

Young Males' Perceptions and Use of Reproductive Health Services in Lusaka, Zambia

Chilobe Muloba Kambikambi

Student number: 2522442

A mini-thesis submitted in partial fulfilment of the requirements for the degree of
Masters in Public Health in the School of Public Health, Faculty of Community and Health Sciences,

University of the Western Cape



Supervisor: Dr Brian Van Wyk

27 October 2014

Abstract**Background**

Male adolescent's needs, behaviours and expectations are unique due to the influence of social constructions of masculinity. These behaviours and expectations have an effect on their health seeking behavior. The routine health services are generally not organized to provide the services that can meet the needs of male adolescents. The aim of this study was to describe the health seeking behaviours, knowledge about the available services, as well as experiences, and barriers to access and utilization of the reproductive health services among male adolescents in Lusaka.

Study design

A descriptive, qualitative study was conducted among male adolescents in a peri-urban setting in Lusaka. Four focus group discussions were conducted with 46 adolescents aged between 13 and 24 years of age, and six key informant interviews. Data was audio-tape recorded and transcribed verbatim. Thematic content analysis was done.

Results

Health concerns were related to the social, psychological, societal and puberty needs of participants. Concerns, questions and queries about masturbation were common, especially among the younger adolescents. Most problems related to puberty and body changes rather than sexual and reproductive health matters per se. Knowledge about the available sexual and reproductive health services was generally low, with some young men being completely unaware of the existence of youth friendly services at the local clinic. Contrary to popular opinion, adolescents in this community reported that they did not seek help on sexual matters from friends and did not want to discuss their problems with their peers, due to fears of being marginalized. Perceived gender, cultural and social norms, lack of knowledge about the availability of adolescent reproductive health services, and poor attitudes among the health care providers were some of the identified barriers to seeking health care. Adolescents perceived health providers to be judgmental, not helpful and condescending towards young people. Lack of privacy and confidentiality were also reported as barriers to access and utilization of sexual and reproductive health services. Adolescents were happy to accept available services from nongovernmental

organizations and other private organizations rather than the public clinics and other health facilities.

Conclusions

Despite acknowledging their needs, male adolescents did not access the needed services at Chawama clinic due to negative perceptions of the health services and the health care workers in particular. Gender, cultural and social norms, lack of knowledge on available services, confidentiality and quality of care remained major barriers to accessing SRH services.

The current public health service is not “appropriate” for meeting male adolescents’ sexual and reproductive health needs. Major restructuring and re orientation is needed to “win” over male adolescents to the services.



Declaration

I declare that *Young Males' Perceptions and Use of Reproductive Health Services in Lusaka, Zambia* is my own work and has not been submitted for any degree or examination to any other university and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full Name: Chilobe Muloba Kambikambi

Date: 10/27/14

Signed:



Acknowledgments

My first thanks goes to the participants in Chawama compound who took part in the study and spent time answering my questions and sharing insights into their private lives with me. Your cooperation was essential for the success of the study.

My special thanks go to Dr Brian Van Wyk for his commitment and support in supervising me throughout my research project. His continuous awareness and encouragement over the whole period of my study was crucial to the completion of this thesis. His emphasis on being analytical throughout the analysis of the results and write-up stages of the research advanced my critical and analytical skills.

My appreciation also goes to Gertrude Mwape my colleague and friend for her wonderful support during the data collection, proof reading my work and the whole course of the research. Your selfless commitment to my cause was encouraging and made me endure through. May God richly bless you.

I am also very grateful to my husband Alfred Mwenya Kambikambi and my children, Mwila, Mwenya, Mandla, Mwechi, and Seva for their endurance during the time spent away from them. I had no alternative. Sorry for that! Thank you for your support. Honey thank you for pushing and urging me on to finish the course. I'm forever indebted to you. I love you.

I am indebted to CARE International in Zambia my former employers and Save the Children Federation (USA and Sweden) Zambia office my current employer for allowing me access to their computer and time off to enable me document my research.

Lastly, I thank the almighty God for His mercy and grace for allowing me to fulfill the dream I never dreamt but hoped to dream one day.

Key words

- Adolescents
- Perceptions
- Puberty
- Health seeking
- Behaviours
- Reproductive health services
- Sexual and reproductive health
- Youth friendly service
- Peer educators
- Sexuality



Acronyms and Abbreviations

| | |
|--------|--|
| RHS | Reproductive Health Services |
| CSO | Central Statistics Office |
| DHMT | District Health Management Team |
| FGD | Focus Group Discussion |
| HBM | Health Belief Model |
| HIV | Human Immunodeficiency Virus |
| ICPD | International Conference on Population and Development |
| IEC | Information Education Communication |
| IPPF | International Planned Parenthood Foundation |
| MDG | Millennium Development Goals |
| MOH | Ministry of Health |
| NGOs | Nongovernmental Organizations |
| RH | Reproductive Health |
| RHS | Reproductive Health Services |
| SRHS | Sexual and Reproductive Health Services |
| STI | Sexually Transmitted Illness |
| UNAIDS | United Nations for Acquired Immune Deficiency Syndrome |
| UNFPA | United Nations for Population Action |
| UNGASS | United Nations General Assembly Session |
| UNICEF | United Nations Children Fund |
| VCT | Voluntary Counseling and Testing |
| WHO | World Health Organization |
| WPD | World Population Day |
| YFS | Youth Friendly Services |
| ZDHS | Zambia Demographic Survey |
| ZSBS | Zambia Sexual Behaviour Survey |

TABLE OF CONTENTS

| | |
|----------------------------------|-----|
| Title Page | i |
| Abstract | ii |
| Declaration..... | iii |
| Acknowledgement | iv |
| Key words..... | v |
| Acronyms and Abbreviations | vi |

CHAPTER 1: INTRODUCTION

| | |
|-----------------------------|---|
| 1.1 Background..... | 1 |
| 1.2 Problem Statement | 5 |
| 1.3 Outline of Thesis | 6 |



CHAPTER 2 : LITERATURE REVIEW

| | |
|---|----|
| 2.1 Introduction..... | 7 |
| 2.2 The Health Belief Model | 7 |
| 2.2.1 <i>Perceived Threat</i> | 8 |
| 2.2.2 <i>Perceived Benefits</i> | 9 |
| 2.2.3 <i>Perceived Barriers</i> | 10 |
| 2.2.4 <i>Availability and Accessibility of the Services</i> | 10 |
| 2.2.5 <i>Acceptability of the Services</i> | 11 |
| 2.3 Modifying Factors of Health Seeking Behaviours..... | 12 |
| 2.4 Summary..... | 15 |

CHAPTER 3 : METHODOLOGY

| | |
|--|----|
| 3.1 Aim of the Study | 17 |
| 3.2 Objectives | 17 |
| 3.3 Description of Research Setting..... | 17 |
| 3.4 Study Design..... | 18 |
| 3.5 Study Population..... | 18 |
| 3.6 Sampling and Recruitment of Participants | 19 |
| 3.7 Data Collection | 24 |
| 3.8 Rigour | 25 |
| 3.9 Data Analysis | 26 |
| 3.10 Ethical considerations | 27 |

CHAPTER 4 : RESULTS

| | |
|---|----|
| 4.1 Study context | 29 |
| 4.2 Presentation of Categories | 29 |
| 4.3 Health Concerns among Adolescents | 29 |
| 4.3.1 <i>Social and Psychological Concerns</i> | 30 |
| 4.3.2 <i>Relationship Concerns</i> | 31 |
| 4.3.3 <i>Societal Concerns</i> | 31 |
| 4.3.4 <i>Sexual and Reproductive Health Problems</i> | 32 |
| 4.4 Perceived susceptibility to STI including HIV | 34 |
| 4.5 Substance Abuse | 37 |
| 4.6 Sources of Information on Reproductive Health and Services..... | 38 |
| 4.7 Gender Norms related to Sex and Sexuality..... | 38 |
| 4.8 Health Seeking Behaviours..... | 40 |



| | |
|---|----|
| 4.9 Utilization of Health Services | 43 |
| 4.10 Barriers to Accessing Sexual and Reproductive Health Services..... | 43 |
| 4.10.1 <i>Lack of Knowledge about the Available Sexual and Reproductive Health Services</i> | 44 |
| 4.10.2 <i>Social Norms about Age</i> | 46 |
| 4.10.3 <i>Health Care Providers Gender</i> | 46 |
| 4.10.4 <i>Attitudes of the Health Providers</i> | 47 |
| 4.10.5 <i>Perceived Lack of Privacy and Confidentiality</i> | 48 |
| 4.11 Perceptions of the Health Services | 50 |
| 4.11.1 <i>Inadequate Services</i> | 50 |
| 4.11.2 <i>Services Perceived to be Slow</i> | 53 |
| 4.12 Perceptions of the Youth Friendly Services | 54 |
| 4.12.1 <i>Poor Accessibility</i> | 55 |
| 4.12.2 <i>Lack of Environmentally Friendly Space</i> | 56 |
| 4.12.3 <i>Lack of Service Integration</i> | 57 |
| 4.12.4 <i>Lack of Skilled Personnel</i> | 58 |
| 4.12.5 <i>Perception of the Peer Educators</i> | 58 |
| 4.13 Enabling Factors to Utilization of Sexual and Reproductive Health Services | 59 |
| 4.13.1 <i>Awareness Raising</i> | 59 |
| 4.13.2 <i>Provision of Special Clinics for Young People</i> | 60 |
| 4.13.3 <i>Need for Skilled Health Care Providers</i> | 61 |
| 4.14 Summary | 62 |
| CHAPTER 5 : DISCUSSION | |
| 5.1 Introduction..... | 64 |
| 5.2 Health Needs and Concerns | 64 |

| | |
|--|----|
| 5.3 Male Adolescent Health Seeking Behaviours | 65 |
| 5.3.1 <i>Lack of Knowledge on the Available Services</i> | 66 |
| 5.3.2 <i>Lack of Knowledge on STIS and other Sexual Reproductive Health Issues</i> | 67 |
| 5.3.3 <i>Social and Cultural Norms</i> | 68 |
| 5.3.4 <i>Social Norms about Age</i> | 68 |
| 5.3.5 <i>Perception of Available Health Services</i> | 69 |
| 5.3.6 <i>Gender Norms</i> | 71 |
| 5.4 Preferences of Sexual Reproductive Health Services | 72 |

CHAPTER 6 : CONCLUSION AND RECOMMENDATIONS

| | |
|---|----|
| 6.1 Conclusion..... | 73 |
| 6.2 Study Limitations..... | 73 |
| 6.3 Recommendations..... | 74 |
| 6.4 Implication for Future Research | 77 |



| | |
|-------------------------|----|
| REFERENCES | 78 |
|-------------------------|----|

| | |
|----------------------------------|----|
| LIST OF APPENDICES | 90 |
|----------------------------------|----|

| | |
|--|----|
| Appendix 1: Participant Information Sheet | 90 |
| Appendix 2: Informed Consent..... | 92 |
| Appendix 3: Focus Group Discussion/Interview Guide | 93 |
| Appendix 4: Permission Letter from DHMT:..... | 97 |
| Appendix 5: Approval Letter from the Ethics Committee University of Zambia | 98 |

CHAPTER 1

INTRODUCTION

1.1 Background

Adolescents comprise about 20% of the world's population, of which 85% live in developing countries (United Nations Division for Population [UNDP], 2009). There are about 157 million youths aged 15 -24 years in the sub-Saharan Africa region, and by 2015, this number is expected to increase to 198 million (UNDP, 2006). By 2050, the number of youth will have risen from just under a half billion in 1950 to 1.2 billion (UNDP, 2009). At that point, about nine in 10 youths will be in developing countries. In Zambia, 17% of the population is between 15 and 24 years (Central Statistics Office [CSO], Ministry of Health [MOH], Tropical Diseases Research Centre [TDRC], University of Zambia and Macro International Inclusion, 2009).

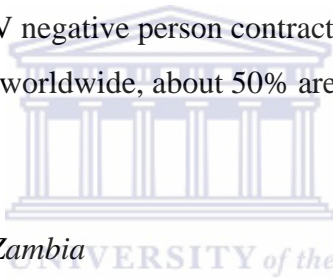
Adolescence

Adolescents are defined by the World Health Organization (WHO) as persons between 10 and 19 years of age (WHO, 2000). The definition of adolescents overlaps with that of youth (aged 15-24 years) and young people (aged 10-24 years) (UNFPA, 2003). During the period of adolescence a child experiences biological changes characterized by puberty, which entails changes in physical appearance and developing reproductive ability. Psychological changes which reveal the individual's thinking and social changes related to rights, privileges and responsibilities of a person also take place. This is usually influenced by culture and shapes and determines the sexuality and identity of an individual (WHO, 2000).

Adolescent Health

Although adolescents are a reasonably healthy group of people with no major physical illnesses, it is increasingly recognized that they face distinctive reproductive health vulnerabilities (UNFPA, 2009). Butler (2003) reported that nearly 10% of the global burden of disease in terms of disability-adjusted life years (DALYS) lost is borne by young people between 10 – 19 years of age. The major causes of morbidity and mortality among young people are accidents, drug abuse and sexual and reproductive health problems including HIV (Patton *et al.*, 2009). Young people usually do not have adequate support systems for promoting health life styles. They lack

appropriate information and adequate health services. In addition youth's sexuality is not adequately addressed. The sexual and reproductive health problems or needs faced by young people differ from one region to the other and between sexes but mainly are due to unprotected sex (Bearinger *et al.*, 2007). Unprotected sex often results in unwanted pregnancy and sexually transmitted infections (STIs) including HIV (UNFPA, 2009; WHO, 2006). In Zambia, overall, 28 percent of women age 15-19 have begun childbearing; 22 percent have had a child and 6 percent are pregnant with their first child and Lusaka teenage pregnancy was at 21 percent (CSO, *et al.*, 2009). According to the 2005 WHO estimates, 448 million new cases of curable STIs (syphilis, gonorrhoea, Chlamydia and trichomoniasis) occur annually throughout the world in adults aged 15-49 years with the highest rates among 20-24 year olds, followed by 15-19 year olds (WHO, 2005). STIs are a major worldwide public health concern and are a significant cause for morbidity and early mortality amongst adolescents and young adults (Hill & Biro, 2009). STIs increase the chances of an HIV negative person contracting HIV (WHO, 2006). Among the new HIV infections that take place worldwide, about 50% are among people aged between 15 and 29 years (UNAIDS, 2008).



Sexual and reproductive health in Zambia

The 2009 Zambia Sexual Behaviour Survey [ZSBS] states that the median age for sexual debut in Zambia for young people aged 15-24 years was 19.5 years for males and 17.5 years for females, with many unmarried adolescents engaging in sex as young as 15 years (Central Statistics Office, Ministry of Health [MOH], and University of Zambia, and MEASURE Evaluation, 2010). The percentage of young people engaging in sex has increased, whereas condom use has decreased. A large percentage of young men (72%) aged 15-24 years reported having sex with non-marital partners compared to women (28%) in the same age category. Compared to young women, young men aged 15-24 years were more likely to have multiple sexual partners (2% vs. 15%). Male youths were more likely to report concurrent multiple sexual partnership than females (11% vs. <1%). In addition among adolescents and young adults who have ever had sex, only 29% reported using a condom the first time they had sex, and only 30%-40% used a condom at last sexual encounter. Condom use varied with sex, with young women more likely to use condoms the first time they had sex than their male counterparts whose condom use was at (27% vs. 31%) (CSO *et al.*, 2010).

Age at first sex and unprotected sex are risk factors for pregnancy and STIs, including HIV. Young people who initiate sex at an early age are usually at higher risk of contracting an STI than youths who wait until at a later age (WHO, 2006). In Zambia, STIs account for about 10 % of all out-patient attendances in public health facilities (MOH and National AIDS Council [NAC] of Zambia, 2008). Between 2005 and 2009 there was a decline in the proportion of respondents in the sexual behaviour survey of 2009 who reported that they had symptoms of an STI from 3% to 2%. This proportion decline was minimal and the rate remained constant in the rural areas (CSO *et al.*, 2010). This signifies that STIs are still a major public health problem in Zambia. The HIV prevalence rate for the 15-49 years age group in Zambia was at 14% in 2007. Young people aged 15-24 years accounted for 7.7% of the HIV-positive population.

Although HIV prevalence was higher in females aged between 15- 49 years at 16% compared to males of same age group at 12%, there seemed to be a steady increase in prevalence rates among young males from 2001 to 2007. HIV prevalence among females aged 15-17 years declined from 6.6% in 2001 to 5.7% in 2007. Similarly in the age group 20- 24 years the HIV prevalence among females also declined from 16.3% in 2001 to 11.8% in 2007. However, HIV prevalence for males aged 15- 19 years was 1.9% in 2001; and increased to 3.6% in 2007 while that of the 20 -24 years age group increased from 4.4% in 2001 to 5.1% in 2007 (CSO *et al.*, 2009). The steady decrease of the HIV prevalence in females could be attributed to the traditional sex education and HIV prevention which has often focused on young women and have not adequately addressed the needs of young men (Family Health International, 2008). While the focus on young women and girls remains necessary, particularly in sub-Saharan Africa where more than 75% of those living with HIV are female, it risks excluding the young men whose involvement is essential to successfully turn the tide on HIV (UNAIDS, 2006). The steady increase in the prevalence rate for young males is of great concern and needs to be addressed.

Access to sexual and reproductive health services

The many challenges that young people face to their health and development are largely preventable. Young people need friendly sexual and reproductive health (SRH) prevention programmes to protect themselves from HIV and other STIs, unwanted pregnancy and unplanned fatherhood. Ensuring access to primary health care services including preventive

health is seen as an important element to care and improving the health outcomes of young people (Tylee, Haller, Graham, Churchill & Sanci, 2007). The WHO emphasizes that these services need to be integrated and comprehensive and should address both the female and male sexual and reproductive health needs (WHO, 2000). The importance of addressing the reproductive health of adolescent males along with that of females was acknowledged at the meeting of the International Council for Population Development (ICPD) held in Cairo in 1994 (UN, 1995a) and at the Fourth UN Conference on Women held in Beijing in 1995 (UN, 1995b). Participants at both conferences concluded that the reproductive health behaviors of adolescent males are not only directly related to the reproductive health of adolescent females, but also to their own health as future adults (WHO, 2000).

Research has however shown that in many countries in sub-Saharan Africa, young people face significant barriers to receiving SRH services resulting in the under utilization of the service (Boonstra, 2007). For instance, the national representative surveys conducted by Biddlecom, Munthali, Singh & Woog(2007) in Burkina Faso, Ghana, Malawi and Uganda, found that young people aged 12-19 years old underutilized services such as contraception, STI prevention and treatment including HIV testing.

Research has also recognized major barriers to young people's ability to access contraception and HIV testing. These barriers relate mainly to the way the SRH facilities are set up and the design of services. They include lack of privacy and confidentiality; no area set aside where young people can wait to be seen; and décor that is too clinical, too adult, and/or welcoming *only* to women and not men (Lindberg, Lewis-Spruill & Crownover, 2006).

The poor access and low use of reproductive health services have been also attributed to lack of availability of reproductive health services, lack of knowledge of the available services, and social and cultural norms forbidding access to sexual and reproductive services (Kamau, 2006; Biddlecom *et al.*, 2007).

In Zambia, despite the calls of the ICPD and the country's commitment to the program of action, many adolescents do not have access to SRH services (Warenus, 2008; Mmari & Magnani, 2003). The government through the Ministry of Health (MOH) is the major service provider through public hospitals and clinics with SRH services in 50 districts by the MOH (MOH, 2005).

