The purpose of this chapter is to examine the extent to which adolescents freely and responsibly decide on matters of sex and whether or not the decisions they make are informed ones. The main goal of this chapter is to identify and analyse the main factors that influence adolescent's sexual decision-making.. We also aim to highlight the environment in which these decisions are being made. By doing so we hope to begin to explain the dynamics of adolescent decision-making in Zambia.

Adolescents Perceptions of the Value of Information

In order to investigate the views of adolescents concerning information about sex, they were asked to indicate whether or not this information should be readily available to all adolescents who want it, whether they always had the information they needed to enable them decide when to have sex, how old they should be before they are allowed full and complete knowledge about sex, and what type of information gave them confidence to decide to have sex. Results from the survey showed that 61.7% thought information about sex ought to be readily available to all adolescents who wanted it as against 38.3% who thought it should not be available. This is shown in Table 3.1 below

TABLE 3.1 PERCEPTIONS OF VALUES OF INFORMATION

Information must be readily available	Girls (a)%(30)	Boys (b)%(17)	Total (c)%(47)
Yes	65.5	34.5	61.7
No	61.5	38.9	38.3
Total*	63.8	36.2	100.0

(a) Proportion of girls from the total percentage
(b) Proportion of boys from the total percentage
(c) Total percentage
* Total responses

Of the 61.7% adolescents who felt that information about sex should be readily available 65.5% were female. This is probably because the burden and implications of uninformed

decisions on sex, which might result in pregnancy, largely falls on them. As a result they are more concerned to know and have information on sex. A few girls, however, felt that information should not be readily available to adolescent. Of the 38% who said 'no' to information availability , there were slightly more girls than boys. As to how old adolescents should be before they are allowed full and complete knowledge about sex, the majority, 38%, said adolescents should be between 15 and 19 years, 21% said they should be between 10 and 12 years. Only 2.1 thought they should be below 10 years of age. Table 3.2 shows the distribution of responses.

TABLE 3.2: ACCESS TO INFORMATION BY AGE

AGE	Boys(17)	Girls(30)	Total(47)
Below 10	100%	0%	2.1%
10 and 12	40%	60%	21.3%
13 and 15	33.3%	66.7%	12.8%
15 and 19	16.7%	83.3%	38.3%
Above 19	57.1%	42.9%	14.9%
N/A	66.7%	33.3%	6.4%
No Response	50%	50%	4.3%
Total*	36.2%	63.8%	100.0%

(a) Proportion of boys from the total percentage
(b) Proportion of girls from the total percentage
(c) Total percentage
* Total responses

Cumulatively 36.2.% adolescents favoured information about sex to be available before age 15. Again girls show stronger support for early availability of information registering 60% of 21.3% for the 10-12 age group and 66.7% for the age group 13-15. This could be because girls mature faster than boys and feel the need for information much earlier than the boys do.

When asked to indicate what type of information gave them confidence to decide to have sex 23.2% said that the fear of diseases and the behaviour of the person determined whether they would have sex with them or not. These appeared to be more compelling reasons to them than even the fear of pregnancy. Most probably this is because of the

HIV/AIDS pandemic. This is in sharp contrast to the behaviour of adolescents in Japan for example, where a national survey of 5000 students (althaus,1997) found that students worried more about unwanted pregnancy during intercourse than about HIV/AIDS and sexually transmitted diseases. This specificity in behavioural reactions to sex, between Zambian and Japanese adolescents, appears to be steeped in the specific socio-cultural temperature and conditions of their respective societies. In Japan it is not popular to have a child out of wedlock. It is socially ostracizing. In Zambia having children out of wedlock has rapidly come to be accepted as one of the facts of life. A pregnant teen in Zambian society has no fear any more of being ostracized. It is these underlying dynamics, among others, that appear to be influencing adolescent sexual decision-making in these two societies.

The fear of disease and the behaviour of their partner was only followed by the confidence that sex education including initiation ceremonies give which also registered 17.8%. The promise of marriage also registered 17.8%. This combined data from both the survey and in-depth interviews revealed that only 9.3% mentioned that contraceptives gave them confidence to decide to have sex. This probably explains the findings of other studies, which have demonstrated low usage of contraceptives by adolescents (ZDHS 1992,1996,Siyanga 1996).

This is summarized in Table 3.3 below.

TABLE 3.3: TYPE OF INFORMATION DESIRED

Information	Girls (a)(30)	Boys (a)(17)	Total (c)(47)
Diseases	61.9%	38.1%	29.6%
Education	83.3%	16.7%	16.9%
Contraception	60%	40%	14.1%
Marriage	100%	0%	8.5%
Peers	6.5%	37.5%	11.3%
Indifferent	100%	0%	5.6%
None	100%	0%	4.2%
Age	100%	0%	9.9%
Total*	76.1%	23.9%	100.0%

(a) Proportion of girls from the total percentage
(b) Proportion of boys from the total percentage
(c) Total percentage

* Total responses

Perception on the practices of sex

In order to investigate the environment in which adolescents in this study made decisions about sex, they were asked to indicate whether or not their partner listened to them when they refused to have sex or whether or not it was forced on them, whether or not they had been exposed to unwanted or exploitative sexual relations, what role peers played in influencing sexual behaviour and what influenced them to start having sex. The majority 55% indicated that their partners listened to them, while 36.6% indicated that they did not. Of the 55% of adolescents who indicated that their partners listened to them 77.3% were girls. The ratio was again higher for girls among those who indicated their partners did not listen to them at 80.0%.

From the data it was clear that girls in their late teens and in senior secondary school were better able to stand against their partners pressures for sex. They appear to be more assertive than younger teenage girls and those girls with little or no years of schooling. This in part explains the ZDHS (1992:1996) and Kasonde (1997) findings that uneducated girls start child bearing much earlier than their counterparts in school. They lack the ability to discuss and negotiate with their partners. In light of this, it is imperative that government expands the opportunities for the advancement of girl's education. Education empowers them and makes them assertive and better able to say no to sexual pressures. It also bolsters their self-image in that they feel more in control of their lives. This is in keeping with the underlying assumptions of the cognitive behavioural perspective, which emphasises activities to personalise information about sexuality and contraception, training in decision-making skills and practice in applying those skills in personally difficult settings and situations. This entails that, access to sexual and reproductive health be freely and readily available through official channels of society.

The social learning theory also lends credence to this in that to change the situation of girls and boys in the country, there needs to be concerted efforts to change the behavioural capacity of the girls and boys and this can only be achieved through observational learning, self control, expectations to anticipate outcomes, and self-efficiency or confidence in performing their new behaviours. So the learning environment for girls has to be changed from its hitherto patriarchal, traditional and cultural prescriptions and assumptions on the girl child. Only then can the girls be expected to effectively change their behaviour. This support from the community, government and society at large is crucial.

In terms of exploitative sexual relations only 8% of all adolescents indicated ever having been exposed to it. These were predominantly girls at about two-thirds of 8%. Invariably it was a situation of rape and violent physical abuse. Although the figure is low, there is the possibility of some of the adolescents not wanting to divulge information of this type of experience in their lives.

A lot of adolescents, 43.2%, thought that peers played a significant role in influencing sexual behaviour by exhorting and persuading others to engage in sex. About forty percent of adolescents thought peers were a bad influence in that they misled others by giving wrong information about sex and making others believe that if they were not having sex they were incomplete or not "macho" or "cool". This, no doubt, exerts a lot of pressure on innocent and unsuspecting teens who might have these peer structures as the only source of information on matters of sex. Seemingly, peers fill in a vacuum that is left by the absence of legitimate information flow structures like parents, the school system and other societal channels that could better and accurately inform adolescents on sex. With the many and varied problems that arise out of teenage sex it might not be amazing that only 5.4% of adolescents thought their peers played a positive influence on sexual behaviour.

