The problems that sexually active teenagers experience in accessing contraceptive information and services in Lusaka (urban) and Sesheke (rural) Zambia

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CHAPTER ONE

Introduction

> 'You may house their bodies but not their souls, for their souls dwell in the house of tomorrow which you can not visit, not even in your dreams[1].'

There are many barriers to young people's access to sexual and reproductive information, including provision of timely services and interventions. Barriers to young people's access to contraceptive information and services have continued to disadvantage teenagers in their quest for answers on reproductive issues. This generation seems to have been forgotten by the older generations who are the parents and guardians, yet the faces of teenagers remain a reminder to all of us adults and policy planners of what remains to be done. Young people's sexuality seems to raise eyebrows amongst adults and programme planners as to why it should be the focus of attention and secondly why the youth cannot just abstain and wait for the appropriate time to have sexual intercourse.

While teenagers want and search for answers to their sexuality questions many parents and guardians have continued to display discomfort in discussing reproductive and health issues and even communicating with their children directly seems to be a daily struggle.

Many policy makers, programme planners and parents mistakenly believe that information and education about sexuality and reproduction encourages sexual activity among unmarried teenagers (Hughes and McCauley,1998.).[2] This is further compounded by the fact that despite denials, the teenagers receive most of the information from their peers and by experimenting. As such most teenagers and young people are torn between what they think is relevant to them and what society wants and expects them to do. The end result is confusion in the lives of the teenagers.

McCauley and Salter (1998)[3] say that young people are poorly informed about basic sexual and reproductive health. This is because no one thinks it is a very important part of their overall development. If they have the information, usually the messages are totally contradictory as these may come from different sources with different intentions and approaches to life issues. This can be either in the form of a lecture on morality or what individuals think is correct for a young person, even if it is not feasible and relevant to teenagers.

Sexually active teenagers, it would seem, attract less approval in the quest to gain information and access to contraceptive services. A study by AGI (1998)[4] alludes to the fact that for sexually active young people, particularly those who are not married, obtaining reproductive health services is even more difficult than gaining accurate, culturally-specific and relevant information.

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[1] Kahil Gibran, the prophet(1923) "On children" http://inquier .gn.apc.org/gibran.hotmail

[2] Hughes ,J and A. McCauley (1998)Improving the fit : Adolescent needs and future programs
[3] McCauley A. and Salter C,(1995) Meeting the needs of young adults.
[4]AGI:(1998) Into a new world.: young people and women's sexual and reproductive lives .

Traditionally young people used to get information about sexuality from their uncles, aunts and, especially, grandparents. Issues of sexuality and family planning were not subjects of open debate or ones available from radio transmissions. This meant that adults were the ones who determined at which stage a child was supposed to get advice on practical issues of sexuality depending on the physical development of the child or the culture and practices of the ethnic grouping.

In previous times, movement from one place to another was limited as activities for most communities were subject to the confines of small community boundaries. Young people's movements in the traditional communities were under the constant scrutiny of the family which steered young people according to what the elders thought was right and best for the community, the family and the young individual. What was best for the young person was determined not by the teenagers themselves but by their parents in liaison with community elders or relatives. Matters of sex and 'who to sleep with' was not so much a personal choice but that which should be approved by the community. Good behaviour with no sex before marriage for a young person reflected the family standing and the whole community. Marriage was seen as the ultimate goal and all young people behaved themselves in order to achieve what was considered by many as the ultimate achievement. It is little wonder that any sex or sex talk before marriage was considered promiscuous by the parents and adults, especially if it related to the sexuality of females. The issues of family planning or contraceptive access and use still attract resentment among the older generation.

As people began to migrate from rural to urban centres and vice versa and as children went to formal western education centres, parental scrutiny was somehow informally abandoned. This meant that young people were now venturing beyond the boundaries of their homes to a world with diverse views, freedom and expectations. This and the introduction of religions like Christianity and Islam and new practices, depending on the location, all meant that people embraced new ideas while clinging to old practices.

This in essence gave mixed messages, not only to parents but to the new generation of young people. Most Christian life styles in Zambia can be said to reflect both African values and Christian ones. Known Christians may be said to practise African religions with its rituals, customs and beliefs. This puts teenagers in a dilemma. Apart from this issue of religion, cross-ethnic migration and inter-marriages also brought changes in language, dress code, places to visit and who to socialize with. While communities continue to be affected by world changes and sexuality patterns, adults continue to hold on to what they think are the correct values and beliefs. The end result is that different expectations about what is correct and appropriate behaviour is a mixture of different institutional, family and community beliefs that send different messages to the teenagers who still need guidance and protection in all matters that relate to reproductive and sexual health.

The issue of teenagers' access to contraception cannot be ignored in the era of high infection rates of sexually transmitted infections (STI's), including HIV; this to a large extent puts a spotlight not only on sexuality as an issue (which also focuses on the family) but also on the question of long range reproductive and sexual health for future parents. Adults' and religious leaders' misconceptions about teenagers' access to contraception is as a result of not only individualistic and opportunistic tendencies but also lack of knowledge of issues that need to be continually looked at from the teenagers' perspective of the need to lead healthy lives.

Although sex education in schools and mass campaigns directed at young people can improve their knowledge about contraceptive use, they rarely employ effective delivery methods and skills development to enable the young people to share and communicate their feelings to other people. This means that young people are not put into developmental plans but have to be content with societies' ad hoc sexual boundary curriculum of 'don't do it' or 'you are too young to have sex'. Meanwhile, the young people themselves are already having sex, much to the consternation of adults who take it as insolence and an outright insult to the older generation. They complain of the moral breakdown or ask 'What has society come to?' without realizing that times have changed.

Urbanization, industrialization and mass communication have all contributed to changes in social and sexual behaviours in Zambia as evident from the high levels of sexual activity, the high percentage of teenage pregnancies and the increasing prevalence of STDs and HIV/AIDS among teenagers. Teenagers are said to have problems on matters pertaining to sexuality and contraceptive access in Zambia. Sexual activity is relatively common among Zambian teenagers. The ZDHS 2001–2002 [5] reports most teenagers have had sexual intercourse before the age of 15. So while parents sulk in the guise of parental responsibility and deny young people access to information on contraceptives, teenagers are ahead of them and already engaging in sex. Many studies conducted (Chipoma,1990:)[6] have shown that parents need to come to terms with teenagers being sexually active. This study looks at the sexually active teenagers and their access to contraceptive information and services in Lusaka (urban) and Sesheke (rural) in Zambia.

Problem statement

Studies done among teenagers on access to contraceptives show that young persons have difficulties in obtaining information and contraceptive services. Often they are poorly informed about reproductive and sexual health issues. More often than not parents, teachers and other adults are not prepared to discuss sexuality issues or problems with them. While they may have the information, obtaining a service that is responsive and friendly to their needs is even more difficult. This research explored the problems that sexually active teenagers experience in accessing contraceptive information and services in Lusaka (urban) and Sesheke (rural) Zambia.

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Purpose of the study

The study set out to explore sexually active teenagers and 'access to contraceptive services in Lusaka (urban) and Sesheke (rural) Zambia. It was also designed to examine barriers that exist from the multiple societal values, norms and beliefs and systems of control on teenage sexuality, laws and policies, including the lack of communication between parents and their children. It is envisaged that the research findings will assist in putting measures in place that will help address gaps in delivery of services and reform and review policies that create barriers to teenagers' access to contraceptive information and services.