Despite such services being offered, coverage tends to be limited with the extent and quality of care varying from time to time (Tylee *et al.*, 2007; Warenius, 2008).

Adolescent's health seeking behaviours

Health or help seeking behaviors among adolescents in developing and developed countries are comparable despite disparities in service provision and the social context (Tylee *et al.*, 2007). Research from developed countries shows that 70–90% of young people contact primary care services at least once a year, and mostly for respiratory or dermatological reasons (Haller *et al.*, 2007). For psychological and social -health problems they seek help from friends and family rather than from the health services (Rickwood, Deane & Wilson, 2007). Similarly in developing countries, studies have shown that young people are less likely to seek professional help for more sensitive matters and turn more to friends or family members they can trust for sexual advice (Biddlecom *et al.*, 2007; Erulkar, Onoka & Phiri, 2005). An international literature review and purposive international survey of expert informants showed that adolescents often prefer to consult peers or suffer in silence when they face reproductive health problems. Further, most of the adolescents who had medical problems during the last three months prior to the data collection did not seek medical care, especially for problems related to reproductive health (Barker, Olukoya & Aggleton, 2005).

1.2 Problem Statement

While the HIV prevalence rate among young men is on the increase in Zambia (CSO *et al.*, 2010), access and utilization of SRH services among adolescents remains low (Warenius, 2008). For example, Chawama clinic records of 2007 show only 10% of the adolescent males had accessed the youth friendly services in one year compared to almost 80% of their female counterparts.

Social and cultural barriers to accessing SRH services, understanding the needs, the expectations and preferences of young males' need are of great importance to improving the health outcomes of all young people. The emic (insider) perspectives of young male adolescents on sexual health issues and health seeking behaviours are key to the development of policies and services that will meet their needs.

1.3 Outline of thesis

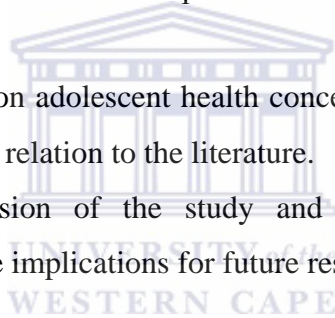
Chapter 2 comprises a critical review of relevant literature from journals, articles and reports reviewed on the study topic. The chapter also presents the one theoretical perspective of the many theories that explain health seeking behaviours. It highlights the variables that influence utilization of sexual and reproductive health services.

Chapter 3 contains the description of the study methodology. It describes the study site, the study design, data sources, sampling, data collection methods and analysis.

Chapter 4 presents the results derived from the adolescents' discussions about their sexual and reproductive health concerns and needs, knowledge on the available sexual and reproductive health services as well as their health seeking behaviors and barriers encountered in accessing the services. The chapter also includes the adolescents' perceptions of the available services. It also includes a description of the male adolescents' preferences for sexual and reproductive health services.

Chapter 5 discusses the findings on adolescent health concerns, health seeking behaviours and perceptions of available services in relation to the literature.

Chapter 6 includes the conclusion of the study and the limitations. It also includes recommendations and describes the implications for future research.



CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter discusses the literature on the health seeking behaviours of adolescents and the factors affecting utilization of sexual and reproductive health services so as to understand these behaviours. Understanding health care seeking behaviour has been said to possibly reduce delay to diagnosis, improve treatment compliance and improve health promotion approaches in various contexts (Shaikh, 2008). The literature review was framed within the theoretical framework of the study. The Health Belief Model (HBM) was used as theoretical framework to understand the factors influencing male adolescents' health seeking behaviours.

The literature review showed that considerable research has been done on adolescent sexuality, health related problems and health seeking behaviours but there was dearth of literature on adolescent males' perceptions of available SRH services in Zambia.

2.2 Health belief model

The study and its structure are guided by a theoretical framework (Brink & Wood, 1998). Burns and Groove (2001) define a theoretical framework as the rationale that directs the course of the study and let the researcher link his/her findings to knowledge in the health science area. The HBM explains health related behaviour at the level of individual decision making (Mikhail, 2001). The model is often used to envisage different preventive health behaviors where perceived risks are studied (Becker, 1974). It usually focuses on the individuals' attitudes and beliefs. Polit and Beck (2008) state that the model proposes that health seeking behavior is influenced by a person's perceptions of threat that is brought about by a health problem and the significance related to actions taken to reduce the threat.

The HBM was chosen as appropriate for this study because most of the key concepts used in the model are applicable to the study on adolescents' perceptions and behaviors towards sexual reproductive health.

The HBM is based on the following major variables:

- a) **Perceived Threat:** is comprised of perceived susceptibility and perceived severity of a health condition.
 - **Perceived Susceptibility:** a person's belief of risk of contracting a health condition or illness
 - **Perceived Severity:** a person's feelings as regards to the seriousness of contracting an illness or leaving it untreated and its consequences.
- b) **Perceived Benefits:** These are the given beliefs of an individual that a given intervention or strategy will cure or prevent the illness from occurring.
- c) **Perceived Barriers:** These are the potential negative effects of taking particular health actions. These include physical, psychological, and financial demands.
- d) **Modifying factors:** include various demographic, sociopsychological and structural factors that affect an individual's perceptions and hence ultimately influence health-related behavior (Polit & Beck, 2008).

Polit and Beck (2008) argue that these four major components influence a person's readiness to act. In addition to the four beliefs and perceptions and modifying variables the HBM suggests that behavior is also influenced by cues to action. The cues to action are events, things that move one to change their behaviour. These could include media reports such as seeing a condom poster (Glanz, Rimer & Lewis, 2002). Cues to actions are an aspect of the HBM that has not been systematically studied. The model also includes self efficacy; which shows the individual's self-belief to successfully act or seek help. The discussion will focus on the perceived threat, perceived benefits, perceived barriers and modifying factors.

2.2.1 Perceived threat

• 2.2.1.1 Perceived susceptibility

Perceived susceptibility to poor health outcomes is a major factor in theoretical models of behaviour change (Fisher & Fisher, 1992; 2000; Lagarde *et al.*, cited in Kibombo, Neema & Fatima, 2007). For instance having a high perceived susceptibility to contracting HIV leads one to assume protective behaviors such as using a condom during sexual intercourse. This was demonstrated in a survey on knowledge of correct condom use and consistency among

adolescents in Malawi, Burkina Faso, Ghana and Uganda which showed young people who did not use condoms did not perceive themselves to be susceptible to HIV infection (Bankole *et al.*, 2007).

If the perceived susceptibility is not accurate, it may be a major barrier to preventing poor health outcomes such as STIs and eventually HIV infection by young people. For adolescents to perceive themselves as susceptible to STIs, they should be aware of the indicators of risk for STIs such as unprotected sexual intercourse and having multiple concurrent sexual partners (Robin *et al.*, 2003). Young males often see themselves as not vulnerable to illness or not at risk and may seek health services only as a last resort (UNFPA, 2003; Lindberg *et al.*, 2006). In Malawi and Uganda for instance, Izugbara, Undie, Mudege and Ezeh (2009) found that some young males failed to test for HIV because their perceived risk of contracting HIV was not high.

- **2.2.1.2 Perceived Severity**

Perceived severity is based on an individual's belief about the seriousness or the severity of the disease (Mikhail, 1981). It is often based on health information or knowledge but it may also depend on individual beliefs about the difficulties the disease will cause or the effects it will have on one's life in general (McCormick-Brown *et al.*, 1999). McCormick-Brown *et al.* further suggest that the person may not take concomitant action if the diagnosis is not perceived as severe. Studies on health-seeking behaviors of adolescents for STIs have shown that young people have a tendency to delay treatment because they do not regard the symptoms of the disease as serious (Mmari, Oseni & Fatusi, 2010).

2.2.2 Perceived benefits

According to the HBM, one of the reasons for behaviour change is the perceived benefits of preventive action (Becker, 1978). According to Ross (2001), people are more likely to conform to health advice when they believe that a particular intervention will be helpful in preventing, detecting or treating disease and consequently reduce the threat to them. This is important because the effectiveness of SRH services in prevention, care and support of young people is positively associated with their consistent use. Izugbara *et al.* (2009) have pointed out that young people may not agree that getting tested for STIs and HIV would benefit them in any way.

Further they may not pay particular attention to health-related information because they do not trust the source or may see it as unreliable or not helpful.

2.2.3 Perceived barriers

Perceived barriers are probable obstacles that prevent one from engaging in preventative behaviours (Glanz *et al.*, 2002). These include factors such as repulsiveness and inconvenience, reluctance of service providers to provide reproductive health services to unmarried adolescents, long waiting lines, overcrowding at the health facility, fear of incorrect treatment, and fear that privacy and confidentiality would not be honored. Other barriers that have been identified include negative community perceptions of adolescent reproductive health services and adolescent embarrassment at being seen at health facilities, lack of transportation and cost of the service (Manlove, Terry-Humen, Ikramullah & Holcombe, 2008; Agampodi, Agampodi & Piyaseeli, 2008; Amuyunzu-Nyamongo, Biddlecom, Ouedraogo & Woog, 2005). By and large the barriers to use of SRH services by adolescents when categorized relate to the availability and accessibility, acceptability and equity of health services (WHO, 2008).

2.2.4 Availability and accessibility of the service

Ensuring access to health services which address HIV and sexual and reproductive health issues is crucial to meeting the needs of young people, the majority of whom lack access to effective prevention programmes. In developing countries such services are every so often still not available with studies showing that young people might also not access available services because they lack knowledge of where and what kind of services are offered (Biddlecom *et al.*, 2007; Erulkar *et al.*, 2005). In countries where these health services are available, laws and policies may be so restrictive that they may prevent young people from accessing the service. Furthermore for reasons related to lack of publicity and visibility, the services might not be accessible (WHO, 2008; Tylee *et al.*, 2007). Studies have also shown the variation of knowledge of the services among males and females. For instance focus group discussions with young males and females aged 17-19 years in Sri Lanka found that the lack of knowledge about the availability of SRH services was more evident among the boys than girls (Agampodi *et al.*, 2008). Similarly cross sectional studies in Burkina Faso, Ghana, Malawi and Uganda, found that compared to females, significantly more males in all countries, with the exception of Ghana,

reported that they did not know where to go for either STI or contraceptive services (Bankole *et al.*, 2007; Biddlecom *et al.*, 2006). The services might also be inaccessible due to being located a long distance from where young people live, study or work (Amuyunzu- Nyamongo *et al.*, 2005).

2.2.5 Acceptability of the service

Reproductive health services might not be acceptable even when available and accessible to young people. Acceptability seeks to change the social norms that hinder access (Shawn, 2010). These include the provider's attitudes such as lack of privacy and confidentiality, experiencing clinic staff as hostile and being judged by the provider as undeserving of the service. It also includes the community and cultural norms about the service (WHO, 2002; MacKian, 2001).

In a study conducted in Zambia on SRH services, young people aged 12 – 24 years said that they did not trust that the information they shared with the health workers would be kept confidential. Further, 33% of the males with STIs and 16% of the females with STIs or abortion related issues did not also think the health information shared with the health workers would be kept private (Warenius, 2008). In South Africa, researchers noted that providers, who did not honor adolescents' confidentiality by telling their parents, or by demanding parental consent, in fact discouraged young clients from returning (Wood & Jewkes, 2006).

A study conducted in Kenya and Zimbabwe on adolescents' preferences for reproductive health found that many young people reported feeling unwanted, meeting providers who were critical and treated them with disrespect (Erulkar *et al.*, 2005). A cross-sectional survey in Ethiopia which assessed adolescents' health service utilization patterns, their attitudes towards the existing health services and their preferences, also showed that the adolescents felt that the services were not acceptable to them and that the services were stigmatizing because of the location. Young people felt embarrassed to be seen at the youth specific services (Berhane, Berhane & Fantahun, 2005). Fear of being in a clinic waiting room with the possible stigma attached to sexual and reproductive health services discourages young people from visiting health services (Rickwood, Deane, Wilson & Ciarrochi, 2005).

Recognizing that determinants of an individual's health go beyond individual and household risk factors, recent studies have examined community and cultural influences on health outcomes (Shaw, 2009). A study with adults in Burkina Faso on perceptions of adolescents and sexual reproductive health problems showed that despite the adults supporting the need for reproductive and sexual health information, they did not accept young people accessing SRH services (Ouedraogo, Woog & Ouedraogo, 2007). Studies have also shown that in cultures in which social norms do not condone premarital sex, young people who are not married and experience sexual problems such as a genital ulcer or unplanned pregnancy will probably address the issue on their own. They may ask for help from trusted friends or siblings, or go to private clinics and access care from clinics that are far from their home (Tylee *et al.*, 2007).

A study on VCT in Zambia found that respondents who believed that their families would not be angry if they got tested were more likely to have tested for HIV (Denison *et al.*, 2006). On the other hand, the expected negative reactions of family and friends, and fear of HIV-related stigma prevented youth from utilizing the VCT services. Another study in South Africa on young people's attitudes to knowing their HIV status showed that young people were reluctant to go for an HIV test, fearing stigma and discrimination from their community. The youth also thought that they would not get support from the community if they tested positive for HIV (MacPhail, Pettifor, Moyo & Rees, 2009).

2.3 Modifying factors of health seeking behaviours

The four constructs of perception are modified by other variables such as gender, past experiences and education level. These are individual characteristics that influence a person's behaviour or perception (McCormick- Brown, 1999).

2.3.1 Gender norms

Gender is different from sex; it refers to the expectations and norms in society that are commonly shared, it is about "proper" male and female behaviour and roles (Crawford, 1995; Crawford & Unger, 2004). Gender is described as socially and culturally constructed and differentiates women from men and describes the way men and women relate to each other (Gupta, 2000; Nelson & Robinson, 2002). Research is increasingly showing that gender norms – which are

social expectations of fitting roles and behaviour for men (and boys) and women (and girls) – as well as the social reproduction of these norms in society and cultural practices are directly related a lot to men’s health-related behaviour (Izugbara, 2008). Gender norms have health implications for men, their partners, their families and their children (Cohen & Burger, 2000). Some of the male gender norms include ideas that men should take risks, endure pain, be tough or should have multiple sexual partners to prove that they are “real men” (Connell, 2003). The boys also seldom seek information at the public health services and they are more likely to deny being vulnerable than girls because often boys and men are expected to be sexually knowledgeable and experienced. This negatively prevents many men and young men from asking questions or seeking STI and HIV/AIDS services (Burns & Mahalik, 2007). In addition girls are generally more likely to pay attention to health-related issues and use health services than boys (Izugbara, 2008; Barker, 2007; Agampodi *et al.*, 2008).

Carternay (2000) also suggests that as a result of the gender ideology of invulnerability and emotional control, men and boys tend to keep away from and /or stigmatize actions that go against their reputation as tough, strong and confident people. These traditional expectations related to masculinity are often associated with behaviors that increase the risk of contracting STIs including HIV infection (Pan American Health Organization [PAHO], 2008; Barker & Ricardo, 2005). For instance, a study conducted in Malawi and Uganda with young males on the uptake of Voluntary Counseling and Testing (VCT) found that the main barrier to VCT uptake among male youth was male self-confidence. Male self-confidence is described as a masculine gender ideology which encourages and expects men and boys to carry themselves with self-belief and determination, even when the facts show otherwise (Izugbara *et al.*, 2009). In this study the commonly stated reason by responding male youth for not seeking VCT services was that they were sure that they were not infected, even though they admitted engaging in risk behaviour. On many occasions the young males interviewed instead argued that they risked becoming infected with HIV in the course of testing, with many of them claiming that they knew people who had been infected in a similar way. Being sure of their own negative HIV status, they considered going for HIV testing to be very risky. The study concludes that male youths were to a certain extent prevented from testing for HIV by the male ideology of invulnerability and emotional control (Izugbara *et al.*, 2009).

Other literature available on male adolescent health seeking behavior proposes that young males may not feel empowered enough to seek reproductive health services from female providers and that they may sometimes feel anxious and embarrassed when they rely on women for help (Kapphahn, Wilson & Klein, 1999; Burns & Mahalik, 2007). Further, for many young males, relying on female service providers tended to represent some kind of submission especially when the service requires them to go through uncomfortable or embarrassing medical procedures and confide in women for the issues affecting them. This was demonstrated in a study conducted in Nigeria with a sample of male youths: feelings of helplessness, resentment, powerlessness, and discomfort among the male youth receiving reproductive healthcare services from female providers were reported (Afangideh, Etuk & Akpabio, 2006).

In addition sexual reproductive health services are sometimes perceived as female spaces. In a study on boys' access to reproductive health services, it was demonstrated that boys tend to perceive reproductive health services as female spaces. This reported tendency for boys and young men to see reproductive health as a "female" concern means that even when specific youth services exist, the majority of clients who access them tend to be young females (Lindberg, Lewis-Spruill & Crownover, 2006). Another study conducted in Uganda also found that reproductive health services in primary health care clinics attracted more females than males (Horizons, 2004). This implies that more females than males access sexual and reproductive health services. To this effect researchers and WHO have called for more research on where, why and how adolescents seek help and the sources of and the context in which the help is sought and the kind of help available for them (Barker, 2007).

2.3.2 Past experience

The individual's previous experiences with health services also influence the decision as to whether to seek the service or not (Tylee *et al.*, 2007; Barker, 2007). This experience could either be positive, negative or neutral. Adolescents who have had bad experiences in seeking help may be unwilling to access and seek such help or services in the future (Barker, 2007; Atuyumbe, 2008). If and when young people seek help, they may not be happy with the service and would be determined not to go back, if possible (WHO, 2002). In a study on utilization of reproductive health services by secondary school adolescents in Mochudi in Botswana, Ngomi

(2008) found that many young people had not accessed the service when they needed to, because they had negative experiences with health workers. The health workers had turned them away and that staff were not friendly the last time they visited the health service. Similarly a study on provider's attitude and young people's needs and experiences in Zambia showed that adolescents preferred traditional healers and private health practitioners because such services were faster and more private and that in their past experiences at public clinics, they had been rebuked for being sexually active by health workers (Warenius, 2008).

2.3.3 Education level

Education is a key component of sustainable development and is conceivably one of the most important underlying determinants of health at both individual and community levels. Education decreases poverty through improved employment opportunities, and provides skills for attaining better health (WHO, 2007). Evidence available indicate that certain population groups – such as the poor and adolescents with less education are underserved by sexual reproductive health services (Gwatkins *et al.*, 2007).

2.4 Summary

This chapter discussed the literature framed within the Health Belief Model. Four components of the HBM were used as a guide. These are perceived threat which is comprised of two components- perceived susceptibility and perceived severity of a health condition. Literature showed that if the perceived susceptibility is not accurate, it may be a major barrier to preventing poor health outcomes such as STIs and, eventually HIV infection by young people. The health seeking behaviors were also determined by perceived benefits. In addition other barriers identified that hinder access to SRH services include negative community perceptions of adolescent reproductive health services, long waiting lines, overcrowding, adolescent embarrassment at being seen at such facilities, fear of incorrect treatment, fear that privacy and lack of confidentiality. Modifying factors discussed include various demographic, sociopsychological and structural factors that affect an individual's perceptions and hence ultimately influence health-related behavior (Polit & Beck, 2008). These include past experience, the gender norms and education levels. In relation to gender norms the literature showed that the masculinity constructs of boys tends to influence their health seeking behaviour in negative way,

with boys shunning the SRH services even when there is need to seek the service. In addition compared to girls the later are more likely than boys to pay attention to health related issues and access the services. Further, adolescent past experiences - either positive or negative - were a modifying factor in seeking the health services. Education levels were also another modifying factor discussed, with evidence showing that adolescents who are less educated are also less likely to access SRH services.