In fact 54.1% of adolescents indicated that they were influenced to start sex by their peers. Only 20.6% attributed their decision to start engaging in sexual activities to age while 12.5% indicated pressure from their partner. It is quite clear from the data that peers play a major role in influencing adolescent sexual decision-making. Some of the reasons for this have been alluded to above but can also be generally attributed to the traditional unwillingness to discuss sex openly in Zambian society and the tendency to withhold information on sex wholesale. This leaves peers as the only practising sex educators and informers for adolescents on matters of sex with no strings attached.

This unwillingness by adults to discuss with adolescents appears to be a problem in many societies. Nelson (1996) partly attributed the high rates of adolescent pregnancies in the United States to unwillingness among adults to discuss sexuality issues with adolescents and provide them with contraception. And as he points out, teenagers are often concrete thinkers dedicated to taking risks. Mohamud (1996) also found that resistance to discussion of adolescent sexuality by adults was one of the factors that in Kenya led to 8000 girls dropping out of primary school because of pregnancy in 1998 alone. So adults or no adult's adolescents are still determined to have sex. To bring about , attitudinal change amongst adults and society at large, there needs to be sustained and vigorous education campaigns on teenage sexuality and reproductive health. Additionally, adolescent reproductive health needs to be a substantive and legitimate component and pillar of the government and country's National Reproductive Health Policy. Not just rhetoric and window dressing. This is important because quite often these negative attitudes and practices are deep rooted and require vigorous and pro-active measures to uproot and replace with more positive values and perceptions.

That there is little communication between parents and adolescents became quite clear during focus group discussions. In all the discussions participants pointed out that parents only talked generally about good behaviour and the need to complete school. The adolescents indicated that they are not allowed to ask questions and do not talk about sex, contraceptives or reproduction with their parents. They indicated that they know about

these things from friends in school and the neighbourhood. The point is that they find it easier to talk amongst themselves or with grandparents. In terms of grandparents though, very few teenagers have easy and ready access to them as they usually will be domiciled in a different place.

Although peers are a major source of information on matters of sex for most adolescents, discussions during focus group sessions revealed that most participants in all groups had very little knowledge on various aspects of sexuality. Although they had a good understanding of the menstruation cycle, for most of them this seemed to be the only important thing to know before a decision to have sex could be made. This undermines the limited and narrow understanding of all the factors at play in making a decision to have sex.

During focus group discussions boys exhibited a more casual attitude towards sex. Although they showed a good awareness of the AIDS/HIV pandemic and the risk of pregnancy most did not favour the use of a condom as it "spoiled everything". Apparently this is because they felt pregnancy was a girl's problem. This was confirmed by most girls in the groups who indicated that their partners discouraged them from insisting on condoms. Most girls however felt that it was in the final analysis the girl's personal decision as she was the one to suffer the consequences.

It would seem that the sexual environment of adolescents is one of an intricate web of deceit, intimidation between partners, cajoling and a battle of wills between partners as to who successfully imposes their notions and beliefs about sex on the other. This state of affairs seems to come about probably because adolescents only mostly compare notes amongst themselves. The prevailing ideas and perceptions about sex within this age group apparently influence and colour the way of thinking and acting of most adolescents. The decisions are partly influenced by perceptions and adventurism rather than the realities of the decision to engage in sex.

In examining the extent to which adolescents freely and responsibly decide on matters of sex and whether or not the decisions they make are informed ones, the goal was to identify and analyse the main factors that influence adolescent's sexual decision-making.

To arrive at some assessment and understanding regarding the extent to which both female and male adolescents share responsibly for their sexual behaviour, their fertility, and the health and well-being of their partner and in order to investigate the attitudes of adolescents to sexual behaviour, fertility and the health well-being of their partner, they were asked to indicate the attitude of their partner towards sex, whether or not family planning responsibilities should be shared, the best way to learn about fertility and sexual behaviours and whether partners were interested in them as persons or just because of sex. It was found that in terms of attitude towards sex, overwhelmingly most adolescents 43.7% thought their partners were responsible, while 23.9% indicated that they were not responsible. Table 3.4 gives a summary of the results.

TABLE 3.4: ATTITUDE OF PARTNER TOWARDS SEX

Attitude	Boys (a)(17)	Girls (b)(30)	Total (c)(47)
Not Responsible	5.9%	94.1%	23.9%
Very Responsible	100%	0%	1.4%
Don't know	0%	100%	9.9%
No Partner	53.3%	46.7%	21.1%
Responsible	22.6%	77.4%	43.7%
Total*	23.9%	76.1%	100%

(a) Proportion of boys from total percentage
(b) Proportion of girls from the total percentage
(c) Total percentage
* Total responses

It can be seen from Table 3.4 that the majority of the girls (94.1%) overwhelmingly indicated that their partners were not responsible. This says a lot about boys attitudes towards sex and is a confirmation of the recurring pattern of boys casual and carefree approach towards matters of sex and sexuality. They are simply interested in girls specifically because of sex. On the other hand only a small percentage of boys think that

girls don not have a responsible attitude towards sex constituting only 5.9%. The background of the adolescents in terms of residential area did not seem to have a significant influence on both categories of adolescents as attitudes to sex were consistent background notwithstanding. A study done in Switzerland by (Narring et al, 1996) on sexual activity in institutions of learning, also found that background and demographic characteristics did not significantly affect the behavioural outcomes of the adolescents in the sample. This could be because most adolescents share similar socializing agents in terms of schools and teenage culture. These common influences seem to shape their attitudes and experiences independent of socio-economic and/or residential background.

In terms of taking responsibility for their fertility and family planning 33.8% adolescents indicated that both partners should share responsibility for getting the correct information on family planning and learning about it. Only a small proportion 2.1% thought it was the responsibility of their partner.

Table 3.5 shows the distribution of preferences

TABLE 3.5: RESPONSIBILITY FRO FAMILY PLANNING

Preference	Boys (a)(17)	Girls (b)(30)	Total (c)(47)
Self	18.2%	81.8%	30.9%
Partner	16.7%	83.3%	8.5%
Both	13.8%	86.2%	40.8%
Women	62.5%	37.5%	11.3%
Men	50%	50%	8.5%
Total*	23.9%	76.1%	100.0%

(a) Percentage of boys from total percentage
(b) Percentage of girls from the total percentage
(c) Percentage total
* Total responses

It is important to note that in the categories of respondents who indicated "I should learn (30.9%)" and "both of us should learn (40.8%)", the figures desegregated by sex show that female adolescents dominated these categories at 81.8% and 86.2% respectively. Girls particularly felt both partners should share responsibility for learning about family

planning and teaching it to others. Most likely, girls feel that by taking personal responsibility themselves and involving their partners as well, they would significantly eliminate the risks of pregnancy when they decided to have sex.

The situation is however, made difficult by male adolescents who do not appear keen to personally learn about family planning and largely do not even think that both partners should learn. Only 18.2% of the boys thought that both should learn about family planning. This attitude exhibited by the boys could be explained by the fact that they appear to have a casual approach to sex. This confirms the girls' responses in Table 3.4 that most boys are not responsible. This is probably motivated by the fact that they are not the ones who fall pregnant. This was borne out during focus group discussions where most of them claimed family planning matters were a woman's responsibility and duty as women were the ones who bear children.

