FACTORS AFFECTING ACCESS TO AND UTILISATION OF REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENTS IN LUSAKA DISTRICT: CASE STUDY OF KAMANGA COMPOUND

By

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DECLARATION

I, the undersigned, confirm that this dissertation is all my own work. Reference to, quotation from and discussion of the work of any other person has been correctly acknowledged within this dissertation.

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CERTIFICATE OF APPROVAL

This dissertation of Barbara Nkonde-Bwalya is approved in partial fulfilment of the requirements for the award of the Masters of Arts in Gender Studies by the University of Zambia.

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DEDICATION

To my dear husband, Genesis Bwalya, for his prayers and support; my two children, Joanna and Bukata for their patience with me when I was busy writing the dissertation and not having enough time to spend with them.

ABSTRACT

Sexual and reproductive health is part of physical and emotional well-being of all human beings. Adolescents globally have unique sexual and reproductive health needs and accompanying vulnerabilities. Many adolescents face sexual health risks of early sexual debut, sexually transmitted infections including HIV/AIDS, unplanned pregnancies and illegal abortions.

The general objective of the study was to identify factors affecting access to and utilisation of reproductive health services among adolescents in Lusaka District. Specific objectives were:

1. To assess gender variations in adolescents' knowledge and utilisation of reproductive health services.
2. To find out factors affecting access to and utilisation of reproductive health services.
3. To identify measures to improve access to and utilisation of reproductive health services among adolescents.

The study sample comprised 200 respondents. Data collection was done by carrying out structured face-to-face interviews with 180 adolescents, interview guides were used to collect data from 3 focus group discussions comprising 6 adolescents each and 2 key informants (health service providers). Quantifiable data were coded and analysed using SPSS to generate frequency tables and percentages, whereas qualitative data were analysed using thematic analysis.

This study has established that there are gender gaps in knowledge and utilisation of RHS among the adolescents in Kamanga Compound. For instance, the study discovered that more girls than boys were aware of specific types of RHS including family planning methods. It was discovered that more (23.9%) male than female (21.7%) had utilised family planning methods. The findings further revealed that more (26.4%) female than male, (25.3%) adolescents had received RHS. At the same time, the study noted that dispite the gender gaps, the level of access and utilisation of RHS among adolescents was low for both sexes. Reasons for low utilisation of RHS included shortage of health services providers, and lack of adolescent-friendly services, adolescents' preference for service providers of the same sex, age difference between adolescents and the service providers, distance to the health facility and lack of transport; lack of specific consulting rooms for adolescents and non-confidential condom outlets, lack of services like lifebuoy soap at

Chelstone Clinic for male adolescents undergoing male circumcision, and judgmental attitude among health providers.

Drawing from the lifespan theoretical concepts, the study concluded that there existed a service gap in provision of adolescent RHS. Adolescents continued to be socially excluded from accessing and utilising RHS. The study therefore, recommended for scaling up of adolescent-friendly services; use of brochures and youth magazines to increase awareness of available services for adolescents and sensitisation of health providers, parents/ guardians, communities and key stakeholders about RHS for adolescents; Use mobile service provision within the Community by the Ministry of Health in order to address the problem of distance faced by adolescents, regular training and in-servicing of health providers to effectively serve adolescents with emphasis on adolescents' rights to confidential and comprehensive RHS. This study further recommended for a study on a similar topic to be carried out on a larger scale so that the results could be generalised to the rest of the country.

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ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
ASRH	Adolescent sexual and reproductive health
CSO	Central Statistical Office
FP	Family planning
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
MCH	Maternal and Child Health
MoH	Ministry of Health (Zambia)
RH	Reproductive Health
RHS	Reproductive Health Services
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population
UNICEF	United Nations Children's Fund
VCT	Voluntary counselling and testing
WHO	World Health Organisation
ZDHS	Zambia Demographic Health Survey

CHAPTER ONE
INTRODUCTION

1.1 Background

Adolescent sexuality and reproductive health has become a global concern in the recent past. The concern has grown due to unprecedented increasing rates of sexual activity, early pregnancies and sexually transmitted infections (STIs) including human immune deficiency virus (HIV) among adolescents (Shivaram et al., 2011). Adolescence is a time of great change for young people when physical changes are happening at an accelerated rate (Spano, 2004). Research shows that many adolescents become sexually active before the age of twenty (WHO, 1998). As a result, they require a wide range of counseling, clinical, and preventive care. Research further shows that adolescents face challenges in accessing reproductive health services leading to them seeking the services after sexual exposure (Hocklong et al., 2003).

The 1994 International Conference on Population and Development (ICPD) marked a paradigm shift by recognising that adolescents have unique needs and vulnerabilities and called for greater recognition of adolescents as a special category with special needs. The conference emphasized on the need to provide adolescents with sexual and reproductive health information and services, and for the adoption of integrated and comprehensive approaches to reproductive health, (UNFPA, 1994). Furthermore, this conference called for removal of social barriers that hinder adolescents' access to reproductive health services, and to modify policies and programs to meet the demographic realities of the 21st century (Germain, 2000). The 1994 ICPD also talked about the need to promote universal access to youth-friendly sexual reproductive information, services and commodities and providing comprehensive sexual education to enable young people delay childbearing and acquire the education and skills needed to lead long, health lives and contribute productively to a sustainable future (United Nations, 1995). It was hoped that this would not only curb adolescents' exposure to sexual health risks of unwanted pregnancies but prevent sexually transmitted infections (STIs) including HIV/AIDS, and early sexual debut (Dehne and Riedner, 2005).

Zambia was among the thirty-eight participating countries from Sub-Saharan Africa at the 1994 ICPD in Cairo. These Countries committed themselves to a Program of Action aimed at

providing adolescents with sexual and reproductive health education, accurate information and services. Despite the efforts by ICPD and Zambia's commitment to the Program of Action, adolescents in Zambia still lack access to sexual and reproductive health services (Ministry of Health, 2012).

Several factors have been associated with poor access and low utilization of reproductive health services among adolescents in developing countries. These include general lack of access to family planning services (including contraceptives), lack of access to prevention and treatment services for sexually transmitted infections, and to pregnancy care. For many adolescents, the attitude of service providers, distance to the health facility and cost of services make the services inaccessible. It is also not unusual for health providers to request for parental or spousal consent before providing services to adolescents below 18 years. There are also situations in which provision of adolescent sexual and reproductive health (ASRH) services is prohibited and regulated by law. This presents additional challenges for adolescents since they may not wish to involve their parents in matters relating to their sexual health.

In addition, the lack of clear adolescent health policies, lack of guidelines for provision of adolescent services, and lack of information about existing services hamper adolescents' access and use of reproductive health services. In Zambia, reproductive health services provided by the government are offered within the Maternal and Child Health and Family Planning (MCH/FP) programmes. The services fail not only to target adolescents, but also to enhance their confidentiality. This makes adolescents to shy away from using the services, preferring instead to seek care from private service providers. The private sector services are usually expensive for adolescents who have no income of their own and have to depend on their parents or guardians for support. The lack of adequate skills among health care providers contributes to their having judgmental attitude towards adolescents, and failure to enhance adolescents confidentiality and privacy during service provision.

Adolescents are also embedded within policy, cultural and social contexts that are likely to affect their access and use of reproductive health services (RHS). In Zambia, like in most African communities, sexuality matters are seen as a taboo for adolescents. Sex is regarded as sacred and

often a topic for the married. The prohibitive silence that says no to sex before marriage and the prevailing socio-cultural and policy environment affect provision of reproductive health information and services to adolescents. This culture of silence leads to lack of sexuality information among adolescents, and necessary services to help protect themselves from reproductive health challenges facing them. Failure to provide adolescents with reproductive health information has led to some of them seeking such information from peers. As a result, adolescents have wrong information and myths regarding sexual and reproductive health (Ahlberg et al., 2001). For example, they assume that conception can be prevented if one takes a bath immediately after a sexual encounter, by having sex while standing up or by jumping up and down after sex.

In as much as there is considerable literature about adolescent-friendly services in developed countries, few studies have looked at the factors determining the extent to which adolescents access and utilise existing services. Moreover, while adolescent-friendly health services are more pronounced in developed countries, they are lacking in developing countries, Zambia inclusive. For instance, in Zambia currently, there are no adolescent-tailored sexual and reproductive health services, and often adolescents find it difficult to attend sexual and reproductive health services together with adults (Ministry of Health, 2012).

This study tried to identify factors affecting access to and utilisation of reproductive health services among adolescents in Lusaka District. It tried to assess gender variations in adolescents' knowledge about and utilisation of reproductive health services. Finally, measures to improve access to and utilisation of reproductive health services among adolescents were be addressed.

1.2 Statement of the Problem

Many adolescents around the world are sexually active with many sexual contacts among them being unprotected, thereby, exposing them to risks of contracting sexually transmitted infections (STIs) including HIV; unwanted pregnancies and unsafe abortions. In Zambia, for instance, CSO (2007) reported that 56% of female aged between 15 and 24 years had sex before the age of 18 years, while only 24% of female aged between 15-24 years old used a condom at first sex.

Similarly, 51% of male between 15-24 years had sex before the age of 18 years, and only 22% of them used a condom at first sex. However, there is limited documented evidence on which sex has low knowledge and utilization of reproductive health services among adolescents. It is for this reason that this study will attempt *to identify factors affecting access to and utilization of reproductive health services among adolescents in Lusaka District.*

1.3 Research Objectives

1.3.1 Main objective:

The general objective was to identify factors affecting access to and utilisation of reproductive health services among adolescents in Kamanga Compound.

1.3.2 Specific Objectives:

1. To assess gender variations in adolescents' knowledge and utilisation of reproductive health services.
2. To find out factors affecting access to and utilisation of reproductive health services.
3. To identify measures to improve access to and utilisation of reproductive health services among adolescents.

1.4 Research Questions:

1. What reproductive health services are available for adolescents in Kamanga Compound?
2. What factors affect access to and utilization of reproductive health services?
3. What measures should be put in place in order to improve access to and utilization of reproductive health services among adolescents?

1.5 Rationale/ Justification

The purpose of the study was to help identify gender gaps in knowledge and utilisation of reproductive health services among adolescents in Lusaka thereby adding to the existing body of knowledge on the topic. Low utilization of adolescent reproductive health services is a global problem especially in the developing countries (Abajobir, 2014 and Warenius, 2008). The study

attempted to identify measures to improve adolescents' access to and utilization of reproductive health services in Lusaka District.

1.6 Definition of key terms, concepts and variables

Adolescents are defined by WHO as persons between 10 and 19 years of age (WHO, 1998) make up about 20% of the world's population, of whom 85% live in developing countries.

Reproductive Health is defined as a state of physical, mental, and social well-being in all matters relating to the reproductive system, at all stages of life. It is also defined as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (United Nations, 1995).

Teenage pregnancy refers to a girl between the ages of 13 – 19 years falling pregnant.

Sexually Transmitted Infections (STIs) – Any infection that is usually passed through sexual contact.

Risk behaviour - Specific forms of behaviour which are proven to be associated with increased susceptibility to STIs.

Policy is defined as "an explicit or implicit single decision or group of decisions which may set out directives for guiding future decisions, initiate or retard action, or guide implementation of previous decisions" (Haddad and Demsky, 1995:18).

Access in this study was used to mean the ability, right, or permission to use reproductive health services.

Utilisation was used to mean effective and correct use of reproductive health services among adolescents.

Confidentiality was defined as an explicit or implied guarantee by a researcher to a respondent in social science research whereby the respondent is confident that any information provided to the researcher cannot be attributed back to that respondent.

CHAPTER TWO

LITERATURE REVIEW

This section provides reviewed related literature that has been conducted on the topic thereby clarifying the knowledge gap that this study was trying to fill.

2.1 Adolescent sexuality a global public health concern

Adolescent sexual and reproductive health is a global public health concern. This is because adolescent sexual activity has increased in many countries around the world in the past two decades (Naré, Katz and Tolley, 1997). Adolescence is described as a period of increased risk-taking because adolescents are vulnerable to behavioural problems during puberty (UNFPA, 2007). A study by Merluzzi and Nairn (1999) revealed that adolescents during this period see themselves as being healthy since they have few peers facing major illness. This perception creates the tendency among adolescents to engage in risk-taking behaviours that expose them to health risks which adversely affect their present and future health. Most adolescents engage in early and unplanned sexual activity thus exposing them to the risk of unplanned pregnancies and STIs including HIV.

According to Allen (2013), the most recent Global School-Based Student Health Surveys discovered that approximately 20% of girls and 40% of boys (13-15 years of age) have been sexually active. In terms of age at first sex, the Global School-Based Student Health Surveys (GSHS), the Pan American Health Organisation (PAHO), Adolescent Health Survey and the British and Dutch Overseas Caribbean Territories studies, as well as a number of surveys with 15-24 year olds, boys consistently report earlier age at first sex than girls.

In the Caribbean GSHS, 56% of girls and 79% of boys on average had sex before the age of 14. More than half of adolescents who have ever had sex report initiating sex before the age of 16. First sex for boys was usually with someone roughly the same age while girls were more likely to have an older partner and a larger age difference. The study further revealed that more males than females reported multiple partnerships. According to the most recent GSHS surveys, on

average three times as many boys (31%) as girls (10%) (13-15 years of age) reported multiple partners (Allen, 2013).

Worldwide estimates show that every year, about 3 million adolescents (one in every eight sexually active adolescents) are infected with an STI; and that the highest rates of Chlamydia are among the 15 - 19 year olds, mainly adolescent women. In many developing countries, more than half of all new HIV infections are among young people 15 - 24 (UNFPA, 2007). The WHO estimates indicate that STI rates are highest in Sub-Saharan Africa with 69 million new cases per year in a population of 269 million adults aged 15 – 49 years (Corbett et al., 2002).

2.2 Gender variations in access to and utilization of Reproductive Health Services

There are gender variations in sexual reproductive challenges experienced by girls and boys. Girls face greater reproductive health challenges than boys following puberty. Notable ones among these are early pregnancies and childbearing. Furthermore, adolescent girls face greater risks of contracting STIs including HIV/AIDS compared to boys due to social and physiological factors (Leslie et al., 2002). According to the CSO (2007) approximately 7% of young women (aged 15-19 years) and only 4% of young men in the same age group were HIV positive. Adolescent girls in Zambia also face other reproductive health problems including fistula problems especially in rural areas, and puberty related illnesses (Ministry of Health, 2012).