CHAPTER 3

METHODOLOGY

3.1 Aim of the study

This study aimed to explore young males' perceptions and use of sexual and reproductive health services (SRHS) in Chawama compound, Lusaka.

3.2 Objectives

The objectives of the study were:

1. To investigate young males' perceptions of sexual and reproductive health services offered in Chawama compound.
2. To describe young males' experiences regarding access and use of adolescent reproductive health services at Chawama clinic.
3. To explore young males' preferences with regard to reproductive health services.

3.3 Description of research setting

This study took place from October 2009 to August 2010 in Chawama compound. The compound is a peri-urban settlement, situated to the south east of the city centre of Lusaka, the capital city of Zambia. Lusaka city has the highest HIV prevalence in the country at 21 % (CSO *et al.*, 2009). According to the Zambia census of population conducted in 2001, Chawama compound had a population of 59,585. Young people aged between 15 and 24 years constituted 11 percent (6,554) of this population (CSO, 2002).

Chawama is one of the six peri-urban communities where sexual and reproductive health programs have been implemented by the Ministry of Health since 2003. The youth friendly services (YFS) are implemented through a youth friendly corner at Chawama clinic. Youth friendly SRH services include voluntary counseling and testing, distribution of condoms, and Information Education Communication (IEC) materials. Peer educators run the day to day activities of the youth friendly corner and are supervised by the nurse coordinator based at the clinic. Peer educators are youths aged between 15 and 24 years old who volunteer their time to

the youth friendly service corner. They are trained to reach out to other youths in the area of sexual and reproductive health including HIV prevention. The peer educators' tasks include counseling, conducting home visits, providing information on sexual and reproductive health during workshops and conducting one-on-one discussions with other young people. They also hold monthly meetings at the clinic to discuss various issues affecting the youth friendly corner. The nurse coordinator is a trained health worker assigned to offer technical support to the peer educators at the clinic. She/he works with the peer educators to plan activities designed to reach the youth with SRH services in the community.

3.4 Study design

A descriptive qualitative study design was used to investigate the perceptions and experiences of male adolescents regarding the available SRH services in Chawama compound, Lusaka, Zambia. This approach is most suitable to explore knowledge, perceptions and beliefs about health care (Pope & Mays, 1995). This type of approach allowed the researcher to explore and understand young male adolescents' perspectives regarding health seeking behaviours.

3.5 Study population

The study population comprised males aged from 13 -24 years residing in Chawama compound, Lusaka. The sample was drawn from the sub-population of adolescents who had previously accessed SRH services and adolescents who had not accessed any such services in the past. Participants who had not previously accessed the sexual reproductive health services were selected from four zones of Chawama. Two zones had a community school, the third zone had a youth friendly corner located at the local clinic and the fourth had a youth welfare centre. Eligible participants for the focus group discussions were male, aged between 13 – 24 years, and residing in the four zones of Chawama compound.

The key informants were volunteer peer educators at the youth friendly services for at least two years. Four had completed their secondary school education while the remaining two had completed college education. None of the peer educators were in any form of employment.

3.6 Sampling and recruitment of participants

3.6.1 Sampling and recruitment of focus group discussion participants

This study focused on relatively small samples purposefully selected because the researcher is concerned with information richness and not representation (Patton, 1990). The school principal of a community school and the youth welfare centre patron were contacted by the researcher to identify eligible participants for the study. The young males aged between 13 and 24 years living in Chawama were sampled based on whether they either had accessed sexual and reproductive health services or had not. In order to saturate the study sample more participants were identified through the peer educators from the youth friendly corner at Chawama clinic. The peer educators purposively identified youths that had previously attended the youth friendly -sexual and reproductive health services through door-to-door home visits as they knew where they resided. A total of 66 participants were enlisted for the study out of which 46 participated in the focus group discussions (FGDs).

3.6.2 Sampling and recruitment of key informants

To select the key informants, a meeting was held with the Sister-in-Charge at Chawama clinic. The Sister-in-Charge then referred the researcher to the youth friendly services nurse coordinator and the peer educator leader who helped in identifying the research participants. The peer educator leader was used to recruit other peer educators he worked with at the youth friendly corner. This method helped identify other peer educators who had previously worked as peer educators at the youth friendly service. Eligibility criteria for the key informants included having been trained in peer education, worked as peer educator for at least two years or more and representing at least one the four zones from which the FGDs participants were drawn. Six out of the 13 identified peer educators participated in the study.

3.6.3 Characteristics of sample

Forty-six (46) young males aged 13 -24 years participated in four focus group discussions. Thirty of these participants had not accessed any SRH services while 16 had previously utilized the services. Ten (10) participants were between 13 and 15 years of age; thirty six (36) between 16 and 24 years old. The mean age for the participants was 17 years.

The focus groups included in and out-of-school youths. Seventeen (17) participants had completed their secondary schooling; two had dropped out of school; and 27 were still in school.

All except two participants lived with a parent or guardian. The two in question lived by themselves. It was interesting to note that in many cases participants did not know exactly what form of employment their parents or guardians were in – these are indicated by responses in Tables 1-4.

Table 1: Focus Group 1. Older adolescents (16-24 year old)

| No | Age (in years) | In /out of school | Adults lived with | Occupation of parent |
|----|----------------|-------------------|-------------------|-------------------------------|
| 1. | 17 | In school | Father | Pastor |
| | | | Mother | Housewife |
| 2 | 18 | In school | Father | Engineer |
| | | | Mother | Employed |
| 3 | 19 | School leaver | Father | Pastor |
| | | | Mother | Housewife |
| 4 | 22 | School leaver | Older brother | Employed as a “Caterer” |
| | | | Sister-in law | Bakes cakes for sale |
| 5 | 17 | In school | Uncle | Retired |
| | | | Aunt | Housewife |
| 6 | 23 | School leaver | Friend | Runs bottle store with friend |
| 7 | 24 | School leaver | Friend | Runs bottle store with friend |
| 8 | 19 | School leaver | Father | Handyman |
| | | | Mother | Housewife |
| 9 | 17 | In school | Father | Employed |
| 10 | 18 | School leaver | Father | Unemployed |
| | | | Mother | Sells chicken pieces |
| 11 | 21 | School leaver | Mother | Employed |
| 12 | 22 | School leaver | Uncle | Not working due to illness |
| | | | Aunt | Housewife |

Table 2: Focus Group 2. Younger adolescents (13 -15 years old)

| No | Age (in years) | In school/out of school | Adults lived with | Occupation of parent |
|----|----------------|-------------------------|-------------------|----------------------|
| 1 | 15 | In school | Mother | Business woman |
| 2 | 13 | In school | Father | Businessman |
| | | | Mother | House wife |
| 3 | 14 | In school | Father | Not employed |
| | | | Mother | Business woman |
| 4 | 13 | In school | Father | Unemployed |
| | | | Mother | Business woman |
| 5 | 15 | In school | Father | Unemployed |
| | | | Mother | Business woman |
| 6 | 14 | In school | Father | Unemployed |
| | | | Mother | Business woman |
| 7 | 14 | In school | Father | Retired |
| | | | Mother | Business woman |
| 8 | 14 | In school | Father | Business man |
| | | | Mother | Housewife |
| 9 | 14 | In school | Father | Self employed |
| | | | Mother | Teacher |
| 10 | 13 | In school | Father | Employed |
| | | | Mother | Housewife |

Table 3: Focus Group Discussions 3 older adolescents (16-24 years old)

| No | Age (in years) | In school/out of school | Adults lived with | Occupation of parent |
|----|----------------|-------------------------|-------------------|----------------------|
| 1 | 17 | In school | Mother | Sell in market |
| | | | Father | Employed |
| 2 | 19 | In school | Father | Works as brick layer |
| | | | Mother | Business woman |
| 3 | 18 | In school | Father | Employed |
| | | | Mother | House wife |
| 4 | 16 | In school | Father | Does not work |
| | | | Mother | Business woman |
| 5 | 20 | School leaver | Father | Father died |
| | | | Mother | Business woman |
| 6 | 21 | School leaver | Father | Self employed |
| | | | Mother | Mother died |
| 7 | 24 | School leaver | Father | Employed |
| | | | Mother | Housewife |
| 8 | 18 | School leaver | Father | Un employed |
| | | | Mother | Housewife |
| 9 | 19 | School leaver | Father | Retired |
| 10 | 20 | School leaver | Mother | Business woman |
| 11 | 16 | In school | Father | Employed |
| 12 | 16 | School drop out | Father | Deceased |
| | | | Mother | Sells at the market |
| 13 | 16 | School drop out | Father | Self employed |
| | | | Mother | Housewife |

Table 4: Focus Group Discussion 4 older adolescents (15-24 years old)

| No | Age(in years) | In school/out of school | Adults lived with | Occupation of parent |
|----|----------------|-------------------------|-------------------|------------------------|
| 1 | 16 | In school | Father | Business man |
| | | | Mother | Maid |
| 2 | 23 | School leaver | Father | Formal employment |
| | | | Mother | Housewife |
| 3 | 24 | School leaver | Father | Teacher |
| | | | Mother | Housewife |
| 4 | 23 | School leaver | Father | Sells in liqueur store |
| | | | Mother | Housewife |
| 5 | 16 | In school | Father | Formal employment |
| | | | Mother | Housewife |
| 6 | 17 | In school | Father | Formal employment |
| | | | Mother | Sells at the market |
| 7 | 16 | In school | Father | Self employed |
| 8 | 16 | In school | Mother | Teacher |
| 9 | 17 | In school | Father | Unemployed |
| | | | Mother | Business woman |
| 10 | 18 | In school | Father | Un employed |
| | | | Mother | Housewife |
| 11 | 15 | In school | Father | Employed |
| | | | Mother | Housewife |

3.7. Data collection

Data was collected through four FGDs with the male adolescents and interviews held with the key informants. The first two FGDs and interviews with key informants were held from 18th December, 2008 to February, 2009. The last two FGDs and last interviews with key informants were held from August 2010 to September, 2010. The FGDs with younger participants aged between 13 -15 years was done separately from the older participants. This was to allow the participants to express themselves freely among their peers and to allow the researcher to look at whether or not results differentiate according to age.

The FGDs and interviews were guided by a topic guide (Appendix-3). The guide was developed based on the objectives of the study. The topic guide was designed in English but the discussion with participants was conducted in the local languages, Bemba or Nyanja, depending on which one the participants preferred. The topic guide comprised of open ended questions to help elicit detailed information on views and experiences that the participants had on the topic explored in the study. The researcher and the research assistant also probed and sought for clarifications where necessary, during the discussions. A research assistant, a lecturer experienced in qualitative research in the school of public health at the University of Zambia assisted the researcher in data collection and checked for consistency in the data that was collected.

The researcher used the FGDs with male adolescents and in-depth interviews with key informants with the expectation that this would yield rich information from which the perceptions and experiences of adolescent males regarding adolescent reproductive health services could be obtained.

Each focus group consisted of 10-13 participants with each discussion taking about two hours and 15 minutes. Each key informant interview took 30-40 minutes.

All the discussions were audiotape-recorded. The researcher also recorded the non-verbal responses and the group dynamics during discussions and for the purposes of debriefing after the sessions. At the end of the sessions the participants were provided with some refreshments.

Table 5: Details of Focus Group Discussions

| Focus group discussion | Characteristics of the focus group | Date of discussion |
|--|---|----------------------------------|
| 1 st Focus group discussion | Males aged 16-24 years who had never accessed any sexual and reproductive health services. | 18 th December, 2008 |
| 2 nd Focus group discussion | Males aged 16-24 years who had previously accessed reproductive health services or somehow had contact with the service | 19 th December, 2008 |
| 3 rd Focus group discussion | 16-24 years old males who had previously accessed sexual and reproductive health services and those that had not. | 14 th August, 2010 |
| 4 th Focus group discussion | 13- 15 year-old males who had never accessed any sexual and reproductive health services | 17 th September, 2010 |

3.8 Rigour

Rigour is the way of demonstrating the credibility, and integrity of the qualitative research process (Koch, 2006). Rigour was improved by paying attention to credibility, dependability (Auditability), transferability and conformability in the study.

Credibility refers to the truthfulness of the description of the phenomenon in question (Koch & Harrington, 1998). It addresses the issue of whether there is consistency between the participants' views and how the researcher has represented them. Descriptions of the male adolescents' views from all the group discussions were presented in the verbatim transcriptions.

When the discussions were completed, the research assistant experienced in qualitative data analysis from the University of Zambia rechecked the interpretation and analysis of the data. The list of codes and themes were sent to the researcher's supervisor to check for clarity and to ensure that the research protocol had been followed correctly.

Triangulation of data sources was used to validate the data. The emerging concepts were validated by conducting six individual interviews with peer educators representing the same

sample population as the focus group participants. The peer educators, who were regarded as key informants, verified the findings from the focus group discussion and provided variation to the analysis.

Dependability (Auditability) is an integral part of rigour which is achieved when the researcher leaves a clear decision trail regarding the study from the beginning to the end (Guba & Lincoln, 1985). This means that any reader or another researcher can follow the way events in the study unfold and understand their logic. Dependability was assured through documentation of the study's development and keeping records of the study process. The researcher kept records of study discussions through audio recording and the diary. Cross-checks with the participants to clarify the researcher's understanding of a particular response were done to ascertain if the responses were in line with the original thinking of the respondents. The topic guide was used to guide the discussions to give consistency in the data collection.

Transferability- the researcher is aware that the results of this study cannot be generalized but can be transferable to another similar context. Provision of background data to establish context of study and detailed description of phenomenon in question has been done to allow comparisons to be made.

Confirmability- The researcher's beliefs and assumptions were kept in the journal throughout the study. In-depth methodological description to allow integrity of research results to be scrutinized was done.

3.9 Data analysis

Tape recorded data were transcribed verbatim and analyzed manually. Thematic content analysis was done to achieve the objectives and bring out the main ideas of the study.

Preparing the Data

All the questions from the discussion guide, verbalizations and relevant observations during the discussions were transcribed based on the research questions. All the various accounts were gathered and written. The discussions and interview transcripts were printed with enough room for notes.

Developing Categories and a Coding Scheme

The researcher prepared definitions of five predetermined themes. These themes were set prior to the focus group discussion purposively to guide the researcher. The themes were categorized using the study objectives and the health belief model. The initial identified themes were health seeking behaviors, utilization of health services, barriers to utilization of SRHS, perceived susceptibility to STI including HIV, perceptions of the quality of health care, and enabling factors to utilization SRHS. Inductive qualitative content analysis was used in an effort to generate a detailed and systematic list of categories arising from the discussions (Miles & Huberman, 1994). The researcher reviewed all transcripts carefully, underlining all the text that appeared to describe each category. All the underlined text was coded accordingly using the predetermined themes wherever possible. The researcher did not, however, limit herself to the six guided themes; text that could not be coded into one of the categories was coded with another label to describe a different category relevant to the study. The researcher examined the data again for each category after coding, to determine whether sub-categories were needed for a theme. Data that could not be coded into one of the six themes were rechecked to describe a different category. The researcher explored and identified the relationships between categories including the emerging patterns of the data until saturation was reached where no more categories emerged. The data was then rechecked for consistency and reliability to ensure that no key categories were omitted.

The researcher's supervisor acted as an independent coder and was given the research objectives, categories and descriptions of each category that were developed. This improved the credibility and trustworthiness of the data.

3.10 Ethical considerations

Ethical clearance for the study was obtained from the University of the Western Cape and from the University of Zambia. Permission to carry out the study was granted by the MOH on the 8th December, 2008. The University of Zambia provided the clearance to conduct the study on 6th November, 2008. A letter of authorization from MOH was then taken to the Chawama clinic Sister-in-Charge in December, 2008. The study commenced in December, 2008.

Issues of reproductive health can be sensitive and as such confidentiality was maintained at all times. Participation in the study was voluntary and participants were given free choice to

participate in the study. The peer educator leader, the community school principal and the community welfare centre patron signed the confidentiality forms and visited the homes of all the young males to explain the nature and purpose of the study to participants and their guardians. During these home visits consent from the parents/guardians was obtained for participants younger than eighteen years of age. No names of the participants or the organizations that they are attached to have been used in the reporting of the findings.

Two meetings were held on two different dates with the participants prior to the focus group discussions. The aim of the meetings was for the researcher to further explain the nature of the study and to obtain consent from all the participants. The researcher explained the purpose of the study using the participant sheet to ensure that all participants understood the intention of the study. The consent form was then signed by all the participants and the researcher. This was also an opportunity to learn more about the participants.



CHAPTER 4

RESULTS

4.1 Study context

The study was conducted in Chawama, a peri-urban high-density area in Lusaka, the capital city of Zambia. Chawama is a poor township several kilometres south of the centre of Lusaka. The poverty levels are high and the area is densely populated with crammed houses of concrete block; the open drains filled with garbage; an excess of plastic rubbish littering the rare open space. Many people are unemployed or are in informal employment and many adults including young people spend their time heavy beer drinking, so the intoxicated are a common sight by late afternoon.

4.2 Presentation of categories

The themes were categorized according to the following categories:

Arising themes

- Health concerns of male adolescents,
- sources of information on sexual and reproductive health services,
- gender norms about sex and sexuality,

Initial identified themes

- health seeking behaviors,
- utilization of health services,
- barriers to utilization of SRHS,
- perceptions of the quality of health care, and
- perceived susceptibility to STI including HIV
- Enabling factors to utilization SRHS.

4.3 Health concerns of male adolescents

The study showed that male adolescents had numerous health concerns that needed them to use health services. These were centered on social and psychological aspects, relationship concerns, societal concerns, and sexual health problems including maturation. Other concerns were

related to substance abuse and lack of knowledge about the available sexual and reproductive health services.

4.3.1 Social and psychological concerns

During the discussion the male adolescents indicated that one of the most common problems faced by adolescent males was the lack of money. Those who indicated that they lacked money were both in and out of school. They said that they needed money to buy food and provide for current family responsibilities and for the future. The need to earn an income to support the family emerged as a major concern. This was most noticeable among the older adolescents who had either dropped out of school or had finished secondary schooling or college.

“For us now we have finished school and there are no jobs around. We do not have money to support families. Our parents no longer buy clothes for us. This is not good.”

(23 year-old FGD 1)

“The government should make more jobs for young people so that we are kept busy and can support ourselves.”

(21 year-old FGD 3)



The lack of clothes was a worry for some participants. They said that the lack of clothes affected their self-esteem. They felt that good self-image was important to receive positive approval from their peers. It was also a key factor in maintaining relationships with friends.

“It is important for us guys to look nice. I mean like nice “toggy” (clothes). It makes you feel nice when you are with your friends.”

(17 year-old FGD 2)

“When you do not have clothes, the girls run away from you and you cannot have a girlfriend and they think you cannot give them anything.”

(18 year-old FGD 3)

4.3.2 Relationship Concerns

The adolescents in this study were concerned about relationships with their peers, their parents and other adults. They feared sharing their problems with their peers especially problems related to sex and sexually related illnesses; because they thought that their secrets could be divulged to other people. In almost all the focus group discussions it emerged that the adolescents did not trust their parents and teachers when it came to reproductive health issues. They feared that they would be misunderstood and perceived to be engaging in premarital sex. They also complained about parents denying them to have girlfriends.

“You want to be in a relationship and your parents tell you that you can’t have a girlfriend, not allowing you to go out. Then you are confused.”

(17 year old -male FGD 1)

4.3.3 Societal concerns

During the discussions, some of the adolescents were concerned that exposure to pornography among young people had become a widespread problem. Pornographic movies were reported to be available in small community video outlets without restrictions. The participants mentioned that it was a common habit for young people to frequent these video outlets to watch these movies. They indicated that once young people started watching these movies it was difficult for them to stop. The participants perceived pornography as a contributing factor to young people engaging in premarital sex - as they often wanted to practice what they saw in the movies.