These attitudes could also possibly have been transmitted by older men in society as either consciously or unconsciously they also appear on a general level to hold similar views on family planning matters as the boys do. So implicitly or explicitly, there appears to be a transfer of values by generation and these are packaged by gender and circumscribed within the parameters of patriarchy. This attitude of course impacts negatively on adolescent pregnancy as these cultural influences seem to be pointing them in the wrong direction. Other research has also indicated that adolescent pregnancy is influenced by the behaviour of adults. Langdon (1997) found that teenage mothers mirror the behaviour of their parents' generation. In another study by Luker (1996) it was found that out of a sample of 36 teenage mothers half reported that their mothers themselves had had teenage pregnancies. Since boys and men play such an influential role in reproductive decisions, there needs to be developed new communications programs on sexuality and reproductive health, to target specifically boys and men. This is important in view of the fact that men play important roles in reproductive health programmes as mangers and policy-makers. Only then can a fundamental attitudinal change be achieved.

With regards to the best ways of learning about fertility and sexual behaviour mixed group meetings recorded the highest at 25.3%. Group meetings of female only community lectures and parents recorded the lowest at only 1.4% each.

Table 3.6 below summarizes these findings.

TABLE 3.6: BEST WAY OF LEARNING ABOUT FERTILITY AND SEXUAL BEHAVIOUR

Method	Girls (a)(30)	Boys (a)(17)	Total (a)(47)
Female Group	100%	0%	1.4%
Mixed Group	70%	30%	28.2%
Booklet	0%	100%	.8%
Media	85.7%	14.3%	9.9%
All	100%	0%	9.9%
Clinic	57.1%	42.9%	9.9%
School	50%	50%	14.1%
Community	100%	0%	4.2%
Initiation	100%	0%	8.5%
Parents	100%	0%	1.4%
Don't Know	100%	0%	9.9%
Total*	76.1%	23.9%	100%

(a) Percentage of girls from the total percentage
(b) Percentage of boys from the total percentage
(c) Percentage Total
* Total responses

In terms of indications by sex more girls at 70% of 28.2% favoured group meetings. Media ways of disseminating information were favoured least by boys at 14.3% for each group. The 14.1 % who preferred the schools as a channel of learning thought fertility and sexual behaviour should be taught in biology classes. Group meetings are viewed to be he best way because the present a more relaxed and supportive environment that allows teenagers to open up and be less inhibited. They also present a more conducive environment to challenge and examine peer assumptions and ways of thinking.

When asked to indicate what they thought their partner should share in protecting their rights most adolescents thought this could be best achieved through respect for their

person. The figure was high at 25.4%. The rest were equally disturbed, rights can be protected through partner being supportive 12.7%, listening and communication 12.7% and another 12.7% did not know how their rights could be protected. Girls particularly felt that their partners should share in everything that concerns them and in this way help them achieve their rights. The strongest concern of most girls appears to be security and dignity of their person. Although there is a very vague understanding of what constitutes rights, they, however, in their own way as adolescents understand that the respect of self and person is paramount. This indeed does constitute the core of human rights protection.

Sharing in protecting rights for adolescents included sharing responsibility in the area of health. Most, 53.2%, indicated that their partner should share responsibility for STDs and HIV/AIDS. Only 2.1% were against this view.

Overall, the indication was that rights protection should include male partner sharing in parental, maternal and child health, child rearing, contraception and managing and resolving violence. This is exhibited in the broad definition of health and well-being and the emphasis laid on the aspect of caring.

In the entire study, girls persistently reflected this stance. Boys on the other hand tended to express views that were contradictory to those expressed by the girls. For example, 75% of the boys indicated that their interest was primarily in sex. This is in contrast to the fact that 75% of girls indicated that their interest was in their partner as a person. It would appear that girls are more interested in a responsible relationship while for the boys it is more of casual contact and self-gratification. This is what no doubt leads to exploitation of female adolescents and pressured decisions that lead to pregnancy. One of the reasons for this could be that girls are socialized early into expecting marriage and serious relationships unlike boys who society seems to push in the direction of adventure and exploration before serious commitment to partner and marriage.

This chapter has examined the extent to which adolescents freely and responsibly decide on matters of sex and whether or not decisions they make are informed ones. It was found that the fear of diseases and the behaviour of their parents largely determined whether or not they would have sex. Contraception is not therefore a factor in decisions about sex. It was also found that most adolescents 61.7% indicated that information about sex should be readily available. This was particularly so with the girls. The majority 38% also felt that full and complete knowledge about sex should be allowed to teenagers in age group 15 to 19. Most adolescents (43.2%) further indicated that peers played a significant role in influencing sexual behaviour and persuading others to engage in sex. This indicates that the use of contraceptives plays an insignificant role in determining whether or not to have sex. The study confirms findings from other studies, which attribute low usage of contraceptives as a factor leading to high fertility rates among adolescents. Our study, however, goes beyond this and explains why adolescent pregnancy and childbearing has reached such alarming proportions in Zambia.

This chapter has also examined the extent to which both male and female adolescents share responsibility for their sexual behaviour, their fertility and the health and well being of their partner. It was found that the majority of adolescents thought that their partners were responsible. This was particularly so with the girls, the majority of whom expressed this view. It was also found that the background of adolescents did not significantly affect their attitude towards sex. Girls in particular overwhelmingly indicated that boys were not responsible about sex. This is mainly because of the boy's casual approach towards sex. Mixed group meetings were also indicated to be the best way to learn about fertility and sexual behaviour. The majority of adolescents felt this way. In the next chapter we turn to consider and examine the factors that affect adolescent access to high standard sexual and reproductive health services and information. We also tackle the issues that impact the occurrence of adolescent pregnancy.

CHAPTER SIX

Adolescent Access to High Standard Reproductive Health Services and Information and the Circumstances that Impact the Occurrence of Adolescent Pregnancy.

The previous chapter investigated the extent to which both female and male adolescents share responsibility for their sexual behaviour, the fertility and the health and well being of their partner. The purpose of this chapter is to examine the factors that affect adolescents access to high standard sexual and reproductive health services and information. Our goal is to identify, analyse and isolate the major factors adolescents have to deal with in their quest for reproductive health services. We also aim at highlighting the constraints of the adolescent reproductive health environment. By so doing we hope to explain why access to reproductive health is such an issue for adolescents.

Provision of Reproductive Health Services

In 1994 the Ministry of Health and NGOs came to the realization that primary health care services were not meeting the needs of young people. They, therefore, began a program of Youth Friendly Health /services which is a package of sexual and reproductive health services offered to youths. It was started first as a pilot project in three clinics in Lusaka District, Chilenje, Chawama and Kalingalinga. The Project is trying to learn the best ways to provide such services so that other districts and facilitators can learn from their experiences. The priority areas have been: establishing NGO/clinic linkages; increasing involvement of youths at health centres; and developing systems of monitoring these youth friendly services. Actual services began in August, 1996. On given days, one boy and one girl are on hand to act as a bridge between youths and the health services. They provide information, condoms, referrals and a listening ear to their peers.

