

**TEENAGE GIRLS' ACCESS TO AND UTILIZATION OF ADOLESCENT
REPRODUCTIVE HEALTH SERVICES IN THE MPIKA DISTRICT, ZAMBIA**

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**A mini-thesis submitted in partial fulfillment of the requirement for the Degree of Masters
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KEYWORDS

- Adolescent Reproductive Health Services
- Accessibility and utilization
- Inhibitors and facilitators
- In-school teenage girls
- Pregnant teenagers
- Service providers
- Teenage pregnancy
- Ante-natal clinic
- Qualitative study
- Zambia



ABSTRACT

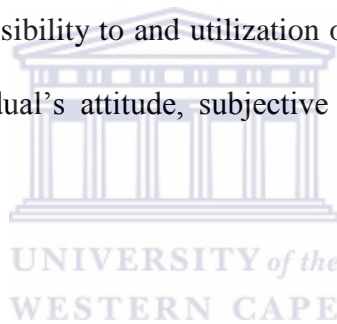
Teenage pregnancy is one of the major public health problems facing teenage girls in Zambia (Webb, 2000; Warenius, 2008). Teenage girls' access to and utilization of adolescent reproductive health (ARH) services is important for the prevention of teenage pregnancies and sexually transmitted infections (STIs) amongst teenagers.

High incidence of teenage pregnancies has been noted in the district despite availability of ARH services. Teenage pregnancy is a major contributing factor to the high school drop-out rate amongst the girls and is one of the challenges faced by non-governmental organizations (NGOs) that support girl child education, such as the campaign for female education (CAMFED) as well as for government agencies such as the Ministry of Education. The high incidence of teenage pregnancies could be an indication of poor access to and utilization of ARH services and therefore an assessment of the accessibility and utilization of the ARH services was done to explore the reasons for this.

This research aimed to explore the factors affecting teenage girls' access to and utilization of ARH services in the Mpika district, Zambia. The research was a qualitative, descriptive and exploratory study using individual interviews with ten in-school teenage girls, four key informants rendering ARH services and a focus group discussion (FGD) with ten pregnant teenage girls. By exploring these participants' perceptions and experiences, appropriate interventions to improve accessibility to and utilization of ARH services could be designed that would be appropriate for the local context in order for them to be effective.

Thematic analysis with categorizing and coding methods was used to analyze the data. The study used the theory of planned behaviour (TPB) which stipulates that an individual's attitude, subjective norms and perceived behavioural control influence behaviour as a framework to explain the findings of the results of the study.

The findings of the study indicated that physical, psychological and social barriers hindered adolescents from accessing and utilizing ARH services. The findings also suggested that high levels of knowledge about RH services do not necessarily translate into accessibility and utilization of ARH services. Accessibility to and utilization of ARH services by adolescents can also be determined by an individual's attitude, subjective norms, and perceived behavioural control as illustrated by the TPB.



Adolescents need to feel comfortable using ARH services. Therefore the three variables of TPB should be taken into consideration when designing comprehensive ARH programmes in order to accommodate the unique reproductive health needs of the adolescents. There is need to encourage participation in and involvement of adolescents in planning and implementation of ARH programmes. The participants also made recommendations which included strengthening information and education on ARH, strengthening adolescent-friendly services, improving staffing levels and promotion of school health services.

DECLARATION

I declare that *Teenage girls' access to and utilization of Adolescent Reproductive Health Services in the Mpika District, Zambia* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Constance Ndhlovu Choka

March 2011



Signed:

CNCP

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
ARH	Adolescent Reproductive Health
CAMFED	Campaign for Female Education
CBO(s)	Community Based Organisation(s)
DEBS	District Education Board Secretary
DHMT	District Health Management Team
FGD	Focus Group Discussion
FHI	Family Health International
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
NGOs	Non-Governmental Organisation(s)
RH	Reproductive Health
STI(s)	Sexually Transmitted Infection(s)
TB	Tuberculosis
TPB	Theory of Planned Behaviour
UN	United Nations
UNFPA	United Nations Population Fund
VCT	Voluntary Counseling Testing
WHO	World Health Organization
YFS	Youth Friendly Services

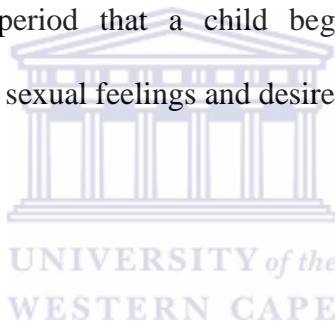
DEFINITION OF TERMS

Adolescent

The World Health Organization (WHO) defines an adolescent as a person between 10 and 19 years of age (WHO, 2008). The word adolescent is synonymous with the word teenager and the words are used interchangeably (Onike, 2007).

Teenager

Onike, (2007), defines a teenager as a child who falls within the chronological age of twelve to nineteen and it is within this period that a child begins to develop secondary sexual characteristics and starts to express sexual feelings and desires.



Reproductive Health

The United Nations (UN) defines reproductive health (RH) as physical, mental and social well-being in all matters relating to the reproductive system and functions at all stages in life (UN, 1995).

Reproductive Health Services

According to the UN, reproductive health services include prevention, diagnosis and treatment as related to STIs and contraceptive service and counseling, pre and post natal care, delivery care, safe abortion and post abortion care and access to information and education to the above issues (UN, 1995)

Teenage Pregnancy

Pregnancies occurring in women aged 19 or below, (WHO, 2004a)



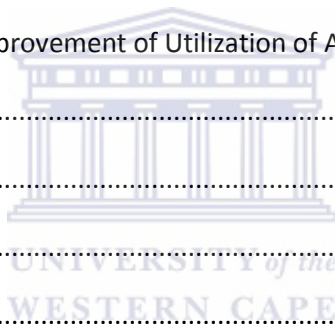
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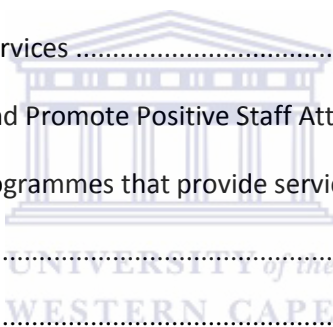
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CHAPTER 1: INTRODUCTION

1.1 Background

According to DiCenso, Guyatt, William & Griffth (2002), adolescence is a time of great biological, social and psychological changes. This is accompanied by increased interest in sex which predisposes adolescents to the risk of unwanted pregnancy and its consequences. Behaviour patterns developed during this period such as sexual risk taking or protection can have long lasting negative or positive effects respectively, on the future well being of an individual (Adamchak, Bond, MacLaren, Magnani, Nelson & Seltzer, 2000). In his commentary on teenage pregnancy, Langille (2007) states that studies have shown that by the end of high school, the majority of teenagers will have had sex. For example 75% of Zambian adolescents will have had sex by the age of 19 (Kikade & Macy, 2003). This predisposes them to a high risk of teenage pregnancy and childbearing. Kikade and Macy (2003) further claim that almost 60% of young Zambians have had their first child by the age of 19. Sub-Saharan Africa has the highest birth rate, namely 143 per 1000 among girls aged 15-19 (Bearinger, Sieving, Ferguson & Sharma, 2007).

Teenage pregnancy has been identified as a major cause of school dropout in Zambia (WIDNet, 2008). Teenage pregnancy, defined as pregnancies occurring in women aged 19 or below by WHO (2004a), is an important public health problem with negative consequences both for teenage mothers and their children (Xu & Shtarkshall, 2004; Langille, 2007). It is a major contributing factor to maternal risk factors associated with adverse birth outcomes such as neonatal mortality (Chen, Wen, Fleming, Demissie, Roads & Walker, 2007). In addition, the proportion of girls in the age group 15-19 in Sub-Saharan Africa who have resorted to unsafe

abortion is proportionally higher than in any other region (Shah & Ahman, 2004; WHO, 2004a) as they are more likely to turn to unskilled practitioners for termination of the pregnancy (Xu & Shtarkshall, 2004). Despite the Zambian abortion laws being less restrictive and allows abortion on social grounds, abortion services are inaccessible and unacceptable (Warenius, 2008). As a result, an estimated two thirds of unwanted teenage pregnancies in urban Zambia lead to unsafe abortions which often result in future reproductive ill health and even death (Webb, 2000; Warenius, 2008).

A number of risk factors strongly influence teenage pregnancy rates, such as declining age at menarche and early sexual debut (Chen et al., 2007). Other factors include adolescents having limited knowledge about reproductive health (UNFPA, 2002) and limited access to contraceptives (Chen et al., 2007). For example condom distribution is prohibited in schools in Zambia. The decision to ban distribution of condoms in schools by the then President in 2004 on moral grounds was supported by the national AIDS council.

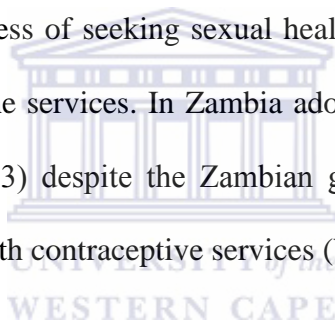
Socio-economic status also plays a role in teenage pregnancy. Girls from poor families are more likely to fall pregnant than those from rich families due to a lack of social and economic support from their families (Harding, 2003; International Women's Health Coalition, 2008). In Zambia this is confirmed by the fact that most of the pregnant girls that drop out of school in the district are supported by an NGO called campaign for female education (CAMFED) (CAMFED report, 2006). CAMFED supports poor and vulnerable girls by providing school bursaries, training in life skills and promoting the child protection policy. Apart from reproductive ill health, girls in Zambia as compared to the boys are more affected by the consequences of unprotected sex in

terms of social stigma such as rejection for having brought shame to the family and weakened future career prospects despite the school re-entry policy. The Ministry of Education's re-entry policy allows girls back into school after leaving school due to pregnancy. However, it has been found that most of the re-entry girls feel out of place as they find it difficult to mix with the other girls (WIDNet, 2008). The policy has also received resistance at community, faith based schools and government school levels (WIDNet, 2008). It is felt that it encourages immorality and will lead to increased cases of pregnancies although there is no evidence to back this assertion (Sifuniso, Undated).

The Zambian government ratified the international conference on population and development (ICPD) agreement (UN, 1995) that requires provision of reproductive health (RH) services for adolescents. Despite adopting the ICPD, utilization of RH services by adolescents is influenced by factors such as lack of youth-friendly services (YFS) and lack of awareness of the available RH services among adolescents. This is coupled with the resistance from the community for the provision of such services to adolescents and judgmental attitudes among service providers (Mmari & Magnani 2003; Kamau, 2006; Erulker, Onoka, & Phiri, 2005).

Few adolescents in Zambia visit health centres for their sexual and RH needs despite their great need for these services (Warenus, 2008). This is also confirmed by Mmari & Magnani (2003) who assert that despite these services being available, they are under utilized in Zambia because teenage pregnancy continues to be a common RH problem among teenage girls.

The United Nations (UN) general assembly reviewing the progress towards meeting the ICPD goals revealed that adolescents are still grossly underserved regarding RH information and services in many countries (Girard, 1999). They continue to face challenges in accessing RH services (Kamau, 2006). According to Chen et al. (2007), teenage pregnancy could be the result of low utilization of adolescent reproductive health (ARH) services because of lack of awareness and access to ARH services. Many adolescents are sexually active but have no place to turn to, to get the information, services and support that they need. Lack of access to information makes it difficult for the adolescents to make informed health choices in their lives (Kikade & Macy, 2003). According to Langille (2007), discussions about sexual health issues are rarely initiated by adolescents for whom the process of seeking sexual health advice is a complicated one and who hence may not want to use the services. In Zambia adolescents have limited access to RH services (Mmari & Magnani, 2003) despite the Zambian government's policy to provide all sexually active men and women with contraceptive services (WHO, 1995).



1.2 Study Context

This study was carried out in the Mpika district. The district has a total population of 175,357. Like other rural districts in Zambia, 70% of the population lives in the rural areas (Mpika District Health Management Team, 2008). The Mpika District Health Management Team, (2008) states that 80% of the Mpika population lives in abject poverty. The vastness of the district, compounded by the rough terrain, (valleys, escarpments, plains) makes access to health and social services very difficult.

The district has twenty four health centres, one government hospital and one mission hospital. These provide ARH services although the mission hospital does not provide modern family planning methods such as the pill and condoms. Thirty two percent of the population are adolescents of which 28,618 are female and 27,496 are male. Mpika has only six high schools. Only 50% of the high schools, including the high school selected for this study, are within walking distances (less than 3 km) from the health facilities. In the district action plan for 2009 - 2011, the Mpika District Health Management Team, concludes that "...although figures may not be readily available, it is strongly felt that there is a high school dropout rate, high unemployment levels resulting in youth engaging in risky behavior such as alcohol and drug abuse and unsafe sex" (Mpika District Health Management Team, 2008:3). The school dropout rate of 4.2% due to pregnancy in the Mpika district supports these assertions (CAMFED report, 2006; Mpika District Health Management Team, 2008). The national teenage pregnancy rate in Zambia is at 6.2% (Central Statistics Office, Ministry of Health, Tropical Diseases Research Centre, University of Zambia, & Macro International Inc., 2009).

1.3 Problem Statement

The goal of the Zambian national RH policy is to achieve the highest possible RH for all Zambians through a multi-sectoral approach. It reflects a strong adherence to the 1994 ICPD mandate to provide adolescents with sexual and RH information and services (Merrick, 1999). The strategies included adoption of an essential services package for primary health care which integrates RH with maternal and child health (Merrick, 1999). However, findings indicate that primary health care is used mainly by women and children but not adolescents (Lush, Walt, Cleland & Mayhew, 2001). According to Warenus (2008), RH services are traditionally used by

married and older women in many developing countries as young unmarried people are not expected by society to be in need of such services.

A number of programmes have been put in place in Zambia to address ARH needs. These include integration of RH and YFS in health centres and promotion of the ABC (Abstain, Be faithful or use a Condom) programmes. As strategies, these ARH services are under utilized in Zambia for various reasons such as lack of confidentiality, judgmental attitude by service providers, and lack of awareness on available RH services (Mmari & Magnani, 2003; Warenius, Faxelid, Chishimba, Musandu, Onga'any & Nissen, 2006). Additionally, despite all the interventions, teenage pregnancy (4.2%) continues to be a problem in the Mpika district. It has been found that the ARH needs have not been addressed as adolescents' needs are often misunderstood, unrecognized or underestimated (International Women Health Coalition, 2008).