“In Chawama here there are a lot of blue movies (pornography) they show them everywhere and you only pay K1, 000 to see them.”¹

(17 year-old FGD 2)

“When you watch the blue movie you have an erection, then you want to practice with a girl.”

(15 year-old FGD 4)

¹ K1,000 is Equivalent to 25 US cents

4.3.4 Sexual and reproductive health problems

During the ensuing discussions it was evident that most of the participants had experienced SRH problems and required help or support. Participants affirmed that they knew of many other young people in their community who had SRH needs and equally required support. These needs related to puberty, masturbation, sexually transmitted illnesses (STIs) and HIV.

Masturbation was a big issue during the discussions. Although it was perceived to be wrong and against most religions in the community, most of the participants acknowledged that many adolescent males practiced it and were not sure if it was right or wrong. Misinformation flourished about masturbation, with some perceiving it as leading to health problems such as chronic back pains, infertility and sperms drying up.

“If you do ponyo- ponyo (masturbation) you get addicted to it and you cannot stop and then it will affect your backbone. Then you will not be able to produce children.”

(17 year-old FGD 1)

When asked about their thoughts concerning the practice, the majority of the participants stated that masturbation brought out feelings of pleasure and relief. At the same time they pointed out that the practice elicited feelings of guilt. The guilt was as a result of religious teachings that the practice was wrong and sinful. This worried the participants, as exemplified by a participant who asked:

“You may have a question about masturbation- is it sin or what?”

(19 year -old FGD 1)

4.3.4.1 Puberty concerns

Puberty concerns were mostly related to maturation. These were perceived to be more important to the adolescents than reproductive health issues such as prevention of pregnancy or having an STI. During the discussion all the participants were able to identify the major signs of puberty and maturation. These included breaking of the voice, growth of pubic hair, breakout of pimples on the face and enlargement of the penis. Despite knowledge of pubertal changes, some adolescents admitted that these changes created anxiety among them. Some of the adolescents

were embarrassed with changes occurring with their bodies such as the increase in the penile size. This feeling of embarrassment was more common among the younger participants between 13-15 years of age.

“When, the penis started growing bigger, I started hiding. I did not want the penis to show in my pants. I felt shy especially when I saw girls.”

(15 year-old FGD 2)

Spontaneous erections at inopportune times and night emissions were the other concerns especially among the younger males who had just attained puberty. They worried that these inopportune erections could cause them to be ill and did not know what to do to stop them from happening.

“I want know if wet dreams are good or bad. Other people say if you have wet dreams you slept with a witch in the night.”

(15 year-old FGD 2)

Other participants added that these spontaneous erections caused them discomfort and embarrassment. As a result they resorted to abating the erections through unsafe means.

“When I have an erection I feel so embarrassed I want it to go away, so I once tied the penis tightly with a rubber band.”

(14 year-old FGD 2)

“I tied ‘John’ (the penis) so hard that it got sore. I had to run to my brother who helped untie it. I will never do that again. It was so painful.”

(13 year-old FGD 2)

On the other hand, the discussions showed that puberty was a time of excitement for some adolescents. The pubertal changes were perceived to be indication of one finally growing up into a man—something they had fervently waited for. These changes prompted thoughts of engaging in sexual activities at a young age. It was apparent that the participants related reaching puberty to being old enough to have a girlfriend and perhaps engage in sexual intercourse.

“What I felt was that I started wanting to have a girlfriend at the age of 13. I even felt proud. I thought I had now grown up, that I was now mature and ready for a girl.”

(17-year-old FGD 1)

Lack of communication on issues related to puberty was also highlighted in the discussions. Most of the participants complained that society did not encourage them to talk about pubertal changes nor offered spaces for them to ask questions or seek information about these changes. They lamented the lack of knowledge on puberty and how it affects their development as males.

“You know we do not talk about these things. When they happen, they say you learn on your own, as you grow up. This is not good for us.”

(16 year-old FGD 3)

The key informants concurred with FGDs that young people have limited information about issues related to puberty. They indicated that challenges facing young people including puberty were rarely discussed with parents and that this made it difficult for the young people to make correct decisions on their reproductive health.

“Who do you consult when you experience certain things within your body for instance wet dreams?”

(Key informant #5)

4.4 Perceived susceptibility to STIs including HIV

Some narratives from participants acknowledged the susceptibility of young men to HIV and other STIs. Lack of knowledge about the available sexual and reproductive health services, non-use of condoms, peer pressure to engage in sex, cultural norms and practices were cited as some factors that contribute to making young men vulnerable to HIV and other STIs.

A cultural practice cited as making young males vulnerable to STIs including HIV was “Mukanda” a traditional rite of passage through which boys are prepared for adulthood. A prominent feature of Mukanda is the circumcision of boys. This practice occurs predominantly

among some tribes in the Northwestern and Western provinces of Zambia. This ceremony was perceived by some participants to be encouraging young males to engage in unprotected sex.

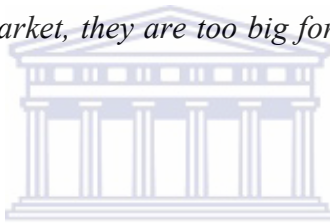
“After being initiated young people want to practice what they have learned; they think that they are now men.”

(24 year -old FGD 1)

The unavailability of condoms suitable for younger boys with regard to size was also cited as a factor that increases vulnerability to STIs. In the FGDs with younger males, some participants pointed out that they knew of their peers who engaged in unprotected sex because the available condoms were not suitable for their small penile size.

“These condoms they sell in the market, they are too big for small boys; they cannot fit so they do not use them.”

(15 year -old FGD 4)



Six participants believed that condoms did not protect against STIs as they perceived them not to be so strong. Some thought sex with condoms made the girls lose trust in them.

“If your wear a condom, the girl will think you have many girlfriends and then she will go to someone else.”

(21 year- old FGD 1)

Lack of condoms for older adolescents was not an issue as these condoms were readily available and affordable in the market stalls.

“Getting condoms is easy. They are sold at K500 (equivalent to 10 cents US dollars) for three, but no one wants to use them.”

(19 year- old FGD 3)

Although the participants acknowledged their susceptibility to HIV and STIs, the awareness of the severity of STIs seemed to be low among some. They only considered an STI as serious

when the STI did not heal using any alternative medicines sourced from elsewhere other than the local clinic.

“If one has a STI, you cannot die... it is part of growing up, but if it cannot be cured then you have problems but usually we get medicines and it’s gone.”

(17 year-old FGD 1)

Some participants perceived HIV to be more serious than other STIs such as gonorrhoea. This perception was related to the fact that HIV had no cure while STIs such as gonorrhoea were easily treated. For some young males contracting an STI was seen as a sign of virility.

“If you never had an STI or made a woman pregnant before then you are not a man.”

(21 year- old FGD 1)

“Here in Chawama young men don’t worry about the STIs because they say it makes you strong when you have an STI.”

(19 year -old FGD 3)



A few participants however regarded STIs as being serious. They spoke at length of the seriousness of syphilis. They spoke of how they could lose friends because they stink as result of the disease. Others thought STIs lead to death and hence needed to be treated. Despite the different perceptions on the severity of STIs, all the participants agreed that young men could reduce their susceptibility to STI including HIV if they protected themselves.

“If you abstain from sex then you will not get sick or get HIV, abstinence is just fine”

(16 year -old FGD 3)

“I know that when you abstain from sex you cannot get HIV”

(15 year- old FGD 2)

“I thought HIV was for big people only but I have seen even young boys and girls with HIV; that is scary but I know how it comes and I can make sure I don’t get the disease.”

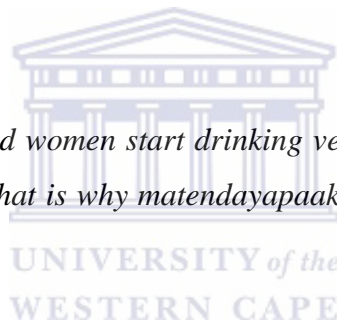
(13 year -old FGD 2)

4.5 Substance abuse

Discussions in the focus groups and interviews with the key informants showed that substance abuse was a common problem among their peers. Alcohol was reported as the most abused substance among young men in Chawama. The high alcohol use was attributed to the high number of bars in the community and lack of regulatory mechanisms restricting young people from accessing bars and other liquor outlets. In addition the participants thought that the lack of employment among young people was another contributing factor to the high levels of alcohol abuse among young people. In their own view, most young people abused drugs because they had nothing else to keep them occupied. The FGD participants added that SRH problems such as STIs were a consequence of substance abuse as most young people engaged in unprotected sex while under the influence.

“Here in Chawama young men and women start drinking very early because they have nothing to do. There are no jobs for us. That is why matendayapaakamaningi.” (The reason why there so many STIs).

(22 year-old FGD 3)



“You find that young girls and boys get so drunk and they forget to even use condoms.”

(19 year -old FGD 4)

“When you walk in Chawama around 16:00 hrs, you will see a lot young people drunk with alcohol. They have nothing to do, so they just drink beer the whole day.”

(Key informant #3)

4.6 Sources of information on sexual and reproductive health

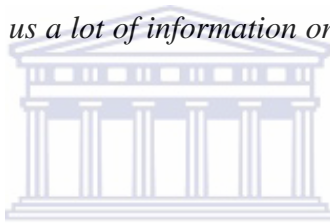
Sources of information for most participants were largely informal; relying more on their peers and the media for SRH information. The majority of participants in the FGDs and interviews with key informants indicated that the media was the major source of information on SRH followed by the Nongovernmental organizations (NGOs) that provided SRH services in the community. Information was also obtained through advertisements on the bill boards and streets walls in the community, television and books.

“Sometimes we do not trust some organizations, because they give different information e.g. on masturbation but a book or television will tell you everything.”

(18 year-old FGD 1)

“Magazines movies and songs give us a lot of information on these issues. You just read on your own and get stuff.”

(16 year-old FGD 3)



The participants also identified the school and teachers as key sources of information. The local health facility and the health workers were not identified as major sources of information. The in school participants indicated that sexual and reproductive health information was provided through lessons in the Science class. Anti-AIDS clubs and peer educators in schools were also cited as sources of information though mainly on HIV and AIDS.

Information obtained from the media was perceived and regarded as the most reliable of all.

“The young people in our community do not get information on sexual and reproductive health issues from the nurses at the clinic. They would rather listen to the radio or watch what’s being shown on TV.”

(Key informant #1)

4.7 Gender norms related to sex and sexuality

During the discussions the issue of specific norms related to masculinity emerged. The participants indicated that it was important for boys to engage in sex experience before marriage

compared to girls. Engaging in sexual activities was perceived by some participants as a way of demonstrating their virility as males, rather than achieving intimacy and connection. Sexual initiation was believed to confirm their identity as males. Engaging in sex to prove one's masculinity was also demonstrated through a male impregnating a girl.

“For us if you want a girl, you are thinking of sex for the girl it is different they think you love them.”

(21 year -old FGD 4)

“It is very important for boys to have children. Seventy percent of boys in this area have children.”

(22 year-old FGD 1)

The participants pointed out that in their community some parents gave boys more freedom than girls in that the former could do whatever they liked. The lack of parental restrictions for the boys compared to the girls seemed to be a societal norm. The participants indicated that this norm encouraged boys to engage in unsafe behaviours such as premarital sex and drug abuse.

“Parents are very strict with girls but for us guys they let us do what we want and come home at any time. We do what we want any time.”

(18 year -old FGD 3)

Peer pressure was also mentioned as a reason for young males engaging in sex before marriage. Some of the participants believed and thought that sexual initiation was an act of approval of their status in the male peer group.

“You get a girlfriend and sleep with her (meaning have sex with a girl) to show to your friends that you are a guy as well.”

(18 year- old FGD 3)

“If you do not have a girlfriend, your friends will laugh and think you are not man enough.”

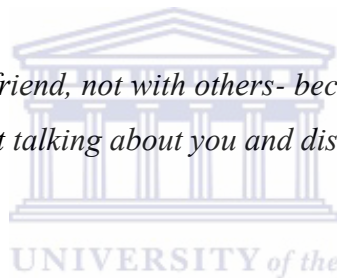
(17 year -old FGD 3)

4.8 Health seeking behaviors

During the discussions participants expressed a strong desire to talk to someone about their feelings and anxieties related to their general well-being including SRH issues. They however admitted that most of the time they had no one to confide in. Nearly all the participants agreed that friends were the first source of help for most of their health problems. Yet, despite friends being mentioned as first contacts for help, the participants emphasized that the contact was just useful for seeking advice for minor health problems and this usually did not extend to sexual health-related issues. For major problems such as STIs they hesitated to consult even their friends. The fear of being marginalized and mocked by their peers was the reason they did not openly talk about their problems. In addition, they feared that their secrets would be divulged to other people. They pointed out that the choice with regard to whom they consulted or sought advice from depended on the level of trust and confidence they had in that particular individual.

“You can maybe talk to your best friend, not with others- because we do not trust all our friends. When you are walking, people start talking about you and discriminating against you.”

(17 year-old FGD 3)



In discussing or seeking help from friends for sexually related health issues such as STIs, the male adolescents often referred to a fictitious person as having experienced the problem.

“We boys don’t talk specifically about our problems...we pretend to be speaking about someone else and listen to what others have to say about it. That way you get to get the answers for-ahh you don’t trust the other guys.”

(21 year-old FGD 1)

In-school participants indicated that they did not discuss SRH problems with teachers because they had no trust in them. They also never discussed matters related to sex with their parents especially the female parents because it was culturally inappropriate. The participants mentioned that the gender dimensions created a health seeking barrier as is the case when the service provider is an older female.

“You cannot talk to your mother about your sex problems; she will think you have no respect.”
(16 year-old FGD 3)

Some participants mentioned that they confided in other elderly adults such as grandparents and uncles. They were sure that these persons would keep their secrets. One boy narrated how a friend of his told his grandmother about a swelling he had on his testis and she later took him to a traditional healer for help.

“One of my friend’s private parts were swelling He told his grandmother who took him to the traditional healer. He was given medicine which cured him.”
(15 year -old FGD2)

Using self-medication was common among the adolescent males. Parents or guardians sometimes made the decision to use the self-medication but usually the decision was made by the adolescents themselves. This was often after consulting with their friends. Home remedies were mostly used for minor illnesses such as headaches, flu, and sometimes for the treatment of STIs.

“I first kept quiet, but when the sickness got worse, I told my mother that I was sick. I do not like the clinic. I first bought cafenol [a pain killer] for myself without telling anybody, but I did not get better. Then I told my mother and she took me to a clinic where I was given an injection.”
(18year-old FGD 1)

Other participants pointed out that males generally delay getting help for their health problems until the situation got worse.

“Generally us guys wait until the illness gets bad and then go and seek medical help.”
(23 year -old FGD 4)

“When one has a problem, he just sits and hopes that the problem will go away. Because that’s what guys do.”
(21 year -old FGD 3)

More often help was sought from chemists or drug stores and private clinics. These services were frequented to obtain condoms and buy off the counter medicines for treatment of STIs. The chemist and private clinics were usually perceived to be friendlier and confidential than the local government clinic.

“When you go to the chemist they will ask you no questions and provide the necessary information you want. At the clinic they will ask you a lot questions.”

(20 year -old FGD 3)

The assertion by in the FGDs on the preference of private clinics was confirmed by the key informants as can be seen from the statement below.

“They prefer private clinics what limits them is the money.”

(Key informant #2 and #5)

They key informants however added that the private clinics only offered drugs and did not offer any advice on sexual and reproductive health issues.

Traditional healers and herbalists were also frequently mentioned as sources of help for sexual and reproductive health problems such as swollen testicles and STIs. The traditional healers were believed to have the ability to treat any illness especially STIs successfully. In addition their terms of payment were negotiable, unlike the hospitals. The service was also sought for reasons of confidentiality and privacy.

A number of participants did not seek any kind of health care at all for their SRH problems for various reasons; some thought that the problem would go away on its own while others thought that they could manage on their own. Another commonly mentioned reason given by some responding male youth for not seeking SRH services was that they were sure they were fine and not sick. Some even thought that they were not infected with HIV, although some admitted to engaging in unprotected sex.

“Why should we go to the clinic when we are not sick we are ok, so there is no need?”
(18 year-old FGD 3)

“And sometimes when you go they will test you for some disease like HIV and then you find you are positive. So is better to not go.”
(16 year -old FGD 4)

Some of the adolescents kept their problems to themselves as they did not feel comfortable talking to anyone about their concerns and some did not simply know where to seek help.

“Us guys sometimes do not need a doctor or nurse . . . you know it is guy thing.”
(15 year- old FGD 2)

4.9 Utilization of health services

When participants were asked about the extent of utilization of the health services at the government local clinic, they had different views about their use of health services. Some stated that they only use the health service for curative care of medical ailments such as malaria, flu and cough. Others stated that they do not use the service at all as they felt that the service offered was not attractive or they had no need to visit the service.

“I only attend clinic when I have malaria.”(19 year- old -FGD 1)

“Yes we only go there when we are sick.” (16 year -old FGD 1)

“I never fall sick so I never attend the clinic.” (21 year- old FGD 3)

“There is nothing at the clinic that would make me go there.” (15 year-old FGD 2)

4.10 Barriers to accessing sexual and reproductive health services

Regarding the SRH services, participants highlighted many limiting factors to access and utilization of the service. These barriers include lack of knowledge about the available services, social norms, providers’ gender, and providers’ attitudes, lack of privacy and confidentiality and stigma.

4.10.1 Lack of knowledge about the available sexual and reproductive services

Knowledge about the available SRH services was very poor among the participants. Only three out of the 30 participants who had not previously accessed the service knew that they could seek SRH services such as condoms and STI treatment from the local government clinic. Despite some participants using the local clinic for other ailments, they were completely unaware of the availability of SRH services.

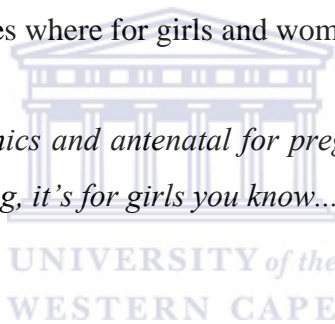
“Where I live no one knows about these services at the clinic including STI and youth friendly services; people just stay at home and think the problem will go away.”

(17 year-old FGD 1)

A few participants mentioned that they knew about the family planning and antenatal clinics, but were quick to add that these services were for girls and women only.

“You can find family planning clinics and antenatal for pregnant women at the clinic, we guys are not interested in family planning, it’s for girls you know...”

(17 year-old FGD 1)



The lack of knowledge about the available SRH services among some participants was to a certain extent related to the lack of understanding of what SRH services were. They did not seem to know what these services were.

“We do not know what those services are. We have never heard about them.”

(16 year old FGD 1)

Participants in the FGD were of the view that the local clinic did not provide sufficient information to the young people on available contraceptive and other preventive SRH services, such as information on the identification and prevention of STIs.

The peer educators who are key informants confirmed that many young people did not know about the youth friendly services offered at the local government clinic. They related this to the lack sensitization on the availability of the service and low motivation by the peer educators.

“The clinic here does not conduct outreach programs now to teach people about these services. The clinic says they have no money to do this.”

(Key informant # 1)

“Peer educators do not go out in the community to inform young people about the service because they do not get paid to go out and do these activities.”

(Key informant #6)

While participants were generally not aware of the availability of SRH service programs at the local clinic, a few had good knowledge of the location and supply of alternative SRH services such as the private clinics, traditional healers, private chemists and NGOs.