The peers have dealt with issues ranging from information and worries about pregnancy to communication with parents or their partner obtaining condoms, to TB, substance abuse (drugs) and financial worries (MOH/GRZ, 1997; 1998). The project has been

making use of drama and radio as mediums of advertising. Dramas are performed in communities by peers. The Task Force for this project works under the Ministry of Health's (MOH) Reproductive and Child Health Unit and involves UNICEF, NGOs, Lusaka City Council, certain government ministries, youths and health staff. The program is still in its infancy and it's therefore, difficult to assess its full impact. Suffice to say however, that problems of adolescent access to sexual and reproductive health continue to vex the majority of adolescents. This is borne out by our findings at one of the project clinics in Chawama where access for adolescents is as problematic as in the non-project clinics.

Apart from this MOH initiative, the Planned Parenthood Association of Zambia (PPAZ) is also involved with a number of interventions aimed at providing reproductive and sexual health care to adolescents. Peer educators, income generation for young people and developing a peer educator curriculum for adolescents form the core of PPAZ activities for adolescents. PPAZ also provides special clinic services for young people, the old one in Kitwe and the new one in Lusaka, the Rachel Lumpa Clinic. PPAZ's hope is that by providing an exclusive youth service adolescents will feel happier about seeking out reproductive and sexual health care and so improve adolescent reproductive and sexual health (PPAZ, 1997). It is thus a substantive initiative with adolescents' interests at heart.

CARE Zambia is also implementing adolescent sexual and reproductive health programs in Lusaka, Ndola and Livingstone. They are doing this by working with and through adolescents and clinicians. At clinic level, health workers are supported to provide youth friendly services, to form youth corners, conduct outreach activities and work towards improving the record keeping system. At community level, the project facilitates and supports groups of trained peer counsellors in community based adolescent health education activities (CARE, 1997). CARE is also working with MOH to realize these goals.

The Christian Children's Fund on the other hand, has youths working not only as peer educators but also as community-based distributors (CBDs) on an innovative project in Kafue. The adolescents ages range from 18 to 25 years of age. They provide peers with family planning counselling and services, Oral Re-hydration Salts (ORS) packets for treatment of diarrhoea, and health education about the prevention and treatment of sexually transmitted diseases, diarrhoea, malaria and measles (CCF, 1997). Through health education, counselling and condom distribution the aim is to reduce the school drop out rate and promote behaviour change that will prevent pregnancy, STDs and HIV/AIDS.

Another NGO, the Society for Family Health (SFFH), has begun two programs that are designed to reach both in and out of school youths: Club NTG (New Teen Generation), a youth radio program, uses radio to disseminate reproductive health and sexuality information to youths. Also being run are PEPS which are groups of peer education teams who look for youths at bus stops, schools, colleges, compounds, and other places where young people gather ton discuss safe sex (SFFH, 1997).

All the various approaches looked at above are innovative communication channels aimed at reaching the youth. The efficacy of such programs, however, can only be determined by a full-scale evaluation study after they have been operational for a sufficiently reasonable time. The intentions of these programs are commendable and deserve wider support.

Perception of Reproductive Health Services

There seems to be a lot of awareness among adolescents, regarding the existence of health services and institutions such as clinics, health centres and doctors that give out information on family planning. This was particularly the case among the girls. When asked if they knew of any clinic, health centre or doctor that gives out information on family planning and contraception 66.2% adolescents indicated that they knew where to find these family planning services. Despite this high awareness of availability of family

planning services and where they can be obtained, actual use of these services still remains low (ZDHS, 1992,1996). The present study has also noted similar trends. Table 4.1 below shows adolescent knowledge of family planning centres.

TABLE 4.1: KNOWLEDGE OF FAMILY PLANNING

Do you know of any centre?	Boys (a)(17)	Girls (b)(30)	Total (c)(47)
Yes	19.1%	80.9%	66.2%
No	34.8%	65.2%	32.4%
No Response	0%	100%	1.4%
Total*	23.9%	76.1%	100%

(a) Percentage of boys from the total percentage
(b) Percentage of girls from the total percentage
(c) Total percentage
* Total responses

From table 4.1 it can be seen that girls have a very high knowledge level at 80.9% of those who indicated yes. Not only do adolescents know the Government facilities where family planning services can be obtained, but 64.8% were equally aware of where they could buy, birth control pills, condoms, jelly, tablets and suppositories and foam. Despite the good knowledge base that adolescents posses concerning reproductive health services and products they however do not fully benefit from and utilize these services for a number of reasons. When asked to indicate some of the problems they faced in their efforts to access family planning services and information, discussion with pregnant adolescents reveal that they received very little co-operation from providers, and no co-operation from the boyfriend or husband. The female adolescents themselves felt shy to face the providers of family planning services. Another problem was resistance from parents. A few adolescents felt it was hard to find information. Those that felt they faced no problems in accessing family planning services felt this way mainly because the services were free. For them the fact that they paid nothing meant the service was all right since it allowed them to access the services at any time without having to worry about money. The aspect of free provision of family planning services is important

considering that most adolescents are still outside the labour force and have not yet entered their income earning years.

Regardless of this, however, the majority (69.0%) still indicated that there were a lot of problems. For this group access means more than just free provision of services to include easy access and quality of services. Evidently, from the findings it is clear that access to family planning services for adolescents is still very poor (see table 4.2). this explains why although most adolescents (66.2) know about these facilities and where to find them the facilities are still not being readily used by adolescents. Problems of access appear to be very real and an issue with adolescents. There is therefore need to make access friendly facilities that respond and meet the requirements of adolescents. This will entail departing from past practice of providing these services from the providers perspective. It will require involving adolescents in planning the provision of their reproductive health needs and services.

In terms of the way they were treated specifically by medical practitioners 57.7%indicated that they were not well treated and 35.2% said they did not feel very free attending because of the attitudes of nurses. Table 4.2 summarises the feelings on the way adolescents are treated.

TABLE 4.2: FEELINGS ON WAY TREATED BY MEDICAL PRACTITIONERS

Way Treated	Girls (a)(30)	Boys (b)(17)	Total (c)(47)
Not Well	85.4%	14.6%	57.7%
Not Very Well	64%	36%	35%
Don't Know	0%	100%	2.8%
Total*	76.1%	23.9%	100%

(a) Percentage of girls from the total percentage
(b) Percentage of boys from the total percentage
(c) Total percentage
* Total responses

Cumulatively the figures of those not well treated and not very well treated was found to be extremely high at 93%. It would seem, therefore, the attitudes of health personnel are not very accommodating towards adolescents seeking reproductive health services and solutions. There is probably need to train health personnel specifically about ways and techniques to handle adolescents as a special category of reproductive health seekers and users. To some extent this unaccommodating attitude by the health personnel may be a result of overhangs from the general attitudes of adults towards teenage sex in Zambia.

It is quite clear that most adolescents feel strongly that the adult figures in the community disapprove of their efforts to take responsibility for their sexuality and fertility. The only person adolescents indicated would approve of this kind of behaviour was their best friend or peer. This again is an indication of the extent to which the socio-cultural environment is unsupportive of adolescent reproductive health and sexuality. It would not be far-fetched to assume that this environment exerts some influence on medical personnel handling teenage family planning services and information. In this kind of environment it is very difficult for adolescents to access high standard reproductive health services and information. It simply exposes teenagers to start practising and adopt unsafe sex practices. It increases the risk of pregnancy for sexually active adolescents. This could partly be linked to poor access to reproductive health services and information. In fact it impairs their ability take responsibility for their sexuality. This was also depicted in a study done by CARE Zambia and PPAZ (1997), which also found similar scenarios of negative attitudes on the part of health providers.