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[5] Zambia Demographic Health Survery 2001- 2002
[6] Chipoma (1990)Teenage sexuality in Lusaka, Zambia

Objectives of the study

1. To find out if sexually active teenagers are aware of contraceptive services available.

2. To examine societal values, norms and beliefs that inhibit sexually active teenagers in accessing contraceptive services.

3. To explore possible policy and legal measures that could be put in place to enable sexually active teenagers to access contraceptive services.

Research assumptions

1. That sexually active teenagers are not aware of the contraceptive services available;

2. That societal values, norms and beliefs inhibit sexually active teenagers from accessing contraceptive services;

3. That policy and legal measures should be put in place to encourage sexually active teenagers to access contraceptive information and services;

4. That there is lack of communication between children and parents which prevents sexually active teenagers from accessing contraceptives.

Research questions

1. Are sexually active teenagers aware of the contraceptive services available?

2. Do societal values, norms and beliefs inhibit sexually active teenagers from accessing contraceptive services?

3. Should policy measures and legal measures be put in place to improve sexually active teenagers' access to contraceptive services?

4. Does lack of communication between parents and their children prevent teenagers from accessing contraceptives?

Target group

Although aimed at sexually active teenagers, it was not possible to ascertain which teenagers were sexually active. As such the study inclusively targeted all teenagers in the areas chosen. The targeted teenagers were limited to those living in and around Kamwala with a special focus on the area around Misisi and those living around Chilenje compound. Lotus basic school was also sampled in Lusaka. In Sesheke, this study focused on teenagers around Sesheke town around Mulimambango health centre as well as Nakatindi and Sesheke basic.

The respondents in this study covered:

- Out of school youths

- In-school teenagers
- Adults and other key informants.

Scope of the study

The study was limited to:

- Two Lusaka urban health centres
- Lotus basic school in Lusaka
- Sesheke district hospital.
- Mulimambango Health Centre in Sesheke
- Nakatindi and Sesheke basic schools in Sesheke
- Adult communities from both Lusaka and Sesheke towns

CHAPTER TWO

Literature review

Contraceptive access and the teenager

Contraceptive information access has basically increased debate on who is eligible socially, morally, physically and biologically to access the services. Contraceptive use is not a totally new idea as even traditionally there were different methods of contraception like withdrawal methods. This was done by mainly married couples. What seems to be new is the idea that teenagers and young unmarried people are asking to be allowed to use contraceptive methods as they feel they need to protect themselves against diseases and unwanted pregnancies. This newly found freedom and concept of wanting to access contraceptives has met disapproval from many adults.

Studies done in Zambia (Likwa,1993)[7] on teenagers and contraceptives show that young people, especially sexually active teenagers, attract less approval in their quest to gain information and access to contraceptive services. Adults and parents meanwhile continue to display discomfort in discussing sexuality issues with young people. In fact society is still struggling to accept the idea that teenagers, adolescents or young people are continuously having sex where the normative structures does not permit this.

The idea of the family founded on heterosexual marriage continues to regulate sexuality issues among Zambians. Meanwhile urbanization and the transition from traditional to modern culture have given rise to new patterns of sexual behaviour, including unprotected pre-marital intercourse. Societal values continue to inhibit information access on sexual and reproductive health. Teenagers themselves often express concern about lack of information and understanding about their own sexuality.

Cultural values as a barrier to contraceptive access

Many parents are also at the crossroads – holding on to values that were passed on to them during their teen years and trying to live the reality of today which seem to be fast with shifting boundaries on sexual and reproductive issues. Traditional systems of control on teenagers have shifted and parents now have to play the role of aunties, uncles and grandparents.

Before the advent of formal school education in Zambia, most teenagers used to enter sex life and marry immediately after being initiated into adulthood. Adulthood was marked by the first onset of menstruation for girls and other ceremonies and rituals for boys. Girls used to get married at an early age. For example if a girl started menstruation at the age of 13 or 14, she would get married even earlier, before she has reached even the age of16. in the 21st century there has been a shift in age at which a Zambian teenager can start having sex or get married.

Some teenagers and youths now have to be in formal schools a little longer but are not expected by society to indulge in sex or marry. Most youths presently marry later at 20 to 25 but this does

[7] Likwa , R(1993) Report adolescent and reproductive sexual behavior.

not mean that they were not sexually active before and not responding to their sexual needs. Teenagers may seem to be children and not responsible for their own livelihood but are sexually aware and active in one way or another.

Young people's problems are compounded by living in a society with values, beliefs and social norms which send different messages and services to them. Kilboune (1998)[8] refers to social norms, especially those for gender roles, and other environmental factors that contribute to barriers as well as to the conditions underlying poor reproductive health service availability. He also talks about how conditions that limit countries' abilities to offer adequate health services affect their ability to serve young people in most societies with women, and especially young women, having little power to negotiate sexual activity.

Contraceptive service and delivery

Services available in Zambia point to the fact that physical structures are not designed to serve, accommodate and give a friendly service to teenagers. Barriers that inhibit teenagers from accessing contraceptives start from the family confines to religious environments on morals, up to the government level with absent service delivery. This disadvantages teenagers in their struggle to attend to their reproductive and sexual health. The issue of knowledge of contraceptive measures but not of where exactly to access that service is crucial. This means young people teenagers face multiple barriers inhibiting them in accessing contraceptives from all sections of society.

Zambia's family planning policy

According to ZDHS 2001-2002[9], Zambia has a population of 10.3 million people with a growth rate of 2.9 per cent with a youthful population. Issues of reproductive health and population are inter-linked and necessary for planning for the needs of young people. Zambia officially adopted its population policy in 1989 (Chipoma, 1990; NCPP, 1993)[10] Programmes in this area were designed to provide adequate family planning services and to influence population goals.This was further supplemented by the draft national family policy programme of 1990-1992.[11] The document focused primarily on fertility regulation and to address reproductive health issues of citizens including that of young persons.

Zambia's family planning programme has evolved over time. In 1969, the Ministry of Health established its first Maternal and Child Health (MCH) unit with services integrated into its range of services, including family planning. In support of family planning services in Zambia, the family planning association of Zambia (FPWAZ) was founded in March 1972. This organization changed its name to the Planned Parenthood association of Zambia (PPAZ) in 1979 and has since worked closely with Ministry of Health, often providing family planning services.

[8] Kilbourne, B (1998) Adolescent Reproductive Health. Making a difference.
[9] ZDHS 201-2002
[10] Chipoma(1990).NCCP(1993. Zambia Population policy, (1989)
[11] Zambia National Draft family planning Policy (1990-1992)

Zambia's National Family Planning Policy (1997)[12] was put in place to guide the activities and give direction to the issues of reproductive and sexual health. This family planning document in all its purposes caters for all people, including teenagers. The Zambian National Family Planning Policy has its foundation in the fact that reproductive health is an important aspect of human development and access to health information is a basic right of individuals and couples. The policy also recognizes that family planning is an important tool in improving and promoting healthy lives.Young people not only need but have a right to reproductive health information and also need to be availed with services.