“We have private clinics; they sell condoms and treat STIs. You just go to the counter and get the condoms and medicines you want.”

(18 year-old FGD 1)



“Even the traditional healers are many here; they treat all sorts of illnesses including STIs.”

(17 year- old FGD 3)

The participants also mentioned that NGOs provided information on HIV and AIDS, mobile HIV counseling and testing and condoms distribution.

“When a mobile VCT comes many young people go there. It comes maybe twice a year”.

(17 year-old FGD 3)

During the discussion the participants indicated that lack of knowledge about the available SRH services led to the lack of information on SRH issues. This, in turn led to lack of action in addressing their SRH problems. The participants felt that SRH services could potentially help them resist peer pressure to engage in premarital sexual intercourse and consequently contracting STIs.

“Most of our friends do not know about the health risks and see no need to access the services.”

(14 year -old FGD 2)

“If we have this information then one can know how to protect one self.”

(16 year -old FGD 3)

4.10.2 Social norms about age

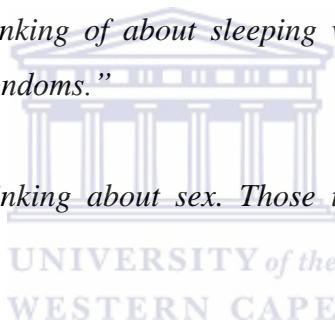
Most of the younger males perceived themselves to be too young to access SRH services. The participants indicated that their own prejudice regarding readiness to use the SRH services was a barrier that prevented them to access and utilize the services.

“Because we have not started thinking of about sleeping with girls (Meaning having sexual intercourse) we cannot go to get condoms.”

(14 year- old FGD 2)

“I think I’m too young to be thinking about sex. Those things are for adults and married people.”

(13 year old FGD 2)



On the other hand during the interviews the key informants indicated that age of the peer educators was a barrier in accessing the youth friendly service. They mentioned that some peer educators providing the service were too young to gain trust from other young people especially those slightly older than they were.

“When a peer educator is young the older guys will not take him seriously. People will also doubt us because we young.”

(Key informant #4)

4.10.3 Health care provider’s gender

During the discussion the providers’ gender seemed to play a significant role in the utilization of the SRH services. It was evident that almost all the participants were reluctant to approach female staff for reproductive health issues. They indicated that they would feel embarrassed to

express themselves freely to a female health provider. This was mostly related to prevailing cultural norms in Zambia where children are not allowed to talk to older parental figures especially those of the opposite sex about sex and sexual related issues. This cultural norm was perceived as a barrier to utilization of sexual and reproductive health care services.

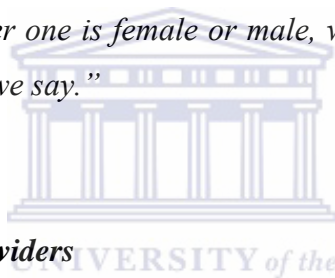
“We prefer males for STI treatment and counseling because we are all men and have the same thing.”

(23 year -old, FGD 3)

Six of the participants however felt that male staff would not make such big difference in terms of the level of utilization.

“For me it does not matter whether one is female or male, what matters is that they need to be nice to patients and listen to what we say.”

(18 year-old FGD 1)



4.10.4 Attitudes of health care providers

One of the frequently cited barriers to using SRH services was the health care providers' disapproving reactions and attitudes towards the young people seeking the service. Participants pointed out that health staff often told them that they were too young to get condoms and were often sent away without attending to their needs.

“Sometimes when you go to the clinic they look at you and feel that you are too young. They ask a lot of questions and say; Go and bring your parents.”

(16 year-old FGD 3)

The participants particularly felt that the nurses at the local clinic were unfriendly and at times reprimanded them for accessing SRH services. They complained that clinic staff were not available to listen and attend to their problems and they had negative attitudes towards young people.

One nurse reportedly said, *“Mwilachusha Kwati ninebo balupwalwenu.”* (*Do not trouble me. I’m not your relation*), to a participant who had gone to the clinic to seek help for malaria.

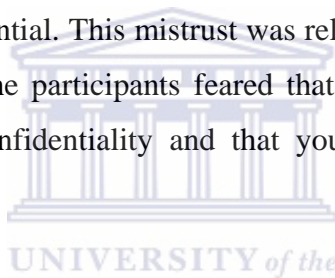
(18 year-old FGD 3)

“Yes. We don’t go to the clinic because of the bad attitude at the clinic; Bakachigumuleche, no panga Chinangu.” (*They should just breakdown the local clinic and build a completely new one with new staff*).

(16 year old-FGD 3)

4.10.5 Perceived lack of privacy and confidentiality

Lack of confidentiality and privacy were identified as limiting factors to accessing SRH services. Most of the participants said they distrusted that the information shared with health providers at the local clinic would be kept confidential. This mistrust was related to the feeling of being familiar with the health care providers. The participants feared that in such circumstances health care providers would not maintain confidentiality and that young people were less likely to be respected.



“If they see me at the clinic they will think I’m sick....I have STD or something. Then they will tell my parents and then it will be trouble at home.”

(15 year-old FGD 2)

“Like me if I got to the STI clinic and I know the nurse, they will tell my mother [All the participants agree with ‘Eeeeh’]. Then I will be in trouble, so I feel shy and I’m afraid to go. It is better I just stay or go to the chemist.”

(17 year old-FGD 3)

The participants also expressed fear of the possibility that adults who might know their parents would see them at the clinic and inform them that they had been seeking SRH services.

“At the clinic I can meet my uncle, who can come and ask me what I was doing at the clinic and there can be trouble at home.” (16 year-old FGD 1)

The participants further perceived the parents or other elders to be judgmental as they felt that adults looked at them in a disapproving and suspicious way when accessing SRHS together with them.

“If people see you going to the sexual and reproductive health services, say the youth friendly centre, it means you are engaging in sexual activities.”

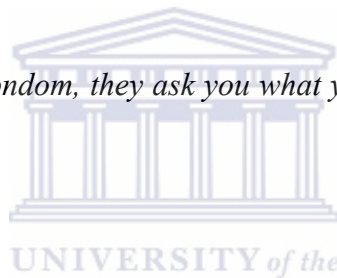
(18 year-old FGD 1)

“When you come to the clinic, adults (the health workers and the patients) judge you because we are in the same queue with them, e.g. when they see you collecting condoms they will murmur at you and say you are promiscuous.”

(20 year-old FGD 3)

“When an adult sees you with a condom, they ask you what you are doing with them. The adults will take condoms away from us.”

(15 year-old FGD 2)



Blame was also put on the parents for failure to discuss SRH issues with their children. Participants thought that silence on sex and sexuality contributed to the negative attitude by the community towards SRH health issues.

“Abakulu muma families (elders) are too religious. They don’t support the use of condoms. They need information and they need to talk to us about the sexual and reproductive health issues, not the way it is now: I cannot talk to my parents about my problems.”

(19 year-old FGD 1)

The study showed that young people often attached stigma to the SRH services especially the VCT services. It was disclosed that it was common for adolescents to be ridiculed by their peers when seen accessing the SRH services. The stigma attached with services created a barrier to accessing and utilization of the SRH services among young people.

“When friends know one has been to VCT, they laugh at you and think you are promiscuous.”
(15 year-old FGD 2)

“They will laugh at me if go to see the doctor for worrying about wet dreams. If my friends know about this I cannot go back to them.”
(18 year-old FGD 1)

4.11 Perceptions of health services

Adolescents were negative about the services provided at the local clinic. They felt that the services were inadequate and not adapted to meet the needs of young people. The adolescents that had previously visited the clinic had no positive experiences about their visit and perceived the service to be slow. They also felt that other organizations such as the NGOs could help them better than the clinic.

“The clinic here is not so helpful to us, the NGOs are better. They help you a lot.”
(14 year-old FGD 2)



4.11.1 Inadequate services

The participants believed that the services at the local clinic were inadequate. This was related to adolescents not seeing any benefits in utilizing the services because of the poor services at the clinic.

“Even when you go to the clinic, they will tell you there is no doctor or there is no medicine, so why go there to waste your time.”
(16 year-old FGD 1)

“It’s better you go somewhere they will help you such as the chemist. This clinic is finished.”
(18 year- old year FGD 3)

In addition they felt that there more services for girls than they were for boys at the local clinic.

“Girls have a lot of places with services such as antenatal, family planning and others. They also have family planning antenatal and special clinics specifically for them. For us boys, we have nothing; we have no place to go or people to discuss our problems with.”

(18year-old FGD1)

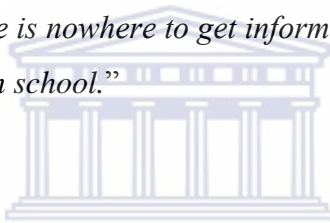
“They think boys are healthy, but we also have our own problems that are different from the girls. No one cares about boys, but we boys also have problems that we want to talk about”

(17 year-old FGD 3)

The out -of- school adolescents added that they did not have any safe spaces for sharing and discussing reproductive health issues in the community. They felt neglected.

“For us who are not in school there is nowhere to get information. At least our friends who go to school can get the information from school.”

(16 year -old FGD 3)



Participants who had previously visited the STI clinic or knew someone who had, pointed out that despite attending the clinic at no cost, the clinic lacked materials and medicines to effectively offer the needed service to young people. This made the service poor and costly.

“They say the clinic is free but you have to buy medicines from the chemists or private clinic. These medicines are expensive. So there is no need to go there.”

(22 year-old FGD 3)

In addition, the clinic policy of partner treatment for STIs discouraged the adolescents from seeking the needed service.

“Boys often feel embarrassed to go to the doctor. They tell you that you should bring your partner. So most of the times you do not want to tell. So you do not go back again”

(23 year-old FGD 3)

Only three participants thought that the clinic was the best place for treatment when one had an STI because it had skilled health personnel.

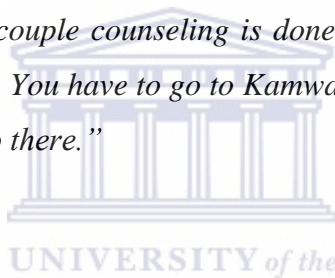
“You just go to the clinical officer and explain to say, ‘Walichaisha’ (Meaning you have an STI) and then he will give you an injection. When I had a problem I went to the clinical officer and he assisted me, he gave me an injection.”

(23 year-old, FGD 3)

The VCT service offered at the local clinic was perceived as being restricted to married couples only and this created a barrier to accessing it. The participants complained that adolescents in need of the service were referred to other clinics outside their community.

“I went for VCT. I was told only couple counseling is done at Chawama clinic. If you are not married they will not attend to you. You have to go to Kamwala clinic (another clinic in the city). It is too far. Many people do not go there.”

(23 year-old FGD 1)



Furthermore, some of the participants were skeptical of the authenticity of the HIV test results obtained at the clinic. They indicated that the HIV testing machines were faulty and usually resulted in false HIV positive results. This created doubt and mistrust in the service, resulting in young people not utilizing it.

“Some are discouraged by their friends from coming to the clinic because they are told that the machines will always bring out a positive result.”

(18 year-old FGD 1)

One participant however, who had accessed the VCT service offered at the clinic thought otherwise. He perceived the service to be reliable and confidential and that the health staff at the VCT centre were friendly. He visited the VCT service three years prior to the focus group discussion.

“When I went for VCT the nurse treated me well, and listened to me.”

(17 year-old FGD 1)

Although the services at the clinic were perceived to be generally inadequate, it was acknowledged by most participants that the clinic was the primary source of care and treatment especially for HIV and AIDS treatment in the community. Some participants thought that the ART service was the best and most convenient service compared to other services at the clinic. Availability of drugs and qualified health personnel were some of the factors cited that could make the service attractive. With regard to cost of the services, the participants indicated that this could not prevent anyone needing the service as the service was provided at no cost at all.

“Those at the ART clinic they work fast. They work with time and the people there are more qualified. They know how to work with people.”

(17 year-old FGD 1)

However, despite the perceived benefits of the ART clinic, some participants thought the location of the ART clinic was an impediment to access for some young people as the clinic was isolated from the services in the clinic. The location contributed to HIV and AIDS stigma and discrimination and discouraged young people from accessing the ART service freely.

“My brother fears to collect his medicine from the clinic because people laugh when they see you in the queue. My mother collects the medicines for him sometimes. He stayed at home without collecting his medicines for a long time. He became very sick and almost died.”

(15 year-old FGD 2)

4.11.2 Services perceived to be slow

The participants in the FGDs and interviews revealed that the service at the clinic was slow and was characterized by long queues. They indicated that they did not have the patience to wait in the long queues and this discouraged them from using the services. It was especially challenging when adolescents had to be in the same queue with adults who they perceived had their own prejudices about young people accessing the SRH services.

"The other thing is that of the queue. There are usually long queues at the clinic that can discourage one from going to the clinic."

(17 year-old FGD 1)

"There is corruption at the clinic, if you want to be seen quickly you have to pay the nurses, even the medicines that go to the clinic we do not see it. They just give you panadol."

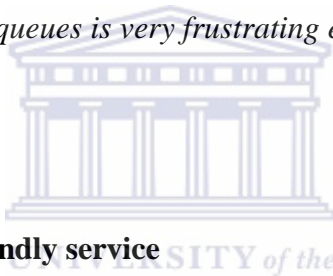
(19 year-old FGD 3)

"Its cumbersome, it takes very long for one to be treated hence this makes others give up."

(Key informant # 5)

"The time that people spend in the queues is very frustrating especially when you are very sick or just need condoms."

(Key informant# 4)



4.12 Perceptions of the youth friendly service

The SRH provided at the local clinic included counseling on STIs and HIV, distribution of condoms and health talks for boys and girls. These were provided through the STI clinic, VCT centre and YFS. Outreach services to the adolescents in the community were part of the service provided by the YFS. Most participants felt that despite the existence of the youth friendly service at the local clinic, it was more or less non-functional and not accessed by young people. During the 2010 interviews, the peer educators disclosed that the YFS had not been functional for almost four months. They indicated that the functionality of the YFS had not been consistent since 2005. This was attributed to various challenges including lack of donor funding specifically for the YFS, lack of materials to use, inadequate support of the service by Ministry of Health and lack of motivation by the peer educators. This contributed to a high turnover of peer educators.

"We need to identify more people here, and they should employ peer educators on permanent basis, because now many people have left. Things are not good here."

(Key informant # 3)

The participants who had previously accessed this service or knew about the service perceived it in a very negative way. Both interviews in 2008 and 2010 with the key informants indicated that the attendance rate for the service had dropped since 2005, adding that most of the clients were female seeking family planning services. And that even these were referred to the family planning clinic.

“We see an average of eight youths per day. The number has gone down to maybe one person per day or even no one comes”

(Key informant #1)

“Guys do not come here most of the times. They think that the YFS will not help them.”

(Key informant #2)

The barriers to SRH care for young men were inherent in the way such YFS was set up. It was revealed that YFS was not utilized by most young people because of factors such as poor accessibility, lack of environmentally friendly space, lack of service integration and lack of skilled staff.

4.12.1 Poor accessibility

The location of the YFS at the local clinic seems to be barrier to accessing the SRH care for young men. The participants indicated that despite the youth friendly service being located away from other departments, it was not utilized by many young people. According to them this was because the boys feared that if they were seen at the YFS they might be perceived to be HIV positive by their peers and the community members. Some perceived the YFS to be a place where HIV testing was done without consent on all young people. They added that the clinic environment was perceived as not being friendly to the young people.

The use of existing clinics to provide adolescent SRH services was not acceptable to most participants. They preferred the services to be located at a school or anywhere else in the community other than the clinic.

“The clinic is not a good place for us, we want services outside that place and many will come.”
(17 year-old FGD 3)

“The service should be moved to another place within Chawama because we feel this is the reason that most people have for not coming to the youth friendly corner.”
(Key informant # 3)

“Many of our age don’t know about the services and feel embarrassed that one will be exposed.”
(15 year-old FGD 2)

“I hear that when you to the clinic they will get your blood without your consent and test you for HIV. I do not want to be tested.”
(13 year-old FGD 2)

The poor accessibility of the youth friendly services was also related to the inconvenient opening hours.



“Apa pa clinic bavalangatiyakwana 16 hours (This clinic closes at 4 pm) after 16 hours ati just emergencies. Uchokaku school ulina problem kulibekoyenda (You come from school with a problem but you have nowhere to go.”
(16 year- old FGD 3)

“People get discouraged because whenever they come here they find the place is locked.”
(Key informant # 4)

4.12.2 Lack of Environmentally friendly space

Interviews with the key informants indicated that the youth friendly service space was not environmentally friendly to the youth; it lacked décor that was attractive to young people.

“This place looks dull. There is nothing here, no pictures, and no materials to attract the youth, there are just boxes with clinic stuff.” (Key informant# 3)

“Look at this place. Look at these items in this room. It has become a storeroom and we do not have space to use to discuss our issues anymore. So we have stopped coming”

(Key informant #1)

4.12.3 Lack of service integration

The adolescents who had previously accessed YFS at the local clinic complained that the service was not a one ‘stop shop’ for all the services. Interviews with key informants also supported this notion. They indicated that if one had an STI, he would have to first explain to the peer educators who would then in turn refer him/her to the nurse. They would explain the same problem repeatedly before the nurse would finally refer them to the STI clinic for treatment. The participants felt that this was a lengthy process that discouraged many young people from accessing the service.

“If you come to the youth friendly and you have an STI, they will ask you questions and not do anything about it. Then they send you somewhere and there another person who will ask the same questions... it is embarrassing to say the same thing over and over again.”

(16 year-old FGD 3)

The participants also revealed that they saw no benefit in accessing the services just for information which they could easily obtain elsewhere.

“Why come here just for information. We can get this information from the TV and radio.”

(17 year-old FGD 3)

“Here at the youth friendly centre we only give information, for the other things such as STI treatment, HIV testing, one goes to the specific clinic.” (Key informant # 3)

4.12.4 Lack of skilled personnel

The participants complained that the YFS at the local clinic lacked qualified health staff to support the service. They pointed out that despite a nurse being allocated to support the YFS, she was not available to offer the needed service. Conducting educational activities by the health staff was mentioned by the key informants as part of the youth friendly service. However, at the time of collecting data, no educational activities including community outreaches had been done for over a year.

“Things are not good here anymore. We have no support from the DHMT (District Health Management Team) to run the program and as such the program has gone down.”

(Key informant# 2)

The lack of health staff was attributed to the shortage of human resources at the clinic. Others cited the lack of financial support to the YFS which discouraged qualified staff to work there.

4.12.5 Perceptions of the peer educators

In this study the peer educators at the Chawama YFS were perceived negatively by most participants and as such adolescents perceived no benefit in seeking help from them. The peer educators at the YFS were perceived as bad role models who lacked adequate knowledge and skill to address the needs of other youths. Some of the peer educators were accused of engaging in risky behaviours such as drug abuse and having multiple sexual partners. Peer educators were thought to be disrespectful, unfriendly, judgmental and unsympathetic to other young people's needs. This negative perception about the peer educators by their fellow youths resulted in loss of trust in the peer educators and ultimately the service they provided. The loss of trust was an impediment to accessing the sexual and reproductive health service at the local clinic by the adolescents.

“These peer educators cannot teach me anything. They are not good role models, they drink beer in the compound and that is a bad example for children.”

(21 year-old FGD 1)

“Those peer educators they do the same things that they tell you not to do, how can you trust them?”

(16 year-old FGD 3)

This poor perception was known to the peer educators themselves as indicated in the statement below.