Due to the high teenage pregnancy rate in the Mpika district, it is important to understand the factors that either facilitate or inhibit teenage girls' access and utilization of ARH services. The present study therefore attempted to explore the factors that facilitate or inhibit teenage girls' access to and utilization of ARH services. Obtaining information from the teenage girls themselves and the service providers on the perceptions and the actual service utilization is critical to determine the types of intervention that could be implemented to improve ARH in the district.

1.4 Rationale

The purpose of the study was to gain insight into the experiences of teenage girls of ARH services in the Mpika district and explore the factors contributing to their access and utilization. According to Save the Children (2007:1), “Young people face a realm of challenges during their transitional years and need information, skills, opportunities and services to make healthy choices”. Adolescents rank sexual health as their main primary health issue and regard teenage pregnancies as a common occurrence (Webb, 2000). According to Kamau (2006) evidence from research shows that girls are concerned about unintended pregnancies and menarche related problems. In order to meet these needs it was imperative that information on factors which facilitate or inhibit access and utilization of ARH services be obtained from teenage girls themselves as the beneficiaries of ARH services. Participation by the beneficiary is an important principle for RH programmes as they can identify what it is they really need and how best to meet those needs (Focus on Young Adults, 2001). To the best of my knowledge there are no documented studies that have been conducted in the Mpika district on access and utilization of ARH services. This study would therefore provide a deeper understanding of access to and utilization of ARH services by teenage girls and inform further interventions to improve these services in an attempt to reduce teenage pregnancies in the district.

1.5 Aim

The aim of the study was to explore the factors which facilitate or inhibit teenage girls’ access to and utilization of ARH services in the Mpika district, Zambia.

1.6 Objectives

- To describe teenage girls' awareness of ARH services in the district
- To explore the barriers experienced by the teenage girls in accessing and utilizing ARH services in the district.
- To explore the factors that facilitate access to and utilization of ARH services in the district.
- To describe the participants' opinions on how to improve access to and utilization of ARH services in the district.

1.7 Structure of the Thesis

This thesis is divided into six chapters. Chapter one gives the background to the research study including the study context. It also discusses the aim and the objectives of the study. Chapter two presents a review of the literature on ARH services, adolescent knowledge and awareness of ARH services, facilitators and barriers to access and utilization of ARH services. The third chapter describes the methodology of the study. It describes the study design, study population and sampling, data collection methods, rigour of the study and analysis of the data. It also highlights ethical issues and limitations. The fourth chapter presents the findings of the study. The fifth chapter discusses and analyzes the results. The final chapter draws conclusions from the study and makes recommendations based on the findings.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter provides a review of some key literature regarding ARH services and places the research topic in a wider context. The literature review discusses the ARH services, adolescent knowledge and awareness of RH services as well as facilitators of and barriers to access and utilization of ARH services by teenage girls. The theory of planned behaviour (TPB) is also discussed.

2.2 Adolescent Reproductive Health Services

The adolescent's right to age-appropriate RH information, education and services to enable them to deal positively and responsibly with their sexuality is supported by international agreements (International Women's Health Coalition, 2008) such as the ICPD. In accordance with ICPD agreement ARH services include:

- (a) Provision of information, education and counseling on human sexuality, RH and parenthood to reduce risky behaviour
- (b) Provision of information, counseling and services such as pregnancy prevention, and prevention and treatment of HIV/AIDS and other STIs to reduce the harmful effects of risky behaviour
- (c) Management of abortion related services and, where legal, safe abortion services
- (d) Prenatal, postnatal and delivery care (UN, 1994; Focus on Young Adults, 2001; WHO, 2004b).

According to Speizer, Magnani & Colvin (2003), ARH interventions seek to influence sexual risk taking behaviour positively among the adolescents. These interventions are directed to achieving the following goals:

- a) Creating a supportive environment for the youth
- b) Improving RH knowledge, attitudes, skills and behaviour of the youth
- c) Increasing utilization of health and related services.

Zambia's commitment to the ICPD to provide the widest possible RH benefits is reflected in Zambia's health sector reforms vision of equitable and affordable health "as close to the family as possible" (Ministry of Health, 2005a). The main priority areas of the Zambian national RH policy are adapted from the ICPD and use strategies such as advocacy, promotion of healthy RH behaviour, equity on access to quality health services, capacity building, collaboration and research promotion (Ministry of Health, 2005a).

In Zambia, the government is the main provider of health care services through its health facilities including ARH services (Ministry of Health, 2005b). The NGOs, private and church health institutions also complement the Zambian government efforts in provision of quality health care. However a baseline needs assessment conducted as part of the Zambia Family & Reproductive Health Project for improving sexual and reproductive health service delivery in ten rural and peri-urban Zambian communities in 2002, found that RH services did not meet the needs of the people especially adolescents (Zambia Family & Reproductive Health Project, Undated). ARH programmes are mostly limited to providing basic sexuality and RH information and not services (Situmorang, 2003) contrary to the ICPD agreement. Where the services do

exist, they often suffer from adult bias as they are designed by adults with little participation by young people (Mashamba & Robson, 2002). However, according to Dickson, Ashton & Smith (2007), provision of ARH services that meet the needs of adolescents is crucial in addressing teenage pregnancy. It is recommended that participation of young people in design and implementation of ARH services should be encouraged to increase quality and accessibility of services (WHO, Population Council & FHI, 2006).

WHO acknowledges that a comprehensive programme of activities encompassing the health and education sectors as well as political, economic and legal sectors is fundamental to successful promotion of sexual health (Kamau, 2006). The goal of the Zambian national RH policy which reflects a strong adherence to the ICPD mandate is to achieve the highest possible RH for all Zambians through the implementation of a multi-sectoral approach (Ministry of Health, 1997). The multi-sectoral approach is a partnership between health, education, social services, NGOs and the private sector. Involving all stakeholders is key to ensure adequate knowledge and favourable attitudes for utilization of ARH services in any locality (Tegegn et al., 2008). Lessons learnt from the Zambia Family and Reproductive Health Project in Zambia indicated that NGOs can complement government run health services particularly when there is effective communication and coordination of information, resources and activities between the health facilities and the NGOs (The Zambia Family & Reproductive Health Project, Undated).

According to Warenus (2008), adolescents are now more in need of RH services than ever before as a result of changes in the traditional socialization processes into adulthood. In this process, adolescence is now associated with longer schooling which has widened the gap

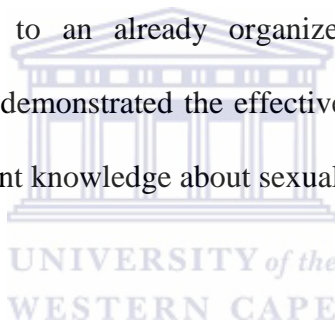
between menarche and marriage leading to increased premarital-sex (Warenius, 2008). Therefore, increased investment in the quality and infrastructure of ARH services is critical to adolescents' present and future wellbeing (International Women's Health Coalition, 2008). This is affirmed by Mashamba and Robson (2002: 273) who conclude that "Effective delivery of services to youthful populations can reduce risky behaviour, ameliorate its negative impacts and ensure good reproductive health". To effectively deliver ARH services it is important to understand the facilitators of and barriers to access and utilization of ARH services.

2.3 Facilitators of Access to and Utilization of ARH Services

As adolescent girls become sexually active, their access to RH services is vital. There are several factors that enhance access to and utilization of ARH services. Evidence from research shows a significant drop in teenage pregnancy rates due to positive adolescent sexual behaviour in countries such as the United States, and other Western European countries where adolescent services are easily available and widely offered (Hocklong, Herce-Baron, Cassidy & Whittaker, 2003). Increased contraceptive use was also observed in Lusaka, Zambia when the city council of Lusaka improved its ARH services which made it more accessible (Advance Africa, 2003). Good communication skills are required to transmit information on sensitive issues such as sexuality (Dehne & Reidner, 2005). Providing adolescents with information, support, services and creating an environment that allows adolescents to practice positive behaviours such as delayed sexual debut, and safer sex are said to be effective approaches for RH (World Bank, 2003). In order to attract, serve and retain adolescents as RH clients, specialized approaches some of which are discussed below, are essential (Senderowitz, Hainsworth & Solter, 2002).

2.3.1 Sex Education

According to Lule, Rosen, Singh, Knowles & Behrman (2006), well designed, well-implemented sexuality and RH education can provide adolescents with a solid foundation of knowledge and skills to enable them to engage in safe and responsible sexual behaviour. Provision of information to adolescents increases their knowledge and understanding of health issues and motivates them to practice positive health behaviours (World Bank, 2003) such as being able to assess risks and avoid unprotected sex (Truong, 2008). One of the critical effective approaches has been sex education in schools. The school has been found to be a good setting for sex education. For example, Speizer et al. (2003) found that school-based programmes provide educational messages and skills to an already organized young audience. Song, Pruitt, McNamara & Colwel (2000) also demonstrated the effectiveness of school sexuality education programmes in increasing adolescent knowledge about sexuality.



2.3.2 Youth Friendly Services at Health Facilities

The 1994 ICPD stressed the need to specifically provide accessible user friendly services to effectively address ARH needs (UN, 1994). YFS initiatives are designed to make existing RH services more acceptable to adolescents and are provided in a way that recognizes that the challenges facing adolescents are different from those experienced by adults (PATH, 1999). They ensure that staff treats adolescents with respect and confidentiality. To be effective the services must include specially trained providers, privacy and accessibility to attract and retain the adolescents (Focus on Young Adults, 2001). Xu and Shtarkshall (2004) assert that improving adolescent access to YFS has made important contributions to the promotion of ARH worldwide especially in the Nordic countries. Findings from the sexual and RH services for young people

in Kenya and Zambia indicated that preference for YFS was related to respectful attitudes, privacy and confidentiality, lower costs and short waiting times (Warenius, 2008).

According to Speizer et al. (2003), YFS can provide a range of services within a single setting when placed within existing facilities, but it is dependent upon adolescents coming to health facilities. WHO has recommended a minimum standard for YFS which include provision of information on sexuality and reproduction, affordable services, privacy and confidentiality and youth friendly trained non-judgmental health workers, to promote access and utilization of ARH services (WHO, 2002). The YFS in Zambia are mainly available in major cities. However, it has been found that even where they are available, the YFS are run poorly due to lack of funding and difficulties in retaining trained volunteers (Warenius, 2008). The findings of a baseline needs assessment conducted in ten rural and peri-urban Zambian communities also found that RH including ARH services are often too distant, too unreliable, too expensive and too unfriendly (Zambia Family & Reproductive Health Project, Undated). It concluded that going to the clinic meant walking for many hours, waiting in a long queue and then finding out that the contraceptives are out of stock or too expensive.

2.3.3 Community-Based Interventions

According to Burket (2006), community-based programmes are an effective way to improve access to and challenge socio-cultural barriers to RH services. They help enhance knowledge, stimulate acceptance, and create awareness and ownership of RH services.

2.3.3.1 Community-Based Delivery of Contraceptives

The Zambia Family and Reproductive Health Project (Undated) found that the community-based delivery of contraceptives is a viable approach to increasing access to contraceptive information and commodities in communities and reduces workload pressure on health clinic staff. The evaluation of the Zambia Family and Reproductive Health Project showed that with appropriate training, supervision and resources, community-based agents chosen within the community could complement existing RH services including ARH, particularly in rural areas where there is insufficient skilled health personnel. The community-based agents are trained mostly by NGOs who are an important complement to government-run health services in the screening of and provision of contraceptives and condoms in the community. The contraceptives are provided at no cost. Community members prefer to receive contraceptives near to their homes. The community-based agents also help correct myths and misconceptions about contraceptives and improve utilization by young women. The evaluation of the project also found that regular supervision by health facilities, continuous supplies of contraceptives and condoms and recognition of volunteers are key to maintaining the motivation of community agents (Zambia Family & Reproductive Health Project, Undated).

2.3.3.2 Community Youth Centres

Community youth centres generally have recreational, educational, RH counseling and clinical components and provide a supportive non-threatening environment (James-Traore et al., 2002). The youth centres also have peer educators who refer adolescents in the community to the youth centre. However situation analyses by the Population Council of some African youth centres in Ghana, Kenya, and Zimbabwe indicated that youth centre utilization is mainly by males for

recreational reasons rather than for counseling or clinical purposes. Additionally, those males and females using the RH services tend to be older than the target age group (James-Traore, Magnani, Murray, Senderowitz, Speizer & Stewart, 2002). According to Kamau 2006 adolescents do not like sharing services with adults. A study on the impact of a youth centre in Lomé, Togo reported that the centre had little impact on RH knowledge or practices as it was largely used for recreation (James-Traore et al., 2002).

2.3.3.3 Community Involvement

Increased community involvement in responding to community RH concerns has been found to help sensitize the communities. It has been found that community mobilization efforts that engage influential adults, such as parents, teachers, community and religious leaders, can help normalize positive adolescent behaviour as well as direct adolescents to appropriate health services (Lule et al., 2006). In the Zambia Reproductive Health Project (Undated) the community steering committees comprising of men, women and adolescents served as a link between the clinic and the community and were trained in community mobilization on RH. They also assisted in identifying community members for training programmes such as being trained to be peer educators. Rosen (2000) concluded that many ARH programmes have overcome resistance by drawing on the support and active involvement of caring adults. For example the parent education programmes in Kenya help parents overcome taboos related to discussing sensitive issues with their children (Rosen, 2000).

Effective community-based programmes promote access and utilization of ARH services by incorporating mass media, campaigns for safer sex, social marketing of condoms, peer

counseling and entertainment through drama, TV, radio and other recreational activities (International Women's Health Coalition, 2008). For example, the showing of videos and drama on ARH topics help stimulate discussions (Matatu et al., 2001). The Zambia Family & Reproductive Health Project, (Undated) noted that Edusport which comprises activities that combine sporting activities with health promotion messages proved popular in Zambian communities. According to Vaughan, Rogers, Singhal & Swalehe (2000), the combination of educational material with entertainment to attract young audiences cannot be overemphasized in programmes that target adolescents.