Urbanization, industrialization and mass communication have all contributed to changes in social and sexual behaviours as evident from high levels of sexual activity, the high percentage of teenage pregnancies and the increasing prevalence of STDs and HIV/AIDS. Teenagers are said to be ill-informed on matters pertaining to sexuality and contraceptive access and use. Sexual activity is relatively common among Zambian teenagers. According to ZDHS 2001–2002[13] the age at first sexual intercourse for Zambian teenagers is between 15-19 years. Almost 20 per cent of teenagers reported that they had sexual intercourse before the age of 15. Likwa (1993)[14] indicated that parents need to come to terms with the fact that teenagers are having sex because they are sexually active and not because anyone is forcing them.

Family planning policy guidelines and standards seek to give direction and authorize a number of practices to be routinely applied and co-ordinated in the delivery of family planning services. The policy facilitates a number of services that could be availed to teenagers, among others. Before the family planning policy was drafted, to access contraceptives, an individual needed written approval of the husband for married couples and from parents or guardians for unmarried persons. Teenagers were not allowed to visit a family planning centre and access contraceptives. Having a policy in place sets the framework and direction to take reproductive health issues one step further even when this is still only on paper. The family planning policy as such gave way to some of the following:

- Abolition of parental consent.
- The eligibility of adolescents to recieve reproductive health care services and provision of contraceptive methods, such as the IUD, by paramedical personnel.
- Authorization of community-based distributors (CBDS) to distribute oral contraceptives.

The provision of the Zambia family policy guidelines and standards is an important starting point although this is facilitated by a political decision This decision was taken and carried out in contrast to what the supreme law provided for on the eligibility of citizens for medical service, including contraceptive access and who should provide the service.

[12] Zambia family Planning policy guidelines, standards and strategies.(1997)
[13] Zambia Demographic Health Survey 2001-2002.
[14]Ibid Likwa, R. (1993)

Article 23 of the Zambian constitution

The inconsistencies send negative and different messages to service providers and deny teenagers a service. For example the constitution still indicates that there should be parental consent for a child below the age of 21 before accessing medical services. WHO (1998)[15] states that at a workshop conducted by health personnel participants who included nurses and clinicians voiced their concern about family planning policy changes contradicting the existing Medical Services Act and how it continued to prohibit them from providing health services, especially to young people. The Medical Services Act prohibits medical counselling and services to persons below the age of 21 without parental or guardian consent. This sends different messages to service providers who may offer a service according to what they think is best for them not their client. A WHO (1991) report on family planning options in Zambia noted that 'service providers felt vulnerable to the inconsistencies and regulatory requirements insofar as it is they who are responsible for actually implementing the reforms.'

Arising from lack of clear legislation brought about by contradictions between law and policy, political statements are the only cushions to achieving the services of contraceptive information and services. With inconsistencies between the law and policy, most times decisions are not taken in the best interest of the client or a teenager who may be in need of an urgent service. The Zambian family planning policy contradicts the Zambian constitution which has not specified the age at which medical counselling can take place and so affects contraceptive service access to teenagers. This may not bind any service provider to give a friendly and desirable service or advice. They will do it according to what they feel is appropriate to them.

Zambia is signatory and party to the Convention on the Rights of the Child (1990) and ratified the convention the same year. Although this is so, the constitution does not have a specific article specifying how reproductive health for teenagers will be dealt with by service providers. It would seem that article 23 is adequate to provide direction on non-discrimination against citizens, especially that relating to teenagers. Other issues relate to the non-provision of a definition of a child. This is left to different child-related laws, for example the Juvenile Act and Sexual Offences Act (Penal code 87).[16] While there is already a youth policy and child policy, a national youth health policy, which has been in draft form for many years, would have made a difference in targeting the welfare and quality of teenagers' access to health services. Young people not only need but have a right to reproductive health information and need to be availed with services as well.

The Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child provides for, among others, rights to life, rights to the highest attainable standard of health and, in dealing with children, the commitment to ensure that the best interest of the child takes precedence over other issues. This is commendable but teenagers' right to life and to a high standard of health has not been given the attention it deserves. As a result, teenagers worldwide and in Zambia do not enjoy their full reproductive rights as very often their needs are not taken into consideration.

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[15] WHO Report on Expanding Family Planning Options in Zambia (1995)
[16] Juvenal act, Penal code(87) of the laws of Zambia

The Convention on the Rights of the Child[17]provides that:

> 'State parties should ensure that there is accessibility to children of information and materials from a diversity of sources.'

According to Article 17,11 the state party shall:

> 'Encourage the mass media to disseminate information which is of social and cultural benefit to the children and take steps to protect them from harmful materials. The information and materials and especially those aimed at the promotion of children's social, spiritual and moral wellbeing and physical and mental health.'

The Convention also spells out in Article 16 the right to privacy and confidentiality:

> 'Health care providers have the obligation to ensure confidentiality, including confidential advice on all health matters or medical information of adolescents, in light of the principle of non-discrimination, best interests of the child, right to life, to survival and development and the right to express its views freely in matters 2,3, 6 and 12 of the convention.'

The convention spells out the importance of contraceptive information access by teenagers with additional focus on teenage girls. The committee on the rights of the child goes further in promoting teenagers' rights not only to information but to services and specifically indicates this under Article 13 which gives states parties obligations in relation to health and information. Articles 24, 13 and 17 articulate how:

> 'Children should have adequate information related to HIV/AIDS prevention and care, through formal channels.'

This is crucial in the era of HIV/AIDS as it means that if children are not properly catered for the concept of promoting future generations will not, in effect, be achieved.

Young girls especially need services and information because as adolescents they need information about general sexuality and reproduction, STDs so they can safeguard themselves. Both girls and boys benefit from health education programmes that include vital sexual health information. It is important to say that despite this, programmes for teenagers are not sensitive to the needs of this age group. Sometimes hard-pressed health systems and administrators feel they have done what they can to cater for needs of teenagers by establishing a link from the existing health care system. More often than not this results in teenagers not accessing services that are vital to their development.

Youth-friendly centres

The critical issue is that of unmet policy needs and service delivery with regard to young people's ability to reproduce and the freedom to decide if, when and how often to do so. Reproductive

[17] Convention on the Rights of the Child 1990

health has been defined as a state of complete physical, mental and social wellbeing, not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its function and processes. Reproductive health therefore implies that people are able to have a satisfying and safe life which should be facilitated by the state in the provision of programmes and materials for social service delivery.

The committee on the rights of the child (2003) obligates states to offer child and adolescent sensitive health services.

Article (16) of the Convention on the Rights of the Child says that state parties are encouraged to ensure that health services employ trained personnel who fully respect the rights of children to privacy and non-discrimination in offering them access to HIV-related information.

The Zambian government sought to fulfill its commitment in the implementation of the Convention on the Rights of the Child. Youth friendly centres in Lusaka urban area within urban health centres were established to cater for the activities of the youths.

These youth-friendly health services were built on the premise of offering quality assurance to teenagers:

> 'This is an intitiative emerging in line with a number of decisions and plans of action that result from international mission statements, conferences, summits and national reforms.'

These include UNICEF mission statement; Convention on the Rights of the Child, 1989, Article 24.2; the international conference on population and development ICDP1.47;[18] and Zambia National Family Planning policy and strategies (1997).