“Some of my friends think I’m wasting time being a peer educator and they do not trust us. Because of this; some have even stooped being peer educators.”

(Key informant # 2)

“People have a bad impression about us peer educators.”

(Key informant #5)

4.13 Enabling factors to utilization of sexual and reproductive health services

Although there were more limiting factors to accessing the SRH services than enabling ones, participants highlighted factors that would enhance their access and use of the services.

4.13.1 Awareness raising

All the participants in the FDG and key informants were of the view that the available SRH services in the community especially those at the local clinic needed to be more publicized. The sensitization of the community by all stakeholders on the available services for young people was considered as critical to the utilization of the adolescent SRH services. The media, which include radio, television, posters and magazines, was thought to be an effective way of disseminating information to the community on various issues including the availability of reproductive health services.

“Give us the information and provide us with services so that we can manage our problems.”

(17 year-old FGD 1)

“Advertising the services for the youth friendly service through the posters and leaflets will inform the people about the service.”

(Key informant # 2)

The participants also expressed the need to educate parents on adolescents' sexual reproductive health issues.

“The parents need information so that they can talk to us about our issues freely and openly.”

(18 year-old FGD 1)

4.13.2 Provision of special clinics for young people

The FGDs participants and the key informants perceived an ideal service to be one that includes STI diagnosis and treatment, HIV testing and supplying of condoms and counseling on the sexual and reproductive health issues. Routine care such as physical check-ups and general wellness services was thought to be an important aspect of the services. Furthermore an integrated service with laboratory and pharmacy services was cited as one that could encourage young people to seek the services. The participants expected the services to be equipped with relevant materials and equipment to inform and meet young people's reproductive health needs.

“If you have everything in one place, it would help the youths do everything immediately rather than coming back again after the visit and most likely not coming back again.”

(17 year-old FGD 1)

“The services are not okay they need to be in one place. They need to be in one place.”

(Key informant # 3)

Convenient opening times were critical to the utilization of the SRH services. The participants indicated that the availability of a 24 hour service, which one could access with no appointment, was an enabling factor to accessing the service. In addition affordable, fast services that are not shared with adults were perceived to be attractive to the adolescent males.

“The clinic takes time... too many people there; we want our clinic to be private with young people only.”

(16 year-old FGD 1)

Participants in both the FGD and interviews described the aesthetics of an inviting atmosphere, which was important to them. They indicated that the SRH services should have time just for fun so that young people could be motivated and attracted to access the service. They added that a youth friendly ambiance should be created by making the rooms more attractive with posters on the walls that are appealing to the youth. They also expressed the desire to have something to entertain them such as television, games and music while they wait.

“We want stuff like video games to keep us entertained not just talking about AIDS all the time.”
(18 year-old FGD 3)

“Yes this place need to be renovated, so that it looks attractive and it will boost our morale to come and work.”
(Key informant # 4)



4.13.3 Need for skilled health care providers

Being knowledgeable and sensitive to their needs were key characteristics identified by the participants for staff working at SRH services for young people. From their perspective warm, caring, friendly staff with a good attitude and without prejudices about sex and sexuality could encourage them to seek the service. Trained health personnel who are consistent and permanently stationed at the respective youth clinics to provide the services were considered as an enabling factor. The participants desired well-informed staff to give information on sexual and reproduction health. A regular healthcare provider who was always available to attend to the young people was considered as a key to building trust and confidentiality.

“We need trained doctors or nurses with adequate knowledge to diagnose and treat our problems.”
(22 year-old FGD 1)

“Doctors are good. We use them even at private clinics, so it is okay to have doctors as long as they can help.”

(17 year-old FGD 1)

Although the key informants supported the need for health worker who was consistent, they emphasized on the importance of updated training for the peer educators on sexual reproductive issues.

“We need to be trained, some of us are not even trained, and how we can tell others about reproductive health. Maybe they know more than us.”

(Key Informant# 3)

The participants in the FGD also added that young doctors were the most preferred to take care of their needs. They also voiced a definite need for counselors to help them with psychological needs. Finally the adolescents expressed gratitude for having been availed the opportunity to participate in the study. They indicated that the study gave them an opportunity to share their sexual and reproductive health concerns. They pointed out that they often lacked someone to talk to on issues of reproductive health and wished that such meetings became a permanent feature. They requested the results of the study and the researcher pledged to make the report available to them.

4.14 Summary

The findings from this study demonstrate that male adolescents had sexual and reproductive health issues that required them to access and utilize the SRH services. The major concerns for them were anxieties caused by pubertal changes, masturbation, STIs and HIV. A lot of myths and misconceptions surrounded puberty and the changes taking place in their bodies. Most of the participants did not know how to deal effectively with these concerns and they largely had nowhere to turn to for support. Most of the participants feared sharing their concerns with their friends, parents and teachers. There were a lot of factors influencing adolescents’ access and utilization of sexual and reproductive health services. These include perceived norms, lack of knowledge on the availability of adolescent SRH services, poor attitude of the health providers,

gender norms, lack of privacy and confidentiality. Negative perceptions of the available clinic based health services were common. According to the participants, the desired adolescent SRH services were those that had skilled staff were friendly, confidential, accessible, less time consuming, and non judgmental. According to the participants, integrated services offered outside the clinic in addition to eliminating the mentioned barriers would increase utilization of SRH services by young males.



CHAPTER 5

DISCUSSION

5.1 Introduction

The study set out to explore young males' perceptions and use of SRH services in Chawama compound, Lusaka in Zambia. This chapter discusses the findings on adolescents' sexual and reproductive health concerns, perceptions about STIs and HIV, young males' health seeking behaviours and barriers related to seeking the available sexual and reproductive health services. The chapter also discusses their perceptions about available SRH services and enabling factors in accessing the service.

5.2 Health needs and concerns

The period of adolescence creates a lot of anxiety among adults as well as adolescents themselves because of the challenges and risks that young people face as they experience sexual maturation (WHO, 2006). Evidence from around the world suggests that although adolescents are generally perceived to be healthy individuals, they face numerous reproductive health challenges (Agampodi *et al.*, 2008; Bankole *et al.*, 2007; WHO, 2006; Spronk, 2005; Dehne & Reidner, 2005). The current study established that male adolescents had SRH concerns that required the use of SRH services. The young people's needs included social and behavioral concerns, interpersonal concerns and sexual and reproductive health concerns. The adolescents longed to talk to someone about these concerns but many did not know where and how to seek help. This finding concurs with a previous study (Lindberg *et al.*, 2006) which shows that although male adolescents had sexual and reproductive health problems, they did not know how to deal with these.

The study showed that the puberty concerns faced by adolescents in the current study were related to sexual maturation. Despite the adolescents identifying the signs of puberty they did not seem to understand the challenges and implications related to sexual maturation. The lack of understanding of developmental changes during puberty was a major unmet need, especially among participants in the younger age group (13-16 years). Despite this need the majority of adolescents did not access any sexual and reproductive health services. Information and

education on puberty, maturation and developmental process in relation to adolescent sexuality is key throughout the period of adolescence.

Interpersonal concerns were related to relationships with peers and parents. There seemed to be a lack of trust among peers as most did not feel comfortable to confide in one another on sexual issues. The distrust was most related to the silence and social stigma attached to sex and sexuality, which is mainly the result of cultural norms that do not allow sexual issues to be discussed freely. In addition there was a lot of negative attitude towards parents and other adults including teachers in the community. This might imply lack of parent and child connectedness which could be related to cultural barriers as well as a sign of the weakening family environment. Studies have found that parent child connectedness reduces adolescent risk taking behavior (DeVore & Ginsburg, 2005).

In this study masturbation was one of the major sexual and reproductive health issue discussed among the young people. The questions posed by the young males on masturbation showed that the adolescents were experiencing a dilemma in balancing their moral views and their sexual feelings. The misinformation about masturbation also indicates the silence around sexuality in conversations between adolescents and adults; which could result in negative consequences for the young people. Other studies have shown that in settings where sexuality is such a big moral issue young people are sexually active despite being morally prohibited; usually resulting in negative consequences such as unplanned fatherhood and STIs (Klingberg- Alvin *et al.*, 2007).

5.3 Male adolescent's health seeking behaviors

Male adolescents' health seeking behaviors in this study in Zambia were to some extent similar to other developing countries such as Ghana, Burkina Faso, Malawi, Uganda and Sri Lanka (Amuyunzu-Nyamongo *et al.*, 2005; Biddlecom *et al.*, 2007; Agampodi *et al.*, 2008), but some differences do exist. While some studies have shown that adolescents sought help for sexual and reproductive health problems from friends and family (Kumi-Kyereme, Asare & Biddlecom, 2007; Neema *et al.*, 2007), the findings of this study suggest that many adolescents seldom sought help for their sexual health concerns from peers, parents or teachers. Fears about marginalization and stigmatization were some of the factors that inhibited help-seeking. Home

remedies were common measures undertaken for sexual and reproductive health problems. The use of home remedies for STIs is common and has been highlighted in many other studies (Dehne & Reidner, 2005; Mmari *et al.*, 2010). Seeking advice from informal sources such as the chemist, pharmacies and traditional healers was common among the adolescents. Studies have shown that men who seek treatment for STI were more likely to access informal sources such as the traditional healers; whereas women sought treatment from formal settings such as government clinics (Mmari *et al.*, 2010).

The study also found that some of the adolescents opted to ignore any sexual and reproductive health problem and hoped that the problem would go away. Others ignored seeking care when the problem was perceived not to be serious. The perceived seriousness of the problem seemed to have an effect on the decision-making process of seeking care.

The findings of this study also suggest that despite male adolescents seeking help for illnesses such as malaria and cough at the local clinic, the majority did not often seek both sexual and reproductive preventive and curative services at the public clinic. Despite the established sexual and reproductive health needs and the availability of STI and VCT services at the local clinic, these services were underutilized. The tendency not to utilize the preventive SRH services such as condoms and family planning services at the local clinic was found to be a salient feature in this study. Poor seeking of SRH services by adolescents at the public health clinic was linked to social stigma, failures in the health systems, norms and lack of information about the service (Dehne & Reidner, 2005; Amuyunzu-Nyamongo *et al.*, 2005; Erulkar *et al.*, 2005). Other factors influencing access and use of SRH services included knowledge about sexual reproductive health issues including STIs, incorrect perceptions about the severity of illness, gender attitudes, perceived norms and providers' characteristics.

5.3.1 Lack of knowledge on the available services

From this study it's clear that some male adolescents in Chawama compound did not know the facilities that offered SRH services in the community. The majority did not know of any SRH services were offered at the local clinic. The lack of adequate knowledge on the available services created a huge challenge to adolescents accessing and utilizing the services. This lack

of knowledge made male adolescents feel disempowered to seek the required SRH services. Other studies have also shown that in order for young people to access the service they need to have knowledge about the existence of such services. For instance, Biddlecom *et al.* (2007) showed that sexually-active young people did not use contraception or seek treatment for an STI because of lack of knowledge of where to obtain methods of contraception or STI treatment. The lack of knowledge on existing services as a limiting factor to access of SRH services has also been demonstrated in other studies around the world (Dehne & Reidner, 2005; Amunyunzu-Nyamongo *et al.*, 2005).

The lack of knowledge among the male adolescents in the current study was mainly related to the fact that there had not been a lot of publicity by the government and various stakeholders on the need and availability of the services.

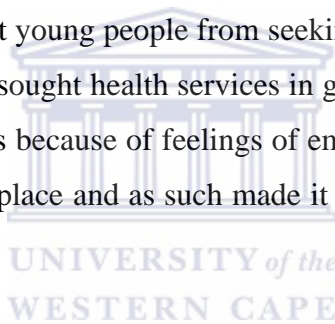
5.3.2 Lack of knowledge on STIs and other sexual and reproductive health issues

The study showed that knowledge about SRH issues including STIs was a key limiting factor to using the SRH services. Other studies have also demonstrated this (Mmari *et al.*, 2010; Biddlecom *et al.*, 2007).

This study also showed that male adolescents were more aware about HIV than they were about other STIs. They did not know the consequences of STIs such as gonorrhoea and syphilis. The adolescents also perceived HIV to be more serious than gonorrhoea or syphilis. There was also poor recognition of the increased risks of contracting HIV when one had an STI. This incorrect perception about the seriousness of STIs could be related to poor knowledge about STIs. This could also be attributed to the fact that since the 1990s, HIV has received a lot funding and support compared to other STIs (National AIDS Council, 2009). The low levels of knowledge and poor perception of STIs did not seem to help the adolescents make decisions to promptly seek care for the illness. This is in line with other studies on health seeking behaviours that have shown that adolescents tend to delay treatment because of the lack of perceived seriousness of the symptoms (Biddlecom *et al.*, 2007; Kibombo *et al.*, 2007). In a study examining barriers to SRH services for young males, Lindberg *et al.* (2006) also observed that male adolescents perceived themselves not to be vulnerable to illness or not at risk and as a result sought health services only as a last resort.

5.3.3 Social and cultural norms

The results from the present study show that one of the most common barriers for young people to obtaining STI treatment, contraceptives or information for sexual and reproductive is social stigma (fear and shyness). Social stigma attached to service use may explain why the male adolescents' needs are not being met fully. The social stigma seemed to arise from within self, from the community and from the health facility. This self stigma was also related to the apparent personal beliefs male adolescents had related to culture and the social taboo about sex and sexuality. These beliefs resulted in questioning whether one was old enough to seek the SRH services or not. The adolescents also feared that health workers and community members who knew them might inform their parents/guardians that they had been to the STI and VCT services at the local clinic. Biddlecom *et al.* (2006) also highlight similar barriers related to the social context of help seeking that prevent young people from seeking SRHS. Kamau (2006) also noted that adolescent males in particular sought health services in groups or resorted to self medication if they have sexual health problems because of feelings of embarrassment. The male adolescents perceived the clinic to be a public place and as such made it difficult for the adolescents to have the privacy they needed.



5.3.4 Social norms about age

The result of the study clearly showed the differences in the way the younger males and older perceived issues related to sexual and reproductive health. The lack of knowledge on sexual and reproductive health issues such as puberty was more prominent in the younger males than their older counterparts aged 15 years and above. The study showed that some adolescents did not seek the services because they thought they were too young to do so. This perceived sense of being young could result from perceptions that the service provider or the parents would regard them to be too young to access the SRH services. This belief could eminent from the cultural beliefs and practice that whoever is accessing the SRHS is sexually active. This is supported by findings of this study has been supported by Oware-Gyekye (2005), who indicates that some of the reasons why adolescents do not use sexual health services is that society more often than not glare at those adolescents who use sexual reproductive health services. Parental ignorance and neglect about adolescent health also contributed to feeling of being young and the ignorance on

the reproductive health issues and availability of the service. In addition parents did not encourage to their children to talk about sex or sexuality nor did they encourage them to access sexual and reproductive health services. This is supported by a study Kibombo *et al.* 2008 who indicates that lack parent support did to help the adolescents.

5.3.5 Perceptions of available health services

The use of public health institutions has been previously known as a good strategy for adolescent reproductive health (WHO, 2006). To the contrary; this study noted that the use of clinics for adolescent health care seems to have challenges in providing the needed care considering the reported negative attitudes of the adolescents. The criteria set by WHO (2002) for adolescent friendly services are that the service should be accessible, acceptable and appropriate for adolescents. The findings of the current study reveal that in the participants' opinions these indicators of adolescent friendly services were not present. Adolescents perceived the services as inadequate and lacking confidentiality.

5.3.5.1 Inadequate services

Participants in this study believed that the services at the local clinic were lacking or inadequate, conceptually this was related to their perceived benefits as the male adolescents did not see any benefits in going to the clinic. This perception could be as a result of the unavailability of medicines and other supplies at the clinic and the lack of qualified staff (WHO, 2002). Studies have shown that people are more likely to conform with health advice when they believe that these actions will be helpful in preventing, detecting or treating disease and consequently reducing the threat to them (Ross, 2001). The perceived benefits for the young males seemed to be more related to the availability of quality services of services than the type of service offered. The HIV test results were perceived to be unreliable and hence the adolescent did not perceive any benefits in accessing the service.

The information received from the peer educators at the YFS was not trusted and was considered inappropriate to the adolescents. This was related to the perception by adolescents that the peer educators were less qualified with poor knowledge levels about SRH issues. This may lead to adolescents not paying particular attention to health-related and help-related information because

they do not trust the source which they saw as unreliable or not helpful. This is in line with a study by Izugbara *et al.* (2009) that showed that young people may not access the services if they felt the service would not benefit them in any way.

5.3.5.2 Lack of privacy and confidentiality

The narratives in this study showed that the male adolescents regarded the SRH service at the local clinic as neither confidential nor helpful and hence did not access the service. The lack of privacy and confidentiality in this study was related to the fact the all SRH services were located in clinic premises and that young people were mixed with adults when accessing services such as STI treatment. The lack of privacy and confidentiality was also exacerbated by the familiarity that existed between the health provider and the adults/parents of adolescents. This familiarity implied that the health providers might not keep the information shared confidential. Studies have shown that adolescents do not seek professional care because they perceive the service to be non-confidential and that the public facilities might not have the necessary materials and support they need (Lindberg *et al.*, 2006; Biddlecom *et al.*, 2007). Other studies have also shown the value that young people place on privacy and confidentiality when seeking information on sexual and reproductive health issues (Biddlecom *et al.*, 2007; Agampodi *et al.*, 2008).

5.3.5.3 Poor perception of peer educators

Findings from previous studies indicate that the peer education strategy provides important sources of information and is shown to be more effective in improving knowledge among adolescents than for instance information and communication materials (Joyce *et al.*, 2008). The use of peer educators as service providers for SRH at youth friendly services have been thought to improve service utilization by young people (African Youth Alliance, 2007). In this study the involvement of peer educators in running the SRH programmes was not regarded highly by the male adolescents contrary to what is universally thought. Most participants perceived the peer educators negatively. They regarded them as poor role models who had low levels of knowledge and were thus not in a position to address the young people's needs. The narrow range of knowledge among peer educators could be a limiting factor to their effectiveness and ultimately to the utilization of the service by their peers whom they are supposed to serve. This could result

in poor SRH outcomes for adolescents. Other studies have observed that peer educators need to be properly trained to deliver education (Mason-Jason, Matthews & Flisher, 2011).

The study also found that age of the peer educator was a key factor determining access to the SRHS services by young men. There seemed to be no clear guidelines as to who the peer educator should target in their work as indicated from the narratives where older males were reluctant to seek services from the younger peer educators. The definition of peer support seems not to be clearly understood. Setting standards in peer education is key to the success of the program. Research has identified that a set of standards, criteria, guidelines or good practices can contribute towards making a peer education programme effective (Adamchak, 2006).

Despite the adolescent citing negative attitudes by some health workers, some participants preferred that the SRH services be provided by a consistent qualified professional than a peer educator. In this regard some of the adolescents perceived the health workers to be more knowledgeable than the peer educators. Studies elsewhere have also shown similar findings to those in the current study that young people are eager to get information from and looked up to health professionals as a reliable source and more knowledgeable source of information on issues of sex and sexuality (Amunyunzu + Nyamongo *et al.*, 2005). Therefore providing a consistent trained health care staff to provide and support reproductive health services in a youth friendly environment could be key to influencing utilization of adolescent sexual and reproductive health services. However the challenge for the implementation of such a programme would be to find a consistent qualified health staff in the health environment where health workers are already in short supply.