This negative attitude is one of reasons why other studies have concluded that advice on risks of pregnancy and on preventing it, is not wide spread in Zambia (Bradley, 1991). Fifty two percent of young pregnant girls in one survey had no advice at all, and 37% had only been advised when they were over 16 (Lungwangwa and Tacon, 1991). Mistaken beliefs are rife, with 40% of pregnant girls under 20 in one survey saying that they had not believed it were possible for someone to become pregnant as result of their first sexual experiences. A further 20% had been unsure (Castle, Likwa, Whittaker, 1990). In

another survey of pregnant adolescents, 94% had never used contraception of any kind (Sampule et al, 1993). It is time, therefore, that adult figures in society realized the power that they have to influence the lives and destinies of adolescents. It is imperative that this power be used to positively affect adolescents lives and outcomes.

These problems taken together make Zambia one of the countries with the highest reproductive risk for adolescents. A study by Population Action International (1996) which used 10 indicators to classify reproductive risk, found that countries with the lowest reproductive risk, Denmark, Norway and Sweden, had low adolescent pregnant rates and low fertility in general, nearly universal access to maternal health services, high rates of contraceptive usage, low HIV infections and access to safe abortions. The findings of our study clearly show that Zambia is far from achieving low reproductive risk for adolescents as the country is still experiencing high adolescent pregnancy rates, high fertility in general, lack of universal access to maternal health services, low rates of contraceptive usage, high rates of HIV infections and lack of access to safe abortions.

On a general level, 35.2% of adolescents indicated that they usually heard favourable discussions in their neighbourhood concerning family planning and contraception. The problem arose when it was family planning and contraception to do with adolescents. That was not welcome and was usually frowned upon. For most adolescents this means that they have to get most of their information through the media 53.5% and their peer structures. Only 4.2% indicated that health centres were useful in this regard. 42.3% indicated they just go ahead and make decisions to have sex with or without family planning services and information.

From the focus group discussions it was clear that most adolescents experience problems of communication especially with their parents on issues about sex and contraceptives. A lot of them felt it was traditionally taboo for their parents to discuss these issues. From the discussions it was clear that most adolescents do not understand the concept and/or issues of reproductive rights. Most of them thought or understand it as the cycle of

reproduction and childbearing. They are not aware that these are special rights that empower and entitle them access to high standard sexual and reproductive health services and information. In fact this ignorance is not only exhibited amongst themselves but medical practitioners and society at large. This is what compounds the whole problem of adolescents efforts to access high standard sexual reproductive health services. Society does not see this as something that adolescents are entitled to, but something that should be kept from them until they "become of age".

Problems of access inevitably impact the occurrence of pregnancy and this forms the core of our study, which is the relationship between adolescents decision-making and pregnancy in Zambia. This affords us the opportunity of closer analysis of the problem of adolescent pregnancy by specifically looking at the experiences of twenty-four pregnant adolescents who were part of this study and had in-depth interviews administered to them and also results from the survey on the same subject. In this way we hope to examine more closely the dynamics of adolescent pregnancy in Zambia.

Experiences of 24 Pregnant Adolescents

The aim of in-depth interviews with pregnant girls was both to explore their sexual experiences that led to pregnancy including the social pressures and the extent to which they felt they had control over their lives and circumstances. The characteristics of the girl's age are shown in Table 4.3 below.

TABLE 4.3 CHARACTERISTICS BY AGE OF 24 PREGNANT GIRLS

Age	Number Of Girls	Percent
13	1	4.2
14	1	4.2
15	1	4.2
16	7	29.2
17	4	16.6
18	5	20.8
19	5	20.8
Total	24	100.0

The youngest pregnant girl in the study was 13 years old. The majority 29.2% were 16 years old. From the data presented in Table 4.3 it can be seen that after age 15 there is increased initiation of sexual activity amongst girls and therefore greater risk for pregnancy. The ZDHS (1992; 1996) found the median age at first intercourse to be 16.3 years. The percentage of girls having sex before this age is smaller.

The majority of girls in the study indicated that they were out of school when they got pregnant 54.2%, while 41.7% were still in school. Only 4.2% fell pregnant in marriage. For 83.3% this was their first pregnancy, while for 16.7 it was the second. For the majority of girls, 37.5%, pregnancy happened within the first three months of acquaintanceship with partner. Only 12.5% had been in long-term relationships of more than two years before pregnancy happened. This is shown in Table 4.4 below.

Table 4.4 DURATION OF RELATIONSHIP BEFORE PREGNANCY

Period(months)	Number of Girls	Percent
1-3	9	37.5
4-6	6	25.0
7-12	2	8.3
13-24	4	16.7
25-60	3	12.5
Total	24	100.0

It would appear that in the early stages of the relationship there is a lot of pressure for sex. Some girls indicated that they would like to cement the relationship through sex in this early period for fear of losing their partner to the competition if they held out for too long. However, other reasons for this apparent pressure were financial amongst the majority of girls (66.7%). Most girls felt compelled for purely financial reasons to engage in sex at the earliest opportunity, so as to have the means to meet their other material needs of life. This is consistent with the findings of a study done by Siyanga (1996), which also found that girls were expected to fend for themselves and thus engage in early sex for financial reward. This indicates that poverty is one of the major factors in adolescent decision-making and pregnancy.

The general economic malaise in Zambia and the harsh effects of the structural adjustment program have wiped out family incomes and livelihoods of most people. The most severely affected are females and children. It is thus out of the quest for sheer survival that girls find themselves trapped in the vicious circle of engaging in sex for money in order to meet their educational bills. Poverty is thus forcing girls to make sexual decisions that are ending in unwanted pregnancies. A qualitative study in Nicaragua of the social, economic, cultural and psychological contexts of adolescent pregnancy (Bergland et al 1997) also revealed close links with the problem of poverty. Nicaragua's economic crisis, combined with a lack of political will to challenge traditional gender relations, was found to have increased the rate of unwanted pregnancies. Moreover, it was found that the economic, political and cultural situation failed to provide favourable conditions for women to gain power over their bodies and reproductive lives. Addressing issues of poverty is, therefore, critical if Zambia is to effectively deal with the problem of rising rates of unwanted adolescent pregnancies. From the Table, only 8.3% indicated the pressures they faced were as a result of marriage and were thus required to get pregnant expeditiously. Table 4.5 shows the social and other pressures the girls faced before they got pregnant.

TABLE 4.5: SOURCE OF PRESSURES LEADING TO PREGNANCY

Pressure Type	Number of Girls	Percent
Marriage	2	8.3
Financial	16	66.7
Age	1	4.2
None	5	20.8
Total	24	100.0

It would appear that for those girls who indicated that they had no social or other pressures before pregnancy (20.8%), the motivation was purely experimentation with sex and fun.

From all these pressures that the girls faced before pregnancy it is perhaps not surprising that 87.5% indicated that their pregnancies were not planned but just happened as accidents. Only 12.5% indicated that their pregnancies were planned. Of these 4.2% planned their pregnancies because they were married and the rest 8.3% planned their pregnancy because they had been in long-term relationship of two years or more. Unplanned pregnancies are a reality for most teenagers in developing countries. A study by Tunick (1996) also found that at least one-third of all adolescent births in eleven of the twenty Sub-Saharan countries and in seven Latin American countries were unplanned.

But when asked to explain if they had done anything to keep from getting pregnant before their current pregnancy occurred, 91.7% said they had been doing nothing. In fact some said they had never though of it. Only 8.3% indicated they had been using oral contraceptives and the withdrawal method both of which had failed. This low usage of contraception is in line with the findings of the ZDHS (1992; 1996), which have consistently found this to be the case. Undoubtedly the financial reasons (66.7%) for engaging in unprotected sex are so compelling that most girls readily take the risks of exposure to pregnancy and infectious diseases like STDs and HIV/AIDS. Poverty is, therefore, a big factor in adolescent decision-making and pregnancy in Zambia.