The concept of youth health clinics grew as part of a youth health service on the basis of the baby-friendly hospital initiatives. Youth health staff and non-governmental organizations set the criteria in three categories: to be able to give not only health care but to ensure that reproductive and sexual health is promoted in line with ICDP and other international agreements. The goal was to ensure continuous quality improvement in services given to all teenagers irrespective of whether the service is given at a government health centre, hospital or any other institution that could give a service.

The Ministry of Health of Zambia put youth friendly centres into the urban clinics to specifically cater for the needs of young people. These centres are put in place to educate and motivate youth to talk and discuss freely matters related to sexuality among themselves. A youth friendly corner is a place where the teenagers seek help and assistance on sexual and reproductive health. Specifically they are attended to by fellow youths, called peer educators, who can refer to nurses and medical officers if there is a complication

As can be observed the government of Zambia, was following closely the recommendations of the Cairo declaration which directed that actions should take care of the reproductive and sexual health of young people specifically with government taking action on the basis that:

[18] Ibid ICDP 1994

> ‘The reproductive health needs of adolescents as a group have been largely ignored to date by existing reproductive health services.’

The basis for action further stated that:

> ‘The response of societies to the reproductive health needs of adolescents should be based on information that helps them attain a level of maturity required to make responsible decisions. In particular information and services made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility.’

CHAPTER THREE

Methodology

This study is on how teenagers in Zambia access information about contraceptives and how this information helps them to get a service. This section covers the methodological framework. It details the methods used to obtain answers and how suitable the methods were. The research framework was chosen to enable the researcher to collect information on how multiple societal systems, laws, policies and social practice in reality affect sexually active teenagers in accessing contraceptive services. Although the research sought to find out experiences and cover sexually active teenage girls only, this was not possible because I was not able to identify sexual active teenagers by appearance. As such all teenagers in the particular sites were targeted in this study. The methods such as grounded theory, the women's law and semi-autonomous social field approaches were engaged continuously throughout the research to give diverse collection of views on the different experiences.

Grounded theory

My starting point was the teenagers themselves. Teenage girls and boys were interviewed to find out how contraceptive access assisted in improving their sexual and reproductive health for the betterment of their lives. It also looked at parents, guardians and health service providers who are the main responders, active promoters and protectors of teenage lives. The experiences of teenagers in accessing service and delivery systems were interrogated. It helped to observe and reflect how political decisions, law and policy in social practice become a barrier to teenagers' access to contraceptive services. Bentzon (1998)[19] writes about how:

> '…the interaction between developing theories and methodology is constant, as preliminary assumptions direct the data collection and then the collected data, when analysed indicates new directions and new sources of data.'

Grounded theory helped to also observe the skewed reality of the experiences of female and teenage boys as separate entities although they stay in one society with the same rules, laws and regulations.

Women's law approach

Every adult person has had the experience of passing through the teenage years with all its intricacies and confusions. Being a teenager and living in a world of dual structures sometimes results in hopelessness. Teenagers are rarely thought of as having urgent problems that need to be solved. The issue of contraceptive access for teenagers brings discomfort to adults thinking that as long as children are in their parents and guardians home, they should not have sex. Are adults ignoring something that won't go away but just postponing the problems to the future? That is where one needs to start: by asking where the teenagers are and how society regulates their

[19] Bentzion et al(1998) Pursuing grounded theory in law.

reproductive and sexual health. One needed to use the women's law approach to be able to go back to the teenagers, trace their footprints, search for the scars, identify barriers and relate to the teenage experiences in accessing contraceptive services. The women's law approach was used in taking stock of the realities of teenagers as individuals within a special group. This was ideal for this study as it further interrogates the intersection between the general law, policies, customary law and the people's expectations, customs and practices. Women's law goes further to analyze the broad-based position of vulnerable groups and the dynamics of these relationships. In this way women focused gender relations and perspectives are combined. It brings out the limitations of the law and how it impacts on women, in this case on the sexually-active teenagers.

Semi-autonomous social fields

Myths form beliefs, beliefs form practices that help us to shape our perceptions and this is how values are formed and shaped. Semi-autonomous social fields were used in this research to analyze the situations that influence and bar teenagers from excercising and enjoying their full reproductive health and rights. This approach was used for this research to look at how structures in society influence teenagers' choices and how actors by their actions influence societal institutions in providing access to contraceptive services or the acquisition of information. Where is the teenager in all this, how do teenagers access contraceptive services, where do they go for help and how does the sub-group with their sub-rules assist teenagers in their quest for access to contraceptive services? The family, the peers, the church and school are the agents of socialization that institute values in teenagers as they grow up. Teenagers look for answers from the traditional structures and other groups in the community to their reproductive and sexual needs because the formal institutions which have been tasked to deliver services have their own inadequacies. This study was able to look at the law and policy and how how it assists teenagers in accessing contraceptives. It also looked at how, in the absence of the services, where would a sexually active youth seek answers, and which structures supports teenage aspirations.

Data collection

During this study, it was imperative to use different methods of data collection to give the research diverse experiences rather than rely on one method which might be biased or unable to give certain categories of people the opportunity to relate their side of the story. In this study, the methods used to collect information were:

- impromptu interviews
- group discussions
- library research
- questionnaires
- observations
- key informants
- open mindedness
- individual interviews

Impromptu interviews

In this study some of the parents and teenagers were asked questions randomly to lessen the possibility of them forming positive answers which the respondents think the researcher is looking for. In this case no preliminary introductions were done. The researcher went into the subject after introducing her name and immediately asked a question on whether teenagers are supposed to access contraceptives or not.

Group discussion

Group discussions are healthy and rich in that members share ideas, experiences and knowledge. Some teenagers and adults were freer when interviewed collectively because they would refer to other teenagers' experiences rather than their own. The beginning of the group discussions was sometimes a bit tense but as the discussion progressed, respondents became eager to put forward their views on the subject under discussion. It was also observed that there were constant reminders from among the respondents about who gets a full service, who society favours and how teenagers continue to struggle to access contraceptive services. Group discussions initially drew silence as respondents digested the topic at hand. They later progressed to lively discussions as teenage boys and girls, men and women jostled to air their views. Sometimes there was laughter, counter-accusation and pointing of fingers between men and women and teenage girls and boys during the group discussions. This was useful as it enabled the researcher to watch facial expressions and strong sentiments in some individuals as they responded to questions put to them. It was also noted in the group discussions that older women found the interviews in reproductive and sexual health not only interesting but a reflection of what they experienced as teenagers and, as such, a pleasure to discuss. Laughter erupted at the concept of non-usage of condoms by sexually- active teenagers and even older people in general and this was a comment from one of the female shop keeper:

> 'I sell male condoms only, but business is not good. If you see a person buying condoms then it must be a visitor to this town. People still prefer skin to skin and who cares we are all here to die.'[20]

Collective individual interviews

This was one of the highlights of my data collection while in the field; I decided to collect information from some respondents from the market in Sesheke. The interviews were meant to be individual interviews. While the respondent agreed to be talked to, there was curiosity among the others standing nearby. It also affected the behavior of the respondent who would look around (maybe for protection) then would agree to be interviewed. Her friends would one-by-one start to come round and sit with their friend. They would not contribute but they would continue to nod their heads in agreement to what the respondent said or laugh at a response from their friend. One woman said:

[20] Comment from a Sesheke female shop keeper.