5.3.6 Gender norms

Research increasingly shows that gender norms – which are social expectations of fitting roles and behaviour for men (and boys) and women (and girls) – as well as the social reproduction of these norms in society and cultural practices are directly related to men's health-related behavior (Gupta, 2000). These traditional expectations related to masculinity are often associated with behaviors that increase the risk of contracting STIs including HIV infection (PAHO, 2008). This study found that accessing SRH services seemed to contradict the male adolescent's sense of

invincibility and courage. The narratives found that some of adolescents thought access and use of the SRH services might mean admitting that they are weak. This could be related to tendencies by males to prove their masculine identities (Barker & Ricardo, 2005) which make them likely to deny being vulnerable (Izugbara, 2008; Agampodi *et al.*, 2008). The study by Izugbara (2008), also showed that the young males were more likely to disclose their physical problems than their emotion problems. Based on this perspective, this poor helping seeking behaviour could result in poor health care and outcomes among adolescent males.

5.4 Preferences of sexual and reproductive health services

Regarding the preferences of the SRH services, an interesting finding of this study is that consensus was not reached on the preferences of adolescents on places of services, and provider type which reflect their diversity. However a considerable proportion of adolescents preferred to access services outside the clinic and their community in order to overcome the stigma attached to the SRH service. Some preferred the services to be in school while a few preferred the service to remain at the clinic. Despite the difference in preferences all wanted confidential, friendly, non-judgmental and skilled services. Hence, the implication is that there is a need to address the diversity of adolescents and using all available options and strategies to provide adolescents with the services suitable for them (Berhane *et al.*, 2005).

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

Despite participating male adolescents' recognized sexual and reproductive health needs, they did not access the available SRH services. The adolescents faced numerous barriers in accessing the service and perceived the health services provided at the local clinic negatively. Lack of knowledge on available services, confidentiality and quality of care remains a major concern. According to male adolescents' perceptions about the accessibility and acceptability of the health services, the current health services delivery system is not suitable and appropriate when it comes to sexual and reproductive health. This signifies that the system needs to consider the specific needs of adolescent males and develop services that are acceptable, appropriate and friendly.

6.2 Study Limitations

It was encouraging to note that the adolescents were open to talk about sexual and reproductive health matters. However there were limitations to be accounted for. Using focus group discussion for disclosing personnel experiences had its own challenges. The participants did not use personnel accounts and experiences in describing experiences in seeking treatment for sexual reproductive health issues especially the STIs. The participants frequently used the third person in stating the experiences related to STI health seeking and often one member of the group would speak on behalf of the rest of the participants. Such statements closed the personnel experiences of seeking care for STIs. To address this challenge the sample could have been broadened by including one on one interviews with respondents selected from the STI clinic.

The second limitation was that the sample was only confined and limited to one community; it would have been helpful and good to have other views from other communities especially the surrounding communities where adolescent SRH services are being implemented. In addition it would have been helpful to get a perspective of rural adolescent males on the study topic. The sample could not however be expanded due to time and budget constraints.

My positionality in this research was important. Being older and of different gender could have created a distance between me and my participants and prevented the young men from speaking freely. However having previously worked in this community made it easy for me to interact with participants. In addition before the study took place I met with all the research participants to explain and prepare them for the study. This offered an opportunity to create the needed rapport for the study.

Although it was noted that there were other important adolescent sexual reproductive health service providers in the community, it was not possible to investigate these services with the available time and resources.

6.3 Recommendations

Adolescent sexual reproductive health is not only a public health issue but it is a key policy issue. This study has shown knowledge, cultural, interpersonal, societal and institutional barriers that need to be seriously addressed to enhance male adolescents' access and utilization of sexual and reproductive health services. In the light of the poor perception of the current SRH service, it is important that the SRH services conform to being youth friendly in line with WHO (2001) set standards. In addition, it calls for all the relevant stakeholders to provide a supportive environment for young people to access the service when they need it.

The following specific recommendations can be considered to improve service delivery of adolescent SRH services aimed at increasing access and utilization for male adolescents.

1) Information on reproductive health and services

All young people including young males need correct and up to date information on sexual and reproductive health. They need information on puberty, maturation, human development, STIs and HIV prevention. They need information on the available social and health services that meet their needs and at the same time make them feel safer. The information needs to be relevant to the situations of the adolescent males and also needs to be reliable, trust worthy and user-friendly.

Using the schools and other learning environment such as community centers can help to make accurate and adequate sexuality information accessible to adolescents. It is important for young

males benefiting from sexual and reproductive health educational programs to learn and become aware of how male prejudices can be a reason for their negative attitudes toward health services. A comprehensive adolescent sexual reproductive health education program needs to be developed. This program must have adequate information on maturation, growth and development. In addition the program should have information on relating with peers, parents and all critical areas that are sensitive to young people such as – gender, cultural and social norms and other issues that affect the sexual and reproductive health of young men.

Adolescents should be sensitized and encouraged to seek sexual and reproductive health services even when they have not been exposed to any sexually transmitted illnesses. The Ministry of Health needs to collaborate with all the relevant stakeholders to disseminate messages on the available services using the mass media, Information, Education and Communication materials and workshops for young people.

2) Engendering the reproductive health services for young people

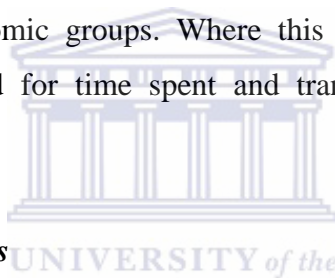
There is need to engender adolescent sexual and reproductive health services in Zambia. The service provision should acknowledge the fact that girls and boys have different sexual and reproductive health needs and should be targeted as such. Programs targeting boys should consider their social- cultural limitations relating to sexual issues. The services should address the various sexual reproductive health issues affecting the boys. The service should have both health promotion and curative services. Services such as STI screening and treatment, family planning and VCT should be integrated and provided as one service. If the public health clinics are not acceptable to adolescent males, it may be useful to develop male only clinics or designate areas where the male adolescent can be cared for by male doctors or nurses or task shifting to another trained cadre specifically for sexual and reproductive health.

3) Improving the quality of health service delivery

Training and equipping health providers with current knowledge and practices in reproductive health can help provide the much needed service to the many underserved young people. The government should allocate enough resources to develop and equip the current youth friendly services with Information, Education and Communication materials that are suitable for the users

if they are to be utilized. Printed materials should contain images of young men as role models to increase access and use.

If peer educators are to be used in providing peer to peer services then a more comprehensive training is needed for peer educators to embrace new and emerging issues and reflect greater diversity in the issues affecting young people. It also calls for greater accountability by peer educators in the way they work while at the same time urging peer education supervisors (the health workers) to be better involved in peer education work at the health facility and in the community. The peer educators need to be motivated through material gain, direct or indirect. This need calls for change in strategies to cope with the changing spirit of volunteerism in order to sustain peer education activities. In addition government should continuously train peer educators with the aim of increasing the number of trained adolescents in the community; drawn from their own social and economic groups. Where this approach is not realistic the peer educators should be compensated for time spent and transport where necessary should be considered.



4) *Involvement of all stakeholders*

The government and various stakeholders, especially NGOs in adolescent SRH services should be strengthened to scale up the services to reach more male adolescents. The government should support all health providers to provide adolescent SRH both within the health facilities and outside the health facilities to set up in wherever places adolescent males frequent.

The government needs to provide materials and financial support to NGOs and other informal alternative sources which provide adolescent SRH services to young people for increased service coverage and private space. Training on reproductive health issues and IEC materials including pamphlets and commodities supplies needs to be provided to these organizations.

5) *Enhancing participation of young males in the sexual and reproductive health*

Evidence of behaviour change in program areas including sexual and reproductive health, HIV prevention, treatment, care and support has been demonstrated when men and boys and engaged (WHO, 2007). In addition it is important to recognize that adolescents can play an important role

in their own health. Role models in the community can be identified whom young men can look up to for support.

Adolescent males should be involved in the design, planning and implementations of their own sexual and reproductive health programs. Programs for adolescents should be developed with them and not for them.

6.4 Implications for future research

This study has attended to an important public health issue by focusing on male sexual and reproductive health. It has contributed important information that can help narrow the gap about the perceptions on access and utilization perceptions of adolescent males in Zambia in an urban setting. However more research needs to be done to get more insight into the adolescent male's health behaviors and perceptions in regard to sexual and reproductive issues, their beliefs as men, social and gender norms. Further qualitative and quantitative studies need to be done in the following areas:

- 1) The research needs to focus on how to encourage change in the behaviors and social norms of young males in respect to access and use of reproductive health services. The behaviour change will ultimately contribute to positive behaviors that benefit both male and females.
- 2) A follow up study is also recommended to compare the use and non-use of reproductive health services among boys and girls.
- 3) Some follow up research to be conducted in order to have a more comprehensive view of the impact of peer education on sexual and reproductive health in Zambia.
- 4) It is recommended that complementary follow up investigations should include a review of the quality of services provided by the alternative providers in relation to access and use by the male adolescents.

REFERENCES

Adamchak, S. (2006). *Youth Peer Education in Reproductive Health and HIV/AIDS: Progress Process and Programming for the Future*. Family Health International Arlington, Virginia.

Afangideh, S., Etuk, A., and Akapabio, M.A. (2006). Gender uptake of reproductive health services in Nigeria: A study of male university students. *Nigerian Journal of Social and Health Sciences Issues*, 3:17- 24.

Agampodi, S.B., Agampodi, T.C., and Piyaseeli, U.K.D. (2008). Adolescent's perception of reproductive health care services in Sri Lanka. *Biomedical Central Health Services Research*, 8: 98. [Online], Available: <http://www.biomedicalcentral.com/1472-6963/8/98>. [12/10/2009, 15.00PM]

African Youth Alliance. (2007). *Improving health, improving lives*. End of Programme Report. New York: PATH, Pathfinder, and United Nations for Population Action.

Amuyunzu-Nyamongo, M., Biddlecom, A.E., Ouedraogo, C., and Woog, V. (2005). *Qualitative evidence on adolescents' views on sexual and reproductive health in Sub Sahara Africa*. Occasional Report. New York: The Alan Guttmacher Institute: 16.

Bankole, A., Biddlecom, A., Guiella, G., Singh, S., and Zulu, E. (2007). Sexual behaviour, knowledge and information sources of young people in four sub-Saharan African countries. *Africa Journal of Reproductive Health*, 11 (3):28-43.

Barker, G. (2007). *Adolescents, social support and help seeking behaviour. An international literature review and programme consultation with recommendations for action*. Geneva: World Health Organization.

Barker, G., Olukoya, G.A., and Aggleton, P. (2005). Young people, social support and help seeking. *International Journal of Adolescent Medical Health*, 17: 315–336.

Barker, G. and Ricardo, C. (2005). *Young men and the construction of masculinity in Sub-Saharan Africa: Implications for HIV/AIDS, conflict, and violence social development papers*. Conflict prevention & reconstruction paper: 26.

Bearinger, L.H., Sieving, R.E., Ferguson, J., and Sharma, V. (2007). Global perspectives on the sexual and reproductive health of adolescents: Patterns, prevention and potential. *Lancet*, 369, 1220-1231.

Becker, M.H. (1978). The health belief model and personnel health behaviour. *Health Education Monographs*, 2(4), 324- 508.

Berhane, F., Berhane, Y., and Fantahun, M. (2005). Adolescents' health service utilization pattern and preferences: Consultation for reproductive health problems and mental stress are less likely. *Ethiopian Journal of Health Development*, 19(1): 29 -36.

Biddlecom, A.E., Munthali, A., Singh, S., and Woog, V. (2007). Adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda. *African Journal on Reproductive Health*, 11(3):99-110.

Brink, M.I. (2006). *Fundamentals of Research Methodology for Health Professionals*. Cape Town: Juta and Company.

Brink, P.J and Wood, M.J. (1998). 2nd Edition -*Advanced design in nursing research*. London: Sage.

Burns, N. and Groove, S.K. (2001). *The practice of nursing research: Conduct critique and utilization*. 4th edition. Philadelphia: W.B Saunders.

Burns, S.M. and Mahalik, J.R. (2007). Understanding how masculine gender scripts may contribute to men's adjustment following treatment for prostate cancer. *American Journal of Men's Health*, 1:250-261.

Butler, J. T. (1994). *Principles of health education and health promotion*. Colorado: Morton Company.

Boonstra, D. H. (2007). Young people need help in preventing pregnancy and HIV: How will the world respond? *Guttmacher Policy Review*, 10(3):2-7.

Butler, P.A. (2003). *The reproductive health situation of adolescents*. Progress in Reproductive Research, 64.

Cartenay, W.H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine*, 50(10): 1385–1401.

Central Statistical Office (CSO) [Zambia]. (2002) *Highlights of 2000 Census Indicators*. Lusaka, Zambia: CSO.

Central Statistical Office (CSO) [Zambia], Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC), University of Zambia and Macro International Inclusion. (2007). *Zambia demographic and health survey 2007*. Calverton, Maryland, USA: CSO and Macro International Inclusion.

Central Statistical Office (CSO) [Zambia], Ministry of Health (MOH), University of Zambia and MEASURE Evaluation. (2010). *Zambia sexual behaviour survey 2009*. Lusaka, Zambia: CSO and MEASURE Evaluation.

Cohen, S. and Burger, M. (2000). *Partnering: A new approach to sexual and reproductive health*. New York: United Nations Population Fund.

Connell, R.W. (2003). Masculinities, change, and conflict in global society: Thinking about the future of men's studies. *Journal of Men's Studies*, 11(3):249.

Crawford, M. (1995). *Talking difference: on gender and language*. London: Sage.

Crawford, M. and Unger, R. (2004). *Women and gender: a feminist psychology* (4). Boston: McGraw Hill.

Dahlbäck, E., Makelele, P., Yamba, C. B., Bergström, S., and Ransjö-Arvidson, A.B. (2006). *Zambian male adolescents' perceptions about premarital sexual relationships*. *African Journal of AIDS Research*, 5(3): 257–264.

Dehne, K. L. and Riedner, G. (2005). *Sexually transmitted infections among adolescents: The need for adequate health services*. Geneva: World Health Organization.

Denison, J.A., Lungu, N., Dunnett-Dagg, W.A., McCauley, A. and Michael, D. S. (2006). *Social relationships and adolescents' HIV counseling and testing decisions in Zambia*. Horizons Research Summary. Washington, DC: Population Council.

DeVore, E.R. and Ginsburg, K.R. (2005). The protective effects of good parenting on adolescents. *Current Opinion in Pediatrics*: 17 (4), 460–465.

Erulkar, A.S., Onoka, C.J., and Phiri, A. (2005). What is youth friendly? Adolescents' preferences for reproductive health services in Kenya and Zimbabwe. *African Journal of Reproductive Health*, 9: 51-58

Family Health International. (2008). *Reaching young men with reproductive health programmes* [In FOCUS series]. Research Triangle Park, North Carolina. [Online], Available: <http://www.fhi.org/en/Youth/YouthNet/Publications/FOCUS/InFOCUS/youngmen.htm> [13/08/09, 10:45 AM]

Fisher, J.D. and Fisher, W.A. (2000). Theoretical approaches to individual – level change in HIV-risk. In Peterson, J. L. and Diclemente, R. J, (eds.) *Handbook of HIV Prevention*. New York: Plenum press: 3-56.

Glanz, K., Rimer., B.K., and Lewis, F.M. (2002). *Health behaviour and health education, theory research and practice*. New Jersey, USA: John Wiley & Sons, Inclusion.

Gwatkins, D.K., Rutstein, S., Johnson, K., Suliman, E., Wagstaff, A., and Amouzou, A. (2007). *Socio-economic differences in health, nutrition, and population within developing countries*. Country Reports on Health, Nutrition and Population, and Poverty. Washington, DC: The World Bank.

Gupta, G.R. (2000). *Gender, sexuality, and HIV/AIDS: The what, the why, and the how*. Plenary address XIIIth International AIDS Conference. Durban, South Africa.

Haller, D.M., Sanci, L.A., Patton, G.C., and Sawyer, S.M. (2007). Toward youth friendly services: A survey of young people in primary care. *Journal of General Internal Medicine*, 22(6):775–781.

Hill, Y.L, and Biro, F.M. (2009) Adolescents and sexually transmitted infections. Sexually transmitted infections in adolescents. *Clinical Challenge*. [Online], Available: <http://www.hawaii.edu/hivandaids/> [13/08/ 09, 10:45 AM]

Horizons Program (2004). *Equitable access to HIV counselling and testing services for youth in developing countries: A review of current practice*. Washington: Population Council.

Izugbara, C.O. (2008). Masculinity scripts and abstinence-related beliefs of rural Nigerian male youth. *Journal of Sex Research*, 45: 262–276.

Izugbara, C.O., Undie, C., Mudege, N.N., and Ezeh, A.C. (2009). Male youth and voluntary counseling and HIV-testing: The case of Malawi and Uganda. *Sex Education*, 9 (3): 243–259.

Joyce, S., Askew, I., Diagne, A. F., Diop, N., and Evelia, H. (2008). *Multisectoral youth RH interventions: The scale-up process in Kenya and Senegal*. FRONTIERS Program Brief No. 13. Washington, DC: Population Council.

Kamau, W. A. (2006). *Factors influencing access and utilization of preventive health services by adolescents in Kenya: A case study of Murang'a district. PhD Thesis*. Bielefeld: University of Bielefeld, German Academic Exchange Service (DAAD).

Kapphahn, C.J., Wilson, K.M., and Klein, J.D. (1999). Adolescent girls' and boys' preferences for provider gender and confidentiality in health care: A survey of knowledge, perceptions and attitudes among school students. *Journal of Adolescent Health*, 25(12):131- 142.

Kibombo, R., Neema, S., and Ahmed, F.H. (2007). Perceptions of risk to HIV infection among adolescents in Uganda: Are they related to sexual behaviour? *African Journal on Reproductive Health*, 11(3):168-181.

Klingberg-Alvin, M., Van Tam, V., Nga, N.T., Ransjo-Avidson, A.B. and Johansson, A. (2007). Ethics of justice and ethics of care. Values and attitudes among midwifery students on adolescent sexuality and abortion in Vietnam and their implications for midwifery education: a survey by questionnaire and interview. *International Journal of Nursing Studies*, 44 (1):37-46.

Koch, T. (2006). Establishing rigour in qualitative research: The decision trail. *Journal of Advanced Nursing*, 53: 91–100.

Koch, T. and Harrington, A. (1998). Re-conceptualizing rigour: The case for reflexivity. *Journal of Advanced Nursing*, 28(4).882-92.

Kumi-Kyereme, A., Awusabo-Asare, K., and Biddlecom, A. (2007). *Adolescents' sexual and reproductive health: Qualitative evidence from Ghana*. New York: Guttmacher Institute: 30.

Lincoln, S. and Guba, E.G. (1985). *Naturalistic enquiry*. Beverly Hills, CA: Sage

Lindberg, C., Lewis-Spruill, C., and Crownover, R. (2006). Barriers to sexual and reproductive healthcare: Urban male adolescents speak out. *Issues of Comprehensive Pediatric Nursing*, 29(2): 73-78.

MacKian, S. (2001). *A review of health seeking behaviour: Problems and prospects*. Internal concept paper. Health Systems Development Programme. London: School of Hygiene and Tropical Medicine.

MacPhail, C., Pettifor, A., Moyo, W., and Rees, H. (2009). Factors associated with HIV testing among sexually active South African youth aged 15-24 years. *AIDS Care*, 23(4):456-67.

Manlove, J., Terry-Humen, E., Kramullah, E., and Holcombe, E. (2008). *Sexual and reproductive health behaviors among teen and young adult men: A descriptive Portrait*. Washington, DC: Child Trends Research Brief.