2.3.4 Mass Media

Rosen (2000) asserts that open communication using mass media is one of the major channels of communication for providing information, redefining social norms and changing attitudes and behaviours. Mass media has enormous influence on young people in most societies and can help normalize positive adolescent behaviours and direct them to appropriate health services (World Bank, 2003). Mass media can reach a large number of people with the same messages and can educate the adolescents about RH issues and encourage them to seek health care services (Focus on Young Adults, 2001). Youth magazines, such as the Trendsetters, a Zambian young people's magazine, give access to health information and services and help young people have a voice on issues that directly affect them (Kinkade & Macy, 2003).

However lack of media and censorship restricts the flow of information to young people (Rosen, 2000). For example, the government officials in Zambia initially rejected advertisements

for condoms as too explicit for a young audience (Rosen, 2000). According to Kinkade & Macy (2003), one of the challenges for the Trendsetters, is reaching the young people in rural areas.

2.3.5 Peer Education

Peer education in ARH programmes has been found to be another effective approach because young people can be among the most effective advocates for change (Rosen, 2000; Troung, 2008). Peer education is a strategy used by people who share similar ages, backgrounds and interests to communicate educational messages and is widely used in behaviour change communication (Troung, 2008). Peer education can successfully improve knowledge, attitudes and behaviour among adolescents (Brieger, Delano, Lane, Oladepo & Oyediran, 2001) because adolescents respond best to their peers when dealing with sexuality which is a sensitive issue (Zambia Family & Reproductive Health Project, Undated). They are more likely to accept information from their peers than adults (Troung, 2008; Sonti & Finger, 2002).

For peer education in ARH, a recruited core group of peers is trained to serve as role models. They also serve as sources of information for their peers and sometimes distribute and sell certain types of contraceptives hence increasing access to contraceptives in a non-threatening environment (Speizer et al., 2003). Study findings from Nigeria and Ghana concluded that peer education had the greatest impact on knowledge and self efficacy among secondary school students (James-Traore et al., 2002). In their evaluation study of a peer-educator programme for adolescents in Cameroon, Speizer, Tambashe, and Tegang (2001) found a significant increase in RH knowledge and behaviour among the adolescents who had an encounter with a peer educator including contraceptive and condom use during their last sexual encounter.

In Zambia, trained peer educators work in communities and youth friendly corners in health centres. Peer education has been associated with sexual RH risk reduction behaviours (Svenson, Burke & Johnson, 2008). On the other hand, some literature argues that peer education has had little if any long term impact on the rates of abortion and STIs (Alleyne, 2008). According to Warenus (2008), one challenge to peer education in Zambia is that there are few female peer educators as many parents do not like their daughters to distribute condoms or talk about sex. Adolescents prefer to be attended to by a provider of the same sex (Warenus, 2008). The other challenge of peer education is attrition. Peer educators often leave the programme as they become older and constant recruitment and re-training is therefore needed (Troung, 2008).

2.3.6 Advocacy

Broad based advocacy efforts which support ARH is key to building multi-sectoral support for policies that promote ARH programmes. Adolescents can help to win support from political leaders, legislators, religious leaders, youth icons and the mass media (WHO, 2004b). Advocacy groups that involve adolescents and the community and speak on behalf of the needs of adolescents are particularly effective in desensitizing ARH issues and in pushing for positive change (Focus on Young Adults, 2001). Advocacy can win support for policies to increase resources to improve the coverage and quality of ARH services, and remove legal obstacles that impede adolescents who need to access such services (WHO, 2004b). In Zambia NGOs such as FAWEZA, play a significant role in advocating for ARH (FAWE, 2005).

2.4 Barriers to Accessing and Utilization of ARH Services

Many ARH programmes attempt to improve health seeking behaviours and increase use of ARH services but literature reviewed has found that getting adolescents to use ARH services is difficult in developing countries especially in Africa and Asia (James-Traore et al., 2002). There are several factors that inhibit the utilization of ARH programmes (Nelson, Magnani & Bond, 2000). According to Neckermann (2002) finding out what keeps adolescents from using existing services could reveal what should be done to make such services attractive to them.

2.4.1 Lack of Adolescent Knowledge and Awareness of RH and Services

According to Tegegn, Yazachew and Gelaw (2008), adolescents often lack basic RH information, knowledge and access to affordable ARH services. Evidence has also shown that there is little discussion around sexuality and reproduction in Zambian schools (Warenius et.al, 2007). Traditionally adolescents learnt about sexuality and reproduction through well defined rituals or rites of passage which are now in flux in the developing world due to rapid economic and social change (Rosen, 2000). Studies seem to differ as to the level of knowledge of ARH and services. A study done in Uganda to assess ARH training and service needs concluded that adolescents had little knowledge about RH. For example only 38% of the adolescent respondents knew about the use and importance of family planning methods, (Matatu, Njau & Yumkella, 2001). On the other hand, a study done in Ghana which assessed knowledge and practices of RH issues indicated that 79.7% of the adolescent female respondents were aware of methods to prevent pregnancy and STIs such as condoms and where these could be obtained (Oware-Gyekye, 2005). A participatory baseline needs assessment in rural and peri urban areas of Zambia revealed that members of the community, especially adolescents, did not have the

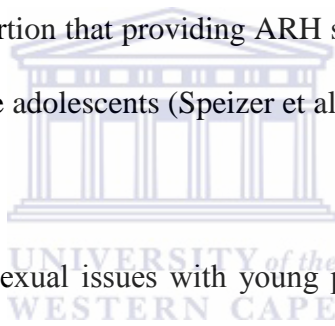
information they needed on how to prevent pregnancies and STIs (Zambia Family & Reproductive Health Project, Undated).

It has been found that lack of access to information makes it difficult for the adolescents to make healthy and informed choices in their lives (Kinkade & Macy, 2003). According to Biddlecom, Munthali, Singh & Woog, (2007) there is a need to inform adolescents about sources of RH services and improve accessibility by reducing social barriers such as negative attitudes of providers, lack of privacy and confidentiality. There is evidence that communicating information about sexuality does not encourage or sanction promiscuity (Iyaniwura, 2004). Iyaniwura (2004) claims that young people need to be given facts about potential negative consequences of unwanted pregnancies. Adolescents mainly turn to books, mass media, and friends for guidance about sexuality even though the information may not be accurate (Oware-Gyekye, 2005). In the absence of proper information adolescents rely on myths and misconceptions such as a belief that condoms cause cancer and AIDS and contraceptives can lead to future infertility (Warenius, 2008; Iyaniwura, 2004). Hence people who give adolescents sexual information must have correct information, a positive attitude to ARH and must be ready to openly communicate RH information to adolescents (Iyaniwura, 2004).

2.4.2 Cultural Beliefs and Influences

Sexuality and RH are influenced by values, cultural norms and traditions adhered to by different communities and these can serve as barriers to accessing and utilization of ARH services (Kamau, 2006). According to Rosen (2000), many societies discourage premarital sex and discussion of sexuality amongst adolescents particularly in developing countries. Parents do not

discuss sex related matters with their children. Most African societies believe that family planning clinics are no place for adolescents and look at adolescents that use family planning services as bad people, forcing adolescents to avoid the services (Mturi, 2001; Oware-Gyekye, 2005; Mashamba & Robson, 2002). In Zambia especially in rural communities, it has been found that discussions about sexuality are considered taboo and ARH services are perceived to promote promiscuity amongst adolescents (Longfield, Cramer & Sachingongu, 2003). However, other studies including some done in Zambia have indicated that ARH services do not increase sexual activity amongst adolescents (James-Traore et al., 2002; Underwood, Hachonda, Seremitsos & Barath, 2001; Ruland, 2003). Other available evidence on the effectiveness of ARH interventions refutes the assertion that providing ARH services to the adolescents results in increased sexual activity among the adolescents (Speizer et al., 2003).



Adults' discomfort at discussing sexual issues with young people limits communication about sexuality with the adolescents (Iyaniwura, 2004). Kamau (2006) maintains that given the secrecy surrounding sexuality, adolescents may not openly share opinions on sexuality issues with their parents or adults and hence find it difficult to request support. Adolescents have limited access to ARH services and information in communities where pre-marital sexual activity is met with prohibition, denial and silence (Chikovore, 2004). Evidence shows that withholding information and services from adolescents only increases the likelihood of unprotected sex if and when sexual initiation occurs (Kirby, 2001). Studies have found that despite moral prohibitions, adolescents are sexually active, often with devastating consequences (Chikovore, 2004; Smith, 2004). For example a study done in Zambia and Kenya by Warenus (2008) on providers' attitudes and young people's needs and experiences with ARH services, found that young people

are caught between the norms and values of society, and the reality of life. They considered premarital sex and contraceptive use as sinful and immoral, but on the other hand struggled with sexual feelings and even participated in sex.

Rosen (2000) concludes that despite the impact of HIV/AIDS and teenage pregnancies on adolescents, community leaders such as faith-based leaders and traditional leaders continue to oppose ARH programmes. Nelson, Magnani & Bond (2000) claim that cultural beliefs, myths and misconceptions regarding RH and services will usually determine when and where adolescents seek services. The World Bank (2003) acknowledges that when supported by their families, schools and communities adolescents can make positive life choices.



2.4.3 Service Providers' Negative Attitudes

The personal values and views of health professionals may affect quality of care as well as the accessibility of ARH services (Warenius et al., 2006). Despite the Zambian government's policy which stipulates that all sexually active men and women have the right to contraceptive services (National HIV/AIDS/STI/TB Council, 2003), many adolescents find it difficult to access services. One reason is due to the resistance and negative attitudes of the service providers when adolescents attempt to obtain RH information and services they need (Matatu et al., 2001; Tegegn et al., 2008). It has been found that the attitude of service providers determine utilization of RH services and if the service providers have negative attitudes, adolescents will avoid the services and seek help from unprofessional people (Atuyambe, Mirembe, Johansson, Kirimira, & Faxelid, 2005).

It has been found that in many cases, service providers lack training to communicate effectively with adolescents seeking RH services (WHO, Population Council and FHI, 2006). A study conducted in Uganda on creating adolescent-friendly RH services confirmed gaps in skills and knowledge of service providers (Matatu et al., 2001). According to Kamau (2006), lack of adequate skills among the service providers contribute to their judgmental attitudes towards the adolescents.

Evidence shows that cultural norms and misinformed clinical practices often cause service providers to be reluctant to provide ARH services to sexually active adolescents (WHO, Population Council, and FHI, 2006). Research has shown that health workers are reluctant to provide unmarried young people with contraception and other professionals also share similar biases. For example, studies on the attitudes of nurses in Kenya and Zambia as well as teachers in Nigeria concluded that service providers disapproved of provision of RH services to adolescents (Iyaniwura, 2004; Warenius, 2008). According to Obasi et al. (2000), the effectiveness of ARH services is undermined due to the belief by the service providers that it would encourage sexual activity amongst young people. However, it was found that adolescents are eager to learn and acquire clear information and regard health professionals as reliable and knowledgeable sources on sexuality matters (Amuyunzu-Nyamongo, Biddlecom, Ouedraogo and Woog, 2005; Buseh, Glass, McElmurry, Mkabela and Sukati, 2002).

2.4.4 Privacy and Confidentiality at Institutions

Another barrier to access and utilization of ARH services is the fear that privacy and confidentiality would not be honoured (Webb, 2000). Privacy and confidentiality are the two

most valued needs of adolescents worldwide regarding RH services (Focus on Young Adults, 2001: Bidlecom et al., 2007). Kamau, (2006) found that institutional and structural barriers such as lack of counseling rooms make it difficult to maintain privacy. Similarly, Nelson et al. (2000) found that adolescents feel embarrassed to be seen at such facilities as they are perceived to be meant for married adults only. Additionally, adolescents have no confidence that the information shared with the service provider would be kept confidential (Warenius, 2008). Thomas, Murray and Rogstad (2006) assert that the belief in confidentiality is of paramount importance in order for clients to visit and revisit the health centre.

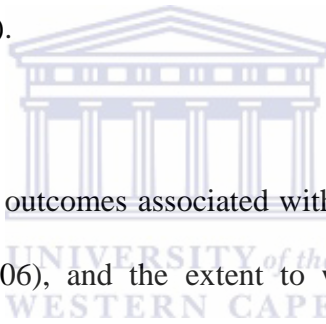
2.4.5 Operational Barriers

Operational barriers such as operating hours, travel time and costs pose barriers to access and utilization of RH services by adolescents. The ARH services may not be temporally accessible to the adolescents because opening hours coincide with times when adolescents are in school (Mashamba & Robson, 2002). In addition, long waiting times and distances to the health centres act as barriers to access and utilization of ARH services (The Zambia Family & Reproductive Health Project, Undated).

2.5 Theoretical Framework

The study used the Theory of Planned Behaviour (TPB) as a framework to look at what factors influence access and utilization of ARH services by the teenage girls. It was useful in helping to understand the determinants of their behaviour towards access and utilization of ARH services.

TPB stipulates that people's behaviour is determined by their intention to perform a given behaviour (Ajzen 1991). It is based on the concept that the stronger the intention to perform a given behaviour, the greater the likelihood that the person will perform that behaviour (Fishbein, Triandis, Kanfer, Becker, Middlestadt & Eichler, 2001). TPB has been used in studies to help understand peoples' intentions to engage in a number of activities (Siragusa & Dixon, 2009) such as health related decision making behaviour in adolescents (Fila & Smith, 2006). TPB asserts that one's intention to perform a behaviour is as a result of these three determinants: the individual's attitude towards the behaviour, subjective norms towards the behaviour, and perceived behavioural control over the behaviour (Cope, Harju & Wuensch, 2001; Casper, 2007; Siragusa & Dixon, 2009) (Figure 1).