Other gender variations can be seen in terms of utilization of sexual reproductive health services among adolescents. According to available literature, condom use varies widely, with no clear pattern by sex. According to the CSO (2007) 56% of female aged between 15 and 24 years had sex before the age of 18 years; only 24% of them used a condom at first sex. Similarly, 51% of male aged between 15-24 years had sex before the age of 18 years, and only 22% of them used a condom at first sex. This implies that more girls (56%) than boys (51%) have sex before the age of 18 years. Furthermore, these results show that more boys than girls use condoms at first sex.

In the most recent GSHS surveys, on average 38% of adolescents (13-15 years of age) did not use a condom at last sexual intercourse. In the British and Dutch Overseas Caribbean Territories

studies, approximately 28% of females and 42% of males (11-24 years of age) had not used a condom at first intercourse. In the study in St. Eustatius, where 31% of girls reported they had ever been pregnant, it should be noted that only 18% of girls who reported multiple partners used a condom at last sex (Allen, 2013).

Meanwhile, a study by Likwa (2009) discovered that 80% of women with induced abortion related complications admitted to hospitals in Zambia were less than 19 years old. Findings from Western Province of Zambia revealed that one in 100 schoolgirls dies from abortion-related complications (Warenius et al., 2006).

Importantly, equality of access requires concerted actions across multiple sectors to reduce the social, legal and economic barriers that women and adolescents, especially girls, face in accessing services. Addressing these and other barriers require, expanding access to comprehensive sexuality education for all adolescents ages 10–19 (Germain, 2014).

2.3 Global challenges in accessing Reproductive Health Services

Adolescents globally continue to face challenges in accessing reproductive health services. They access health services less frequently than expected and are also more likely to seek services after sexual exposure. Kipke (1999) identified problems that adolescents undergo particularly the lack of access to health care services. He noted that many adolescents lack a consistent source of basic care and are less likely to visit a doctor or have any regular source of medical care than adults. Kipke further noted that many of the health issues of adolescents, such as sexuality issues, are socially difficult to discuss. In most African societies issues of sexuality are still considered a taboo and can never be discussed openly between adolescents and their parents who in this regard may be the health services providers. According to Kapungwe (2003) in Zambia, it has long been a taboo to discuss sexual matters with somebody of the opposite sex and with one's own child. As a result, parents feel uncomfortable talking about sexuality issues with their children.

Focus group data from Ghana by Kumi-Kyereme et al (2007) show that young people are

reluctant to discuss sexuality with their parents since they tend to prefer to discuss these issues with their friends, because they feel shy, and also because they may fear physical punishment for discussing sexuality.

Much of the information that children get from their parents is observational and indirect. Quite often, adolescents do not get comprehensive information from parental conversations about sex. Those who seek guidance from parents are not satisfied because the latter try to evade discussion or are not able to give satisfactory answers because parents do not talk to their children about sex, but they also do not want their children to do anything sexual (Wang, 2000). Parents seem afraid to confront their children about what they are or are not doing sexually, mothers do not want to admit that their daughters are growing up, feel threatened by a sexually developing teenager, and thus find it difficult to discuss sexual issues with their daughters.

In Tanzania, in terms of preferences, findings from four studies reviewed which investigated this topic found that young people prefer sexuality communication to take place with the parent of the same sex. The South Africa-Tanzania (SATZ) study conducted among young people aged 11-17 years reported that overall, 44% of participants preferred to communicate with mothers about sexuality, while 15% preferred fathers (Kaaya et al., 2002). In Cape Town, 31% preferred discussing with mothers, and 22% stated a preference for fathers, while in the other two sites, a greater proportion of males preferred discussing with fathers in comparison to mothers (47% and 27% in Dar es Salaam and Mankweng, respectively). Another study in Tanzania found that among in- and out-of-school males, 11% and 10% respectively selected fathers as a preferred partner for communicating about sexuality (Leshabari et al., 2009).

Parent-adolescent communication is an appealing source for influencing adolescents' knowledge, attitudes and behaviour, because parents are an accessible and often willing source of information for their children. Conversations between parents and adolescents about their sexuality in particular are often difficult for both parents and adolescents (Botchway, 2004).

In developed countries, a study by Burgess et al (2005) show that the increasing communication between parents and their teenagers about sex is helpful in reducing adolescent risk-taking sexual

behaviours and practices although there are other barriers which tend to make the process to be not effective. According to a study by Allen (2013) if adolescents felt connected to their families they were less likely to have sex. Connectedness was measured by agreement with statements such as “can tell mom/ dad your problems” and “mom/ dad cares about you”. The study by Allen (2013) further discovered that in the PAHO studies in British and Dutch Overseas Caribbean Territories, more than half of adolescents did not discuss sex with parents or other adults in their households. Furthermore, around two-thirds of females and three-fifths of males did not find it easy to talk to teachers about sex. The evidence suggests that the skills of teachers and parents should be enhanced to address the need for discussions about SRH.

Studies have also shown that female adolescents may prefer to be attended to by female health workers while male adolescents may prefer to be attended to by male health workers. According to a study by Abajobir (2014) adolescents’ preference for healthcare professionals of the same sex as well as parent disapproval and lack of information hindered most adolescents from accessing reproductive health services.

In Zambia, one of the main preventive interventions that have been used to educate and familiarize people on sexual and reproductive health matters is the media. The media has been identified as a major source of such information especially for young people (ZBHS, 2007).

Various socio-economic factors prevent adolescents from accessing sexual reproductive health services. This is because reproductive health services in most settings have been designed for older, married women and men; unmarried female and male adolescents face different barriers to service use. Among these are policies (age restrictions and parental consent) that restrict their access to services and information, negative community attitudes toward providing reproductive health services to unmarried adolescents, adolescent embarrassment of being seen at facilities, and fear that the facility will not honour privacy and confidentiality (WHO/UNFPA, 2007).

Research further shows that challenges of accessing reproductive health services are greater for adolescents living in developing countries where adolescent health care services are few or non-existent, and there are no mandatory health insurance systems (Cohen, 2002). Goodburn and Ross (2000) observed that in developing countries, the health of adolescents has largely been

ignored in comparison to that of children under 5 years and adults. In Bangladesh, for example, the Associates for Community and Population Research (ACPR, 2003) while conducting a baseline survey, discovered that there was lack of adolescent-friendly health care facilities in the country. In sub-Saharan African, although adolescents do not only face greater sexual health risks, they also face greater challenges in access to reproductive health services.

2.4 Efforts to offer adolescent-friendly services at a global level

The 1994 and 2004 ICPD conferences in Cairo and Dakar respectively made several recommendations for improving adolescents' access to reproductive health services and education. Participating countries affirmed their commitment to intensifying efforts to enhance the rights of adolescents to access sexuality information, counseling and youth-friendly services; to safeguard adolescents' right to privacy, confidentiality and informed consent; and to involve them in the design, implementation, monitoring and evaluation of youth programmes (UNFPA, 2007). ICPD 2004 reiterated the need for provision of sexual and reproductive health information, education and services throughout the life cycle.

Since the 1994 ICPD, attempts have been made globally to address reproductive health challenges of adolescence. An example is the establishment of adolescent-friendly clinics, particularly in developed countries. However, there are no standard or uniform models of adolescent health services. Different countries adopt different approaches. Some countries use varying models. In the United States, for example, some programmes maintain the traditional medical model by offering drop-in and after school hours. Others set aside time in clinics for sessions open only to teenagers. In addition, some communities support reproductive health care as a component of school based health services (Hocklong et al., 2003).

Staff attitude and skills, confidentiality, anonymity, ease of geographic access, appropriate opening times, suitable location, and premises are important factors to successful healthcare for the adolescents (Häggström-Nordin, 2005).

The 2012 session of the UN Commission on Population and Development (CPD) held in Addis Ababa - Ethiopia, with Adolescents and Youth as its theme, was another opportunity to generate momentum on Sex Reproductive Health Rights (SRHR). At this conference, governments including the government of the republic of Zambia agreed, notably, with the full involvement of young people and with the support of the international community, to give full attention to meeting the reproductive health-service, information and education needs of young people, with full respect for their privacy and confidentiality, free of discrimination, and to provide them with evidence-based comprehensive education on human sexuality, sexual and reproductive health, human rights and gender equality to enable them to deal in a positive and responsible way with their sexuality (Girard, 2014**)**

In addition, they agreed that the rights of women to control all aspects of their sexuality, already recognised at the 1995 Fourth World Conference on Women in Beijing, also applied to adolescents (aged 10-19) and youth (15-24): protect and promote human rights and fundamental freedoms regardless of age and marital status, including protecting the human rights of adolescents and youth to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health **(**Girard, 2014**).**

Furthermore, at the same conference, governments also pledged to prioritize the prevention of pregnancy among adolescents and eliminate unsafe abortion through comprehensive education on emotional development and sexuality, and timely and confidential access to good-quality information, counseling, technologies and services, including emergency oral contraception without a prescription and male and female condoms. Governments further agreed to guarantee access to safe and effective modern contraceptive methods, respecting the principles of confidentiality and privacy, to enable adolescents and young people to exercise their sexual rights and reproductive rights, to have a responsible, pleasurable and healthy sex life, avoid early and unwanted pregnancies, the transmission of HIV and other sexually transmitted infections, and to take free, informed and responsible decisions regarding their sexual and reproductive life and the exercise of their sexual orientation (Ibid, 2014).

On adolescents' access to education, information and services, governments of various countries agreed to achieve universal access to sexual and reproductive health services, free from all forms

of discrimination by providing an essential package of comprehensive sexual and reproductive health services including through the primary health care system for women and men, with particular attention to the needs of adolescents, youth, older persons, persons with disabilities and indigenous people, especially in the most remote areas (ECA, 2014).

2.5 Efforts to offer adolescent-friendly services and challenges faced – Sub-Saharan Africa

The Zambian government tried to intervene by introducing youth friendly health services. However, this has been done on a small scale. Family life education has been widely promoted although it is encountering problems such as fear of losing moral values as parents and Community members talk to adolescents about sexuality and other related topics (Ministry of Health, 2000).

Efforts have also been made in other Sub-Sahara Africa to provide adolescents friendly services for example in Uganda, Kenya, and Ghana through the USAID *Prime Project* (Intra-Health International, ca. 2004), as well as in South Africa through its National Adolescent Friendly Clinic Initiative (NAFCI) called 'love-life' (FHI, 2000). In most parts of Africa, religious bodies oppose reproductive health care in favour of abstinence only among the unmarried. Attempts by some governments in Africa to introduce sex education in schools in the early 1990s were resisted by religious organisations, particularly the Catholic Church and the Muslims (Brockman, 1997).

However, adolescents still remain under-served through the current health service delivery system in Zambia. There is discrimination against the unmarried adolescents who try to access reproductive health services by the health service providers. A study by Warenius et al (2006) on "Nurse-Midwives' attitudes towards Adolescent Sexual and Reproductive Health Needs in Kenya and Zambia", also discovered that staff behaviour discourages young people from attending clinics or for follow-up visits. For instance, young STI patients turn preferably to traditional healers due to the insensitive attitudes of health professionals, and adolescents face difficulties obtaining contraceptives at public health facilities. Confidentiality and health

providers' attitudes were seen as two important factors affecting whether or not young people would use the services.

Available evidence suggests that achieving quality standards improves the effectiveness of SRH information and services, encourages people to use them effectively, and attracts new people to use them (Darroch and Singh, 2013). The reverse is also true – poor quality discourages use of the SRHS (Ramarao et al., 2012).

To date, despite such evidence and the fact that improvements can be made even in countries with limited capacity and resources, very little attention has been given to quality of care with respect to RHS. Accelerating progress towards provision of quality RHS information, services, and rights protections, especially for disadvantaged women and girls of all ages whether married or not, in ways suited to each person's changing circumstances and health conditions, requires focused and deliberate planning, financing, implementation, monitoring and evaluation, appropriate to the circumstances of each country and sub-national region.

Meanwhile Meuwissen et al (2005) in another study also found that existing Centres lacked confidentiality, privacy, and quality of service, all factors considered essential characteristics by adolescents. Centres with specialized services for adolescents are rare and/or relatively expensive, so poor adolescents cannot access them. The study showed that many doctors lacked the knowledge and skills to provide adequate sexual reproductive health consultations to adolescents and treat them in a paternalistic way.

Further, adolescents remain excluded even from the guidance on sexuality and relationships within their own home environment. According to Hindin and Fatusi (2009), most parents of nowadays were not taught about sexual and reproductive health by their own parents or even in school, leaving them unable to pass on this important information to their children. Available literature shows that parents lack the necessary information and experienced difficulties in discussing sex with their children (Meuwissen et al., 2005). The discomfort many parents feel about talking to their children about sexuality further impedes their ability to provide guidance. Due to this, adolescents depend on their peers for information on reproductive health and sexuality (Ministry of Health, 2000). Adolescents in Zambia still lack access to information and

reproductive health services despite the country's commitment to the ICPD and the Reproductive Health Policy in place whose objective is increasing accessibility and availability of affordable Youth Friendly Health Services to adolescents/youth at all levels of the health care system, (Ministry of Health, 2000).

2.6 Reproductive Health policy situation in Zambia since ICPD

Zambia undertook a multi-sectoral and decentralized approach involving civil society in formulating a new reproductive health policy which addressed gender issues, including male involvement, as well as the allocation of resources for its implementation. The development of the national reproductive health policy was based on an extensive needs assessment process. Health districts, NGOs, donor agencies, and private and industrial institutions were all involved.

2.7 Summary of Literature Review

Reviewed literature shows that there are a number of efforts that have been put in place to promote and improve adolescents' access to and utilization of reproductive health services. However, literature has shown that despite these efforts by governments, adolescents still face barriers mainly because of the way services are provided and the lack of adolescent friendly health facilities. It has been established that adolescents both in the developed and developing countries face challenges in accessing RHS, with the latter facing greater challenges. Furthermore, literature review has shown that removal of these barriers requires concerted efforts not only by governments but by all stakeholders involved in the provision of reproductive health services of the adolescents.

2.8 Theoretical Framework

This study used the life-course approach and life-span approach interchangeably. Different authors have used the terms life-course or life-span to refer to different stages in the human life cycle. According to Shanahan and Macmillan (2008:40), the life-course refers to "the age-graded sequence of roles, opportunities, constraints, and events that shape the biography from birth to

death". At its core, a life-course perspective insists that development is lifelong and that no life stage can be understood in isolation from others. In doing so, it uniquely brings together many conceptual themes that are individually found in a variety of developmental and demographic perspectives (Elder eta l., 2003). It examines an individual's life history and sees, for example, how early events influence future decisions and events such as marriage, divorce, involvement in crime, or disease prevalence (White and Klein, ed. 2007). The life-course perspective argues that there is continuity among all life phases. It also highlights the contradictions surrounding adolescence.