'You never know what you can miss or benefit from strangers.'[21]

This can be attributed to the fact that most close communities and people in villages took interest in what was happening in their neighbour's house.

Library research

This enabled the researcher to read other related literature on the subject of sexually active teenagers starting globally, moving to regionally and then to the local picture in terms of problems related to sexual and reproductive health as well as access to contraceptive services.

Questionnaires

These were used in collecting data from the three schools. Although this is an efficient method in that it reaches a good number of people within a short time, It has it is own disadvantages. A questionnaire has no point of clarification in case one does not understand the questions well. It occurred to the researcher that teenagers in some cases asked each other how to answer questions. The researcher also realized that certain questions could not be understood by the teenagers and they had to seek clarification. As a result it was not found to be a very suitable way of collecting information. On a positive note, because certain teenagers wanted to maintain confidentiality, certain issues were raised which added to the data collected.

Observations

Observations were made during the process of interviewing. This enabled the researcher to watch out for salient issues and how the respondents were reacting. This helped to capture hidden information on non-verbal communication as it was essential to see how a person answers certain questions. Structures in different locations were also checked to find out how friendly they were to teenagers in offering services. Observation of activities at the youth friendly or maternal and child health centres were done by sitting at a centre and observing how the service providers were interacting with the clients.

Key informants

Key people in institutions like the three schools, three clinics and one hospital in both sites were interviewed in order to seek diversity in policy direction, everyday practices, experiences as well as implementation of the issue under discussion of sexually active teenagers and their access to contraceptive services.

[21] Comment from a Sesheke female marketer.

Open mindedness

> 'An open mind means that the research should be aware of the basic assumptions and suppositional and the basis for them and should take nothing for granted' (Bentzon *et. al.* 1998:179).[22]

This helped continuously in accepting changes and reflecting on my own ideas on contraceptive services to teenagers. I was ready for any surprises and this helped me to continue changing my questions to enable me to interrogate the barriers that come into play and influence sexually active teenagers' access to contraceptive services positively/ or negatively. I was able to learn and hear from respondents about teenagers' experiences and the quest to access their rights often, defying law, societal attitudes and values.

Individual interviews

This worked well for teenage girls, especially those who wanted to relate their experiences in contraceptive access as well as the concept of a teenager in a society with multiple laws, customs, and gender and sex expectations. The individual interviews gave the researcher other information on behaviour dynamics of beliefs and attitudes attached to most every day interpretations relating to the topic at hand. In four instances respondents approached the researcher to ask questions about contraceptive access. The respondents had not wanted to be personal in the previous group discussions. It turned out that what the respondents wanted to ask was about the dilemma of teenage pregnancy and the myths surrounding contraceptive use as well as why police arrest teenagers who abort.

Definition of terms

Access	Opportunity or means of reaching contraceptive information and services.
Adolescent	Young people aged 10 to 20 years (WHO)
Contraceptive	Any method of prevention of pregnancy by artificial means.
Contraceptive information	Knowledge acquired for means of controlling conception added to prevention of disease – STDs and HIV/AIDS.
Teenager	Young person between the age of 13 to 19 years old
Family planning	Method of birth control, which includes informed

[22] Ibid Benztion, (1998).

choice, decisions and activities.

Research sites

It occurred to the researcher that it was important to collect information from two different sites to find out how teenagers access contraceptive services in the urban centre of Lusaka and the rural site of Sesheke in Zambia. From that point, the following sites were chosen:

- Two health centres in Lusaka, – Chilenje and Kamwala
- Surrounding places around Chilenje and Kamwala Health Centres focus: Misisi
- Sesheke district hospital
- Mulimambango health centre – Sesheke
- Shopkeepers in Sesheke selling male condoms only.

CHAPTER FOUR

Findings

What I observed and heard

This study elicited a diversity of information in terms of feelings, reactions and attitudes from its respondents. The study made respondents reveal their feelings as they told their side of the story and discussed the issue of teenagers' access to contraceptive information and services in both sites.

A total of 274 people were interviewed during the course of this research. These included adult members of the community, school-going teenagers, service providers and some key informants. The respondents were selected sometimes by the location they were found in at the time of the interview as well as the relation they had to the topic at hand. The teenagers selected were selected to represent a cross-section of young people whether in school or out of school.

Group discussions

Group	Male	Female	Total
Teenagers	20	23	43
Parents	8	12	22
Total	28	35	65

Individual interviews

Group	Male	Female	Total
Teenagers	6	6	12
Parents	4	3	7
Counselors	5	2	7
Key informants	9	6	15
Total	24	17	41

Questionnaire

There were 148 teenagers among the three schools, one in Lusaka and two in Sesheke.

Group	Male	Female	Total
Teenagers	74	76	148

Observation

This was done at the two youth-friendly centres in Lusaka and Sesheke for two days each at each site.

Place	Male	Female	Total
Kamwala	5	1	6
Chilenje	3	-	3
Sesheke Hospital	-	1	1
Mulimambango	1	-	0
Total	9	1	10

Impromptu interviews

Place	Male	Female	Total
Teenagers	4	2	6
Parents	1	3	4
Total	5	5	10

From the questionnaires, ages of the teenagers ranged from 13 to 19 years. Parents or adult community members were presumed to be between 26 and 60 years although in one instance, a parent who joined an adult discussion was discovered to be 19 years old during the course of the discussion. She had two children because she had married at the age of 16. Group discussion, questionnaires and open-ended questions were used to solicit information on the topic under discussion. This included those respondents who gave answers under individual interviews. While group talks gave more information, individual interviews allowed the researcher to solicit some teenagers' life experiences which could not be related in group discussions. For example, in one group discussion in Sesheke; two girls separately followed the researcher to ask questions as well as to relate their individual different stories about teenage sexuality.

In this study, the age at which teenage girls started their monthly period was between 12 and 15 years.

From the 148 teenagers who answered the questionnaire, it indicated that the number that had already had their sexual encounter was higher for boys (49) than for girls (41). The youngest age at which sexual activity started was 12 for Lusaka teenage girls and 14 for the teenage boys while Sesheke had 13 for the teenage girl and 14 for the teenage boy.

Awareness of contraceptive methods

Awareness of contraceptive services refers to the fact that teenagers have reached the stage in life when they need to make choices about their reproductive and sexual health. From the questionnaires it emerged that sources of information about reproductive health came mainly from teenagers' own friends and peers, including at school, for both sites while Lusaka teenagers had the advantage of listening to messages from the radio and television. There was equally an absence of widespread dissemination of contraceptives information in Sesheke which can be attributed to the erratic Zambia radio signal in the area and lack of radios and televisions in most homes. The television services were found to be a hindrance to information access since the border town was not receiving any services from the Zambian national channel but being serviced by the neighbouring channel from Namibia.

The only method of contraception which was indicated and widely known was the male condom with 40 percent knowledge in Sesheke and 90 per cent in Lusaka. The gap in knowledge was wider for females as only 10 per cent of the girls had seen a female condom, while there was no interest shown in female condoms by the teenage boys. Other methods of contraception indicated were oral contraceptive pills and injectables for the teenage girls with Lusaka recording 85 per cent knowledge and Sesheke 25 per cent. Awareness of STDs had an urban–rural difference with only 45 per cent aware in Sesheke.