Attitudes refer to beliefs about the outcomes associated with performing a particular behaviour, (Casper, 2007; Fila & Smith, 2006), and the extent to which the individual perceives the behaviour as desirable or favourable (Moss, 2008). Subjective norms refer to perceptions about how others would judge a person for performing the behaviour, and it measures the importance others place on performing or not performing a behaviour and one's willingness to comply to those referents (Casper, 2007; Fila & Smith, 2006). They refer to the degree to which significant individuals, such as relatives or colleagues, condone the behaviour (Ajzen, 1991; Ajzen & Fishbein, 2005). Perceived behavioural control refers to readily available resources, skills, and opportunities to be able to change the individual's behaviour, as well as the person's own perception about the importance of achieving the results. It describes the perceived ease or difficulty with which an individual can perform certain behaviour (Fila & Smith, 2006; Siragusa & Dixon 2009). It also refers to the extent to which individuals conceptualize themselves as

sufficiently knowledgeable, skillful, disciplined, and able to perform some act, and the extent to which individuals feel that other factors, such as the cooperation of colleagues, resources, or time constraints, could inhibit or facilitate the behaviour, (Kraft, Rise, Sutton, & Roysamb, 2005). The more positive the attitude towards performing the behaviour, substantial levels of social pressure to do so and perceived control over one's actions, the more likely the individual is to carry out the behaviour (Siragusa & Dixon, 2009).

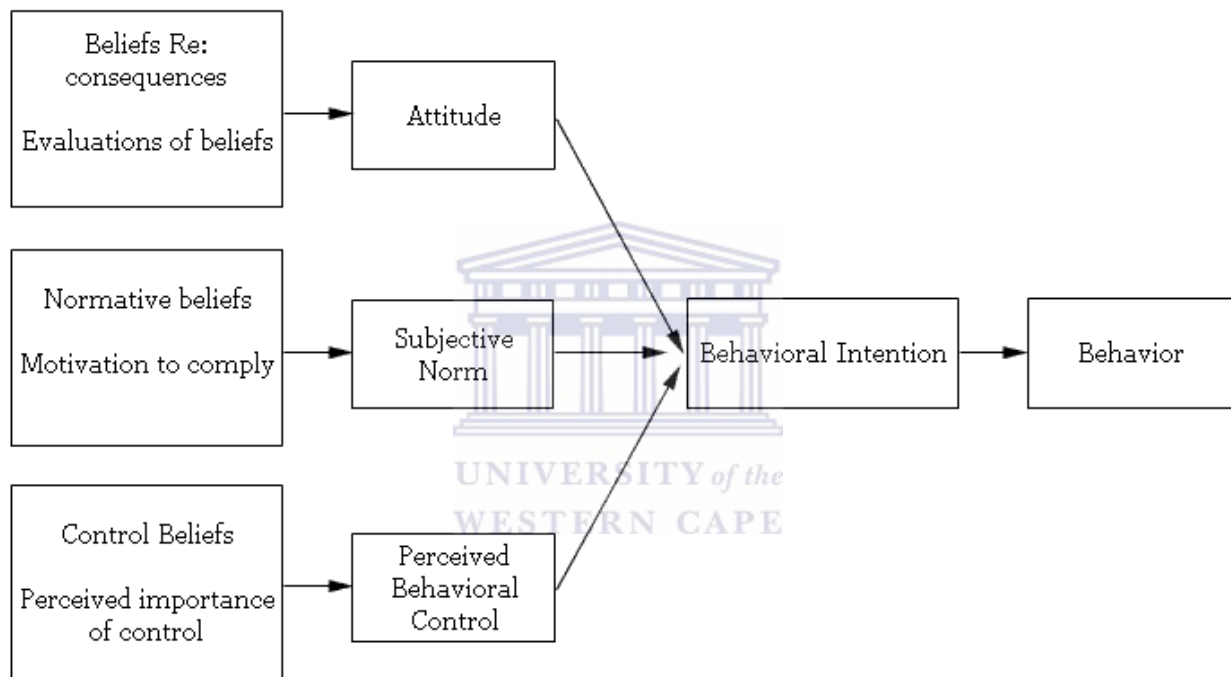


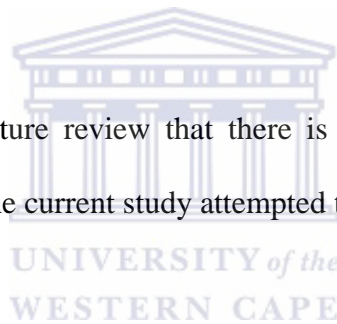
Figure 1: *Theory of Planned Behavior from Dillon and Morris (1996) as cited by EduTech Wiki, (2006).*

2.6 Conclusion

In conclusion, from the literature, it appears that perceived behavioural control will determine the utilization of ARH services as adolescents either have little information about available ARH services or do not utilize them as they have limited access, lack of privacy or lack of youth friendly trained health workers. Subjective norms are also a determinant of ARH services

utilization as adults disapprove of ARH services because they are perceived by adults to promote promiscuity. As a result, adolescents rely on sources outside the formal health sector. Utilization of ARH services is dependent on the level of knowledge, on the type of RH services and on service provider attitudes towards the services they offer to the adolescents. Provision of information, support and services in an enabling environment allow the adolescents to practice positive behaviours. Hence improving access to ARH services is cardinal to reducing teenage pregnancy by overcoming barriers that prevent adolescents from accessing and utilizing ARH services. Access to ARH services will enable them to make informed choices and take responsibility for their own sexuality.

It is also evident from the literature review that there is limited current literature on ARH services in Zambia and therefore the current study attempted to fill this gap.



CHAPTER 3: METHODOLOGY

This chapter describes the methodology used in this research study. It outlines the study design, study population and sampling procedures used. It goes on to describe the data collection procedure which includes the research tools and the process of data collection. It further describes the data coding and analysis procedures. Finally the chapter addresses the issues of rigour, ethics, and limitations of the methodology used.

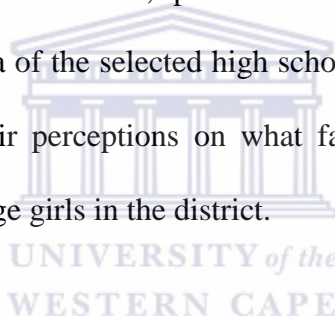
3.1 The Study Design

This is a descriptive and exploratory study using qualitative research methods as it seeks to gain a deeper understanding of the experiences and perceptions of teenage girls and service providers relating to the access to and utilization of ARH services. Qualitative methods can provide an understanding of health behaviour in its every-day context and contribute answers to questions not easily addressed by other methods (Green & Britten, 1998). According to Vaughn, Schumm & Sinagub (1996), people are a valuable source of information as they are able to verbalise their feelings and perceptions especially on issues that directly or indirectly affect them.

Qualitative research methods have been used before in Zambia in similar studies. For example, Nelson et al. (2000) used qualitative methods to identify barriers within the community that discouraged young people from utilizing YFS in Zambia. The qualitative approach enabled the researcher to gain in-depth insight into the factors influencing the access to and utilization of these services.

3.2 Study Population

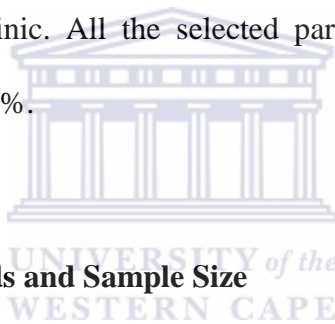
The research study drew on two study populations of teenage girls between 14 and 18 years old. Teenage girls between the ages of 14-18 years were studied because they are within the age group most vulnerable to unwanted pregnancies (UNFPA, 2002; Bearinger, Sieving, Ferguson, & Sharma, 2007). The first study population comprised teenage girls at the high school with the highest dropout rate due to teenage pregnancy. The second study population was pregnant teenage girls attending the ante-natal clinic at a clinic within the catchment area of the selected high school. These two groups were selected because they were potential users of the ARH services. Service providers (health workers, peer educators and guidance and counseling teachers) within the catchment area of the selected high school in the Mpika district were drawn on as key informants to give their perceptions on what factors related to the access to and utilizing of ARH services by teenage girls in the district.



3.3 Sampling Procedure

One high school with the highest teenage pregnancy rate was identified and selected with the help of the CAMFED district committee. They were knowledgeable about where the pregnant teenage girls came from because most of the pregnant teenage girls are recipients of the CAMFED sponsorship programme. According to Rice and Ezzy (1999) sampling strategies in qualitative research are designed to produce information-rich cases that will yield in-depth understanding of all aspects of the phenomenon under investigation. Purposive sampling was therefore used to select all the participants. A sample of teenage girls from grades 10 to 12 was selected with the help of the counseling and guidance teacher because she knew the girls better.

After agreeing on the selection criteria, girls who were able to provide rich information were selected. The pregnant teenage girls were recruited from the only clinic offering RH services within the catchment area of the selected high school. Using the clinic register, pregnant teenage girls in the third trimester were selected. It was assumed that by this time they would have come to terms with their situation and be able to open up during the discussion. From this sample girls living within 3Km of the catchment area of the clinic and were currently on maternity leave from school were selected. The key informants were selected because of their experience or position in dealing with ARH issues and included the guidance and counseling teacher at the selected high school, the health workers providing ARH services and the peer educator at the youth friendly corner at the selected clinic. All the selected participants agreed to participate and therefore the response rate was 100%.



3.4 Data Collection Methods and Sample Size

Data collection methods employed included: focus group discussion (FGD), individual interviews and key informant interviews. Interview guides (Appendix 1 & 2) were used to collect data. The interview guides were structured in such a way that they started with less sensitive questions and progressed to more sensitive questions. All interviews and the FGD were audiotaped with the participants' permission. All interviews and the FGD were conducted in Bemba, the local language which enabled the participants to express themselves explicitly and fluently. This ensured that the participants understood the questions and were in a position to express their views explicitly and accurately in their own language. The researcher did all the interviews and facilitated the FGD herself, being fluent in Bemba. The recorded interviews were transcribed and translated from Bemba into English at the end of the day's data collection process by the

research assistant. The recorded interviews had to be translated for the purpose of this study which had to be written in English.

3.4.1 Focus Group Discussion

A focus group discussion (FGD) was conducted at the clinic with a sample of ten pregnant teenage girls. The researcher opted to choose ten girls so that the recommended number of 6-10 participants would still be maintained in case some selected participants failed to turn up for the FGD. The researcher spent two weeks identifying and meeting the participants with the help of the clinic staff who provided the researcher with the ante-natal registers. As the FGD participants were identified, they were told how they were selected and the purpose of the study was explained to them. The participant information sheet (Appendix 3), consent form (Appendix 4), and the parental permission form (Appendix 5) were given to each participant to read and it was agreed that the researcher would contact them at a later date to give them ample time to study the documents and for their parents/guardians to give consent. The participants were later contacted to inform them of the date for the FGD and to remind them to obtain signed consent from their parents/guardians before they came for the FGD.

The FGD was conducted in the afternoon when there was no ante-natal clinic in session. In order to make the participants feel at ease, the researcher provided a meal for participants before the FGD to enable them get acquainted with each other. This relaxed the participants as they started chatting freely with each other and the researcher and her assistant. The signed consent forms were collected from the participants before the FGD and they were encouraged to participate freely. The FGD was facilitated by the researcher who used an interview guide (Appendix 1). An

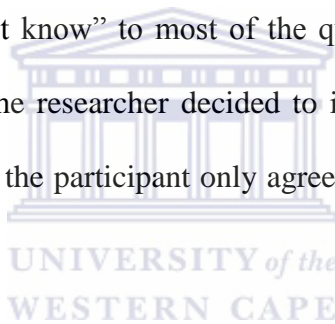
assistant took notes of the non-verbal cues as the discussion was being audio-taped. Some participants were very quiet at the beginning of the FGD but soon began to participate as they saw their peers talk freely. This is in-line with what Kitzinger (1995) asserts namely that the group dynamics in FGD can enable unresponsive participants to open up as the less inhibited participants break the ice for the shyer participants. During the FGD, the domination of the discussion by the more articulate individuals was addressed by effective facilitation by the researcher encouraging the quieter participants to contribute. The researcher being the facilitator was able to clarify questions and probe for further responses.

The FGD allowed the pregnant teenage girls to share their experiences and provide mutual support in expressing feelings that were common to the group. It also allowed them to explore solutions together even though they might not have known one another (Kitzinger (1995). According to Greenbaum (2000) the strength of the FGD is that it enables a group of people to share their views in a non-threatening environment, with the aim of eliciting factors that influence a particular action or attitude. The FGD lasted for one hour forty minutes.

3.4.2 Individual Interviews with Teenage Girls

Individual interviews were conducted with ten teenage girls from the selected high school (three from grade 10, another three from grade 11 and four from grade 12). The participants were met individually and informed of how they were selected and the purpose of the research. The participants were eager to participate and were given the Participant Information Sheet (Appendix 3), Consent Form (Appendix 4) and the Parental Permission Form (Appendix 5). The participants were informed of the date when the signed consent forms would be collected to

giving them enough time to make an informed decision as to whether they wanted to participate and for their parents/guardians to give consent. The signed consent forms were collected after three days and the dates for the interviews were communicated to the participants after making arrangements with the guidance and counseling teacher. Individual interviews were conducted during the study period so as not to interrupt any lessons. The interviews were conducted in the guidance and counseling room and at the school to avoid compromising confidentiality since the topic was sensitive and participants knew each other. Initially the researcher had intended to interview nine girls but ended up interviewing ten girls because one participant was too reserved in her responses. The participant did not want to share openly her perceptions over the subject matter and kept on saying “I don’t know” to most of the questions despite being reassured of confidentiality to the extent that the researcher decided to interview an extra participant. This could have been an indication that the participant only agreed to participate because her teacher asked her to participate.



3.4.3 Key Informant Interviews

Key informant interviews were also conducted with ARH service providers. The researcher identified four key informants based on their positions and experience in provision of ARH services. These included:

- Two female health workers (one general nurse and one nurse midwife) providing ARH services at the clinic. Initially the researcher had intended to interview one female and one male health worker but the only male health worker at the clinic was on vacation and could not be reached.
- The guidance and counseling teacher at the selected high school.

- One peer educator at the youth friendly corner at the clinic. Initially the researcher had intended to interview two (male and female) peer educators but during data collection the researcher discovered that the clinic only had one peer educator (male) as the rest had dropped out.

The key informant interviews were done at the clinic for the health workers and the peer educator. These were done during the afternoons when they were not attending to clients. The guidance and counseling teacher was interviewed in her office when she had no class in session.