The life-course approach was developed in the 1960s for analyzing people's lives within structural, social and cultural contexts. Increasingly, the life-course approach plays an important role in understanding population health and well-being. This perspective views health as the product of risk behaviours, protective factors, and environmental agents that we encounter throughout our entire lives and that have cumulative, additive, and even multiplicative impacts on specific outcomes. It thus provides a construct for interpreting how peoples' experiences in their early years influence their later health and functioning.

Adolescence is seen as one of the most fascinating and complex transitions in the lifespan. Kipke (1999) noted that events at this crucial formative phase can shape an individual's life course. The importance of taking a life-course contextual view of adolescence is also apparent in the study of risk behaviours in which many adolescents engage that includes delinquency, aggression, and substance use.

2.9 Relevance of selected theoretical approach to this study

The life-course (lifespan) approach was relevant to this study because it is concerned with the human development process from conception to death. The developmental perspective of adolescence was relevant to this study because it provided the intellectual tools needed to understand issues surrounding adolescent sexuality. The perspective adopted a life course approach and saw adolescent sexuality as part of the normal human growth path in which individuals develop needs and wants as they grow. The life-course approach considered that

adolescents had unique sexual and reproductive health needs whose gratification is determined by several socio-cultural, policy and structural factors.

The life-course perspective is also relevant for examining and addressing health disparities between vulnerable and well-off populations. For example, lack of health insurance and limited or no access to health care in developing countries impairs the growth and developmental trajectories of many adolescents. Therefore, by systematically pursuing the life-course paradigm, we could potentially reduce the heavy human and economic costs precipitated by health inequities. The life-course approach offers knowledge which could be applied to health and other programs in different age and gender groups to relieve suffering and offer hope of living healthy and fulfilling lives across the lifespan.

The above perspective was also relevant because it highlighted the need to understand the present and future reproductive health needs of adolescents. The sexual behaviour of today's adolescents has implications for their future reproductive health, thus, the need to provide a range of health services required to meet the different reproductive health needs of individuals throughout their lifespan.

CHAPTER THREE
METHODOLOGY

This section focuses on the methodology that was used in this study. Research designs, target population, sample size, sampling techniques, data collection instruments and analysis are discussed in detail.

3.1 Research Design

The study used descriptive study design because it provides an accurate representation of the characteristics of a particular phenomenon by describing what exists and determining the frequency with which something takes place (Burns and Grove, 2005).

Further, the study used both quantitative and qualitative research methods. Quantitative research method was used because it focused on gathering numerical data and generalizing it across groups of people or to explain a particular phenomenon (Babbie, 2010); while qualitative research method was used to interpret the data within the context of the study. In other words, quantitative research method answered questions like “how many” and “how often”, while the qualitative research method answered questions like “why”.

3.2 Study Location

The study was conducted in Kamanga Compound in Lusaka District. According to Lusaka City Council bill boards, Kamanga Compound is located about 14 kilometres east of the City Centre. It lies opposite Chelstone Police Camp on the left hand side of Galaunia Road off the Great East Road. It shares its boundary with Chamba Valley to the North, Kaunda Square to the West and Chelstone to the East. The settlement has a total surface area of about 526, 211.98 square metres with a total population of over 11, 000 inhabitants (Banda, 2002). Kamanga consists of 2 parts an old part and a new part. There is no proper layout of houses and roads in the Old Kamanga. The houses are mainly built with mud bricks and are constructed close to each other. New Kamanga (overspill area) is planned; the houses are mainly medium-cost housing units.

The study was conducted in Kamanga compound because it is one of the high density areas in Lusaka District where most people of low economic and social class live and also because of the high increase in the number of teenage pregnancies and substance abuse in the area.

3.3 Study Population

The study population included all adolescent girls and boys living in Kamanga Compound and Key Informants (Health Service Providers) from Chelstone Clinic. The researcher selected Chelstone Clinic because it is the only public health facility servicing residents of Kamanga Compound and surrounding areas namely, Chelstone Township and Obama Compound.

3.4 Sample Size

The sample comprised a total of 200 respondents (100 female and 100 male). The aim was to design a sample that was representative of the population from the selected location. A technical determination of the sample size required preliminary calculations in order to design a sample that met the sample size requirements and other design criteria. The sampling frame comprised all adolescents for this study. The size of the sample required to achieve the stated objective for the study was scientifically determined using the 95% confidence level and a $\pm 0.5\%$ margin of error (Gover and Kelly, 1993). This method gave us a sample which we could use with confidence to estimate the parameters required in order to identify factors affecting access to and utilization of reproductive health services among adolescents in Lusaka District.

3.5 Data sources

Data was collected from adolescents aged between 10 to19 years and Key Informants (Health Service Providers) from Chelstone Clinic dealing with reproductive health matters.

3.6 Data collection Methods

The study used close-ended, open-ended questionnaires and Focus Group Discussions (FGDs) to

collect data from the selected sample. Close-ended questionnaires were administered to the sampled adolescents in Kamanga Compound. Open-ended questionnaires were administered to Key Informants (Health Service Providers) from the Chelstone Clinic. FGDs were used to collect in-depth qualitative data from the adolescents. An audio recorder was used to record the conversations during the FGDs.

3.7 Sampling techniques

This study used systematic sampling technique to select the required sample. In order to collect quantitative data from adolescents, 180 households were selected randomly. From these households, 180 respondents (90 girls and 90 boys) were selected using systematic selection method by applying a fixed interval. Selection of the respondents was done first by listing eligible males and females in each sampled household and subsequently selecting the sex of the respondent randomly. If there were two or more eligible respondents in a household, one of them was selected randomly. A selection table was designed to facilitate this operation.

For qualitative data, 18 adolescents (9 girls and 9 boys) sampled purposively were collected through 3 Focus Group Discussions (FGDs) comprising 6 adolescents each. In order to select adolescents for the FGD, the researcher contacted local leaders (Kamanga Market Chairperson and the Area Councilor) and explained the purpose of the study. With the help of the local leaders, participants for the FGD were recruited. FGDs were conducted to provide rich in-depth qualitative data on the topic of study.

In addition, 2 Key Informants (Health Service Providers) were also sampled purposively to provide rich in-depth data. Purposive sampling technique was used to select a sample capable of providing rich information for in-depth analysis related to the focal issue being studied (Sandelowski, 2000 and Kasonde-Ng'andu, 2013) based on the providers' practical experience with adolescents and their familiarity with reproductive health policies for adolescents. Their selection was based on their potential to provide data on the range of reproductive health services offered to adolescents in Kamanga Compound. The selected sample thus generated important data about available reproductive health care services for the adolescents, the extent to which

adolescents in Kamanga Compound sought and used reproductive health services, and the challenges that they faced in accessing the services. Purposive sampling in other words helped answer questions like “who”, “why” and how?

3.8 Data analysis

Quantitative data was analysed using Statistical Package for Social Sciences (SPSS) to generate frequency tables, percentages, cross tabulations and figures. Qualitative data was analysed using thematic analysis based on the research objectives. Data on the audio recorder collected during FGDs were transcribed. The transcribed data was then read several times, paying specific attention to themes that emerged and noting down initial themes. Thereafter, the data was coded and later collated into themes that accurately depicted the data. The Researcher reviewed the themes to see whether they made sense and accounted for all the coded extracts. This led to a comprehensive analysis of what the themes contributed to understanding the data (Braun and Clarke, 2006).

3.9 Ethical considerations

The following ethical considerations were addressed before commencing the study.

3.9.1 Confidentiality and privacy

The researcher safeguarded the privacy and identity of all the respondents. It was made clear that information obtained from the study would be treated with strict confidentiality, and would be used only for the intended research purpose. Participants’ personal characteristics were not made known. In addition, respondents were told before they consented to participate in the study that the researcher would like to publish the findings of the study.

3.9.2 Informed consent

Informed consent from parents/guardians in Kamanga Compound was sought. The researcher gave potential respondents sufficient information on the study in order for them to make informed decisions about their participation. It was made clear that any participant would be free

to withdraw from the any time. Where necessary, the researcher explained the topic of study in Nyanja, the language respondents understood very well. In addition, ethical approval was sought from the Humanities and Social Sciences Research Ethics Committee of the University of Zambia before commencing the study.

3.10 Limitations of the study

This study extends the current level of knowledge, attitude and practice as well as barriers to access to SRH services among adolescents. Another limitation was that some questions were sensitive as a result, affected the interview process because some respondents could not express themselves explicitly even though confidentiality was assured.

CHAPTER FOUR
RESULTS

This chapter presents the findings of the study collected via questionnaires, in-depth interviews and Focus Group Discussions. Findings from questionnaires are supported with tables and figures while those from in-depth interviews and Focus Group Discussions are supported with actual words used by the respondents.

4.1 Demographic Information of the Respondents

This section covers general information on the characteristics of the respondents such as Sex, Age, and Level of education and Religious Affiliation.

4.1.1 Age of Respondents

Out of the total number of 180 respondents interviewed, 90 were male and 90 were female. In terms of age, table 1 below shows that 19 (10.6%) respondents were aged 12 years, 25 (14.0%) were aged 13 years, 20 (11.2%) were aged 14, 26 (14.5%) were aged 15 years, 20 (11.2%) were aged 16 years, 27 (15.1%) were aged 17 years, 21 (11.7%) were aged 18 years and 21 (11.7%) were aged 19 years. The youngest was 12 years old and the oldest was 19 years old.

Table 1: Respondents' Age

		Age								Total
		12	13	14	15	16	17	18	19	
Sex	Male	13	14	13	12	9	11	6	12	90
		7.3%	7.8%	7.3%	6.7%	5.0%	6.1%	3.4%	6.7%	50.3%
	Female	6	11	7	14	11	16	15	9	89
		3.4%	6.1%	3.9%	7.8%	6.1%	8.9%	8.4%	5.0%	49.7%
Total		19	25	20	26	20	27	21	21	179
		10.6 %	14.0 %	11.2 %	14.5 %	11.2 %	15.1 %	11.7 %	11.7%	100.0 %

Further, demographic details of adolescents who participated in FGDs were as follows: 18 (9 female and 9 male) adolescents participated. In terms of age, 4 (2 male and 2 female) were aged 15 years, 2 male were aged 14 years, 1 male was aged 19 years, 5 (1 male and 4 female) were aged 17 years, 3 (1 female and 2 male) were aged 16 years while 3 (2 female and 1 male) were aged 18 years old.

4.1.2 Level of Education

Table 2 below shows the level of education by sex of the adolescents. The results show that 3 (1.7%) boys and 4 (2.2%) girls had never been to school, 44 (24.4%) boys and 34 (18.9%) girls had primary school education, and 26 (14.4%) boys and 36 (20.0%) girls had junior secondary school education while 17 (9.4%) boys and 16 (8.9%) girls had senior secondary school education.

Table 2: Adolescents' Level of Education

	Sex		Total
	Male	Female	
Never been to school	3	4	7
	1.7%	2.2%	3.9%
Primary	44	34	78
	24.4%	18.9%	43.3%
Junior Secondary	26	36	62
	14.4%	20.0%	34.4%
Senior Secondary	17	16	33
	9.4%	8.9%	18.3%
Total	90	90	180
	50.0%	50.0%	100.0%

In terms of educational attainment of adolescents interviewed through FGDs, 2 (1 male and 1 female) had completed grade twelve, 3 (2 female and 1 male) were in grade eleven, 7 (3 female and 4 male) were in grade ten, 6 (3 male and 3 female) were in grade nine.

4.1.3 Respondents' Keepers

Table 3 below shows adolescents' keepers. According to the study, more 47 (26.4%) than girls, 42 (23.6%) lived with both parents; whereas 29 (16.3%) boys compared with 30 (16.9%) girls lived with a single parent. The results further show that more 18 (10.1%) girls than boys, 12 (6.7%) boys lived with other relatives. Adolescents who did not live with their parents were asked to specify other relatives they lived with and these were aunty, cousin, friend, grandmother, sister and uncle.

Table 3: Percentage of adolescents living with their parents by Sex

	Sex		Total
	Male	Female	
Yes (Both Parents)	47	42	89
	26.4%	23.6%	50.0%
Yes (Single Parent)	29	30	59
	16.3%	16.9%	33.1%
Other	12	18	30
	6.7%	10.1%	16.9%
Total	88	90	178
	49.4%	50.6%	100.0%

4.1.4 Religious Affiliation of the Adolescents

In terms of religious affiliation, more boys 28 (15.6%) than girls 26 (14.4%) were Catholics, more girls 10 (5.6%) than boys 6 (3.3%) were Anglican, more boys 14 (7.8%) than girls 10 (5.6%) were SDA, more boys 26 (14.4%) than girls 25 (13.9%) were Pentecostal, 2 (1.1%) boys and 1 (0.6%) girl were Muslim, while 18 (10.0%) female compared to 14 (7.8%) boys belonged to other religious groups. Table 4 below illustrates this information:

Table 4: Adolescents' Religious Affiliation

	Sex		Total
	Male	Female	
Catholic	28	26	54
	15.6%	14.4%	30.0%
Anglican	6	10	16
	3.3%	5.6%	8.9%
SDA	14	10	24
	7.8%	5.6%	13.3%
Pentecostal	26	25	51
	14.4%	13.9%	28.3%
Muslim	2	1	3
	1.1%	0.6%	1.7%
Other	14	18	32
	7.8%	10.0%	17.8%
Total	90	90	180
	50.0%	50.0%	100.0%

4.2 Parent – Adolescent Communication on SRH Matters

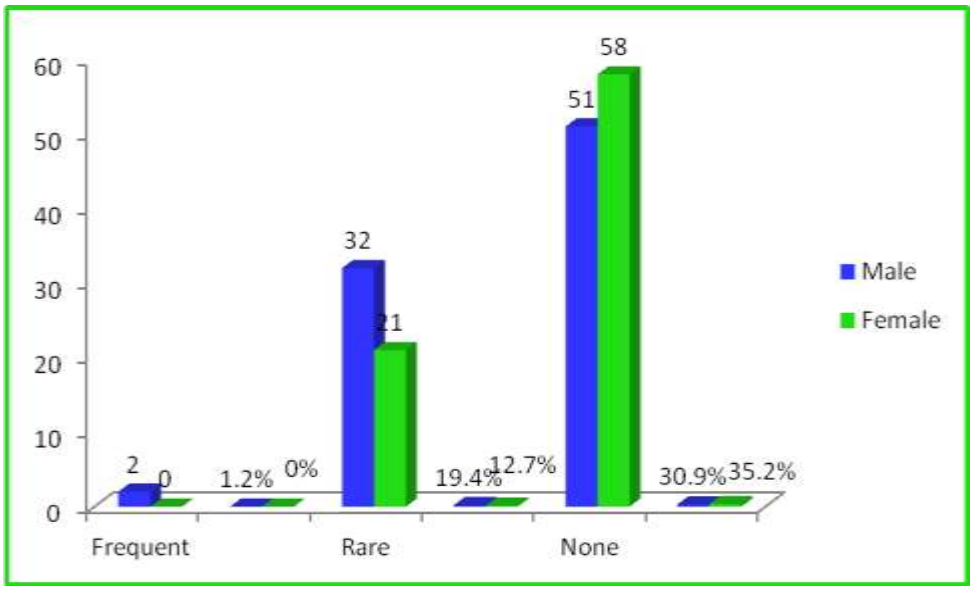
Various questions on communication between adolescents and their parents were asked. The aim was to assess whether adolescents were free to discuss important matters including sexuality issues with their parents and vice versa.