It was also noted that family planning centres or clinics that were offering contraceptive services were not popular among teenagers. Lusaka teenagers' knowledge of the youth friendly-centre location was only 45 per cent and 10 per cent in Sesheke. In Lusaka, only 15 per cent of teenage boys and 10 per cent of females had been to a youth-friendly centre. For Sesheke, only 7 teenagers (4 males and 3 females) had visited the family planning centres. Reasons ranged from:

- Lack of information on where to access the services;
- Ignorance of services provided at the centres;
- Negative staff attitudes towards teenagers;
- Fear of being seen by a neighbour who may communicate to parents or guardians;
- Centres being associated with adults,pregnant mothers and babies only;
- Bad experiences for those that had been at the centres inhibiting future visits;
- Myths and negative ideas attached to contraceptive use which is being transmitted by peers because incorrect information from adults and service providers or from adults who want to scare teenagers to not have sex;
- Mixed messages sent by different church institutions and other community members on the use of contraceptives and its outcome;
- Few centres available in Sesheke. The Lusaka peer educators were indicated by those that had been to the centres (25 per cent) as being friendly maybe because

the providers themselves were fellow youths and their own peers. In Sesheke 70 per cent indicated that the service providers were not friendly.

From the questionnaires, for those that had been to the family planning centres serviced under maternal and child health, teenagers indicated that none of the providers tied any service provision to the question of parental consent in accessing contraceptives in Sesheke, however teenagers indicated that there was no counselling done by the service providers. For the Lusaka youths, only 20 per cent (both male and teenage girls) indicated that they received counselling on contraceptive use and that since it was from their own peers, the service providers were friendly. On the other hand, only 25 per cent of the Lusaka teenagers and 20 per cent of the Sesheke teenagers were willing to share the information on contraceptive access with their parents citing the following reasons:

- Parents could be annoyed by the information that their child is accessing contraceptives;
- Parents would not normally agree to their child accessing contraceptives;
- Contraceptive access is thought of as promoting prostitution;
- Parents could be angry to find out that you are accessing contraceptives and one could be punished.

It was noted that there were myths and negative ideas surrounding the use of contraceptives by teenagers. The myths were the same for both Lusaka and Sesheke.It was shown that parents, guardians and adults, especially, were transmitting negative messages about contraceptives use. The following myths were listed for both Lusaka and Sesheke school-going teenagers:

- Pills cause cancer and other incurable diseases.
- Pills cause illness and infertility among women.
- The more one takes pills or has injections, the less chance one has of carrying a baby.
- One can prevent pregnancy by taking 10 aspirin tablets.

On the question children's rights, the Lusaka teenagers had more information than their Sesheke counterparts with an 80 per cent to 30 per cent ratio. This could be attributed to the fact that there has been widespread information dissemination on both radio and television which is more accessible in Lusaka.

Group discussions

Teenagers and awareness of services

Society make rules and regulations that are transmitted to younger generations and in this study, it was found that teenage girls worry about getting pregnant while teenage boys also worry about impregnating someone. This was not limited to those teenagers who were already having sex but even with those who were also not actively engaging in sex. In one group discussion one teenage boy related that he worries because his

parents always refer to the fact that young people should not have sexual partners and have to wait until an appropriate time. This message would be communicated generally by referring to someone's child who had shown a good example of not engaging in extra-marital affairs and just got married. So teenagers worry because society does not expect them to have sex but to wait for an appropriate time. One teenage girl in Chilenje area had this to say:

> 'I worry about having sex because if I get pregnant, my parents will be upset. My elder sister was chased from home when she got pregnant and now she is living with my aunt.'[23]

It was discovered in this research, that the issues of sexuality and pregnancy are transmitted through different reactions by parents to children and that most parents do not envisage their children having sexual encounters with anyone as long as they are still in their parent's home.

One teenage girl in a group discussion in Sesheke has this to say:

> 'I worry about getting pregnant. I have told my boyfriend this, but he thinks I am overreacting for nothing will come of it. My parents keep talking about why young people cannot abstain and wait till they are married off to a respectable man. I worry about getting pregnant. I am really scared. I wish I could stop having sex.'[24]

It was found in this study the Lusaka teenagers had more information on contraceptives than their Sesheke counterparts. Their sources of information were their own peers, school, radio and, to some extent, posters.

From the group discussions, only 12 out of the 43 teenagers had been to a youth friendly centre and these were mainly Lusaka youths while in Sesheke only two had been and in these cases it was because they were found to be pregnant. One teenage girl in Sesheke had this to say:

> 'I only came to know the maternal and child health centre when I became pregnant, in this case, I was being told to bring my partner because I had an STD. I never knew that I could go to a hospital for family planning as an unmarried youth.I thought they only offer assistance to married women.'[25]

Other responses on not using family planning centres ranged from:

- Lack of proper information on where exactly one can go.
- Fear of being laughed at for this can be a disclosure that one is having sex.
- Staff attitude which sometimes is thought of as threatening and uwelcoming, especially for the centres which are serviced by adults.

[23] Comment from a Chilenje teenage girl.
[24] Comment from a Sesheke teenage girl
[25] Comment from a Lusaka teenage girl .

- Most providers think teenagers are too young to be given contraceptives.
- Fear of health providers' reaction to the request on contraceptives.
- Lack of confidentiality and lack of trust with the providers as they are suspected that they may tell someone else.
- Lack of physically-friendly environment.
- Different messages being put forward by different people.
- Some staff do not readily welcome teenagers.
- Some providers think contraceptive services should be reserved for mature and adult people not children.

Further, it was noted during the group discussions that service providers, both peer educators and others, chose what they thought in their view was best for the teenagers and rather than giving teenagers a range to choose from, for example one teenage girl in Lusaka had this to say:

> 'When I entered the counselling room, the service provider asked me to tell her why I was there.When I told her that I wanted contraceptive pills, she frowned at first and told me that the best I could do for myself was to abstain from sex as pills would not provide me with protection from STDs and HIV/AIDS.'[26]

It was also found that societal reactions and expectations on teenage reproductive health tend to generally inhibit teenagers from seeking answers from adults even if that person can provide a professional service. Teenagers feel uncomfortable and suspicious of most adult persons in seeking answers to reproductive and sexual issues, in this case access to contraceptive information and service. For example, in one group discussion one teenage girl in Lusaka said that she feared going to a family planning centre as she thinks the provider will react the same way her parents react to teenage sexuality and contraceptive use saying her parents, especially her dad, always say that:

> 'Young people should behave properly and not think about sex as it brings babies, added responsibilities and creates prostitution in children.'[27]

Evidently, teenagers may not visit family planning centres because they feel that they may receive the same treatment from service providers because teenagers suspect that the views of the surrounding adults as neighbours and parents will be the same, even if they are in a professional relationship. One teenage boy in Lusaka said:

> 'If you want to buy a male condom, you can easily get one without the shopkeeper asking questions but if you go to a nurse, there will be talk first about why I want a

[26] Comment from a Lusaka teenage girl .
[27] Comment from a Lusaka teenage girl

> condom and why I am engaging in sex. *Bazakuonela mo*, meaning as a teenager you are being seen as a bad boy.'[28]

On the same issue another teenage boy in Sesheke had this to say:

> 'How would I know who I can find at the centre? It might be the people who stay next to us. Instead of asking me, I am sure she will go to my mother say that I saw your son today at the clinic and ask if I am not well and then there would be no secret. My mother definitely would ask me what I was doing at the clinic. I mean that is embarrassing.'[29]

Asked if they would want to share information about using contraceptives, the study found that only 15 teenager girls and 10 teenage boys from both Lusaka and Sesheke were willing to share and ask their parents and guardians about sexuality issues, especially that related to contraceptive service. From both sites, 15 teenage girls and 6 teenage boys indicated that the person they were most willing to talk to was their mother as they thought that their mothers may lend a sympathetic ear and give direction.