3.5 Analysis

Data analysis took place concurrently with data collection (Pope, Ziebland & Mays, 2000). According to Gifford (undated), data remains open to analysis at all points in the qualitative research process. The researcher used the five stage framework approach (Taylor-Powell & Renner, 2003; Pope, Ziebland & Mays, 2000) to analyze the data which was informed by the aims and objectives of this study. The process involved:

Reading through the transcriptions, notes, and listening to the recordings several times in order to familiarize herself with the data. The process also helped to identify key issues and recurrent themes emanating from the data. The data was later sorted according to the questions that the researcher wanted the analysis to answer. Collation of data helped the researcher to look across all the data and identify consistencies and differences. Having identified the themes data was coded, categorized and interpreted. The analysis was discussed with the supervisor.

3.6 Rigour

Rigour in qualitative research relates to whether the findings accurately reflect the real situation and are backed by evidence (Guion (2002). Triangulation is one way of ensuring rigour. Source triangulation was employed for this study. Source triangulation occurred by using different data sources of pregnant teenage girls, teenage school girls and the service providers as key informants. The use of FGD and individual interviews complimented each other and ensured rigour. At the end of each interview or FGD, the researcher verified with the participants that the researcher's interpretations and understanding of their experiences, perceptions and opinions was accurately represented (Creswell & Miller, 2000; Letts et al., 2007). The findings were compared with other research through consultation of relevant literature. The researcher kept a record of all activities and decisions made throughout the research process (Appendix 6). She also kept reflexive notes and acknowledged her personal beliefs on the research topic to avoid researcher bias due to personal perspectives (Creswell & Miller, 2000). The researcher is a nurse by profession and acknowledges the importance of ARH services.

3.7 Ethical Consideration

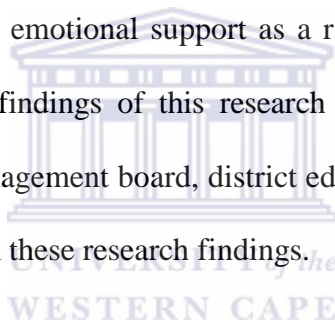
Measures were taken to maintain ethical standards at all stages of the research process. The process was strictly followed with regard to legal and ethical standards and respect for study participants as recommended by the Joint Committee for Educational Evaluation (Joint Committee, 1994: 1-8; as cited in Patton, 1997). Ethical approval was sought from the University of the Western Cape ethical committee before conducting the study. Permission was also sought from the District Medical Officer and the clinic in-charge to conduct the research at the clinic. Permission was also sought from the District Education Board Secretary (DEBS) of

Mpika and the school head of the selected high school to conduct the study at the selected school.

According to Weiss, (1998) prospective participants should be given adequate information concerning the research and its purpose so as to allow them to make an informed decision with regard to participation in the study. The purpose and objectives of the study were explained to the participants before collecting information from them. The researcher explained why and how the participants were selected. The participants were informed that participation in the study was voluntary because participants should not be forced to participate in the study but should be given enough leeway to either refuse or agree to participate in the research (Weiss, 1998). This point was emphasized bearing in mind that the participants were selected with the assistance of the guidance and counseling teacher and that the participants might have found it difficult to refuse to participate. Only willing participants who understood and agreed to participate in the study were enrolled as study participants (Weiss, 1998). The participants were informed that they were free to withdraw from the study at any time without any negative consequences to themselves or services that they were receiving. In the case of the FGD, the participants were requested to respect the others participants' views and to understand that there were no right or wrong answers. They were also informed of the importance of confidentiality within the group.

The participants were assured of the confidentiality of their information and identity. Pseudonyms were used instead of real names and the data collected was secured under lock and key (Weiss, 1998) at the researcher's office. All participants were provided with a written document in Bemba explaining the study, requesting their participation and assuring them of

confidentiality before being taken through the written informed consent process. Permission was also sought to audio-tape the interviews. The teenage study participants fell into the category of minors and therefore the researcher was ethically bound to observe guidelines for research on RH involving minors (WHO, 2003). Therefore, the parents of the participants who were all below 18 years were asked for their written consent for their daughter/ward to participate in the research study. Only thereafter did interviews and FGDs take place. In the case of the individual interviews, the participants' privacy was further enhanced by having the interviews on a one to one basis in a private setting. Given the sensitive nature of the research which talks about personal experiences, participants were notified of a psychosocial counselor at the clinic who was available should anyone need emotional support as a result of the research process. It is anticipated that feedback on the findings of this research study will be disseminated to the selected school, district health management board, district education board secretary, CAMFED, and the clinic that will benefit from these research findings.



3.8 Limitations

This being a sensitive topic, it was anticipated that the limitations might have included response bias such as giving false responses. To overcome this limitation, the participants were reassured of confidentiality and the importance of them giving honest answers in order to provide a better ARH service. The selection of participants by the guidance and counseling teacher could have been a limitation but being a key informant she was better placed to identify information-rich cases. The purpose of the study was thoroughly explained to the teacher along with the importance of selecting information-rich cases which could help in developing evidence-based strategies in improving ARH services in the district.

The findings from the study cannot be generalized to the whole teenage girl population as the sample is not fully representative of this population. However, in qualitative research, the researcher is more concerned with analytical than statistical power (Curtis, Gesler, Smith & Washburn, 2000). For this study, the researcher wanted to gain an in-depth understanding of the factors influencing the access to and utilization of ARH services of teenage girls in the Mpika district and did not want to generalize the findings.



CHAPTER 4: FINDINGS

This chapter presents the findings of the study. The chapter first sets out the characteristics of the participants before describing the findings. The findings are presented thematically focusing on the key research questions used to inform the data collection process. Findings from the different sources have been synthesized into a single set of results. Any differences in the findings are highlighted. Direct quotations have been used to illustrate some key findings.

4.1 Characteristics of the Participants

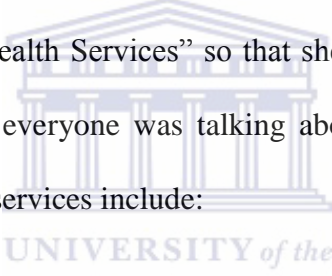
The ten participants who participated in the individual interviews were all pupils from the selected high school. However not all of them lived within the catchment area of the school. Some lived outside the catchment area of the school and commuted to school. They all fell in the age category of 14 – 18 years. Two were teenage mothers (They were selected because they could have been potential users of ARH services). The ten participants who participated in the FGD fell in the age category of 15 – 18 years. They were all in the third trimester of their gestation period. They came from different schools which included the basic schools within the catchment area of the selected high school. Despite coming from four different tribes (Nyanja, Tonga, Bemba, and Namwanga), all the participants were fluent in Bemba, the local language in the Mpika district.

The service providers interviewed included two female nurses (one was not trained in adolescent-friendly services) and one male peer educator providing ARH services at the clinic within the catchment area of the selected high school. The other service provider was the female

guidance and counseling teacher at the selected high school trained in adolescent-friendly services. They were from four different tribes (Lozi, Bemba, Nyanja and Tonga). They were all government workers except for the peer educator who was a volunteer. Interestingly, the peer educator was too old to be a peer educator for the adolescents as he was 36 years old. A peer educator for adolescents is supposed to be an older adolescent (Adolescent HIV Care and Treatment Manual, Undated). He was also trained in pediatric counseling and testing for HIV.

4.2 Findings

In the introductory remarks the researcher asked the participants what they understood by the terms "Adolescent Reproductive Health Services" so that she could be sure that everybody had clarity on what it meant and that everyone was talking about the same thing. The following definition was agreed upon. ARH services include:

- 
- (a) Provision of information, education and counseling on human sexuality, RH and parenthood
 - (b) Provision of information, counseling and services for pregnancy prevention, and prevention and treatment of HIV/AIDS and other STIs
 - (c) Management of abortion related services and, where legal, safe abortion services
 - (d) Prenatal, postnatal and delivery care (Focus on Young Adults, 2001).

4.2.1 Type of ARH Services Available

The ARH services provided by the guidance and counseling teacher include counseling and guidance, and facilitating medical checkups which includes checking for pregnancies which she felt helped the teenage girls abstain from sex:

“Pupils fear to indulge in sexual activities because of the medical checkups”.

She also provided information with a focus on abstinence:

“We explain to them that it is not the right time for them to get involved in sex and we encourage them to abstain which is good for them”.

The nurses said they provided family planning, provided information, medical checkups, ante-natal, postnatal and delivery services to the adolescents. The teenage girls are also given anti-tetanus vaccinations. When asked if the clinic provided abortion services the response was:

“We don't but other districts do since they have nurses that are trained in safe abortion”.

Services provided by the peer educator included provision of information, distribution of condoms and voluntary counseling and testing (VCT). The peer educator also refers those that need contraceptives to the nurses in the Mother Child Health department and those with STIs to the clinical officer.

The service providers were asked about the kind of information they give during counseling. They all said they gave information depending on the needs of the client for example information

on STIs, HIV, and teenage pregnancies. The guidance and counseling teacher said that she focuses on abstinence and the school re-entry policy so that those that fall pregnant do not abort. The guidance and counseling teacher and the peer educator complained about the poor availability of educational materials on ARH. The Ministries of Education and Health and usually in collaboration with NGOs are the main suppliers of educational materials.

4.2.2 Knowledge of Protective Methods against Pregnancy

All participants in the individual interviews had an idea of how one could protect oneself from pregnancy. Methods mentioned included abstinence, condoms, and family planning methods. Abstinence was mentioned by all participants. Family planning methods were mentioned despite the fact that guidance and counseling teacher did not discuss them. Family planning methods were also seen as not safe:

“ The disadvantage is having problems in getting pregnant in future when one gets married and others don't even get pregnant ... pills cause high blood pressure and heart attacks ”.

It was clear that the source of family planning information was not reliable as the participants demonstrated limited knowledge on family planning.

Condoms were mentioned for both pregnancy and STIs prevention although one participant commented that condoms were not 100% safe. Information on protection against pregnancy was mentioned by one participant as one way of preventing unwanted pregnancies. These findings

were confirmed in the FGD. One method that was not brought up in the individual interviews but in the FGD was safe periods.

4.2.3 Knowledge of Types of ARH Services Available and where they are Offered

All teenage participants knew of some kind of ARH services and where they were offered. The type of available services mentioned included ante-natal (ANC) services, deliveries, treatment of STIs, family planning services, condom distribution, information and education, and VCT services. They confirmed that these services are offered at health facilities, youth centres in the community, youth friendly corners at the health facility and NGOs such as AFRICARE. They also said that family planning pills and condoms can also be bought from shops and drug stores. Traditional medicine was mentioned in both the individual interviews and the FGD and some participants expressed lack of confidence in conventional medicine:

“...medicines at the hospital do not cure STIs but just reduce the pain. Let me give you an example, I had a friend who was infected with an STI and was only given pain killers at the hospital. She later went to a nearby village where she was given traditional medicine; though her STI was cured she now can't have children”.

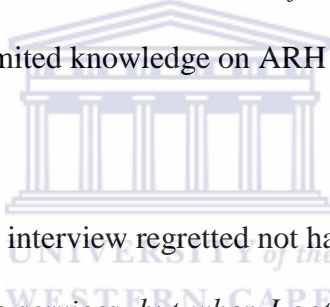
Other places mentioned where ARH services were available included the guidance and counseling teacher and anti-AIDS clubs in schools which were specifically for information and education although they said that the emphasis was on abstinence. However some participants from the individual in-depth interviews said the clubs were not very active.

4.2.4 Experience with Services Offered

Most of the participants from the individual interviews said they had never accessed ARH services before. However, after probing, agreed to have accessed some kind of ARH services at one point in time which included either visiting the clinic, seeing the guidance and counseling teacher, attending the anti-AIDS clubs or buying condoms and contraceptives from the drug stores or shops. This information was confirmed by some of the FGD participants. Half of them confirmed having not accessed any kind of ARH services. Reasons cited for not accessing ARH services included uncertainty as confirmed by this statement:

“I don’t know how to go about it or where to start from or what type of questions to ask”.

This could be as result of having limited knowledge on ARH services offered.



One participant from the individual interview regretted not having utilized ARH services earlier:

“I have never utilized these services, but when I got pregnant I wished I had because I would not have fallen pregnant. I would have used family planning or even condoms”.

Some of the participants who had accessed ARH services said they were happy and content with the services offered at the clinic as can be seen from the following extracts:

“Well at first I was scared ... I got over my fear and asking questions became easy. They were very welcoming and their hospitality was comforting”.

“...the staff was very friendly and gave me all the information I wanted and everything I needed”.

The participants who accessed ARH services at the school were equally satisfied:

“...here at school our teachers are the only people we are free to ask questions about such issues than our parents, so we are able to ask them anything we cannot ask our parents”.

“She is very free (Guidance and Counseling teacher) with everyone and I am very fond of her so I come here now and again to ask her questions”.

4.2.5 Inhibitors of ARH Service Utilization

A number of factors inhibiting ARH service utilization were highlighted by the teenage girls.

Inhibiting factors included fear of being stigmatized by society:

“When they see you going to the clinic or any other health centre that offers such services they will start discriminating against you, saying bad things like she is a prostitute, that girl misbehaves, so there is that fear that people will start laughing at you”.

Secrecy on RH issues was another issue discussed by the teenage girls as also inhibiting utilization of ARH services. They felt that secrecy surrounding sexuality matters made it difficult to request support.

Another factor inhibiting utilization of the ARH services included shortage of qualified staff at health facilities:

“It depends on the situation at the clinic, if they are busy they will tell you to go back to the clinic the following day and if they are not busy they will attend to you”.

Service providers’ negative attitude was also an inhibitor because they come across as being judgmental:

“Well sometimes the nurses are very harsh. They will say you are too young to utilize services like family planning or condoms, so girls fear to be shouted at”.

“The guidance and counseling teacher might say, even you do such things”.

This was confirmed by the attitude of the peer educator who said he does not give condoms to teenage girls that are not married but counsels them on abstinence and tells them to rather focus on their schoolwork. These findings indicate the ethical dilemmas service providers find themselves in where they have to choose between societal norms and values and professionalism.

This is an indication that they are not ready to meet the RH needs of adolescents.