These findings should also be seen in the light of the data presented in preceding chapters where 54.2% of the girls indicated that their partners do not listen to them when they refuse to have sex, but forced them into it instead. So when we combine the findings of this chapter and those of chapter four on the factors that influenced their decisions for sex, we find that in fact the list increases to include pressure from peers and partners. Thus it can be seen that pressure structures for adolescent girls are many and continuously exert pressure on them to give in. This robs them of the ability to freely and responsibly decide about sex. In fact 58.3% indicated that they were not able to decide but their partners made the decision, while 70.8% said they were unable to decide responsibly because of their partners demands. This then leaves most girls vulnerable to exploitation and abuse. In fact they are mostly in unequal relationships in which they negotiate from

positions of extreme weakness especially in terms of fear of loss of economic support, love and affection or outright rejection.

The perception of most girls is that they have little control over their lives. Thirty-eight percent indicated that they had very little control over their lives, while 25% said things happened to them by fate. Overall, 62.5% of the pregnant girls saw themselves as having no control over their lives. These are mostly problems of self-image and confidence. This appeared to be a severe problem for most girls in the study. Only 37.5% perceived themselves to be in control of their lives while 41.7% indicated they tended to make things happen in their lives. Fifty-eight percent believed things happened to them specifically by chance. This implies that the majority of girls are not empowered and assertive. Both families and the education system do not seem to prepare the girls adequately for these challenges. There is need to take another critical look at these crucial socializing agents in Zambian society.

In order to overcome the pressures for sex that lead to pregnancy, the environment for girls has to be changed for them to change their behaviour by evolving support structures in the community and amongst their peers who exert such influence on their lives. The family and education system have to play their role too. The social learning theory points out that in order to change behaviour, the learner needs behavioural capacity to perform a certain behaviour, observation learning, self-control, expectations to anticipate outcomes of actions and self-efficiency or confidence in performing a certain behaviour (Knowles, 1980). But this behaviour change will be difficult to achieve for as long as the girls continue to suffer a severe crisis of self-image, self-confidence and generally control over their lives. So perhaps the starting point would be more in keeping with the cognitive behavioural perspective which emphasises on activities to personalise information about sexuality and contraception, training in decision-making and assertive decision making skills and practice in applying those in personally difficult settings or situations.

To a large extent, therefore, although they face compelling financial pressure for sex, the problem of self-image and confidence leaves them vulnerable and open to a high risk factor in terms of unwanted pregnancy. These factors combined place them in unequal relationships with their partners. This robs adolescent girls of any appreciable capacity to negotiate and decide freely and responsibly in matters of sex. Thus circumstances, their partners and their own lack of proper self-image and confidence conspire to disadvantage and weaken female adolescents ability to make decisions concerning their own sexuality and sex.

Even though most girls gave financial considerations as the most compelling pressure for their action, they still find themselves in a nightmare. The rising trends of poverty in Zambia arising mainly out of the structural adjustment policy initiatives currently being pursued are no doubt impacting more severely and adversely on women including adolescent women. The pressure on them, therefore, is two fold in this respect. First they are in a weaker position as female adolescents and second they, like their mothers, endure the brunt of the structural adjustment programs more than do the boys and men. Studies have, for instance, shown that girls engage in sex to raise money for school. Boys have not had to endure such similar experiences (Siyanga,1996). This is particularly the case that with pregnancy comes the real and greater burden of raising the child. Most of the pregnant adolescents 58.3% indicated that the onus of raising and supporting the child would fall on their parents. This is mainly because their partner refused responsibility for the pregnancy or they were economically unable to provide support (i.e. they were either still in school or unemployed). Forty-one percent indicated that they had assurance of support from the child's father once born. Theses however, still remain assurances and therefore tenuous.

Perceptions on Occurrence of Pregnancy

To get a wider understanding of how adolescents think and perceive issues concerning the circumstances that impact the occurrence of pregnancy, a survey was conducted that captured adolescents of both sexes and involved both those in and out of school. During

the survey adolescents were asked whether they thought their friends were having sex. Fifty-one percent said they were not and 42.6 thought they were. Either way the percentages are significantly high to indicate that sex is widespread amongst adolescents. However, amongst the female respondents 75% thought their friends were having sex compared to only 25% for male respondents. This perception amongst the girls could be one of the pull factors that could be drawing girls into early sex, as the feeling is that the other girls are doing it already. It could also imply that girls begin to engage in sexual activities much earlier than boys.

Despite widespread sexual activity many respondents 75% were aware that one could get pregnant the first time one had sex. Only 17% indicated one cannot get pregnant at first intercourse. It is also interesting to note that 72.3% of all respondents expressed ignorance on how the menstrual cycle works. Only 27.7% indicated they knew how the menstrual cycle works. So despite the widespread sexual activity and the knowledge that first time sex can cause pregnancy the majority of both female and male adolescents do not understand how the female body works in terms of menstruation. Other studies (Likwa, 1993; UNICEF, 1993) also found that only 14% of adolescents could describe their fertile period. This ignorance of the sexuality of the female body must create a lot of pitfalls for them, as they are unaware of the fertile periods and the accompanying risks of engaging in sex during these fertile cycles. This is quite a serious problem since contraceptive usage is very low amongst adolescents. In fact 51.1% of adolescents in the survey indicated that they do not understand how contraceptives work. The behaviour of most female adolescents is extremely ambivalent. Although they exhibit a high level of ignorance on how their bodies work and most do not understand how contraceptives work, let alone use them, they, for instance, still continue to expose themselves to high levels of sexual activity.

This could be explained from the experiences of pregnant adolescents who cited financial reasons and pressures from partners as significant factors in their decisions to engage in sex. These decisions are, therefore, largely circumstantial and would appear to be real

controlling factors in respect to the sexual behaviour of most teenagers. About 82% of all the female adolescents in the sample, for example, indicated that they found it difficult to refuse to have sex with their partners. It is, therefore, not surprising that 63.8% of all adolescents said that adolescent pregnancies are not planned. Only a few indicated that they were pre-planned. Table 4.6 below summarizes the perceptions of adolescents on how they think teenage pregnancies happen.

TABLE 4.6: PERCEPTIONS OF ADOLESCNETS ON HOW TEENAGE PREGNANCIES HAPPEN

Perceptions	Boys(17)	Girls(30)	Total(47)
Pre-Planned	75%	25%	8.5%
Not Planned	26.5	73.3%	63.8%
Rape	0%	100%	2.1%
Spontaneous	33.3%	66.7%	6.4%
Non-Use of Contraception	0%	100%	2.1%
Ineffective Use of Contraception	100%	0%	2.1%
No Education	100%	0%	2.1%
Other	0%	100%	4.3%
Don't Know	75%	25%	8.5%
Total*	36.2%	63.8%	100%

(a) Proportion of boys from the total percentage
(b) Proportion of girls from the total percentage
(c) Total percentage
* Total responses

It is interesting to note that, for almost all adolescents in the sample contraceptives are not a factor in pregnancy. In fact only 2.1% thought pregnancy was a result of none use of contraceptives and another 2.1% felt that it was because of ineffective use of contraceptives. From the data the general perception of most adolescents is that contraceptives cannot be used to prevent pregnancy. This is probably due to the fact that most of the adolescents do not understand how contraceptives work. This factor alone could be inhibiting more widespread use of contraceptives amongst adolescents with resultant loss of benefits that could have resulted from use. Also the perception amongst

adolescents that contraception is not a factor preventing pregnancy could also explain the consistent low usage of contraceptives amongst adolescents. If no clear benefits are anticipated or expected from use the propensity and inclination to use them will remain low.