4.2.1 Communication with father on sexual matters

A cross tabulation of the results on communication and sex of the respondents showed that no female adolescents had frequent communication with their father on sexual matters. The results showed that only boys had frequent communication with their father on sexual matters. The results also show that more boys 32 (19.4%) than girls 21 (12.7%) rarely communicated with their father. Further the results showed that there were more girls 58 (35.2%) than boys 51

(30.9%) who did not communicate with their father on sexual matters as shown in figure 1 below:

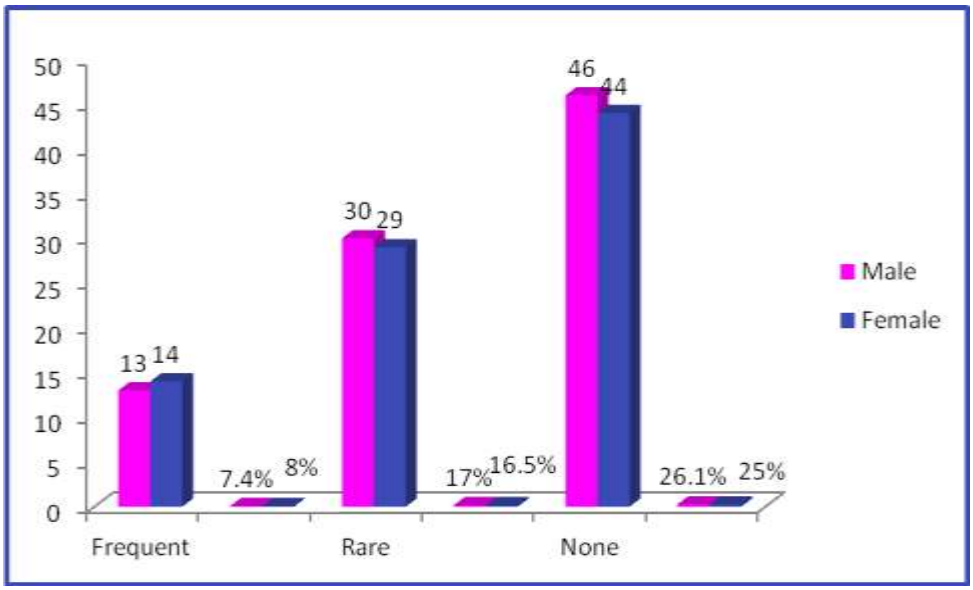
Figure 1: Communication with father on sexual matters by sex



4.2.2 Communication with mother on sexual matters

The results on communication with the mother were also cross tabulated with the sex of the respondents. Results show that more 14 (8%) girls than boys 13 (7.4%) had frequent communication with their mother while more 30 (17%) boys compared to girls 29 (16.5%) rarely communicated with their mother on sexual matters. The results further show that more boys 46 (26.1%) compared to 44 (25%) girls indicated that they did not communicate with their mother on sexual matters at all. Figure 2 below summarises these findings:

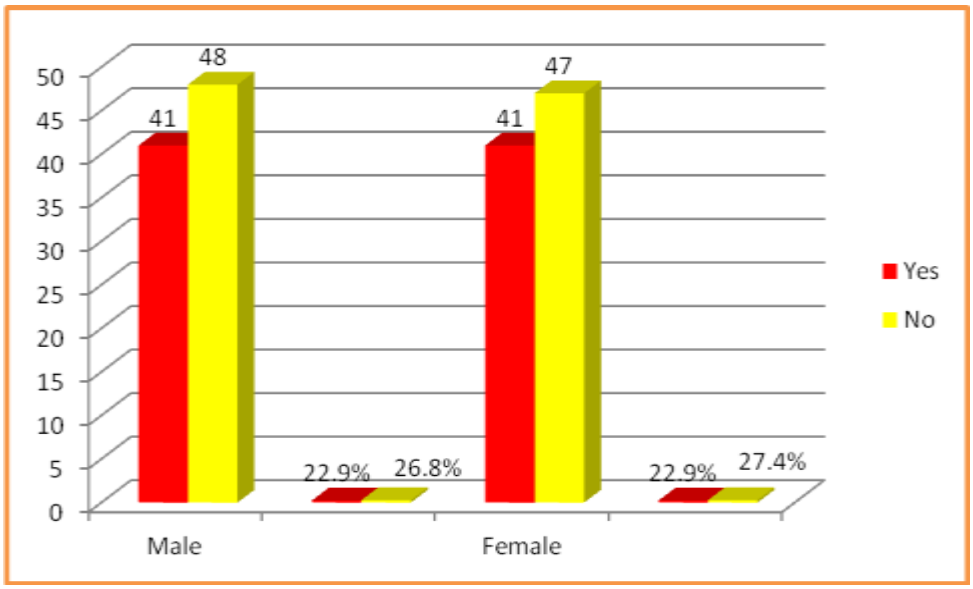
Figure 2: Communication with mother on sexual matters by sex



4.2.3 Discussed STI/HIV/AIDS prevention with parents

Adolescents were asked to state whether they had discussed STI/HIV/AIDS prevention with their parents. The results show that more 49 (27.4%) girls than boys 48 (26.8%) had not discussed STI/HIV/AIDS prevention with their parents. The results further show that there was equal number 41 (22.9%) of adolescents who indicated that they had discussed this topic. Figure 3 below shows the results.

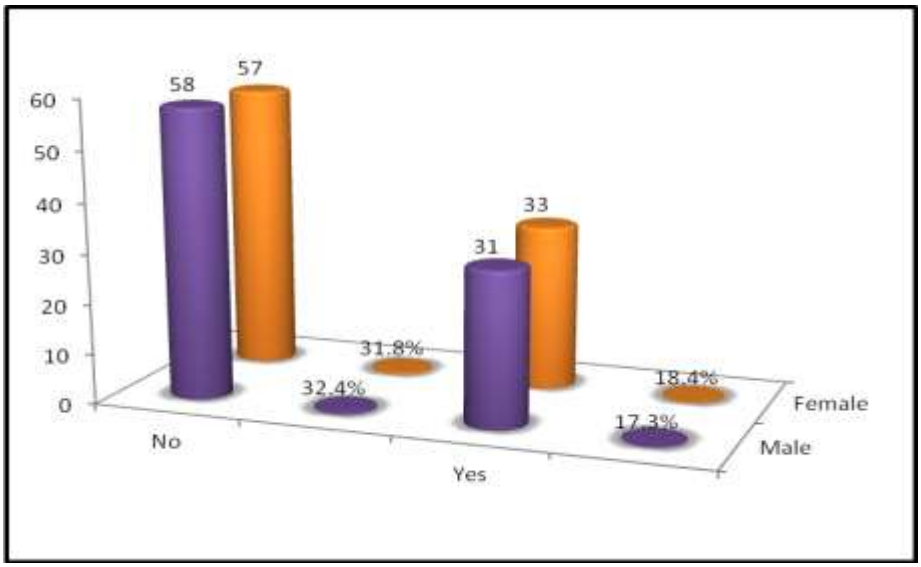
Figure 3: Respondents discussed STI/HIV/AIDS Prevention with parents



4.2.4 Discussed pregnancy prevention with parents

Adolescents were asked whether they had discussed pregnancy prevention with their parents. Out of the 179 adolescents that responded to this question, the majority 115 (64.2%) had never discussed pregnancy prevention while only 64 (35.8%) had discussed pregnancy prevention with their parents. Further, these findings show that of those who had not discussed the topic, the majority 58 (32.7%) were male while few 57 (31.8%) were female. Figure 4 highlights these findings:

Figure 4: Respondents discussed pregnancy prevention with parents



4.2.5 Comfortable discussing Sexual and RH issues with father

Table 5 below shows that more female 62 (35.8%) than male 60 (34.7%) were not comfortable to discuss sexual and reproductive health issues with their father, while only 3 (1.7%) male and 1 (0.6%) female were very comfortable to discuss the topic. From the same results, 23 (13.3%) male and 21 (12.1%) female reported that they were somewhat comfortable.

Table 5: Comfortable discussing SRH issues with their father

	Sex		Total
	Male	Female	
Very comfortable	3	1	4
	1.7%	0.6%	2.3%
Somewhat comfortable	23	21	44
	13.3%	12.1%	25.4%
Not comfortable	60	62	122
	34.7%	35.8%	70.5%
Total	86	87	173
	49.7%	50.3%	100.0%

4.2.6 Comfortable discussing SRH issues with your mother

Results show that more female 17 (9.6%) than male 11 (6.2%) reported that they were very comfortable while more male 27 (15.2%) than female 24 (13.5%), indicated that they were somewhat comfortable and the majority 51 (28.7%) of the male respondents compared to only 47 (26.4%) female reported that they were not comfortable to discuss reproductive health issues with their mother as indicated in table 6 below.

Table 6: Comfortable discussing SRH issues with their mother by Sex

	Sex		Total
	Male	Female	
Very comfortable	11	17	28
	6.2%	9.6%	15.7%
Somewhat comfortable	27	24	51
	15.2%	13.5%	28.7%
Not comfortable	51	47	98
	28.7%	26.4%	55.1%
Total	89	89	178
	50.0%	50.0%	100.0%

Adolescents indicated the reasons why they were uncomfortable to talk about Sexual and RH issues with their father. The majority 132 (75.9%) indicated fear, followed by shyness 127 (73.0%), 78 (44.8%) indicated traditional beliefs or taboos and a smaller number 30 (17.2%) stated religious beliefs. Adolescents also indicated why they felt uncomfortable talking about Sexual and RH issues with their mother. 132 (75.9%) stated shyness, 119 (68.4%) indicated fear, and 65 (37.4%) stated traditional beliefs while 29 (16.7%) indicated religious beliefs. Table 7 below summarises the results from multiple response:

Table 7: Uncomfortable talking about Sexual and RH issues with father and mother by Sex

	Sex		Total
	Male	Female	
Traditional Beliefs(taboo)-**Father**	30	48	78
	17.2%	27.6%	44.8%
Religious Beliefs-**Father**	12	18	30
	6.9%	10.3%	17.2%
Fear-**Father**	68	64	132
	39.1%	36.8%	75.9%
Shyness-**Father**	63	64	127
	36.2%	36.8%	73.0%
Traditional Beliefs(taboo)-**Mother**	31	34	65
	17.8%	19.5%	37.4%
Religious Beliefs-**Mother**	13	16	29
	7.5%	9.2%	16.7%
Fear-**Mother**	63	56	119
	36.2%	32.2%	68.4%
Shyness-**Mother**	68	64	132
	39.1%	36.8%	75.9%
Total	88	86	174
	50.6%	49.4%	100.0%

4.3 Risk Behaviours among Adolescents

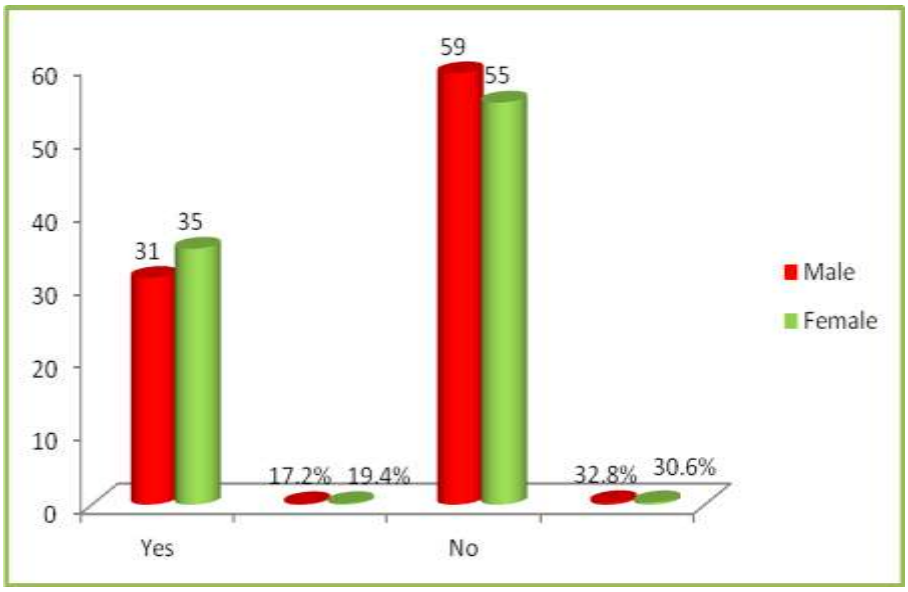
A number of questions were asked to assess risk behaviours among adolescents as a result of involvement in sexual behaviours. These are specified below:

4.3.1 Respondents ever had Sex

Respondents were asked to indicate whether they have had sexual intercourse before. Of the 180 adolescents interviewed, more female 35 (19.4%) than male 31 (17.2%) had sexual intercourse

before the age of twenty. Results further show that 59 (32.8%) male and only 55 (30.6%) female had not had sexual intercourse before the age of twenty. Figure 5 summarises the results:

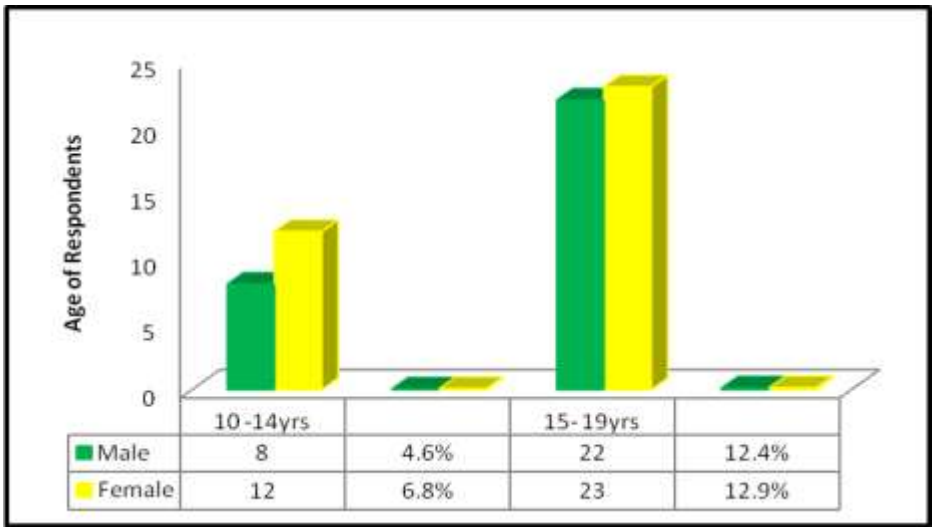
Figure 5: Respondents ever had Sexual Intercourse



4.3.2 Respondents' Age at first Sex

In terms of age at first sex, the study revealed that more female 12 (6.8%) than male 8 (4.6%) had sex before the age of 15. The study further shows that more female 23 (12.9%) than male 22 (12.4%) had sex before the age 20 as highlighted in figure 6 below.