> 'I would tell my mother and would ask her a few questions on contraceptives. Of course my mother would shout at me first and explain later but I prefer her to my dad who when he is around you cannot even make noise.'

In this study, the only methods of contraceptives the teenagers mentioned were:

- Condoms
- Pills
- Injectables

Although the Lusaka youths were aware of other methods of contraception like foam and jelly. There was the issue of misinformation on the emergency pill which from the group discussions showed that teenagers thought it was taking 10 aspirin tablets before or immediately after having sex.

Just like in the questionnaires, the group discussions also covered myths relating to contraceptive use which were strong and regulated teenagers' lives both in Lusaka (75 per cent) and Sesheke (90 per cent). The teenagers think that:

- Pills cause cancer.
- Pills cause sterility.
- Male condoms give thrush.
- Taking 10 tablets of aspirin would prevent pregnancy.
- Ash, tea leaves and a mixture of strong mazoe would prevent pregnancy.

[28] Comment from a Lusaka male teenager
[29] Comment from a Sesheke teenage boy

One Sesheke teenage girl had this to say:

> 'My sister told me that if I start using pills at an early age, I will never be able to bring forth a child. (*Ma pills abulaya lupepo. Ni haiba ba bahulu a ba lukeli ku itusisa ona*). Meaning even adults are not supposed to use pills.'[30]

From the group discussions, 65 per cent of the Lusaka teenagers were found to be generally familiar with the Convention on the Rights of the Child but only 25 per cent in Sesheke could name one right. However, the teenagers did not know how applicable and relevant these rights were to their lives.

Adult community

Accepting change and managing change was found to be a major issue to both Lusaka and Sesheke parents. Although it was generally the complaint that times had changed so children's movement could not be monitored by adults. Parents generally had reservations about teenagers being given leeway to access contraceptives.

Clearly there was universal denial of teenage sexuality rights from the parents who made up the adult community. While 35 per cent of the Lusaka parents were agreeing to the idea that teenagers should access contraceptives, 65 per cent of the Lusaka adult community and 80 per cent in Sesheke opposed the idea particularly for teenage girls who they believed may be encouraged to access contraceptives and yet not be able to use them effectively .They gave their reasons as follows:

- Contraceptives will encourage and motivate the young ones into having sex.
- Teenagers were too young to access contraceptives and are too young to engage and think about sex.
- A girl who has sex before marriage is considered a prostitute.
- Because they are still young, there is no guarantee that the teenagers will use the contraceptives effectively and prevent pregnancy and STDs, including HIV/AIDS.

In one focus group discussion in Sesheke most of the respondents (80 per cent) were opposed to teenagers having access to contraceptives of any kind because they encourage sex and should only be accessed in marriage. The parents on the other hand felt that there should be no problem in boys being availed of contraceptives in form of male condoms but giving contraceptive pills to a teenage girl may affect their future reproductive functions and they would have problems in getting pregnant. Parents saw everything wrong with contraceptive pills. This discussion took place where they sell local brew *Sipesu* within Sesheke town. A male parent in Sesheke who had joined the discussion thought time should not be wasted in talking about issues of contraceptives. He said:

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[30] Comment from a female Sesheke Teenager.

> 'How can we spend time talking about a rubber *Mupila ma-pilusi* (meaning male condoms or pills for females), this age still needs care. They are still children and they need to wait till they are mature and ready to get married. Who is behind this nonsense any way, to-day it's children wanting to be given condoms, tomorrow it is children's rights. What should I do as a parent? How do I control and guide the young ones? They go to school and you tell them if you don't abstain, you should use a condom. Who is in charge? Let me tell you that I do not like these town manners. It is because of travellers that our culture has been spoiled.'[31]

On the other hand most parents – 80 per cent in Lusaka and 65 per cent in Sesheke – felt they were supposed to be consulted if and when their child was being given contraceptives, especially girls who had other options, especially the pill.

On sharing information, 40 per cent of parents were willing to talk to their children while 60 per cent still had reservations. These parents do not expect children to start having sex.

A female parent in Lusaka had this to say:

> 'Especially for girls, I am supposed to be told so that I might be of help to my daughter because I do not think my daughter can remember to take a pill daily. Maybe I can help remind her. Anyway you see this is an added responsibility I think in the end the best is for my daughter to abstain.'[32]

In Lusaka, 70 per cent of the adult community and in Sesheke, 90 per cent thought the emergence of information dissemination on radio, television, at school, in some private video shops and rural-urban movements have increased and motivated teenagers to be sexually active. In Sesheke adults thought the cross-border movements had created sexual activity among the teenagers. High poverty levels among parents also increased the chances of teenagers looking elsewhere for money which may lead them into having sex. The issue of HIV/AIDS which left teenagers as orphans encouraged some to engage in sex in exchange for money.

Some Lusaka and Sesheke adults thought teenagers as children, could not exercise their rights in their parents home since they still needed parental guidance and direction. One male Lusaka parent said the following:

> 'Children are children and as long as they are still kept they cannot claim to have a right to anything. I know that people are supposed to protect themselves from HIV/AIDS but that is another issue. Saying children are supposed to have a right to access contraceptives, is mis -directing the young ones. Let us talk about guiding our children to become good future leaders.'[33]

Another male parent in Lusaka had this to say:

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[31] Comment from a Sesheke man
[32]Comment from a Lusaka woman
[33] Comment from a Lusaka male parent.

> 'How can we spend time to talk about whether a young girl (musikana) should have the right to access contraceptive? These are still children and still need to wait till they are mature and ready to get married. That is why there are so many incurable diseases now because having sex has become a public issue.'[34]

While another male parent in Lusaka had this to say:

> 'All this talk about children having access to contraceptives encourages them to have sex. What with all these messages teaching our children about sex, sex is no longer a private word. It can be found in the sitting room. Society is broken.'[35]

Parents in both Lusaka (40 per cent) and Sesheke (95 per cent) were in agreement that contraceptive pills for teenage girls would cause reproductive and sexual problems in future. Particularly:

- Pills and injections would cause cancer among women.
- Pills cause sterility among women.
- Contraceptives encourage the youth to seek more sex with other partners.