Mason-Jason, A.J., Matthews, C., and Flisher, A.J. (2011) 'Can Peer Education Make a Difference? Evaluation of a South African Adolescent Peer Education Program to Promote Sexual and Reproductive Health.' *AIDS and Behavior* 15:8.

McIntyre, P. (2002). *Adolescent Friendly Services: An agenda for change*. Geneva: World Health Organization.

Mikhail, B.I. (1981). Principles of health belief model: A review and critical evaluation of the model research and practice. *Advanced nursing science*, 4(1):65-82.

Mikhail, B.I. (2001). Transcultural adaptation: Health belief model scales. *Journal of Nursing Scholarships*, 33(2):159-165.

Mmari, K. N., Oseni, O., and Fatusi, O.A. (2010). STI Treatment-Seeking behaviors among youth in Nigeria: Are there gender differences? *International Perspectives on Sexual and Reproductive Health*, 36(2): 72-79.

Miles, M.B and Huberman, M.A. (1994). *An expanded source book: Qualitative data analysis*. New York: Sage.

Ministry of Health. (2005). *National Health Strategic Plan 2005 2010*. Lusaka, Zambia: Ministry of Health.

National AIDS Council. (2008). *Multisectoral AIDS response monitoring and evaluation biannual report*. Lusaka, Zambia: Ministry of Health.

National Aids Council. (2009). *Joint mid-term review of the National AIDS strategic framework 2006–2010*. Lusaka, Government of the Republic of Zambia.

Neema, S., Moore, A.M., and Kibombo, R. (2007). *Adolescents' sexual and reproductive health: Qualitative evidence of experiences from Uganda*. Occasional Report. New York: Guttmacher Institute. No .31.

Nelson, A. and Robinson, B.W (2002). *Gender in Canada* (2nd Edition). Toronto: Prentice Hall.

Ngomi, B.C. (2008). *Utilization of sexual and reproductive health services by secondary school adolescents in Mochudi*. Submitted as partial fulfillment of the requirements of a master's degree in health studies. University of South Africa.

Ouedraogo, C., Woog, V., and Ouedraogo, O. (2007). *Les adultesfaces aux comportements des adollescsntes difficultes etenjeux*. Occasional report No. 32. New York: Guttmacher Institute.

Oware-Gyekye, F. (2005). Knowledge and practices of reproductive health issues among second cycle institution in the Greater Accra Metropolitan Area GAMA, Ghana. [Online], Available: <http://ww.combaceph.org> . [12/11/2010, 10:30 AM]

Pan American Health Organization. (2008). *Regional strategy for improving adolescent and youth health*. Presented in the 48th Directing Council, Washington, DC. [CD48/8 (Eng.)].

Patton, M. (1990). *Qualitative evaluation and research methods*. Beverly Hills, CA: Sage.

Patton, G.C., Coffey, C., Sawyer, S.M., Russell, M .V., Haller, D.G., Bose, K., Vos, T., Ferguson, J., and Mathers, C.D. (2009). Global patterns of mortality in young people: a systematic analysis of population health data. *The Lancet*: 374(9693): 881-892.

Polit, D. F. and Beck, C. T. (2008). *Nursing research: generating and assessing evidence for nursing practice* (8). Philadelphia Pa: Lippincott Williams &Wilkins.

Pope, C. and Mays, N. (1995). Qualitative research: In the name of(Eds), reaching the parts other methods cannot reach: An introduction to qualitative methods in health services research. *British Medical Journal*, 311: 42-45.

Rickwood, D., Deane, F.P., Wilson, C.J., and Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health*, 4(3): 1-34.

Rickwood, D., Deane, F.P., and Wilson, C.J. (2007). When and how do young people seek professional help for mental health problems? *Medical Journal of Australia*. 2007; 187(suppl): 35–39. [Online], Available: [\[PubMed\]](#)[12/11/2009, 7:30 AM]

Robin, L., Dittus, P., Whitaker, D., Crosby, R., Ethier, K., Mezoff, J., Miller, K., and Pappas-Deluca, K. (2003). Behavioral interventions to reduce incidence of HIV, STI and pregnancy: A decade in review. *Journal of Adolescent Health*, 34(1):3-26.

Ross, J.E. (2001). Developing a new model for cross-cultural research: synthesizing the health belief model and theory of reasoned action. *Advances in Nursing Science*, 23(4):9-15.

Shaikh, B.T. (2008).Understanding social determinants of health seeking behaviours, providing a rational framework for health policy and systems development. *Journal of Pakistan Medical Association*, 58(1):33–36. [Online], Available: [\[Medline\]](#)[12/10/2009, 18.00PM]

Shaw, D. (2009). Access to sexual and reproductive health for young people: bridging the disconnect between rights and reality. *International journal of gynecology and obstetrics*, 106: 132-136.

Shawn, M. (2010). *A view of sexual and reproductive health through the equity lens*. Department of Reproductive Health and Research. Geneva, Switzerland: WHO.

Spronk, B. (2005). Female sexuality in Nairobi: Flawed or favoured? *Culture, Health & Sexuality*, 7: 267-277.

Tylee, A., Haller, D.M., Graham, T., Churchill, R., and Sanci, L.A. (2007). Youth friendly primary –care services: How are we doing and what more needs to be done? *Lancet*, 6736(3): 60371-60377.

United Nations. (1995). 'Platform for action and the Beijing declaration.' *Fourth world conference on women, Beijing, China. 4-15 September, 1995*. New York: United Nations Department of Public Information.



United Nations Program on HIV/AIDS. (2006). Report on the global AIDS epidemic Geneva: Joint United Nations Programme on HIV/AIDS; 2006.

United Nations Division for Population. (2006). *World Population Prospects: The 2006 Revision*. New York: United Nations.

United Nations Division for Population. (2009). *World population prospects: The 2008 revision*. New York: United Nations

United Nations program on AIDS and World Health Organization. (2006) *AIDS Epidemic Update*. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS. (2008). *Report on the Global HIV and AIDS epidemic*. Geneva: Joint United Nations Program on HIV and AIDS.

UNFPA. (2003). *State of world population*. New York: UNFPA. [Online], Available: <https://www.unfpa.org/swp/2003/english/ch3/index.htm>. [2/11/2009, 20:00 PM]

Warenius, L. (2008). *Sexual and reproductive health services for young people in Kenya and Zambia. Providers' attitudes and young people's needs and experiences*. PhD Thesis. Karolinska Institutet, Department of Public Health Sciences, Division of International Health (IHCAR).

WHO, UNFPA, UNAIDS and IPPF. (2005). *Sexual and reproductive health and HIV/AIDS: A framework for priority*. Geneva: WHO. [Online], Available http://whqlibdoc.who.int/hq/2005/WHO_HIV_2005.05_eng.pdf [10/04/2009, 21:00 PM]

Wood, K. and Jewkes, R. (2006). Blood blockages and scolding nurses: Barriers to adolescent contraceptive use in South Africa. *Reproductive Health Matters*, 14: 109-118

World Health Organization. (2000). *Working with Street Children. Module 4: Understanding Sexual and Reproductive Health Including HIV/AIDS and STDs among Street Children*. Geneva: WHO. [Online], Available: <http://www.libdoc.who.int/hq>[10/04/2008, 6:00 PM]

World Health Organization. (2001). *Global consultation on adolescent health services: A consensus statement*. Geneva: Department of Child and Adolescent Health and Development, WHO.

World Health Organization. (2002). *Adolescent friendly health services: An agenda for change*. Geneva. WHO.

World Health Organization. (2005). *Global estimates of the incidence and prevalence of sexually transmitted infections (STIs). WHO / CDC symposium: Congenital syphilis and the 2005 WHO estimates of STI incidence and prevalence: Using the second to help eliminate the first*. 18th

International Society for Sexually Transmitted Disease Research conference; 28 June to 1 July; London, United Kingdom.

World Health Organization (2006). *Steady, Ready, Go*. Geneva: WHO.

World Health Organization. (2007). *Engaging men and boys in changing gender based inequity in health: Evidence from programme interventions*. Geneva. WHO. [Online], Available: www.who.int/gender/documents/Engaging_men_boys[03/03/2009, 15:30 PM].

World Health Organization. (2008). *Promoting adolescent sexual and reproductive health through schools: An information brief*. Geneva. WHO.



LIST OF APENDICES

Appendix 1:

Participant information Sheet

(Note: For those participants that are unable to read, I will take time to read the information to them).

1st April, 2008

Dear Participant

You are being invited to take part in a research project. The research is being conducted for a mini-thesis, which is a requirement for the Masters in Public Health, which I am completing at the University of the Western Cape.

Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Please take your time to decide whether or not you wish to take part in this research.

My contact details and those of my supervisor are recorded at the end of this memo.

TITLE OF RESEARCH

Young Males' Perceptions and Use of Reproductive Health Services in Lusaka, Zambia

PURPOSE OF THE STUDY

It is hoped that with your participation a better understanding will be gained of the factors that influence adolescent male health seeking behaviours. Results of the study will be shared with the District Health Management Team in order for the improvement of male adolescent sexual reproductive health service delivery.

DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT

If you decide to participate in this study it will involve myself conducting group discussions with you. I will ask you about your opinions and experiences about what makes it easy or difficult for male adolescents to access and utilise sexual and reproductive health services.

During the discussion I will be taking notes of our discussion and will also use an audio tape recorder in order to adequately collect all the information that is needed for the study.

CONFIDENTIALITY

Your name will not be recorded during the interview so as to maintain confidentiality at all times. I shall keep all records and tapes of your participation, including a signed consent form which I will need from you should you agree to participate in this research study, locked away at all times and will destroy them after the research is completed.

VOLUNTARY PARTICIPATION AND WITHDRAWAL

Your participation in this research is entirely voluntary i.e. you do not have to participate. It is up to you to decide whether or not to take part. Refusal to take part will involve no penalty or loss of services to which you are otherwise entitled (as a client of the service) or, if you are a health worker, it will not impact negatively on your position as a staff member of this Centre.

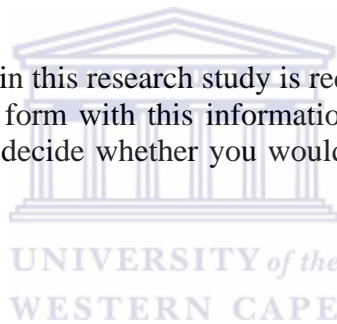
If you do decide to take part you will be given this information sheet to keep (and be asked to sign a consent form). If you decide to take part you are still free to withdraw at any time - and without giving a reason. You may also choose not to answer particular questions that are asked in the study. If there is anything that you would prefer not to discuss, please feel free to say so.

BENEFITS AND COSTS

You may not get any direct benefit from this study. While there are no immediate direct benefits to those participating in the study, the information we learn from you may help in improving service delivery for all adolescents and ensuring that we contribute to the reduction of STIs and new HIV infections among young people.

INFORMED CONSENT

Your signed consent to participate in this research study is required before I proceed to interview you. I have included the consent form with this information sheet so that you will be able to review the consent form and then decide whether you would like to participate in this study or not.



QUESTIONS

Should you have further questions or wish to know more, I can be contacted as follows:

Chilobe Muloba Kambikambi

Student Number:

Cell phone: 260 955815731

Telephone at work 221701/221822 Extension 308

I am accountable to Dr Brian Van Vyk, my supervisor at UWC.

His contact details are:

C/o The School of Public Health, Tel: 021-959-2809 / Fax 021 959 2872

By e-mail at: bvanwyk@uwc.ac.za

Appendix 2:

INFORMED CONSENT

TITLE OF RESEARCH

Young Males' Perceptions and Use of Reproductive Health Services in Lusaka, Zambia

As was mentioned in the *Participant Information Sheet* your participation or child's participation in this research is entirely voluntary i.e. you do not have to participate. It is up to you to decide whether or not to take part. Refusal to take part will involve no penalty or loss of services to which you are otherwise entitled. If you decide to take part you are still free to withdraw at any time, without giving a reason and without penalty or loss of services.

You may also choose not to answer particular questions that are asked in the study. If there is anything that you would prefer not to discuss, please feel free to say so.

The information collected in this interview will be kept strictly confidential.

If you choose to participate in this research study, your signed consent is required before I proceed with the interview with you.

I have read the information about this research study on the *participant information sheet*, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction.

I consent voluntarily to be a participant in this project and understand that I have the right to end the interview at any time, and to choose not to answer particular questions that are asked in the study.

My signature says that I am willing to participate in this research.

Participant name (Printed)

Participant signature

Consent Date

Researcher Conducting Informed Consent (printed)

Signature of Researcher

Date



Appendix 3:

Key informant and Focus Group Discussions Guide

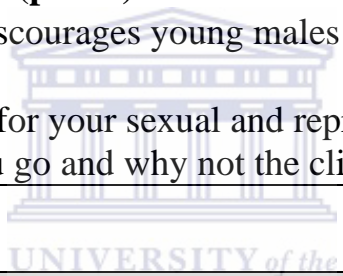
| | |
|--|--------------|
| Study title Young Males Perceptions and Experiences of Reproductive Health Services in Lusaka, Zambia | |
| Objectives | |
| <ol style="list-style-type: none"> 1. To explore the perceptions of urban male's adolescents in Chawama about access of reproductive health care services offered at the local clinic. 2. To describe the experiences of urban male adolescents regarding access and use of adolescent sexual health at the local health facility. 3. To explore the preferences of urban male adolescents regarding the reproductive health services | |
| MAJOR THEMES/ ISSUES | TOOLS |
| Participant selection criteria Small FGDs will be conducted with male adolescents. The researcher will include representation of younger adolescents and older adolescents. | |
| Ice Breakers – Introductory Questions | |
| <p style="text-align: center;">Introduction</p> <p>Thank interviewees for agreeing to participate. Repeat assurances explained during consent process.</p> <p style="text-align: center;">Ice breakers – selection and motivation</p> <ul style="list-style-type: none"> • Can you please tell me your names and how old you are • Can you please tell me if you live with your parents • What is the occupation of your parents <p>Young people like you experience body and emotional changes as they grow up. They also have needs and concerns about their health and they sometimes wish they can someone to talk to and share these concerns. I would like to ask you some questions about your main and how you try to cope or deal with them. Please feel free to ask any questions or seek clarifications.</p> <p>Reproductive health services</p> <ul style="list-style-type: none"> • What do you think are the major health problems facing adolescents in Zambia today? What are some of the most common health issues that make you visit the reproductive health service. | Plenary |

- Which health problems affect you more as adolescent males?
- Are the health issues different from boys and girls? If so what is the difference?
- When you have these health problem where do go for help
- As far as you know is there anything being done by the government, nongovernmental or other organizations to address these concerns
- In your own view do you think that it is necessary for adolescents like you to be provided with sexual health services? Please explain?
- Can you tell me some of the services that you feel should be provided for adolescent boys?
- Please tell me about organizations that you know that provide sexual health services in Chawama.
- If yes please tell me the names o these organizations and the services they provide
- If no then tell me of any organizations in Lusaka or Zambia that provide sexual health services to adolescents.
- If yes what kind of services do these organizations provide?
- How did you know about these organizations
- **Comments:** Need to probe further any possible sources of services or information such peers, school, private

Use of services

- Can any of you please tell me the primary health care services including sexual and reproductive health services available in your community?
Probe question: What kind of service is provided for male adolescents such as yourselves?
- Tell me if you have you ever accessed and used these services from these organizations?
- What was the reason for using these services?
- Who attended to you? **Probing question;** How long did it take for the health worker to see you? What was your impression of the service offered? Tell me more about the whole process, what you went through and how you felt during your visit to the organization? Did the organization offer the service according to you satisfaction? If not why?
- **Have any of you have ever accessed sexual health services from the clinic.**
- If yes what kind of service did you receive at the clinic?

| | |
|--|--|
| <ul style="list-style-type: none"> • Who attended to you? Probing question; How long did it take for the health worker to see you? What was your impression of the service offered? Tell me more about the whole process, what you went through and how you felt during your visit to the clinic? Did the clinic offer the service according to your satisfaction? If not why? • Do you think the clinic meets your needs for sexual and reproductive health services? • What do you think of the services offered at the clinic compared to where you went? How do you feel about this service as young males? • What do you think of the service that was or is provided at this clinic? Please tell me about the things that you liked about the services you accessed. • If not why do think young men like do not go the clinic for sexual and reproductive health services (probe). • What other things do you think discourages young males to visit the clinic? • If you did not go the local clinic for your sexual and reproductive health needs, where did you go and why not the clinic | |
|--|--|



| Perceptions of the service | |
|---|------|
| <ul style="list-style-type: none"> • What do your friends and other community members think of you when you go to a sexual and reproductive health service at your local clinic? What do they think about the service? | FGDs |
| | |
| Preference of Sexual and Reproductive Health service | |
| <ul style="list-style-type: none"> • If you were to design a sexual and reproductive health service for yourself what would you do? What would you prefer as a young male? How would it look like? What things would you prefer to be in that particular service? • What things would you like to be changed at the clinic so that you can be going there more often when you need the service than you do now? | FGDs |
| Recommendations | |

| | |
|--|------|
| <ul style="list-style-type: none"> • What else could the government and other stakeholders do to meet the sexual and reproductive health needs of young males? • What else could government do to support you and to improve the services offered at the clinic? • What other services do you think could be helpful in meeting your sexual and reproductive health needs as young males? | FGDs |
| <p>Thank participants for their contributions. Offer them the opportunity to ask questions. Assure them that the information they have provided will be used to improve adolescent reproductive health services.</p> | |



P.O. Box 50827
Lusaka
Tel: +260-211-235554
Fax: +260-211-236429



Republic of Zambia

**MINISTRY OF HEALTH
LUSAKA DISTRICT HEALTH MANAGEMENT TEAM**

In reply please quote

No.....



Monday, 08 December 2008.

Childne M. Kambikambi
C/o Care Zambia
Box 36238
LUSAKA.

Dear Kambikambi,,

RE: PERMISSION TO CARRY OUT A STUDY CHAWAMA CLINIC.

Thank you for your letter dated 1st December, 2008 concerning the above subject.

Be informed that Lusaka District Health Management Team has no objection for you to undertake the stated study above, in which you requested to conduct your research with young males accessing reproductive health service at Chawama clinic which is taking place on .9th December to 11th December 2008. Please ensure that after completion of the study you avail a copy of your report to Lusaka District Health Office.

By copy of this letter, the In-charge is hereby informed.

Yours sincerely,

**Dr. C. Shictitamba-Wamulume
DISTRICT HEALTH MANAGEMENT TEAM.**

c.c.: In-charge - Chawama

Appendix 5:



THE UNIVERSITY OF ZAMBIA

DIRECTORATE OF RESEARCH AND GRADUATE STUDIES

**HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS
COMMITTEE**

Telephone: 290258/291777
Fax: +260-1-290258/253952
E-mail: Director@drgs.unza.zm

P.O Box 32379
Lusaka,
Zambia.

Ms. Chilobe Muloba Kambikambi,
P.O. Box 36238,
Lusaka.

6th November, 2008.

Dear Ms. Kambikambi,



Re: Research Project Proposal

With reference to your research project proposal (HSSREC 18/09/08) entitled:

**“Young males perception and experiences of reproductive health services in
Lusaka”.**

With reference to my letter to you of 2nd October, 2008 informing you of the decision of the Research Ethics Committee on your research proposal and of the need to clarify with me the concerns raised.

In view of your re-submitted proposal and my personal discussion with you, I am now satisfied that you have satisfactorily responded to the concerns raised.

Consequently, you now have ethical clearance to proceed with your research.

Good luck!

Clive Dillon-Malone

Prof. Clive Dillon-Malone,
Chairperson,
HSS Research Ethics Committee.

cc. Director, DRGS