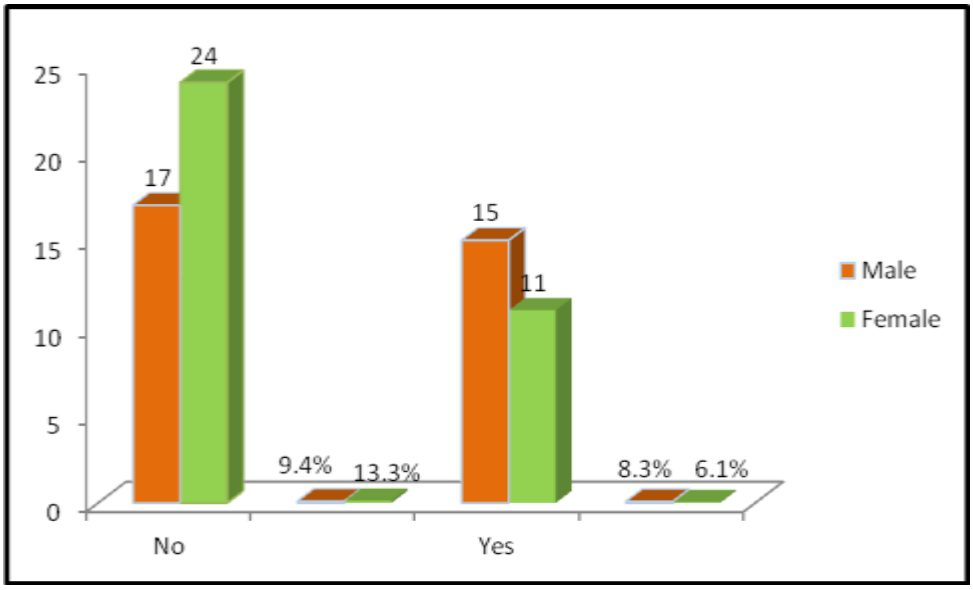
Figure 6: Respondents' Age at First Sex



4.3.3 Condom use at first Sex

In terms of condom use at first sex, results shows that only 26 (14.4%) adolescents used a condom while the majority 41 (22.8%) did not use a condom at first sex. The results further revealed that in terms of sex, the majority 15 (8.3%) of those who used a condom at first sex were male and few 11 (6.1%) were female as shown in figure 7 below.

Figure 7: Condom use at first Sex



4.3.4 Reasons for not using a Condom at first Sex

Of the respondents who did not use a condom at first sex, the majority 15 (53.6%) girls and few 13 (46.4%) boys said they were shy to access condoms, 2 (7.1%) boys and 1 (3.6%) girl said they could not afford the cost of a condom while an equal number, 1 (3.6%) boys and girls said it was difficult to access condoms as shown in table 8 below:

Table 8: Reasons for not using a condom at first Sex

	Sex		Total
	Male	Female	
Difficult to access condoms	1	1	2
	3.6%	3.6%	7.1%
Shy to access condoms	13	15	28
	46.4%	53.6%	100.0%
Could not afford the cost of condoms	2	1	3
	7.1%	3.6%	10.7%
Total	13	15	28
	46.4%	53.6%	100.0%

4.3.5 Number of people had sex with in the last 3 months

Respondents were asked the number of partners they had sexual intercourse with in the last three (3) months. The majority, 6 (3.4%) female compared to few 5 (2.8%) male indicated that they had sex with 2 partners, more male 3 (1.7%) than female 1 (0.6%) indicated 3 partners while 18 (10.1%) female compared with 14 (7.8%) male indicated 1 sexual partner. These results show that there are more male than female who had more than one sexual partner in the last three months. Table 9 below illustrates this information:

Table 9: Percentage of Adolescents' sexual partners in the last 3 months by Sex

	Sex		Total
	Male	Female	
0	8	10	18
	4.5%	5.6%	10.1%
1	14	18	32
	7.8%	10.1%	17.9%
2	5	6	11
	2.8%	3.4%	6.1%
3	3	1	4
	1.7%	0.6%	2.2%
Total	90	89	179
	50.3%	49.7%	100.0%

4.3.6 Condom use at last Sex

The study revealed that only 10% of the sexually active respondents used a condom every time they had sex. Of these, the majority 10 (5.6%) were male and few 8 (4.4%) were female; The study further shows that 26 (14.4%) used a condom most of the time and from these, the majority 15 (8.3%) were female and few 11 (6.1%) were male; the study also revealed that 11 (6.1%) used a condom occasionally and from these, the majority 8 (4.4%) were female while only 3 (1.7%) were male; The results further show that 11 (6.1%) did not use a condom at all and from these, the majority 6 (3.3%) were male compared to 5 (2.8%) female. The results are summarized in table 10 below:

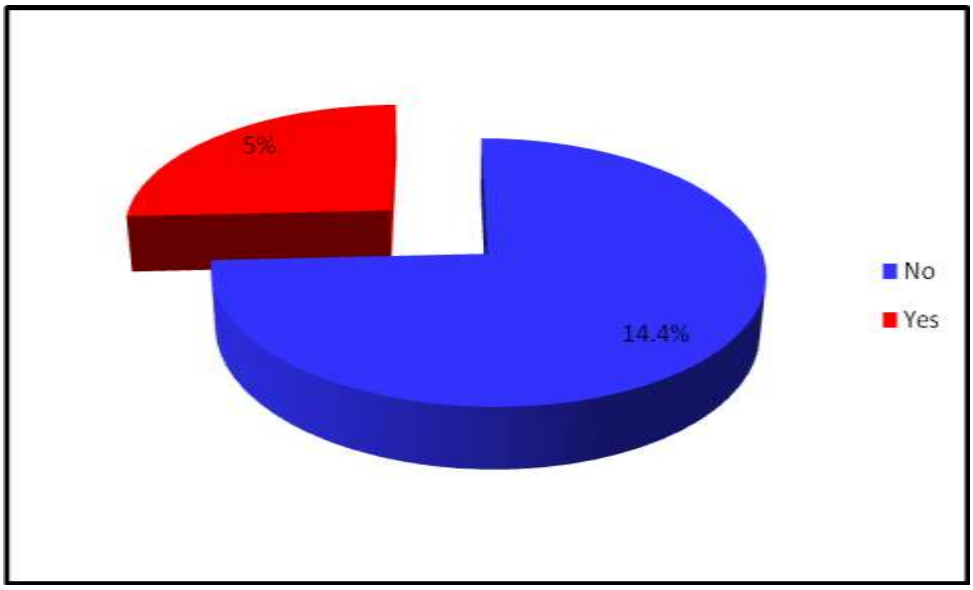
Table 10: Percentage of Condom use at last Sex

	Sex		Total
	Male	Female	
Every time	10	8	18
	5.6%	4.4%	10.0%
Most of the time	11	15	26
	6.1%	8.3%	14.4%
Occasionally	3	8	11
	1.7%	4.4%	6.1%
Not at all	6	5	11
	3.3%	2.8%	6.1%
Total	90	90	180
	50.0%	50.0%	100.0%

4.3.7 Adolescent girls who had unwanted pregnancy

Female adolescents who had sexual intercourse were asked to indicate whether they had unwanted pregnancy before. The aim was to assess some of the consequences of risk behaviours among adolescents. Out of the 37 adolescents who responded to the question, 9 (5%) female indicated that they had unwanted pregnancies. Figure 8 below summarises this information:

Figure 8: Adolescent girls reported having unwanted pregnancy



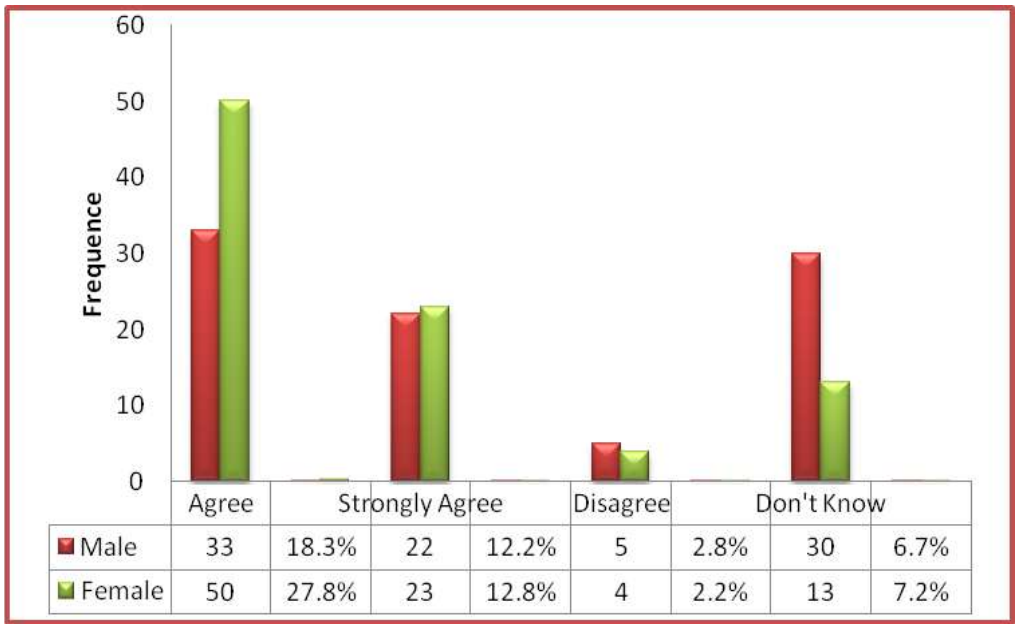
4.4 Reproductive Physiology and myths about Pregnancy

Adolescents were also asked questions on reproductive physiology and myths about pregnancy. The aim was to assess their level of knowledge about their body functioning and makeup. Adolescents were asked to indicate: 1) agree 2) strongly agree 3) disagree 4) strongly disagree 5) do not know against each statement.

4.4.1 A girl can get pregnant at first intercourse

The study revealed that more female 50 (27.8%) than male 33 (18.3%) agreed with the statement while more female 23 (12.8%) than male 22 (12.2%) strongly agreed with the above statement. The results further show that there were more male 5 (2.8%) compared to female 4 (2.2%) who disagreed with the statement while more male 30 (16.7%) than female 13 (7.2%) reported that they did not know. These results are shown in figure 9 below:

Figure 9: Respondents who reported that a girl can get pregnant at first intercourse



	Agree		Strongly Agree		Disagree		Don't Know	
Male	33	18.3%	22	12.2%	5	2.8%	30	6.7%
Female	50	27.8%	23	12.8%	4	2.2%	13	7.2%

4.4.2 A girl cannot get pregnant if she washes up immediately after sexual intercourse

A myth on a girl cannot get pregnant if she washes up immediately after intercourse revealed the following: 5 (2.8%) male and 14 (7.8%) female indicated agree, 4 (2.2%) female and zero male indicated strongly agree, 34 (18.9%) female and 28 (15.6%) male indicated disagree, an equal number of respondents 13 (7.2%) indicated strongly disagree while more 44 (24.4%) male and few 25 (13.9%) female indicated that they did not know.

Another myth about a girl cannot get pregnant if she had sex while standing up about pregnancy was asked and results show that out of more female 20 (11.1%) than male 6 (3.3%) indicated agree, 5 (2.8%) female and 2 (1.1%) stated strongly agree, more female 24 (13.3%) and only 18 (10%) male indicated disagree, 18 (10%) male and 15 (8.3%) female indicated strongly disagree while the majority 46 (25.6%) did not know. Table 11 below summarises these results:

Table 11: Reproductive Physiology and Myths about Pregnancy

	Sex										Total
	Male					Female					
	Agree	Strongly Agree	Disagree	Strongly Disagree	Don't Know	Agree	Strongly Agree	Disagree	Strongly Disagree	Don't Know	
A girl cannot get pregnant if she washes up immediately after sexual intercourse	5	0	28	13	44	14	4	34	13	25	180
	2.8 %	0.0 %	15.6 %	7.2 %	24.4 %	7.8 %	2.2 %	18.9 %	7.2 %	13.9 %	100%
A girl cannot get pregnant if she has sexual intercourse while standing up	6	2	18	18	46	20	5	24	15	26	180
	3.3 %	1.1 %	10 %	10 %	25.6 %	11.1 %	2.8 %	13.3 %	8.3 %	14.4 %	100 %

4.5 Reproductive Health (RH) problems facing adolescent girls and boys

In-depth interviews with Service providers at Chelstone Clinic revealed some of the major reproductive health concerns or problems facing adolescents in Kamanga Compound. According a female service provider, *"the major problems were STIs and teenage pregnancies."*

FGD results show that *if a girl got pregnant at a young age of less than 15, she could have a lot of complications during labour and since the womb is not strong, the baby might be born with different problems such as having a big head.* At the same time, adolescents stated that *if you are young then you get pregnant, you may not know how to take care of the child you may fail to give the baby balanced diet hence this may result into kwashiorkor, (*15 year old female respondent). Other reproductive health problems revealed during FGDs were *early pregnancies, some adolescents contract STIs such as syphilis, bolabola (swelling of testacles) including HIV/AIDS, kusungunuka (*quick lose of weight due to sickness), (19 year old male respondent).

Adolescents also mentioned other reproductive health problems like staining oneself during menstrual periods and lack of sanitary pads. 15 year old female respondent said *if a girl does not know how to take care of herself during menstrual periods you will find that she can leave her*

sanitary pads anywhere and also she can stain her clothes.

Meanwhile a male respondent argued that *defilement* was another example of the reproductive health problems affecting adolescents, (18 year old male respondent).