The status quo of unplanned teenage pregnancy is likely to continue in view of the fact that when it comes to the situation of who initiates sex between partners it is almost always the male who initiates. In fact 93.3% of girls indicated that their partners always initiated sex when they decided to have sex. This was confirmed by 75% of the boys who indicated they always initiated sex. This leaves the girls vulnerable to the sexual whims and desires of their partners. The environment, in which teenage sex takes place, is an environment in which the female adolescent is the confirmed unequal partner largely at the mercy of the male and other circumstances. This impacts negatively on the girls in that the result and consequence of these pressures, economic, social, sexual and coercive have in many instances resulted in unhappy pregnancies. There seems to be high interest in girls only for sex with no interest in the consequences of this sex on the lives, health and well being of the girls.

The youngest pregnant girl in the study was found to be 13 years old. The majority 29.2% were 16 years old. Fifty-four percent were out of school, while 41.7 were still in school. For 83.3% this was first pregnancy, while for 16.7% this was their second pregnancy. The majority of the pregnancies were not planned. Most of the girls indicated money was the biggest pressure, which caused them to engage in sex. Many of the other girls indicated their partners do not listen to them when they refuse to have sex, but forced them instead. Overall, the girls were of the view that they had no control over their lives and a good number believed things happened to them by chance. In the survey 72.3% expressed ignorance on how the menstrual cycle works, while quite a big number do not understand how contraceptives work. Eighty-two percent of all female respondents in the survey indicated that they found it difficult to refuse to have sex with

their partners while a tiny minority, (2.1%); thought use or non-use of contraceptives was a factor as to how pregnancy happened.

CHAPTER SEVEN

Conclusion and Recommendations

Conclusions

This final chapter of our study sets out to accomplish a two-fold objective. First, we present a conclusion of the main findings of the issues highlighted in the study. Second, we make recommendations on some pertinent issues, which we believe will continue to exert influence on the debate concerning adolescent decision-making and pregnancy.

The overall objective was to investigate and examine the phenomena of adolescent decision-making in matters of sexuality and pregnancy. Specifically, the objectives were to determine the extent and magnitude of adolescent pregnancy in Zambia, the extent to which both female and male adolescents were able to decide freely and responsibly when to have sex and have the information to do so, and the extent to which both female and male adolescents share responsibility for their sexual behaviour, their fertility, and the health and well-being of their partners. Additionally, the study sought to determine the factors that affect adolescent access to high standard sexual and reproductive health services and information and the circumstances that impact the occurrence of pregnancy in terms of whether or not pregnancy is pre-planned, is a result of rape situations, is spontaneous, or is a result of non-use or ineffective use of contraception. Lastly, the objective was to outline the future course of adolescent reproductive rights and decision-making in Zambia.

The study was able to establish that the extent and magnitude of the problem of adolescent pregnancy is a serious one in Zambia. This is exhibited by the high levels of pregnancy, births and abortions among girls. The youngest pregnant girl in the study was 13 years old. From all available evidence it is clear that although adolescents and children are determined to experiment with sex and explore their sexuality, they are engaging in sex without full and complete knowledge of the implications of their

decisions to engage in sex. This has serious implications on the trends of adolescent pregnancy and fertility in general in the country.

The situation is made worse by the fact that sex in Zambian society is treated as a taboo subject with adults being generally unwilling to discuss it with adolescents. This creates an information blackout and vacuum as well as an unhealthy climate of silence on matters of teenage sexuality. The result of all this, is that it encourages, indirectly, clandestine adolescent sexual adventurism and experimentation. In such a state of affairs unplanned pregnancies have become the norm rather than the exception. It is thus fair to conclude in this respect that blame lies not only with adolescents themselves but society in general. The study discovered, with dismay, that adults and society have abandoned their responsibility to help steer adolescents through their turbulent period of discovering and understanding their own bodies and sexuality. They have largely been left to their own devices.

Following from this, it becomes easier to understand the continued reported low use of contraceptives by adolescents despite the fact that contraception is an important aspect of sexual activity. However, the disapproval of adolescent sex and societies reluctance to recognize the legitimacy of adolescent sexuality has created serious and often insurmountable obstacles for most teenagers seeking to access contraception. This largely explains why teenagers seeking practical solutions to problems of access, overwhelmingly indicated the fear of diseases and the behaviour of their partner, as the main determining factor on whether or not they would have sex. They are thus evolving their own face value standards of protecting their health. The problems of access to reproductive health services and information are at the root of both the rising cases of adolescent pregnancy and to a large extent adolescents inability to make free and responsible choices in matters of sexuality. This is also the reason why a disproportionately large number of adolescents expressed ignorance on how contraceptives work. This ignorance also extends to issues such as the function of the menstrual cycle and their bodies.

Apart from the foregoing problems, girls in particular experience additional hardships at the hands of their partners. This is mainly tied to the fact that they are in unequal relationships with their partners and are unable in most instances to refuse to have sex or say 'no' to sexual advances. On closer examination, it becomes evident that the dominant and manipulative behaviour and propensity of the girls sexual partners is largely a product and manifestation of the dominant but negative attributes of Zambian cultural traditions and practices. These are beliefs bent on degrading, dominating and subordinating women in general, but especially in matters of sex and marriage. A woman is seen as a sexual object. This overriding social and cultural ideology seems to have trickled down to adolescents and is being integrated as part of the popular male teen culture.

These practices are filtering down to adolescents through the various socializing agents of society and the general behaviour and practice of older men in society. Added to this is the illegitimate high moral ground that male adolescents, like their male seniors, attach to the superiority of their choices and decisions over those of the girls and women. The parameters of decision-making for the boys like those for the men are being defined and enacted within the confines and prescriptions of the practices of the institution of patriarchy. This leaves girls vulnerable to exploitation, abuse, violence and manipulation. In this environment gender equity is untenable and cannot be realistically achieved. Girls are under siege on too many levels and fronts. The inviolability of their bodies and realization and enjoyment of their reproductive rights and health is severely restricted and discouraged in Zambian situation. Unless something is done, the incidence and escalating rate of adolescent pregnancy is set to continue to be impaired. The potential of enhancing adolescents ability to make decisions about sex is therefore important to both the individual human and national development aspirations.

1. Recommendations

A. Recognition of Adolescent Reproductive Health and Sexuality

Introduction

The recommendations for action to prevent unwanted pregnancies, in this study, are directed towards national health and education authorities, the gender division of cabinet office, health workers, men and women in society and to adolescents themselves. At each of these levels, adolescent reproductive health and sexuality should be recognized as part of reproductive life, a means by which people in all societies use to control their fertility. Adolescent reproductive health should thus be included in all national reproductive health policies and programs. This is important, as there is heightened sexual activity amongst adolescents with high rates of pregnancies and abortions amongst girls and extremely low reported use of contraception.

B. National Level

At the national level, the prevention of unwanted teenage pregnancies require the initiative and commitment of government through health and education authorities as well as the gender division at cabinet office. The problem also needs the support of professionals, politicians, women's organizations and other individual and group activists.