The above responses are in contrast to the earlier statements about their experiences with the service providers in which some of them said they were happy and content with the services provided. Others said despite having been treated well personally, some of their peers have not been treated well.

Other inhibitors mentioned included myths and misconceptions about contraceptives:

“We have heard that the lubricant on condoms causes cervical cancer”.

“My mother told me that those that use pills when they are young will not have children when they get married”.

“There was a rumour that the family planning injection they were giving had the HIV virus so people are scared of getting infected and would rather use traditional medicine”.

There was also the belief that RH services are for married people contributing to the low utilization of ARH services.

The above findings indicate lack of health education on RH and that adolescents were using unreliable sources of RH information.



The teenage girls also feared to be labeled promiscuous:

“...when you are seen at the clinic everyone thinks you are having sex unlike here at the guidance teacher’s office, no one will know what you have come here for”.

Despite health facilities offering free RH services participants cited long distances to the health facilities and inconvenient operating hours due to them being at school, as a hindrance to utilization of ARH services.

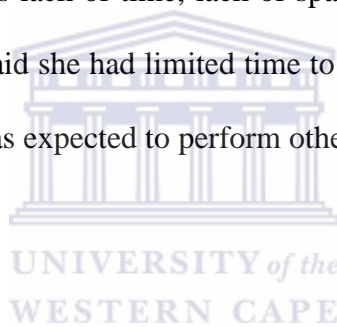
The participants felt lack of knowledge on the existence of ARH services was another inhibiting factor:

“Some of us didn’t know such services existed until after falling pregnant”.

A language barrier was also cited as an inhibitor of ARH service utilization. English is the official Zambian language although not everyone is conversant with the language. For example, one participant from the individual interview said:

“At the clinic they normally use English and then there are those who can’t speak English very well and hence fear that the service provider will use English and she (teenage girl) will not be able to express herself well”.

All the service providers felt the ARH services were not adequate for the adolescents and cited several contributing factors such as lack of time, lack of space, and lack of peer educators. The guidance and counseling teacher said she had limited time to talk to the young people and attend to their ARH needs because she was expected to perform other duties like teaching which is what she was employed for.



The nurses felt that lack of space for adolescent-friendly corner has contributed to poor response of the adolescents towards ARH services as one nurse wishfully said:

“I wish the youth friendly corner could function at all times ... currently the youth friendly corner room is being used as a store room”.

The peer educator who was also a pediatric HIV counselor confirmed that the ARH services were not adequate because adolescents were not using the services. He also lamented about the size of the room he was currently using as being too small and unsuitable for the adolescent-friendly corner because he was using the pediatric counseling and testing for HIV room for ARH

activities. Considering the stigma attached to HIV adolescents find it difficult to access services from such a place.

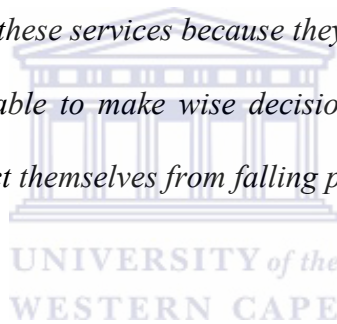
From the above findings it evident that ARH is not a priority for the DHMT.

4.2.6 Perceptions on whether ARH Services Increase Youth Sexual Activities

Most of participants from the individual interviews refuted the assertion that ARH services increase adolescent sexual activities with statements such as:

“Whether the services are offered or not the fact is that we adolescents are having sex. It is only wise that we access these services because they will help us take precautions”.

“The adolescents will be able to make wise decisions and for those that are sexually active will be able to protect themselves from falling pregnant and contracting STIs”.



However other participants gave different views and said that ARH services do promote promiscuity:

“By giving the adolescents condoms the number of girls indulging in sexual activities will increase and they will be at risk of having cancer...moreover condoms are not 100% safe, they burst during intercourse and one is at risk of contracting diseases like HIV/AIDS and STIs”.

The remaining participant argued that it was a two way process, that is:

“It can increase youth sexual activities in the sense that some girls will feel protected and start sleeping around without fear of getting pregnant or contracting STIs and on the other hand the services are good because they will empower girls to take care and protect themselves”.

The scenario was different with the FGD. The majority of the participants said ARH services promote promiscuity. One went on to say that even if the ARH services might be good in terms of protection against teenage pregnancy it was not morally right to provide such services. Interestingly the peer educator also had the same notion that ARH services promote youth sexual activities:

“If they get used to using condoms we are destroying them because they will concentrate on sex knowing that they are protected and won’t concentrate on school”.



However, he also said denying teenage girls’ contraceptives or condoms because they are young contribute to teenage pregnancies.

4.2.7 Service Providers’ Perceptions about Teenage Girls that Access ARH Services

When asked about their perceptions about teenage girls that access ARH services, the guidance and counseling teacher and the nurses expressed the same views saying that the behaviour was bad. For example one of the nurses said:

“Children that involve themselves in sexual activities are not bad, it is the behaviour and sometimes it’s got to do with the background”.

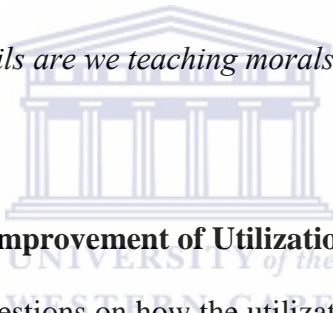
The peer educator had a similar opinion:

“They are doing something that they should not be doing but do it due to influence from their friends and sometimes due to lack of basic needs or broken homes”.

However some of the service providers felt that access to ARH services by teenagers was against Christian values:

“...as Christian parents it is not easy to allow children to start accessing these services...”

“If we give condoms to pupils are we teaching morals...?”



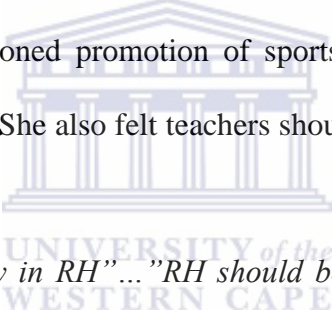
4.2.8 Recommendations for Improvement of Utilization of ARH Services

All teenage participants made suggestions on how the utilization of ARH can be improved. They all said information and education should be the biggest component and encompass all areas of ARH if accessibility to and utilization of ARH services is to be improved. Information and education should be extended to parents to help improve communication between parents and children about RH. Information and education should include different types of ARH services and where they can be accessed. Misconceptions about ARH services should also be corrected as expressed by one of the participants:

“STIs and pregnancies do not just affect married people but also the adolescents, it should be made known to every adolescent that such services are offered at no cost in our country and that anyone can have access”.

The participants recommended that information could be given through meetings, workshops, clubs, and distribution of educational materials such as magazines. RH messages could also be incorporated into sports and games.

When asked what could be done to reduce teenage pregnancies, the guidance and counseling teacher said information and education of the adolescents should also be extended to the community. This was confirmed by the nurses who said the girls should be taught that they have a right to family planning services. The guidance and counseling teacher also talked about distribution of educational materials like books, pamphlets and posters which was confirmed by the peer educator. She also mentioned promotion of sports, debate and games at which RH information could be incorporated. She also felt teachers should be trained in ARH which should be part of the curriculum:



“Train teachers specifically in RH”...”RH should be part of the school curriculum so that the pupils are examined at the end of the year”.

According to the guidance and counseling teacher, counseling can also reduce teenage pregnancies. The nurses felt teaching the teenage girls’ assertiveness could reduce teenage pregnancies.

The teenage participants felt operating hours should be taken into consideration to accommodate school-going teenage girls:

“I would prefer services are offered every day to lessen long queues and allow us school going pupils to have access to these services”.

They all suggested that the service providers should be adolescent-friendly, for example one said:

“The service providers should be told not to yell at adolescents when they go to seek for ARH services”.

They also suggested that the government should improve the staffing levels at the health facilities. Participants felt training of more peer educators would be more helpful to the teenage girls. Most of them suggested that abstinence should be promoted among the teenage girls:

“Tradition teaches that sex before marriage is not good therefore it should not be encouraged”.



Others suggested that condoms should be promoted among the sexually active adolescents. They also suggested that myths and misconceptions about family planning methods should be corrected.

They also felt improving school health services could yield positive results with regards to teenage pregnancy:

“School health services should continue but it should be done on a monthly basis instead of the current situation which is quarterly”.

The peer educator felt that the church should be involved in ARH.

”...Churches should come in and give information especially on HIV and abstinence. ...form youth groups in various churches and some should be trained in peer education...”

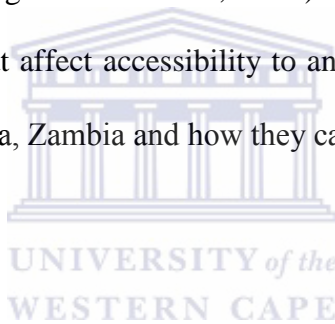
This chapter presented the main findings of the study. The findings indicate that the level of knowledge on availability of ARH services is high though this has not translated into utilization of services. The findings indicate significant barriers that influence accessibility to and utilization of ARH services. These include lack of adolescent-friendly services, lack of awareness on the existence of ARH services, myths and misconceptions about ARH services, and physical barriers such as long distance to the health facility. Other barriers include staff shortages and negative staff attitude, institutional barriers such as inadequate space and age of service providers. Participants also made recommendations for improvement of ARH services.

The following chapter will discuss these findings.



CHAPTER 5: DISCUSSION

This chapter discusses the findings that were presented in chapter 4. Key themes such as awareness of ARH services, barriers to access to and utilization of ARH services and recommendations for improvement of ARH services are drawn from the findings and where relevant are compared to the findings of previous studies as identified in the literature. The findings are discussed in relation to the TPB model to help understand the teenage girls' behaviour in relation to access to and utilization of ARH services. As discussed earlier, the TPB uses attitude, subjective norms, and perceived behavioural control to demonstrate the influence that they have on behaviour (Siragusa and Dixon, 2009). The study findings therefore offer significant insights into factors that affect accessibility to and utilization of ARH services from teenage girls' perspectives in Mpika, Zambia and how they can be addressed.



5.1 Individual Attitude

The findings of the current study indicate that the teenage participant's attitudes towards ARH informed by myths and misconceptions determined their utilization of ARH services. The findings concur with Finkelstein and Brannick (2000) who asserts that those people who have a positive attitude about condoms are more likely to use condoms consistently.

Despite being aware of the available ARH services, some of the teenage participants did not access them because they believed that contraceptives exposed them to other risks such as infertility and cancer. The finding concurs with what Warenius (2008) found in her study on young people's sexual RH health needs and experiences in Kenya and Zambia. She argued that

young people believed in myths and misconceptions such as condoms causing cancer and AIDS. In the current study, some of the teenage participants and the service providers felt provision of ARH services would encourage sexual activity among the adolescents. This means that ARH services will most probably not be promoted. The assumption that offering adolescents ARH services would increase sexual activity among the adolescents is not peculiar to this study alone. For example Longfield, Cramer & Sachingongu (2003) had similar findings from a study that assessed young men's risk for STIs and HIV/AIDS in Zambia.

However several studies have refuted this view. Hocklong et al., (2003) observed that effective RH behavioural approaches did not increase adolescents' promiscuity, instead they increased the knowledge and skills that adolescents needed to make informed RH decisions and to engage in responsible sexual behaviour. This is also confirmed by James-Traore et.al, (2002) who assessed the evaluation of twenty one school programmes in developing countries where nearly all of the school programmes studied had a positive influence on RH knowledge and attitudes. They concluded that education programmes on RH should be strengthened as they do not increase sexual activity. For example in a review of evidence by Speizer et al., (2003) a university peer-counseling program in Kenya reported an impressive decline in the rate of unplanned pregnancies on campus. From the current study it was evident that a negative attitude towards ARH informed by misconceptions about ARH services and family planning methods can impede access to and utilization of ARH services by adolescents.

5.2 Subjective Norms

Subjective norms were another determinant of access to and utilization of ARH services as highlighted by the teenage girls and the service providers in the study. These included:

5.2.1 Fear of Stigma

From the responses of the study participants it was evident that the community disapproved of teenage girls who utilized ARH services and hence the teenage girls avoided these services for fear of being labeled promiscuous. This study finding corresponded with the findings of Moya (2002) who confirmed that adolescents were afraid of being seen by family members or neighbours when utilizing ARH services as they believed they were seeking services which their parents might not approve of. In addition, a study in the greater Accra metropolitan area in Ghana examined the knowledge and practices of RH among second cycle institutions and found that adolescents were not comfortable accessing RH services for fear of older people branding them as bad girls (Oware-Gyekye, 2005). This is also evident in this study from the way participants initially refused to admit to accessing ARH services during the interviews. They only disclosed having accessed ARH services upon probing. The association of ARH services with promiscuity has contributed to the stigmatization surrounding ARH services.

The findings from this study also indicated that ARH services were perceived as unsuitable for the adolescents as they felt that RH especially family planning services were for adults and married people. Studies have shown that adolescents are likely to avoid services they felt are not meant for them. For example Nelson et al., (2000) in their study on the effects of youth-friendly

services project on service utilization among the adolescents in Lusaka Zambia, found that one of the barriers to utilization of ARH services was the perception that family planning services (in particular) were meant for married adults only.

5.2.2 Parenting Role and Sensitivity about Discussing RH issues

This study also indicates that sensitivity about discussing RH issues contributed to low utilization of the ARH services. This is confirmed by Kamau (2006) who asserts that secrecy surrounding sexuality makes it difficult for adolescents to request support. Culturally it is considered taboo or inappropriate to discuss sexual matters between parents and children (Longfield et al., 2003). Amuyunzu-Nyamongo et al., (2005) made similar observations in a qualitative study on adolescents' views of sexual and RH in Sub-Saharan Africa. They observed that adolescents were ashamed to access ARH services because their parents might think they were bad children. This has negative implications for adolescents' RH especially for those that are sexually active.