In addition, FGD results also revealed that *not being circumcised* was another reproductive health problem among male adolescents. A 19 year old male respondent stated that, *if I am not circumcised and I have sex with an HIV positive girl it will be very easy for me to contract the disease because the fore skin keeps some stuff and this stuff makes it easy for someone to get infected with HIV but if one is circumcised it is not easy to get infected with HIV.*

Furthermore, cancer was noted as one of the reproductive health problems facing adolescents. *A person can also get cancer…if a boy is not circumcised and gets to have un protected sex with a girl who has cancer then the boy can contract cancer as well and you find that even if a girl is a virgin but the boy is not circumcised, that string/thread like thing on a penis will get cut when pushing his penis in the vagina…if that happens, blood will mix and the person can get cancer,"* (19 year old male respondent).

4.6 Gender variations in Adolescents' Knowledge about RHS

One of the specific objectives was to assess gender variations in adolescents' knowledge and access to reproductive health services. The aim was to establish which gender had more knowledge and utilized RHS among adolescents. In order to respond to the objective, one of the questions asked was on the types of reproductive health services adolescents were aware of.

4.6.1 Types of RHS adolescents aware of

The study revealed that more girls 80 (48.8%) than boys 60 (36.6%) were aware of family planning, while more boys 81 (49.4%) than girls 76 (46.3%) were aware of male circumcision as a type RHS. In terms of awareness on STI screening and treatment, the study recorded equal level of knowledge between girls, 52 (31.7%) and boys, 52 (31.7%). The study also showed that

more girls 80 (48.8%) than boys 75 (45.7%) were aware of HIV testing and counseling and also more girls 60 (36.6%) than boys 46 (28.0%) were aware of cancer screening service. Table 12 below summarises this information:

Table 12: Types of RHS adolescents aware of by Sex

	Sex		Total
	Male	Female	
Family Planning	60	80	140
	36.6%	48.8%	85.4%
Male circumcision	81	76	157
	49.4%	46.3%	95.7%
STI screening and treatment	52	52	104
	31.7%	31.7%	63.4%
HIV Couselling and testing	75	80	155
	45.7%	48.8%	94.5%
Cancer screening	46	60	106
	28.0%	36.6%	64.6%
Total	81	83	164
	49.4%	50.6%	100.0%

During the focus group discussions, adolescents revealed that some of the reproductive health services offered at Chelstone Clinic were as stated below:

"STI screening and testing, prescriptions for STIs, male circumcision, PMTCT services, advise before conducting male circumcision, HIV testing and counseling, ARVs, provide condoms, family planning services like pills, injections, there is also that thing they insert in the arm it has a V shape (implants), offer advice to HIV positive mothers not to breast feed their babies to prevent transmission of the HIV virus, cancer screening, referrals to Mwanawasa general hospital", (Source: FGD data).

"They just prescribe medicine for STI. If they screen and test a person and they are found to be

reactive, they will just write down the name of the medicine so that the person can go and buy from the drug store. They usually say they do not have drugs. They also give advice before a person is circumcised. They also give ARVs, condoms; they also offer voluntary counselling and testing for HIV," (16 year male respondent).

Meanwhile, a male service provider said Chelstone Clinic offered *"male circumcision (MC), family planning (FP), STI treatment, pregnancy testing and HIV counselling and testing; and provision of ARVs."* Adding that specific reproductive health services offered to adolescents by the clinic were *"family planning services, STI screening and testing, pregnancy testing and male circumcision.* Furthermore, stated that *drugs for most STIs were readily available including treatment for syphilis*.

4.6.2 Preferred Sources of information on RHS (Results of multiple responses)

In order to assess gender variations in knowledge and utilization of reproductive health services further, adolescents were asked about their preferred sources of information on reproductive health. The following were the findings:

The adolescents also stated their preferred source of information on reproductive health. The majority, 150 adolescents (86.7%) indicated their teachers/school, 132 (76.3%) mentioned Health Care providers, 128 adolescents (74.0%) mentioned friends/ classmates, 128 (74.0%) indicated the Radio/Television, 93 (53.8%) stated Public hospital/clinic, 52 (30.1%) said their mother, 37 (21.4%) mentioned private hospital/ Clinic while a few adolescents, 8 (4.6%) indicated their father. Adolescents' preferred source of information on RHS is summarized in table 13 below.

Table 13: Preferred Source of Information on RHS (Results of multiple responses)

	Sex		Total
	Male	Female	
Private hospital/clinic	12	25	37
	6.9%	14.5%	21.4%
Public hospital/clinic	39	54	93
	22.5%	31.2%	53.8%
Father	5	3	8
	2.9%	1.7%	4.6%
Mother	18	34	52
	10.4%	19.7%	30.1%
Friends/Classmates	59	69	128
	34.1%	39.9%	74.0%
Teacher/School	78	72	150
	45.1%	41.6%	86.7%
Health Care providers	65	67	132
	37.6%	38.7%	76.3%
Radio/Television	64	64	128
	37.0%	37.0%	74.0%
Total	86	87	173
	49.7%	50.3%	100.0%

4.6.3 Most Preferred Source of Information on RHS

The adolescents were further asked their most preferred source of information on RH and majority 82 (93.2%) of them mentioned public hospital/ clinic while a few, 24 (27.3%) mentioned private hospital/ clinic. The results further show that of those who preferred private hospital/ clinic, the majority 17 (19.3%) were female and few 7 (8%) were male. At the same time the results also show that of those who indicated public hospital/ clinic, the majority 43

(48.9%) were female and few 39 (44.3%) were male. The results are summarized in the table 14 below:

Table 14: Most Preferred Source of Information on RHS by Sex

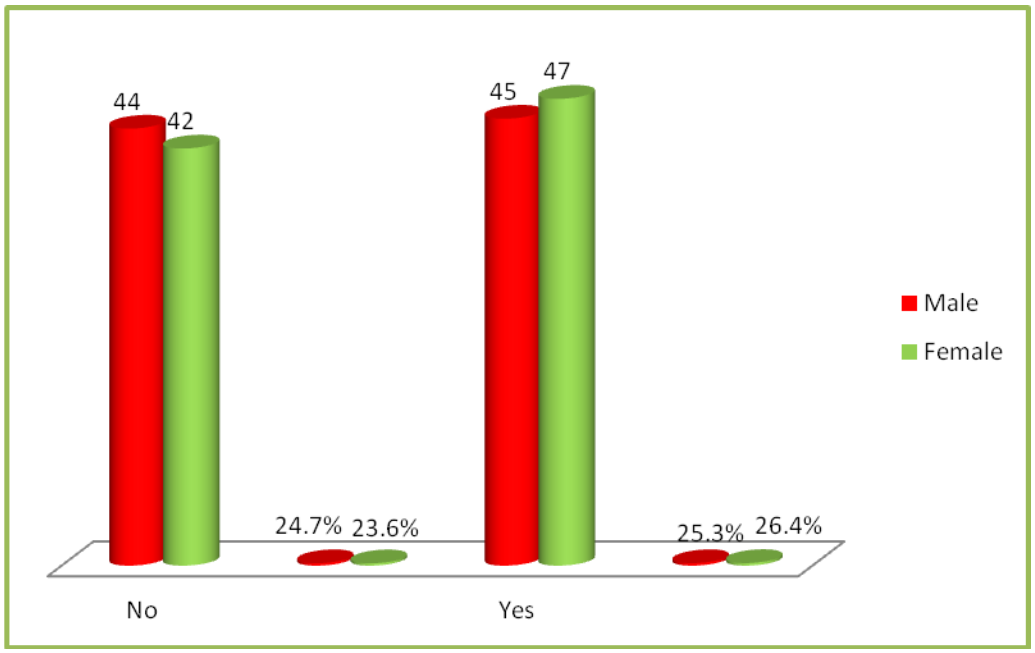
	Sex		Total
	Male	Female	
Private hospital/clinic	7	17	24
	8.0%	19.3%	27.3%
Public hospital/clinic	39	43	82
	44.3%	48.9%	93.2%
Total	41	47	88
	46.6%	53.4%	100.0%

4.7 Access to and Utilisation of RHS among Adolescents

The adolescents were asked whether they had used any reproductive health services. The aim was to assess whether adolescents' knowledge about available services resulted in their use of the services. They were asked to indicate (a) type of reproductive health service received, (b) whether they were satisfied with the reproductive health services they had received and (c) the source of the reproductive health services they had received.

Findings of the study show that 92 (51.7%) adolescents reported having used reproductive health services while 86 (48.3%) reported that they had never used any RHS. The findings further revealed that more female 47 (26.4%) than male 45 (25.3%) adolescents had received reproductive health services. Figure 10 below highlights this information:

Figure 10: Adolescents ever received RHS



4.7.1 Type of RHS adolescents reported having received

In terms of the types of reproductive health services received, findings show that 45 (42.9%) male and 51 (48.6%) female had received information on HIV/STI prevention, 8 (7.6%) male and 15 (14.3%) female received STI screening and treatment, 39 (37.1%) boys indicated male circumcision service, only 8 (7.6%) male compared to 22 (21%) female had received family planning services while 22 (21%) male and 30 (28.6%) female received HIV counseling and testing. These findings are illustrated in table 15 below:

Table 15: Type of RHS adolescents reported having received (Results of multiple responses)

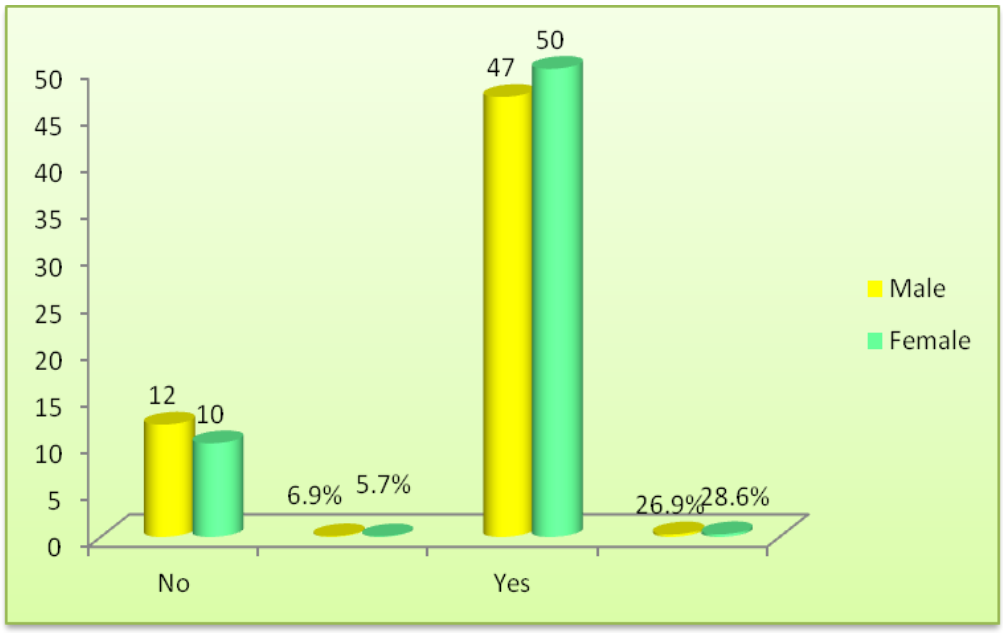
	Sex		Total
	Male	Female	
Information on HIV/STI prevention	45	51	96
	42.9%	48.6%	91.4%
STI screening and treatment	8	15	23
	7.6%	14.3%	21.9%
Male circumcision	39	0	39
	37.1%	0%	37.1%
Family planning services	8	22	30
	7.6%	21.0%	28.6%
HIV counseling and testing	22	30	52
	21.0%	28.6%	49.5%
Total	50	55	105
	47.6%	52.4%	100.0%

During the FGDs, it was revealed that Chelstone Clinic provided free reproductive health services such as condoms, injections, male circumcision services and many more to clients except in cases where the clinic had run out of the drugs.

4.7.2 Satisfaction with the RHS Received

Adolescents were asked to indicate whether they were satisfied with the reproductive health services they had received. Out of 119 adolescents who responded to the question, the majority, 92 (53.9%) indicated that they were satisfied with the services received while a few, 22 (12.2%) adolescents reported that they were not satisfied with the services. In terms of gender disaggregation, there were more female, 50 (28.6%) than male, 47 (26.9%) who reported being satisfied with the reproductive health services. Figure 11 below summarises this information:

Figure 11: Adolescents Satisfied with RHS received



4.7.3 Sources of RHS Received

The majority, 53 (88.3%) adolescents indicated that they had accessed services from public hospital/clinic while only 7 (11.7%) indicated that they had accessed services from private hospital/clinic. The results further show that of those who indicated private hospital/clinic, more 5 (8.3%) were female and few, 2 (3.3%) were male. While respondents who indicated public hospital/ clinic, majority were male and few were female as highlighted in table 16 below.

Table 16: Sources of RHS received by Sex

	Sex		Total
	Male	Female	
Private hospital/clinic	2	5	7
	3.3%	8.3%	11.7%
Public hospitals/clinic	29	24	53
	48.3%	40.0%	88.3%
Total	31	29	60
	51.7%	48.3%	100.0%

A few adolescents cited other sources of reproductive health services received such as classmates, parents, teachers and community members.