The necessary political actions by government through its relevant line ministries and departments referred to above to reduce adolescent pregnancy include:

(i) Continuously identifying the specific needs for services in relation to adolescent reproductive health; and

(ii) Providing appropriate adolescent friendly services for contraception and abortion, including training of service providers who understand and identify with adolescent reproductive health needs. This will entail working closely and hand in hand with adolescents and involving them in identifying.

formulating, designing and implementing of their own reproductive health programs and agenda. They need to identify and feel that they own the programs as their own.

C. Policy Issues

Government has through the Ministry of Health task force developed a national program for youth and an action plan. The current draft National Reproductive Health Program contains a specific section on adolescent reproductive health. There is need, however, to go beyond this and deepen not only policy reform but legal and legislative reforms. The specific priorities for promoting adolescent reproductive health and sexuality should include the following issues:

(i) Laws and regulations for equal rights for girls and boys in society and family. For example, government needs to pass legislation compelling compulsory education for all boys and girls below the age 18. Such a law would remove the biases of parents and guardians exercising the commonplace preference of educating boys at the expense of girls;

(ii) Involvement of adolescents in policy decisions on population and fertility and boys in family planning practices;

(iii) Sexual and reproductive health education in the basic school curriculum, including information on family planning, abortion and prevention of STDs and HIV/AIDS. This should include deliberate curricula in science subjects at an early stage, on such vexing issues to young people as those pertaining to the female and male body and their functioning in reproduction;

(iv) Policies to strengthen the general adolescent reproductive health infrastructure and service delivery; and

(v) Laws and regulations to punish men and boys who make school girls or girls under the age 18 pregnant

In the context of legislation, to ensure that adolescent reproductive rights are observed and respected, new laws should be enacted including those pertaining to:

a. Access to contraceptive services, irrespective of age and marital status
b. Responsibility of fathers for children outside marriage
c. Legislative measures to allow all pregnant girls to continue their education and return to school after childbirth

D. Provision of Services

Government in collaboration with NGOs is currently spearheading a number of adolescent reproductive health initiatives. NGOs are also independently implementing their own programs. The focus of these programs is the youth. Government is currently operating three youth friendly clinics in Lusaka district on a pilot project basis. Although this is a relatively new concept in Zambia, government could have involved more than just one district covering three small community clinics. This portrays a lack of serious commitment both in terms of vision and resources. A number of NGOs are also providing direct services to adolescents. These include PPAZ, SFH, CARE and YWCA, NGOs are proving to be more innovative and committed to adolescents than government. Government needs to emulate NGOs more and be more innovative and willing to involve adolescents more directly on different levels of program development. This will entail more co-ordinated and vigorous action and leadership from MOH and not the half-hearted attempts of involving one district out of well over 65 districts in Zambia.

A national program for essential adolescent reproductive health should include:

(i) Explorations of adolescent specific needs and inventory of existing adolescent resources for family planning and abortion services;
(ii) Provision of appropriate abortion services as an integral component of essential obstetric and family planning services;

(iii) Implementation of special information, education and communication services for adolescents on sexuality and fertility regulation; and

(iv) Co-ordination of all adolescent reproductive health services provided by NGOs and the private sector by the government through MOH.

E. Operational Level

Adolescent Reproductive Health Services

It is the responsibility of the Zambian health care system to provide high quality contraceptive services and appropriate information, education and communication management as part of an essential adolescent reproductive health care package. Care should be decentralized and carried out by adequately trained health personnel at the lowest service level in the health system. Measures will entail government through the ministries of health and education and the gender division at cabinet office, introducing sexual and reproductive health education as early as at senior primary level, to enabled schools to capture sexually active kids at an early age. This will help get around the current problem of kids engaging in sex without full and complete knowledge and information of the implications of their decisions to engage in sex. It is imperative that information about sex be readily available. This will encourage informed and responsible decisions about sex. Efforts and resources primarily by government need to be made available for this purpose.

F. Service Providers

Enhancing adolescent decision-making entails not only improving information flows to teenagers, but also improving physical access to reproductive health facilities and services. At the moment adolescents face a lot of problems in trying to access these services. This is mainly because of the negative and unsupportive attitudes of health providers. There is urgent need of re-training and re-orienting of health workers to fully take into account the needs and expectations of adolescents. Negative attitudes, in fact, extend to most adults in society. This can be overcome by bringing adolescent sexual and reproductive health out of the closet and treat it like the legitimate reproductive health

issue that it is. Currently, there is a weekly program on adolescent reproductive health running on radio phoenix. But this needs to extend to other media institutions with national coverage to expand and deepen the scope of presentation. Open discussion of teenage sexuality will have the added effect of helping to improve and bolster the self-image and confidence of girls, as it will empower them to take control of their lives. This will benefit not only the girls themselves, but society at large.

Service providers should be trained in both technical and communication skills, and should have thorough understanding of the cultural, social and psychological aspects of adolescent sexuality, reproduction and abortion. The training curricula of service providers in colleges needs to be reviewed with the view to integrating issues on adolescents sexual reproductive health and rights. Doing this will enhance and build capacity in health providers on how to handle and approach the whole issue of adolescent sexuality and reproductive health.

Additionally, more innovative community based initiatives need to be introduced. A community based 'Adopt a School or Community' program needs to be initiated. Under this program health workers (i.e. doctors, nurses and medical assistants) can be attached to a school or community preferably in their neighbourhood or place of residence.

Weekend sessions can be held on school premises for pupils and within community facilities (i.e. community halls, welfare and health centres) for the residents of the community. These sessions can be effective interactive vehicles for dissemination of information and sex education as well as for dispensing family planning services and products. Other specialists in adolescent reproductive health and NGOs dealing with adolescent reproductive health can be co-opted in these 'adopt a school or community programs'. Government, donors NGOs and the private sector involved in the reproductive health field can provide logistical and financial support to help initiate and implement the programs. Incentives for health workers and others would motivate them to participate in these programs.

These issues can be addressed alongside the issues of poverty. One way to tackle poverty among adolescents would be to introduce community credit schemes for small-scale projects involving both parents and adolescents. These initiatives and mechanisms would have the additional advantage of being utilized as channels for providing sexual and reproductive health education and information both to the adolescents themselves and to the community at large. The rationale should be a move to develop a more holistic approach to addressing issues of adolescent sexually and reproductive health unlike the present disjointed and uncoordinated approach.

G. Contraceptive Services

Appropriate contraceptive services include information, education and provision of a wide range of safe and reliable contraceptive methods for boys and girls in places where they traditionally gather in large numbers like schools, variety shows, teen-time discos, beauty pageants and others.

Family planning should be accessible particularly for the girls. Information, education and communication services should be adapted to the needs and expectations of adolescents. Particularly in respect to contraception, there should be a concerted and sustained effort of information, education and communication campaigns targeted specifically at adolescents. Current messages in most if not all IEC campaigns are aimed and designed with adult audiences in mind. This needs to change. Government, NGOs dealing with reproductive health, and institutions dealing with social marketing of contraceptives will need to alter and re-design their IEC delivery methods to take into account the specific and special needs of adolescents. The current approach of lumping teenagers together with the general adult populace is unlikely to succeed and contraceptive use amongst adolescents will continue to be low.

In concluding this study, it is important to point out that with the expansion of civil, political, cultural and social rights of all peoples in all societies, adolescents cannot be legitimately left out of this contemporary and internationally endorsed human rights

agenda. Not doubt in this re-focusing, a number of issues discussed above will prove relevant regarding how we move towards a future in which the protection of adolescents sexual and reproductive rights is no longer an empty rhetorical pastime but a meaningful reality for adolescents and society at large.

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