The current study findings suggest that social norms have an impact on access to and utilization of ARH services (Casper, 2007; Fila & Smith, 2006). The African culture being based on respect for elders and strong community ties may explain why adolescents were affected by social norms. Social norms that condemn ARH services set barriers to rational decision-making and utilization of such services by adolescents. Relating to the social exclusion paradigm, entitlement to access RH services is socially defined and influenced by values, cultural norms and traditions adhered to by different communities (Kamau, 2006). Adolescents living in communities that resist provision of ARH services may be socially excluded from accessing and

utilizing existing ARH services (Kamau, 2006). The findings of the current study concur with the findings from a study that evaluated the impact of youth-friendly projects in Lusaka, Zambia by Mmari and Magnani (2003). They concluded that the use of family planning services among adolescents was positively associated with the levels of community acceptance of ARH services (Mmari & Magnani, 2003). Speizer et al., (2003) also concluded that service utilization was more closely related to community attitudes towards provision of RH services to the adolescents in a study done in Lusaka, Zambia. The findings of the current study imply the importance of the creation of a social environment that is supportive to ARH services with interventions focusing on social norms around ARH.

5.3 Perceived Behavioural Control

The findings of the study indicate that access to and utilization of ARH services was also determined by perceived behavioural control. The findings of the study indicate that while adolescents seemed informed about ARH they found it difficult to access and utilize the services because they perceived too many barriers.

5.3.1 Awareness of ARH Services

Some of the teenage participants were aware of ARH services and places offering ARH services. Despite some teenage participants' awareness of ARH services other participants demonstrated lack of awareness of ARH services. Lack of awareness of the existence of the ARH services contributed to low use of or lack of utilization of ARH services. Adolescents with better knowledge about ARH services are more likely to access and utilize ARH services. The finding in this study corresponded with the study by Kamau (2006) in a study conducted in Kenya on

factors influencing access to and utilization of preventive RH services by adolescents. The author concluded that adolescents have to know about services to use them. According to the United Nations Population Fund (Undated), access to information and services is a right but the finding in this study suggests that adolescents do not seem to enjoy this right because of certain barriers to accessing RH information and services. Denial of the right to ARH information and services can translate into teenage pregnancy.

5.3.2 Negative Staff Attitude

Negative staff attitude was noted as a barrier to accessibility and utilization of ARH services in this study. The teenage girls stayed away from ARH services for fear of being ostracized. The finding from this study confirmed the finding by Atuyambe et al., (2005) in a study on the experiences of pregnant adolescents in Uganda. They concluded that adolescents will avoid the services and seek unprofessional help if the service providers have negative attitudes. Warenaus (2008) found similar results in her study on service providers' attitude and young people's needs in Kenya and Zambia. However, other factors such as lack of skills to effectively communicate with adolescents seeking RH (WHO, Population Council & FHI 2006), personal values and views (Warenaus et al., 2006) contribute to the service providers' negative attitude towards adolescents that seek ARH services. Clashing beliefs about the role of an adult as a transmitter of community values and beliefs and that of a professional contribute to the reluctance of service providers to provide ARH services (Rosen, 2000). One of the needs stressed by the 1994 ICPD is the specific user-friendly and accessible services to effectively address the RH needs of the adolescents (Xu & Shtarkshall, 2008). Similarly, in the current study, the teenage participants felt that service providers should be more sensitive to ARH needs to improve access to and

utilization of ARH services. WHO has set a minimum standard for adolescent-friendly services which includes confidentiality and adolescent-friendly trained non-judgmental health workers (WHO, 2002) which in many instances did not seem to be the case in this study. The finding of the current study implies the need for adolescent-friendly trained staff.

Despite most of the participants indicating bad staff attitude, some of the participants however expressed satisfaction with the services offered. The high level of satisfaction reported in this study could be as a result of reporting bias in which the participants were giving socially desirable responses. The participants could have been reluctant to express negative opinion as they may have felt dependent upon the services provided and feared that negative comments would negatively affect their ability to access the services in future.



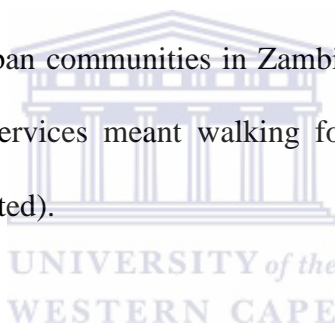
5.3.3 Lack of Privacy at Health Facilities

The study also established that lack of privacy at the health facilities contributed to low utilization of ARH services. Most public health facilities are congested and privacy cannot be guaranteed at waiting areas and during consultation. The teenage participants also shied away from public health facilities because they did not like to be seen seeking services that are perceived to be for adults only. Sharing of services with adults hinders adolescents' access to and utilization of ARH services. Nelson et al., (2000) in a study done in Lusaka, Zambia on the effects of an adolescent-friendly services project on service utilization among adolescents had similar findings. They established that the perception that family planning services are meant for married adults only deterred adolescents from utilizing the services. The findings of the current

study imply the need to organize services in such a way that they enhance privacy for adolescents and sensitize the community on the importance of ARH services. For example there could be the re-establishment of a specifically equipped adolescent-friendly corner room at the health facility to accommodate the unique RH needs of the adolescents.

5.3.4 Long Distance to Health Facility

Long distance was another identified challenge to access to and utilization of the ARH services. Despite the selected high school being within walking distance from the health facility (2.5 km), not all pupils at this school stayed within this catchment area. Similarly, a needs assessment conducted in ten rural and peri urban communities in Zambia confirmed that services are often too distant and accessing these services meant walking for many hours (Zambia Family & Reproductive Health Project, Undated).

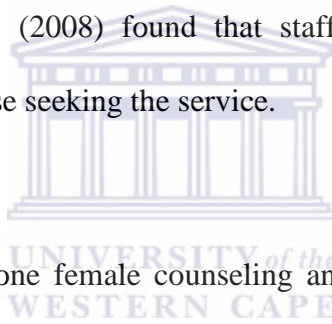


5.3.5 Operating Hours

Operating hours posed as a hindrance to access to and utilization of ARH services as they coincided with the times when adolescents were in school and hence they could not access the services that they needed. This finding is confirmed by a study done by Mashamba and Robson (2000), on adolescent RH services in Bulawayo, Zimbabwe which found that operating hours hindered accessibility to and utilization of ARH services by in-school adolescents. The finding implies the need to extend operating hours to meet the needs of the in-school adolescents.

5.3.6 Shortage of Staff

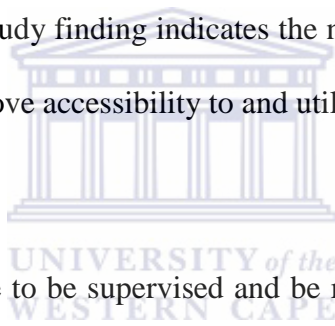
The current study established that staff shortages and heavy workload affected access to and utilization of ARH services and the ability of the service providers to effectively serve adolescents. During data collection, the researcher observed that the department only had two nurses who attended to a large number of clients. This concurs with Kamau (2006) in her study on factors influencing access to and utilization of preventive RH services by adolescents in Kenya. She concluded that long queues discouraged adolescents from seeking ARH services and that staff shortages and heavy workloads affected the ability to effectively serve the adolescents. Similarly, in a study conducted in Zambia and Kenya on providers' attitudes and young people's needs and experiences, Warenius (2008) found that staff could be unfriendly when tired, affecting their attitude towards those seeking the service.



In addition, the school only had one female counseling and guidance teacher who had other duties to perform as well. The shortage of staff implies that adolescents do not receive the comprehensive ARH services that they needed and were entitled to. The findings imply the need for interventions to address staff shortages. For example, a strategy to recruit and train community-based agents reduced workload pressure on the health facility service providers because they complemented existing ARH services, and proved effective in the Zambia Family and Reproductive Health Project (Undated).

Another way of addressing staff shortages is to recruit volunteers as peer educators. However, during data collection the researcher observed that the only peer educator at the selected health

facility was a male and was too old to be a peer educator for adolescents as he was above 30 years of age. Peer educators are meant to be people who share similar ages, backgrounds and interests to communicate messages to their peers (Truong, 2008). The suggestion by the participants that more adolescents should be trained in peer education to help improve access to and utilization of ARH services was an indication that age could be a hindrance to access to and utilization of ARH services. This is in line with the view that adolescents respond best and are more likely to accept information from their peers than adults when dealing with sensitive issues (Zambia Family & Reproductive Health Project, Undated). Speizer et al., (2001) also concluded that an encounter with a peer educator was positively associated with contraceptive and condom use at last sexual encounter. The study finding indicates the need for health facilities to have age appropriate peer educators to improve accessibility to and utilization of ARH services.



However, peer educators will have to be supervised and be motivated to continue offering their services. Warenius (2008) in her study on sexual and RH services for young people in Kenya and Zambia demonstrated that many peer educators are initially highly motivated but after a while drop out as they felt isolated and wished for supervision from the service providers. Truong (2008) also noted that peer educators leave the programme as they get older and constant recruitment and re-training is needed. He further recommended that attrition can be reduced by close supervision, harmonizing peer educators' values and beliefs with those of the organization, and developing creative compensation strategies.

5.3.7 Communication Barriers

This study established that poor communication affected the level of access to and utilization of ARH services. Poor communication was perpetuated by linguistic barriers, discomfort about discussing sexuality matters, age of service providers, and negative staff attitude.

The teenage participants in this study identified language as a communication barrier that affected their access to and utilization of ARH services. Despite English being an official language in Zambia, it is not everyone who is conversant with the language. This made communication about RH between adolescents and service providers difficult. The use of a language that they were not familiar with widened the communication gap because it made it awkward for them to discuss RH issues. According to Wyn et al., (1999) linguistic barriers are difficult under any circumstances but when dealing with the critical issues in health care, lack of information because of language barriers can be devastating and can impede appropriate care. This finding implies the need to enhance communication skills of service providers to improve their capacity to effectively communicate with adolescents.

In conclusion it is evident from this study that awareness of ARH services and where they could be obtained did not translate into service utilization but were influenced by attitude, subjective norms and perceived behavioural control. Even when adolescents have information and access to family planning services, many contextual factors such as social norms affect the final decision to use them (Oware-Gyekye, 2005). Strategies to improve access to and utilization of ARH services should go beyond information dissemination. Casper (2007) recommends the use of the

TPB model as a theoretical framework in designing strategies that are required to translate the findings into improved practice. Adolescents need to feel safe and comfortable to use ARH services. Therefore adolescent girls would benefit more from programmes designed to improve their attitude, their perceived behavioural control and address social norms related to ARH.

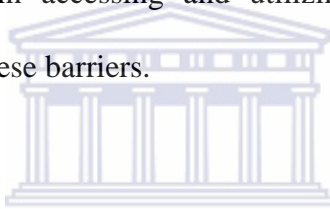


CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

This chapter sets out the overall study conclusions and recommendations on what needs to be done to address identified barriers that hinder effective access to and utilization of ARH services by teenage girls in the Mpika district.

6.1 Conclusion

The aim of the study was to explore the factors that facilitate or inhibit teenage girls' access to and utilization of ARH services in the Mpika district, Zambia. The study expected to identify the barriers that teenage girls face in accessing and utilizing ARH services and to provide recommendations for addressing these barriers.



The study found that although there was a high level of knowledge about ARH services and where these services could be obtained, this did not translate into ARH service utilization by teenage girls. There were indeed significant barriers that influenced accessibility to and utilization of ARH services by the teenage girls. These are summarized as follows:

6.1.2 Individual Attitude

Negative attitude towards ARH services informed by myths and misconceptions about ARH services contributed to low access to and utilization of ARH services.

6.1.3 Subjective Norms

Social norms posed barriers that hindered adolescent girls' access to and utilization of services. Ambivalence and misconceptions about ARH services lead to stigmatization and social exclusion of adolescents from RH services. It was evident from the study that service utilization was closely related to community attitudes towards provision of RH services to the adolescents.

6.1.4 Perceived Behavioural Control

Factors related to perceived behavioural control such as lack of adolescent-friendly services deterred teenage girls from utilizing ARH services.

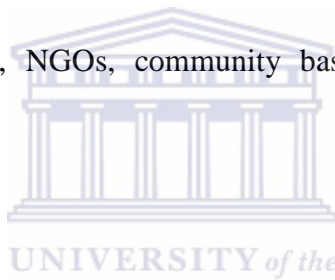
The study concludes that lack of access to and utilization of ARH services by adolescents leads to exposure to sexual health risks. Therefore adolescents just like adults and children should be accorded their basic right to health which includes access to confidential ARH services. Barriers need to be aggressively and amicably addressed to improve access to and utilization of ARH services. The current ARH strategies in place do not seem to be having the desired effect. Therefore the study underscores the need to bridge this gap to ensure complete accessibility to and utilization of ARH services. This can be done through establishment of comprehensive integrated ARH programmes to accommodate the unique RH needs of adolescents.

It is apparent that low utilization of ARH services leads to unintended teenage pregnancies. The study findings indicate that improved access to and utilization of ARH services will contribute to the reduction of unintended pregnancies thereby reducing school drop-out rate in the district. The intervention programmes should take into consideration that problems of low utilization of

ARH services is not based on ignorance but rather on difficulties in accessibility and utilization due to psychosocial, societal and physical barriers. Therefore it is imperative that, the TPB model be used as a theoretical framework in designing strategies that are required to improve access to and utilization of ARH services in the Mpika district.

6.2 Recommendations

Most of the recommendations were made by the participants themselves. If the users and the service providers of the services make suggestions, then there is a much better chance of the programmes being successful. The adolescents' access to ARH should be enhanced and provided through health facilities, schools, NGOs, community based organizations and appropriate community forums.



6.2.1. Intensify Information and Education on ARH E

Provision of comprehensive information and education on ARH to adolescents and adults will help to reduce the stigma associated with the services and address negative individual attitudes of teenage girls informed by myths and misconceptions. This strategy can be effective as evidenced by the Zambia Family and Reproductive Health Project (Undated) in which trained community based agents were used to correct misconceptions about contraceptives and hence improved utilization of the services by the adolescents. Given adolescents' reliance upon their peers for information, peer-based interventions should be enhanced to ensure that adolescents have access to well-informed sources of advice to improve RH.