4.7.4 Knowledge of Family Planning Methods

The adolescents were asked whether they were aware of specific types of family planning methods. The findings show that more, 72 (47.1%) female and few, 54 (35.3%) male had knowledge of the pill, 28 (18.3%) female compared to 10 (6.5%) had knowledge of the IUD, more 68 (44.4%) female compared to 48 (31.4%) male had knowledge of the injections, few 3 (2%) female and more 5 (3.3%) had knowledge of the diaphragm/ foam/ jelly, 44 (28.8%) female compared to 49 (32%) male had knowledge of female condom, more 74 (48.4%) female and few 68 (44.4%) male had knowledge of male condom, more 8 (5.2%) female and few 5 (3.3%) male had knowledge of male sterilization, 4 (2.6%) male and female had knowledge of female sterilization, more 15 (9.8%) female and few 7 (4.6%) male had knowledge of the rhythm method, more 28 (18.3%) male and few 25 (16.3%) female had knowledge of the withdrawal method, more 27 (17.6%) female and few 19 (12.4%) male had knowledge of traditional methods while more 59 (38.6%) and few 51 (33.3%) had knowledge of abstinence as a family planning method. These results show that more female than male adolescents had knowledge of specific types of family planning methods. Table 17 below shows the findings from multi-responses results:

Table 17: Adolescents' knowledge of Family Planning Methods

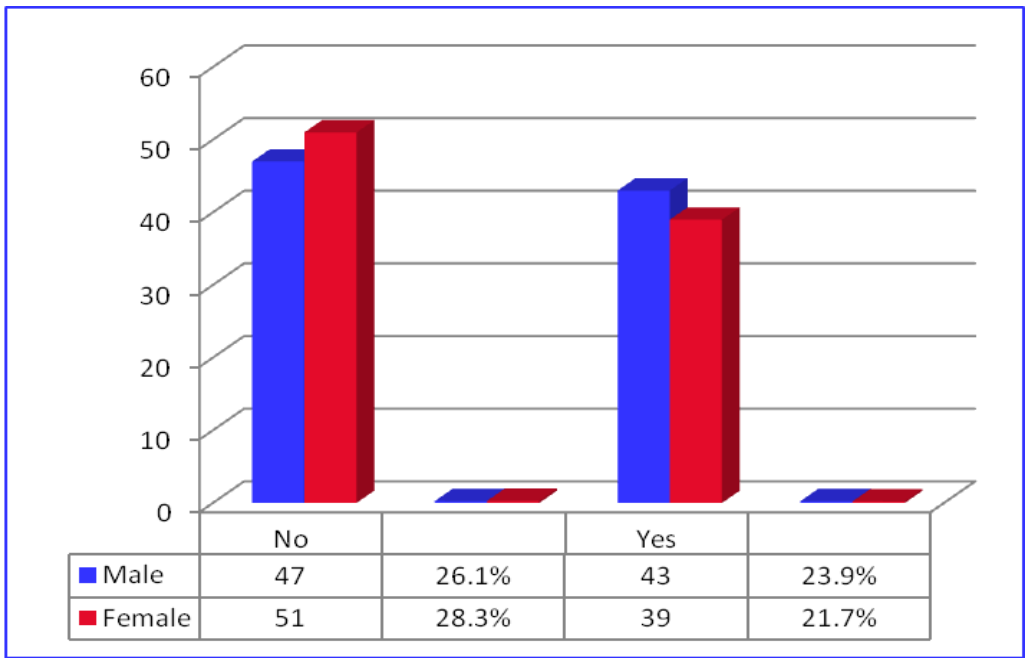
	Sex		Total
	Male	Female	
Pill	54	72	126
	35.3%	47.1%	82.4%
IUD	10	28	38
	6.5%	18.3%	24.8%
Injections	48	68	116
	31.4%	44.4%	75.8%
Diaphragm/foam/jelly	5	3	8
	3.3%	2.0%	5.2%
Female condom	49	44	93
	32.0%	28.8%	60.8%
Male condom	68	74	142
	44.4%	48.4%	92.8%
Male sterilization	5	8	13
	3.3%	5.2%	8.5%
Female sterilization	4	4	8
	2.6%	2.6%	5.2%
Rhythm method	7	15	22
	4.6%	9.8%	14.4%
Withdrawal	28	25	53
	18.3%	16.3%	34.6%
Traditional Methods	19	27	46
	12.4%	17.6%	30.1%
Abstinence	59	51	110
	38.6%	33.3%	71.9%
Total	72	81	153
	47.1%	52.9%	100.0%

During FGDs, adolescents also mentioned some of the family planning services they were aware of and these included contraceptive pills, use of injections, implants (insert in the arm), and condoms.

4.7.5 Used Family Planning Methods

The aim of the above question was to assess whether adolescents' knowledge about specific family planning methods resulted in their use of the services. Out of 180 adolescents who responded to the question, the majority, 98 (54.4%) indicated that they had never used any family planning method while 82 (45.6%) reported that they had used family planning method. Of those who reported having used family planning method, the majority 43 (23.9%) were male and few 39 (21.7%) were female. Figure 12 below illustrates this information:

Figure 12: Adolescents used Family Planning Method by Sex



However, in-depth interviews with service providers revealed that *"girls were in the majority in terms of seeking family planning services due to fear of early pregnancies. Adolescents girls in most cases come for the services after indulging in sex, so they want to know whether they are pregnant or not,"* (Female service provider).

4.7.6 Adolescents currently using Family Planning Methods

Out of 180 adolescents who responded to the question, the majority, 104 (57.8%) indicated that they were not using any family planning method while 76 reported that they were using some family planning methods. Out of 76 (42.2%) adolescents reported using family planning currently, the majority 41 (22.8%) were male and few 35 (19.4%) were female. Table 18 below shows this information:

Table 18: Adolescents currently using Family Planning Methods by Sex

	Sex		Total
	Male	Female	
No	49	55	104
	27.2%	30.6%	57.8%
Yes	41	35	76
	22.8%	19.4%	42.2%
Total	90	90	180
	50.0%	50.0%	100.0%

4.7.7 Types of Family Planning Method currently using

In terms of specific types of family planning methods adolescents were currently using, 12 (11.2%) female adolescents indicated the pill, 8 (7.5%) female adolescents stated injections, 6 (5.6%) female compared to 3 (2.8%) male indicated female condom, more male 22 (20.6%) than female, 15 (14.0%) indicated male condom, 2 (1.9%) female reported male sterilization, 2 (1.9%) male adolescents indicated withdrawal method, 2 (1.9%) female adolescents indicated traditional methods and the majority 39 (36.4%) male and few 33 (30.8%) female indicated abstinence. Table 19 below shows this information:

Table 19: Types of Family planning method currently using by Sex

	Sex		Total
	Male	Female	
Pill	0	12	12
	0.0%	11.2%	11.2%
Injections	0	8	8
	0.0%	7.5%	7.5%
Female condom	3	6	9
	2.8%	5.6%	8.4%
Male condom	22	15	37
	20.6%	14.0%	34.6%
Male sterilization	0	2	2
	0.0%	1.9%	1.9%
Withdrawal	2	0	2
	1.9%	0.0%	1.9%
Traditional Methods	0	2	2
	0.0%	1.9%	1.9%
Abstinence	39	33	72
	36.4%	30.8%	67.3%
Total	54	53	107
	50.5%	49.5%	100.0%

4.8 Attitudes towards utilization of RHS

Adolescents' attitude towards utilization of RHS was assessed. To achieve this aim, adolescents were asked to indicate: 1) agree 2) strongly agree 3) disagree 4) strongly disagree 5) do not know against each statement.

4.8.1 Do you think adolescents like you should be provided with RH services?

Table 20 below shows that more female 82 (45.6%) than male 75 (41.7%) reported that they should be provided with RHS. The results further show that out of the few 22 (12.2%) adolescents, who did not agree with the statement, the majority 15 (8.3%) were male and few 7 (3.9%), were female.

Table 20: Adolescents on whether they should be provided with RHS by Sex

	Sex		Total
	Male	Female	
No	15	7	22
	8.3%	3.9%	12.2%
Yes	75	82	157
	41.7%	45.6%	87.2%
Total	90	90	180
	50.0%	50.0%	100.0%

4.8.2 All young people should be aware of the importance of RHS

With regards to a statement on all young people should be aware of the importance of RHS, the study revealed that more 50 (27.8%) female than male 44 (24.4%) indicated agree, 35 (19.4%) female compared to 34 (18.9%) male reported strongly agree; 4 (2.2%) male and 1 (0.6%) female indicated disagree, 1 (0.6%) male and zero female indicated strongly disagree while 6 (3.3%) male and 3 (1.7%) female indicated don't know.

4.8.3 Only females should use RHS

A statement on only females should use reproductive health services had the following results: 180 adolescents responded to this statement. Out of these, 15 (8.3%) male and 24 (13.3%) female indicated agree, 3 (1.7%) male and 2 (1.1%) female indicated strongly agree, 28 (15.6%) male and 32 (17.8%) female indicated disagree, 30 (16.7%) male and 26 (14.4%) female

indicated strongly disagree while 14 (7.8%) male and 6 (3.3%) female indicated don't know. Table 21 below demonstrates the results of the two statements above:

Table 21: Percentage of Respondents' attitude towards utilization of RHS

	Sex										
	Male					Female					
	Agree	Strongly Agree	Disagree	Strongly Disagree	Don't Know	Agree	Strongly Agree	Disagree	Strongly Disagree	Don't Know	Total
All young people should be aware of the importance of RHS	44	34	4	1	6	50	35	1	0	3	173
	24.4 %	18.9 %	2.2 %	0.6 %	3.3 %	27.8 %	19.4 %	0.6 %	0.0 %	1.7 %	98.9 %
Only females should use RHS	15	3	28	30	14	24	2	32	26	6	180
	8.3 %	1.7 %	15.6 %	16.7 %	7.8 %	13.3 %	1.1 %	17.8 %	14.4 %	3.3 %	100 %

4.8.4 Likely to use RHS in future

A cross tabulation of respondents who answered the statement on likely to use Reproductive Health Services in future revealed that 38 (21.3%) were male and 37 (20.8%) were female. Those who indicated very likely, 37 (20.8%) were female and another 37 (20.8%) were male while those who indicated never, 8 (4.5%) were male and 7 (3.9%) were female. The study findings show that both male and female adolescents were likely to use Reproductive Health Services in future. Table 22 below summarises the results:

Table 22: Adolescents likely to use health services for RH in future

	Sex		Total
	Male	Female	
Very likely	37	37	74
	20.8%	20.8%	41.6%
Likely	38	37	75
	21.3%	20.8%	42.1%
Unlikely	7	7	14
	3.9%	3.9%	7.9%
Never	8	7	15
	4.5%	3.9%	8.4%
Total	90	88	178
	50.6%	49.4%	100.0%

4.9 Factors affecting Access to and Utilization of RHS

4.9.1 Barriers faced by adolescents in obtaining RHS

Adolescents were asked about the barriers they faced in obtaining RHS. The aim was to find out whether there were challenges that prevented them from accessing and utilizing the services. 36 (22.5%) male and 32 (20.0%) female stated that they did not know any contraceptive method, 76 (47.5%) male and 75 (46.9%) female said they felt afraid, embarrassment and shy to request for the services, 53 (33.1%) male and 55 (34.4%) indicated age restrictions, 48 (30.0%) male and 57 (35.6%) female felt lack of privacy/confidentiality, 47 (29.4%) male and 46 (28.8%) female said they did not know where to go or how to get there while 35 (21.9%) male and 37 (23.1%) indicated costs. These results are summarised in table 23 below:

Table 23: Barriers faced by adolescents in obtaining RHS

	Sex		Total
	Male	Female	
Does not know any contraceptive methods	36	32	68
	22.5%	20.0%	42.5%
Feel afraid, embarrassed & shy	76	75	151
	47.5%	46.9%	94.4%
Age restriction	53	55	108
	33.1%	34.4%	67.5%
Cost	35	37	72
	21.9%	23.1%	45.0%
Privacy/confidentiality not respected	48	57	105
	30.0%	35.6%	65.6%
Does not know where to go or how to get there	47	46	93
	29.4%	28.8%	58.1%
Total	80	80	160
	50.0%	50.0%	100.0%

During the in-depth interviews with the Servive Providers other barriers hindering the provision of RHS to adolescents were revealed and these were, *"staff shortages, staff-adolescent age differences, adolescents feel shy to be attended to by staff of the opposite sex,"* (Male service provider at Chelstone Clinic).

FGD results show that there was discrimination in the way certain services were offered to clients. For instance, adolescents were in agreement that at Chelstone Clinic there was a building designated for the provision of ARVs nicknamed "white house". Adolescents revealed that sometimes patients were advised to spend a night at the Clinic so that they are attended to early the following morning before queues of people begin building up. Stated that some patients were shy to go and stand on the queue outside the "white house" where everyone including some familiar people would see them. These opted to collect their ARVs from far away health facilities including Levy Mwanawasa Hospital.

4.9.2 Privacy and Confidentiality

To assess barriers faced by adolescents in accessing RHS, respondents were asked to state whether service providers honoured privacy and confidentiality when dealing with adolescent clients. The study revealed that 13 (7.3%) male and 19 (10.7%) female adolescents felt that service providers did not honour privacy and confidentiality. The study further revealed that 75 (42.1%) male and 71 (39.9%) female adolescents stated that service providers owner privacy and confidentiality. The results are outlined in table 24 below:

Table 24: Service providers' honour privacy and confidentiality

	Sex		Total
	Male	Female	
No	13	19	32
	7.3%	10.7%	18.0%
Yes	75	71	146
	42.1%	39.9%	82.0%
Total	88	90	178
	49.4%	50.6%	100.0%

Meanwhile, adolescents had this to say during the focus group discussion with regards to the issue of privacy at the same Clinic:

"Privacy is there when doing HIV counseling and testing, STI screening and male circumcision because we enter the room one by one. There is no privacy when accessing condoms because condom dispensers are placed outside on the open for people to collect," (17 years old male respondent).

The above was supported by another respondent who pointed out that*, "there is no privacy when accessing family planning pills because lessons are conducted in a group (classroom arrangement for all the women)",* (19 years old female respondent).

4.9.3 Separate Rooms for Adolescents seeking RHS at Clinic

Adolescents were also asked whether there were separate rooms for adolescents seeking RHS. 177 (98.3%) adolescents responded to this question. Out of these, 50 (28.2%) male and another 50 (28.2%) female indicated that there were no separate rooms for adolescents seeking RHS at Chelstone Clinic while 37 (20.9%) male and 40 (22.6%) female adolescents agreed that there were separate rooms for adolescents seeking RHS at Chelstone Clinic. These results are highlighted in table 25 below:

Table 25: Separate Rooms for adolescents seeking RHS

	Sex		Total
	Male	Female	
No	50	50	100
	28.2%	28.2%	56.5%
Yes	37	40	77
	20.9%	22.6%	43.5%
Total	87	90	177
	49.2%	50.8%	100.0%

In-depth interviews with service providers revealed that there were *"trained Counsellors who attend to adolescents. Unfortunately there are no separate rooms specifically for adolescents, instead people go in one by one when being screened or receiving the services,"* (Female service provider at Chelstone Clinic).

In terms of treatment, adolescent boys who go for male circumcision were treated well. "*We are made to lie on a bed when being operating on and they even give us an injection to reduce the pain. At first they (Service Providers) used to provide soap for cleaning the wound but now they have stopped and they just tell you to buy the soap (lifebuoy). The wound is then stitched and bandaged. Adolescents seeking HIV counseling and testing are also treated well. They are welcomed nicely. If someone is going for the first time, they advise them to go back for retest after 3 months," (*15 year old male respondent).

A 16 year old female respondent said *"Adolescent girls are not allowed to take family planning pills. They are told that if they take family planning pills they will not have children in future".*

4.10 Measures to improve access and utilization of RHS

Adolescents were asked to suggest ways for improving their access and utilisation of RHS. The aim was to make recommendations for strengthening RHS for adolescents. Adolescents indicated the need for scaling up adolescent friendly services, providing non school based sexual education, encouraging community participation; strengthen peer education, providing separate rooms for adolescents seeking reproductive health services and encouraging general and sex communication between parents and children. Table 26 below presents the results of multiple responses from adolescents:

Table 26: Measures to improve access to RHS among adolescents

	Sex		Total
	Male	Female	
Scale up adolescent friendly services	85	83	168
	47.8%	46.6%	94.4%
Provide non school based sexual education	85	87	172
	47.8%	48.9%	96.6%
Encourage community participation	87	87	174
	48.9%	48.9%	97.8%
Strengthen peer education	87	88	175
	48.9%	49.4%	98.3%
Provide separate rooms for adolescents seeking RHS	88	88	176
	49.4%	49.4%	98.9%
Encourage general and sex communication between parents and children	88	89	177
	49.4%	50.0%	99.4%
Total	89	89	178
	50.0%	50.0%	100.0%

FGDs with adolescents further revealed some measures to improve access and utilization of RHS. There was unison among adolescents on the need for the Clinic Staff to ensure that confidentiality and privacy were upheld.

"Chelstone Clinic should stock drugs for STIs (especially syphilis) and not telling people to go and buy. What if they don't have money? (18 year old male respondent*).*

The Clinic should use promotions to encourage people to go for services. Also use brochures and youth magazines to increase awareness of available reproductive services among adolescents, (17 year old female respondent).

The male adolescents were also in agreement that *"Chelstone Clinic should provide lifebuoy soap for cleaning the wound after doing male circumcision.* While a 15 year male respondent, said that the Clinic should also *"provide transport for male adolescents after doing circumcision because the drug given did not last long in reducing the pain since there was a distance between their homes and the Clinic".*

Interviews with service providers further revealed other measures to improve access to RHS among adolescents. For instance, it was proposed that Clinic Staff attending to adolescents should be of the same sex. *"Boys want to be attended to by male service providers while girls prefer female service providers",* (Female Service Provider).

"Proposed that the Clinic through the Ministry of Health should employ young service providers (of about 20 years old) to attend to adolescents since they feel uncomfortable to be attended to by old women and men. The Clinic should also introduce youth-friendly corner services for adolescents seeking RHS in order to address the issue of mixing young people with the old ones, (Female Service Provider).

CHAPTER FIVE
DISCUSSION OF RESEARCH RESULTS

This chapter is divided into the following sections: Demographic information of respondents, Parent – Adolescent Communication on SRH Matters, Risk behaviours among adolescents, Gender variations in adolescents' knowledge about RHS, Factors affecting Access to and Utilization of RHS, Measures to improve Access to and Utilization of RHS. The discussion is supported with data (quotations) from adolescents, health service providers' interviews and with findings from previous studies.

5.1 Demographic information of the respondents

Results of the study show that the majority 27 (15.1%) of the respondents were aged 17 years while few 19 (10.6%) were aged 12 years. Out of the total number of 180 respondents interviewed, 90 were male and 90 were female. Majority of the respondents had attained secondary education. In terms of utilization, it was discovered that adolescents with secondary education had used Reproductive Health Services more than those without secondary education.

Findings of the study revealed that 89 (50%) of adolescents lived with both parents, whereas 59 (33.1%) lived with a single parent and 30 (16.9%) lived with other relatives. Adolescents specified other relatives they lived with and these included aunty, cousin, friend, grandmother, sister and uncle. The study revealed that the majority of the respondents were Christians while a few were Muslims and other religious groups. Religious affiliation was important in order to establish factors affecting access to and utilization of RHS among adolescents. Some religious groupings in particular, the Catholics do not encourage the use of RHS such as family planning among the unmarried for fear of promoting premarital sex.

5.2 Parent – Adolescent Communication on SRH Matters

The study revealed that adolescents' level of communication with their parents on sexual matters was low and varied according to the sex of the parent. Additionally, the results show that

generally, the majority of the respondents did not communicate about sexual matters either with their mother or father. This is typical of most cultures in Zambia and Africa at large. For instance, the study revealed that only 3 (1.7%) male and 1 (0.6%) female were very comfortable to discuss sexual and reproductive health issues with their father while more female 17 (9.6%) than male 11 (6.2%) reported that they were very comfortable to discuss this topic with their mother.

The above results are in line with the findings by Kapungwe (2003) who discovered that in Zambia, it has long been a taboo to discuss sexual matters with somebody of the opposite sex and with one's own child. These findings imply that despite having health concerns, adolescents were less likely to seek guidance and information from their parents on matters pertaining to sexuality. As a result, these adolescents would end up getting these services from peers and in most cases this may not be accurate. The findings point towards the need to adequately sensitize both parents and adolescents about the need for open discussions on important matters including sexuality issues.

5.3 Risk Behaviours among Adolescents

The study revealed that more female 35 (19.4%) compared to male 31 (17.2%) had sexual intercourse before the age of twenty. The study further revealed that condom use at first sex for both sexes was low. This is because out of 19.4% female that had sex before the age of twenty only 11 (6.1%) of them used a condom at first sex while out of 17.2% male that had sex before the age of twenty, only 15 (8.3%) used a condom at first sex. The implications of these findings are vulnerability to unwanted pregnancies, STIs including HIV among adolescents. This means adolescents especially girls should be sensitized on the need for consistency use of condoms every time they had sex.

These results are in line with the findings by CSO (2007) which showed that 56% of female aged between 15 and 24 years had sex before the age of 18 years, only 24% of them used a condom at first sex; Similarly, 51% of male aged between 15-24 years had sex before the age of 18 years, and only 22% of them used a condom at first sex. These results are further in line with the

findings by Abajobir (2014) and Warenius (2008) who pointed out that low utilization of adolescent reproductive health services is a global problem especially in the developing countries.

Adolescents cited shyness as the major reason for not using a condom at first sex followed by cost of a condom and difficult to access condoms. Other reasons for not using a condom at first sex were; lack of knowledge about condoms and where to get them including having sex while under the influence beer and did not think of a condom. These findings point towards the need to adequately sensitise adolescents about risky behaviours associated with early sex debut and available Reproductive Health Services for adolescents. This would equip them with necessary awareness and information about their sexual health needs.

The study has established that more female than male adolescents had a poor understanding about their reproductive physiology. With regards to pregnancy prevention, for instance, the study shows that more female 14 (7.8%) than male 5 (2.8%) believed that a girl could not get pregnant if she washed up immediately after sex. Furthermore, the study shows that more female 20 (11.1%) than male 6 (3.3%) believed that a girl could not get pregnant if she had sexual intercourse while standing up. These results are in line with the findings by Ahlberg et al (2001) who discovered that adolescents assume that conception can be prevented if one took a bath immediately after a sexual encounter or by having sex while standing up or by jumping up and down after sex. The above findings imply that female adolescents were less likely to take appropriate action such as demand for the use of a condom every time they had sex. These myths are also worsened especially in African societies where females are not expected to initiate sex let alone demand for the use of a condom. This is even worse among adolescent girls whose sexual encounters in most cases are with male much older than they. The findings point towards the need to adequately educate adolescents especially the girls, about their sexuality and developmental processes across the lifespan.

5.4 Gender variations in adolescents' knowledge and utilisation of RHS

The first specific objective of this study was to assess gender variations in adolescents'

knowledge and utilisation of Reproductive Health Services. The aim was to establish which gender had more knowledge about Reproductive Health Services and also whether adolescents' knowledge about available services resulted in their use of these services.

The study has revealed that more girls than boys were aware of most of the Reproductive Health Services namely; family planning services, HIV testing and counselling; and cancer screening services while more boys than girls were ware of male circumcision as a type RHS. The study further revealed equal knowledge in terms of awareness on STI screening and treatment for both boys and girls.

However, in terms of utilization, the study has revealed that knowledge of Reproductive Health Services among the adolescents did not translate into their use of the services. Findings of this study show that there was low utilization of Reproductive Health Services for both sexes. For instance, the study has shown that only 47 (26.4 %) female and 45 (25.4%) male had received RHS. The results further show that more female 51 (28.3%) than male 47 (26.1%) had not used any family planning method despite being sexually active at an early age. This explains why despite more girls being aware of specific family planning methods, they were still falling pregnant at an early age and leaving the education system prematurely. As a result, the lifespan approach should be adopted by all stakeholders involved in adolescent health since it offers knowledge which could be applied to the provision of reproductive health services in different age and gender groups to improve the health status of people across the lifespan.

5.5 Factors affecting Access to and Utilization of RHS

The second objective of this study was to find out factors affecting access to and utilization of Reproductive Health Services. The study has established major factors or barriers faced by adolescents in obtaining RHS were: For instance, 76 (47.5%) male and 75 (46.9%) female feel afraid, embarrassed and shy to request for the service, 53 (33.1%) male and 55 (34.4%) female stated age restriction while 48 (30%) male and 57 (35.6%) female reported that privacy/ confidentiality was not respected. The above results are in line with the study findings by Meuwissen et al (2005) in another study that revealed that existing Centres lacked

confidentiality, privacy, and quality of service, all factors considered essential characteristics by adolescents.

During the focus group discussions the researcher established that the issue of privacy and confidentiality was cardinal if adolescents were to adequately access and utilize Reproductive Health Services. *"There is no privacy when accessing family planning pills because lessons are conducted in a group (classroom arrangement for all the women) so young people like us feel shy to go there. Confidentiality is the most important aspect and should be observed,"* (19 years old female respondent).

According to the Ministry of Health (2012) in Zambia currently there are no adolescent-tailored sexual and reproductive health services, and often adolescents find it difficult to attend sexual and reproductive health services together with adults.

Generally, there was consensus among the adolescents that the quality of the services offered was poor. This made some people to end up buying these services from the drug store if they had money. Adolescents were usually discouraged by the "I don't care" attitude by service providers and also fear that they would be turned away. Drawing from the life-course approach, the study established that there are implications on the way individuals' reproductive health needs are considered and the way health facilities are designed to cater for individuals' health care needs including that of adolescents. For instance, adolescents' preference for service providers of the same sex was seen as one of the barriers affecting access and utilization of RHS.

5.6 Measures to improve Access to and Utilization of RHS

The last specific objective of this study was to identify measures to improve access to and utilisation of Reproductive Health Services among adolescents. Whilst acknowledging the barriers adolescents faced in obtaining Reproductive Health Services, they (adolescents) came up with measures to improve access and utilisation of their services. These included the need for scaling up adolescent friendly services, encouraging community participation and strengthen peer education. They further noted the need for providing separate rooms for adolescents seeking

Reproductive Health Services; and encouraging general and sex communication between parents and children.

In addition, a female service provider also stated that *the Clinic should introduce youth-friendly corner services for adolescents seeking RHS in order to address the issue of mixing young people with the old ones and since they feel uncomfortable to be attended to by elderly men and women at the Clinic, there is need to put young people (staff) of about 20 years old.*

FGDs with adolescents further revealed other measures to improve access and utilization of RHS. There was unison among adolescents on the need for the Clinic Staff to ensure that confidentiality was upheld. Adolescents further stated that Chelstone Clinic should stock drugs for STIs and provide lifebuoy soap for male adolescents under-going circumcision at the health facility.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

This Chapter presents the conclusion and recommendations of the study findings. The conclusion is presented first and the recommendations follow the conclusion.

6.1 CONCLUSION

This study sought to identify factors affecting access to and utilisation of reproductive health services among adolescents in Kamanga Compound. The study expected to find out factors affecting access to and utilization of RHS. The study further aimed at assessing gender variations in adolescents' knowledge and utilisations reproductive health services. The study was carried out in Kamanga Compound in Lusaka District. 180 adolescents (90 female and 90 male), 18 (9 male and 9 female) adolescents participated in FGDs and 2 (1 male and 1 female) health service providers from Chelstone Clinic.

This study has established that there are gender variations in knowledge and utilisation of reproductive health services among the adolescents in Kamanga Compound. It has shown that more girls than boys were aware of specific types of reproductive health services including family planning methods. It was discovered that more male than female had utilised family planning methods. In other words, the study revealed that knowledge of reproductive health services did not translate into their use of the service. At the same time, the study revealed that the level of access and utilisation of reproductive health services among adolescents was low for both sexes.

Some of the factors leading to low utilisation of reproductive health services included: lack of adolescent-friendly services, shortage of health services providers, adolescents' preference for service providers of the same sex. The study discovered that male adolescents preferred to be attended to by male service providers while female adolescents preferred female service providers. Age difference between adolescents and the service providers also made them (adolescents) shun the services. Other factors leading to low utilisation were distance to the

health facility and lack of transport; lack of specific consulting rooms for adolescents and non-confidential condom outlets, lack of certain services like soap (lifebuoy) at the health facility for those undergoing male circumcision, and judgmental attitude among health providers.

It has discovered that Chelstone Clinic lacked privacy and providers lacked confidentiality. In several studies, confidentiality and privacy have been found to be a contributing factor associated with low utilization of sexual reproductive health services among adolescents. Service providers need to be trained on principles such as confidentiality and privacy; this will help improve utilization of health services among adolescents.

Various types of information on reproductive health and family planning must be delivered to both male and female adolescents without bias. For instance, information to support informed decision making with regards to adolescents' reproductive health should be availed to them (adolescents) indicating the services available and the pros and cons of these services, including where they can be obtained.

Based on the lifespan theoretical approach, this study has concluded that adolescents have continued to be excluded from accessing and utilising reproductive health services due to the way health facilities are designed and operated.

6.2 RECOMMENDATIONS

The study has made the following recommendations for improving adolescents' access and use of services.

6.2.1 Chelstone Clinic should use brochures and youth magazines to increase awareness of available reproductive health services for adolescents.

6.2.2 Chelstone Clinic through the Ministry of Health should scale up adolescent-friendly services in order to meet the needs of both boys and girls.

6.2.3 Chelstone Clinic through the Ministry of Health should use mobile services to provide services in order to address the problem of distance boys and girls cover to the nearest health facility.

6.2.4 The Ministry of Health to have regular training and in-servicing of health service providers to effectively serve adolescents with emphasis on adolescents' rights to confidential and comprehensive reproductive health services.

6.2.5 The Government of the Republic of Zambia to increase funding to the Ministry of Health and Chelstone Clinic to be specific so that problems of shortages of staff and drugs including essential items such as lifebuoy soap for boys under going circumcision is addressed.

6.2.6 High rates of multiple partnerships among boys show that adolescent interventions to address concepts of masculinity are needed and should be part of the education curriculum provided by the Ministry of General Education.

6.2.7 The study further recommends for a study on a similar topic to be carried out on a larger scale so that the results could be generalised to the rest of the country.

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