Facilities providing ARH services should be equipped with a range of educational materials to enhance adolescents' awareness about various RH issues. The current study found that the demand for educational materials was higher than the supply. Strategies that could be used to give information and education include organizing meetings and workshops for adolescents, and distribution of educational materials such as magazines. Intervention programmes should collaborate with communities to create long-term strategies for increasing access to ARH services. Information and education should be extended to parents and adults. This is in line with the findings in Kenya where parent education programmes help parents overcome taboos in discussing sensitive issues with their children (Rosen, 2000).

6.2.2 Enhance Participation and Involvement of Adolescents

Active participation in and involvement of adolescents in designing and implementation of ARH interventions is important to ensure the effectiveness and relevance of ARH programmes and services.

6.2.3 Intensify Community Awareness

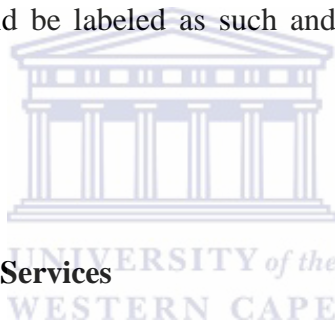
The Ministry of Health should intensify community awareness about the benefits of early access to and utilization of ARH services by adolescents. ARH programmes should be devised to provide a supportive environment for adolescents so as to enhance adolescents' ability to access and utilize ARH services.

6.2.4 Training Adolescents in Life Skills

There is a need to initiate and support the training of adolescents to equip them with basic negotiation and communication skills to help them relate to and communicate effectively with both peers and adults about ARH issues.

6.2.5 Establishment of Specific Adolescent-Friendly Services

There is a need for the establishment of comprehensive integrated adolescent-friendly services to ensure adolescents equal access to information and services which they can identify with. Adolescent-friendly services should be labeled as such and also indicate that the services are “free of charge” (PATH, 2003).



6.2.6 Promote School Health Services

The District Health Management Team (DHMT) in collaboration with the District Education Board Secretary (DEBS) office should strengthen school health services to make them comprehensive and responsive to the RH needs of adolescents. The schools should liaise with health care providers to design appropriate school health referral services.

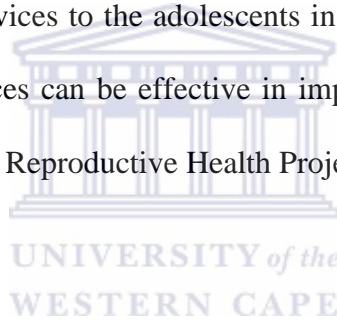
6.2.7 Improve Staffing Levels and Promote Positive Staff Attitude

There is a need to assess and improve health facilities’ capacity to provide comprehensive ARH services by addressing staff shortages and the continuous assessment of the training needs of health professionals serving adolescents. Recruitment of peer educators should be age and

gender sensitive to enhance open discussions on RH matters. Incentives should be put in place to motivate and retain the volunteers. Training of service providers in adolescent-friendly services cannot be overemphasized if they are to change their attitude and be sensitive to ARH needs. Adolescent-friendly trained staff has proved to be an effective strategy for improving access to and utilization of ARH services (Zambia Family & Reproductive Health Project, Undated).

6.2.8 Enhance community-based programmes that provide services in a non-clinical setting.

Programmes that take the RH services to the adolescents in the community rather than making the adolescents come to the services can be effective in improving access to and utilization of ARH services (Zambia Family and Reproductive Health Project (Undated).



It is hoped that with the aid of the findings of this study and the above recommendations, the DHMT and other stakeholders will be able to design appropriate ARH programmes that will help reduce the incidence of teenage pregnancies in the district. A more extended and in-depth study on the knowledge and practices of RH issues among teenage girls in high schools in the Mpika district should be carried out in order to adopt a more comprehensive approach in addressing ARH issues.

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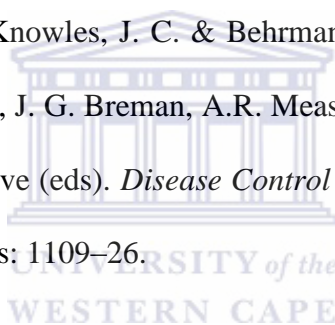
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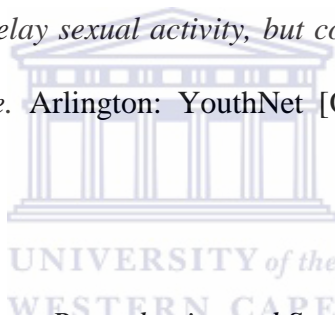
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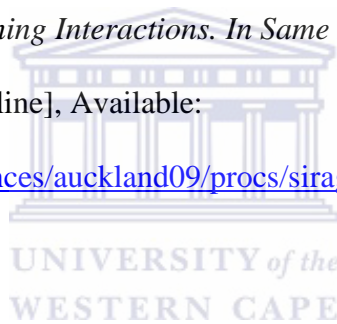
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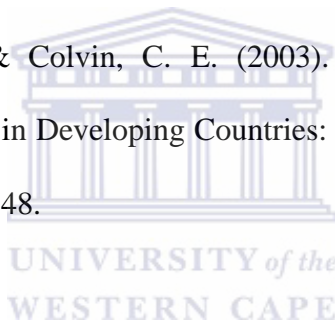
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LIST OF APPENDICES

Appendix 1 Interview guide for the FGD with pregnant teenage girls attending ante-natal services at urban clinic and interviews with in-school girls at the selected high school.

Appendix 2 Interview guide for the service providers

Appendix 3 Information Sheet

Appendix 4 Consent Form

Appendix 5 Parental Permission Form

Appendix 6 Field Research Diary



Appendix 1

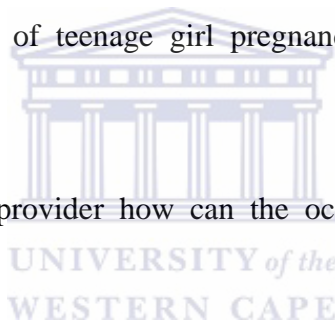
Interview guide for the FGD with pregnant teenage girls attending ante-natal services at urban clinic and interviews with in-school girls at the selected high school.

1. How can one protect one's self from pregnancy and STIs ? *Probe on all methods*
2. What types of adolescent reproductive health services are available and where are they offered in your area? *Probe on all types.*
3. Have you ever accessed the services offered? If not *probe why* , if yes go to next question.**(School girls only)**
4. Would you share your experience with the services offered? How did you find the services? *Probe what was good, what was bad*
5. In your opinion what inhibits utilization of adolescent reproductive health services? *Probe on social, cultural and physical barriers*
6. How can these problems be reduced or solved?
7. In your opinion what facilitates utilization of adolescent reproductive health services? (If it doesn't come up with the previous question)
8. Some people feel adolescent reproductive health services increase youth sexual activities, what is your opinion?

Appendix 2

Interview guide for the service providers

1. Are you trained in youth friendly services?
2. What adolescent reproductive health services do you provide? *Probe on type of services offered, opening time and how often.*
3. What is your perception of teenage girls who come to access the services?
4. What is your opinion on the services provided? *Probe whether adequate and accessible for the youths?*
5. The District experiences a lot of teenage girl pregnancies. What do think could be the contributing factors?
6. In your opinion as a service provider how can the occurrence of teenage pregnancy be reduced?
7. What kind of information do you provide during education and counseling and how? *Probe on IEC materials.*



Appendix 3

Participant Information Sheet



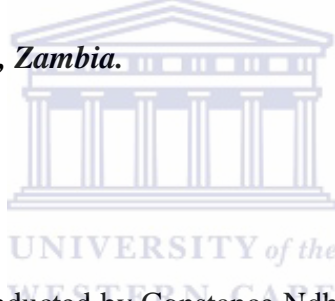
UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

INFORMATION SHEET

Project Title: *Exploring the accessibility and utilization of Adolescent Reproductive Health Services by teenage girls in Mpika, Zambia.*



What is this study about?

This is a research project being conducted by Constance Ndhlovu Choka at the University of the Western Cape. We are inviting you to participate in this research project because you are a teenage girl / adolescent reproductive health service provider. The purpose of this research project is to gain insight into the experiences of teenage girls' access and utilization of adolescent reproductive health services. It is hoped that with your participation, an understanding of what affects the access and utilization of adolescent reproductive health services will be elicited which can help improve the planning of youth programs in the district.

What will I be asked to do if I agree to participate?

You will be asked a number of questions on the following issues:

Teenage girls

Type of reproductive health services offered, to share your experiences with the services offered and the impact on your life.

Obstacles inhibiting utilization of adolescent reproductive health services and how they can be minimised.

Your perception of the attitude of service providers and the adolescent reproductive health services



Service provider

Type of services offered.

Perception of quality of services offered and teenagers who seek reproductive health services.

Type of information offered during counseling.

Suggestions on how to reduce the incidence of teenage pregnancy.

The interviews will not take more than two hours and the interviews will take place at your workplace/school/clinic.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality, we will not put your name on the data forms/questionnaires but instead we'll use codes (pseudonyms). The identification key will be used by the researcher to link the survey to your identity and no one other than the researcher will have access to the identification key. The data forms or questionnaires will be kept in a lockable filing cabinet and we'll use password protected computer files. The research will also involve audio-taping. The audio-tapes will solely be used during the data analysis process. The audio-tapes will be kept under lock and key no one other than the researcher will have access to them.

If we write a report or article about this research project, your identity will be protected to the maximum extent possible.



What are the risks of this research?

The possible risk of participating in the study might be that of embarrassment when you disclose certain information which you might consider personal.

What are the benefits of this research?

The research is not designed to help you personally but results may help the investigator learn more about issues affecting accessibility and utilization of adolescent reproductive health services in the district. We hope that, in the future, other people might benefit from this study through improved understanding of adolescent reproductive health needs. The anticipated benefit

to science is knowledge concerning factors that affect access to and utilization of adolescent reproductive health services in the district.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?

Should you need emotional support as result of the research process; a counselor will be made available to counsel and help you.



What if I have questions?

This research is being conducted by Mrs. Constance Ndhlovu Choka at the University of the Western Cape. If you have any questions about the research study itself, please contact Mrs. Constance Ndhlovu Choka at: C/O of District Health Office, Box 450046, Musakanya Kombe Drive, Mpika.

Cell phone; +260 0977 610885 / +260 0966 686944.

E-mail conniezenzile@yahoo.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department:

Dean of the Faculty of Community and Health Sciences:

University of the Western Cape

Private Bag X17 Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.



Appendix 4

Consent Form



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

CONSENT FORM

Title of Research Project: *Exploring the accessibility and utilization of Adolescent Reproductive Health Services by teenage girls in Mpika, Zambia.*

The study has been described to me in language that I understand and I freely and voluntarily agree to participate including being audio-taped. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name.....

Participant's signature.....

Witness.....

Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Head of Department:

Dean of the Faculty of Community and Health Sciences:

University of the Western Cape

Private Bag X17 Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.



Appendix 5

PARENTAL PERMISSION FORM

Title of Research Project: Exploring the accessibility and utilization of Adolescent Reproductive Health Services by teenage girls in Mpika, Zambia.

The study has been described to me in language that I understand and I freely give consent to my child / ward to participate. I understand that my child's / ward's identity will not be disclosed and that she may withdraw from the study without giving a reason at any time and this will not negatively affect her in any way.

Parent's/Guardian's name.....

Parent's/Guardian's signature.....

Witness.....

Date.....



Should you have any questions regarding this study or wish to report any problems your child / ward has experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Constance Ndhlovu Choka

C/O District Health Management Team

Box 450046

Mpika

Appendix 6

Field Research Diary

Date	Observation/what I heard?	How I felt?
5-14 th May 2010	<p>Preparation for Data Collection</p> <p>DEBS and DHMT enthusiastic about the research. RHC in-charge, school head teacher, and prospective participants eager and willing to take part in the research.</p>	I feel encouraged with the positive response.
17 th – 21 st May 2010	<p>Individual Interviews with In-School Girls</p> <p>The girls’ knowledge about ARH services and where they are offered is high. Most of them do not utilize them due to lack of privacy and confidentiality, negative staff attitude and disapproval by adults, fear of stigma, myths and misconceptions about ARH services, Others fail to utilize the services due to distance and operational hours.</p>	Physical, societal and psychosocial barriers deter the teenage girls from accessing and utilizing ARH services. Knowledge about ARH services alone does not mean adolescents will access and utilize the services.
24 th May 2010	<p>Interview with Guidance and Counseling Teacher.</p> <p>The counseling and guidance teacher is overwhelmed by other duties and</p>	There is little support for ARH activities from the DEBS’ office and the school authority.

	<p>offers ARH services as a by the way thing.</p> <p>There is no replacement of peer educators that graduate from school.</p> <p>Counseling with focus on abstinence is the only ARH service offered.</p>	<p>ARH services being offered are not comprehensive (counseling on abstinence only).</p>
<p>26th May 2010</p>	<p>Interview with Nurses at the Health Facility.</p> <p>The adolescent-friendly corner room is used as storage facility and the staff said very few adolescents seek ARH services. ARH services are offered on certain specific days from 14- 16 hours. There are only two nurses in the Mother Child Health Department which also offers ARH services</p> <p>School health services are not offered on a regular basis and educational materials on ARH are in short supply.</p>	<p>There is little support to provision of comprehensive ARH services from the DHMT</p> <p>Adolescents are denied right to comprehensive ARH services.</p>
<p>27/5/10</p>	<p>FGD with Pregnant Teenage Girls.</p> <p>Knowledge on ARH services is high. Some believe RH services promote</p>	<p>Knowledge of ARH services did not translate into utilization of ARH services as evidenced</p>

	<p>sexual activity amongst youth and are for married people. Most of them claimed to be happy with the service providers.</p>	<p>by the pregnancies. There is report bias by the participants probably due to fear that negative response may affect accessibility of services in future.</p>
<p>31st May 2010</p>	<p>Interview with Peer Educator</p> <p>The peer educator denied teenage girls access to some services such as contraceptives.</p> <p>ARH services were offered from a very small room meant for pediatric HIV/AIDs counseling</p> <p>Peer educator was too old to be a peer educator for adolescents</p>	<p>The peer educator experiences clashing beliefs about community values and beliefs and that of professional responsibility contributing to his negative attitude. His age (36) coupled with negative attitude contributes to low utilization of ARH services by adolescents.</p> <p>There is little support from DHMT probably contributing to high attrition of peer educators</p>