Peer educators and youth-friendly centres

In this study, it was found that Lusaka urban clinics have youth-friendly centres and some non-governmental organizations also have adolescent reproductive centres which were reaching out to the youth in the capital city. Some of the non-governmental organizations are Young Women's Christian Organization, Planned Parenthood Association of Zambia, Care International and World Vision, among others. Some have physical structures for youth friendly services while some give support services in terms of supplying contraceptives and training service providers.

On the other hand in Sesheke it was discovered that although there were representatives of non-governmental organizations, there were no active non-governmental organizations in the areas which were catering for teenagers' reproductive and sexual health. While Lusaka had peer educators, there were no peer educators, except for school children and active teachers, who would supplement reproductive health activities, for example when commemorating World AIDS day.

One female informant form Sesheke hospital had this to say:

> 'Most activities are not available here. We cannot deny that teenagers have reproductive needs that could be addressed. This place is a border town and you know by that it means there is a lot of sexual exploitation done by older men especially to young girls who in turn have other young boy friends. But this goes to mean that being a rural town, many non-governmental organizations do not want to come here as what to come here for when you watch a foreign television station? Anyway I think the hospital, schools and the social welfare carries out information but

[34] Comment from a Lusaka male parent.
[35] Comment from a Lusaka male Adult.

> as there is no formal structure, it is difficult to cater for the needs of the youth. We can only watch.'[36]

What key informants said

The key informants from the Ministry of Health and Education in Lusaka and Sesheke indicated that they were doing the best for the teenagers under the circumstances of limited material and human resources. They reported:

- No discrimination in the provision of service,but that there is need to target negative views from society which still thinks contraceptive services are supposed to be accessed only by married couples not by unmarried teens.
- That the services are widely advertised both by government and non-governmental organizations.
- That the creation of youth friendly corners served teenagers and they thought maternal and child health was a good delivery point to access contraceptives.
- That they expected all service providers to be friendly to teenagers in the service provision.

In Sesheke, the situation was the same except that not much information was disseminated in a systematic manner like at the urban centre.

Service delivery in Sesheke was found to be wanting because there was no specific place where teenagers could go for assistance as well as to find answers to their biological questions.

It was found in this study that although parents acknowledged the fact that there is need to discuss sexuality issues with their children, there emerged the question of the age at which a parent should start talking about sexuality. It was indicated by most parents that contraception and reproductive health were not pleasant subject to discuss with children. The male parent in Sesheke had this to say:

> 'How can I start now to talk about contraceptives without touching the subject of sex? It is embarrassing. These are my children and not my wife or grand mother.'[37]

Religion as a barrier to teenagers' access to contraceptives

Religion was found to be another major factor inhibiting teenagers from exercising their sexual and reproductive rights. Christian churches react against the use of contraceptives as they think that these corrupt the moral fibre of society. Most church counsellors were refusing to accept that times have changed and that preserving life meant reflection on church doctrines and messages. The counsellors interviewed in this study related the fact that contraceptive access corrupts the young ones and that sex outside marriage is not allowed in the eyes of the creator.

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[36]One female key informant in Sesheke.
[37] Comment from a male parent in Sesheke

One male Pentecostal believer and a counsellor had this to say:

> 'The bible is very clear on the subject of sex. This is only allowed in marriage. If you give children condoms, then you are promoting lawlessness. You are encouraging young ones to continue having sex.
>
> We have to preserve their future by passing on correct virtues and values.'[38]

It was found in this study that the issue of morality was paramount and the idea of family emanating from marriage was considered to send a strong foundation for marriage. A female Catholic counsellor detached herself from the position of the church and spoke as a believer.

She had this to say:

> 'I do not believe in modern contraceptive services because it encourages sexual activities and destroys the idea of God's place of marriage. When you allow young ones to have the freedom to access contraceptives then you are sending them to experiment with each other or to be lured into having sex with older men in exchange for money. Contraceptives should be reserved for adults who are married. Children should be taught that there is a good reward in waiting to have sex at the right time.'

However, although this was so, despite messages of abstinence and natural family planning, teenagers were continuously having sex and it is a teenage girl who is more disadvantaged by getting pregnant. Further, most African Christians were living double lives and not following the Bible teaching to the letter.

[38] Comment from a Pentecostal counselor.

CHAPTER FIVE

Analysis

Getting the message across

This chapter presents an analysis of the findings presented in chapter four. Among the major discussion points are: awareness of contraceptive services availability as well as access, service delivery and problems. It also looks at the policies, laws, multiple societal controls and adolescent rights.

Information access and service availability

In the context of reproductive and sexual health, access to information can prevent serious problems among teenagers. Enjoyment of the right to health requires, among other things, access to correct and motivating health information. The right to preserve the health of teenagers through preventative care requires that teenagers are given information and knowledge about their bodies and its functions. As shown in this study, there was a clear gap between urban and rural respondents in terms of access to information. While 80 per cent of the Lusaka teenagers had information on contraceptives, only 40 per cent of the Sesheke teenagers had this information. When it came to the issue of where to access these services, 90 per cent in Lusaka knew and only 10 per cent in Sesheke. This means that although one can get information the practical side of service availability becomes a stumbling block in accessing contraceptives. It was also found that information about contraceptives is got from peers, school, radio and posters mostly by the Lusaka teenagers (70 per cent) while only 20 per cent got this information in Sesheke. So in this study, information tended to be incomplete as far as empowering teenagers to make the right decisions and choices about their reproductive and sexual health. The incomplete information left teenagers to interpret issues about their sexual and reproductive health and also on contraceptive use. For example, in this study it was found that certain teenagers confused emergency contraception or the 'morning after pill' with ideas they passed around as their own interpretation. Some teenage girls thought that emergency contraception meant taking 10 aspirins before or after having sex. It is no wonder that some teenagers are surprised that their wrong choice of prevention of pregnancy did not do anything and soon enough they discover that they are pregnant! One teenage girl from Misisi compound had this to say:

> 'I thought I was smart and knew how to prevent pregnancy. My friends had told me that you could not get pregnant if you take 10 aspirin tablets before or immediately after you have sex. The method was said to be 'not human' and referred to as *Chigayo* meaning hammer mill. Before long I noticed there was a big lump in my stomach, I thought I was diseased and asked my mother. She took a good look at me and she started crying fearing what my father would do to me.'

Most service providers and administrators feel that putting messages at the roadside will motivate teenagers to visit the centres but it takes more than a poster to encourage a

young person to seek services in a world of so many conflicting values and beliefs. So access and services being advertised require more effort than just the advert itself. This study found that there were various issues which discouraged teenagers from visiting the family planning centres. It was found that physical location of youth friendly corners had a negative impact on teenagers visiting the centres in Lusaka. In one instance, the centre was next to an injection room while in another it was being serviced from the maternal and child health centre which caters for ante-natal and post-natal activities. The teenagers in this study expressed concern as to what one teenage boy around Chilenje termed as *ma one* meaning not able to feel free to enter such a place. It was found teenagers like visiting the youth friendly centres when they know that there are fewer adults around. This means that there is a huge gap in terms of access to services considering the fact that Zambia has a youthful population with sexual encounters starting around and before teenagers reach the age of 15.

In Sesheke, it was found that services for teenagers were not specific and service providers expected teenagers to access services along with adults during the normal general hospital activities. It was clear that there was no specific area where teenagers could go for contraceptive service. This created a huge gap and clearly the teenagers are busy navigating through a set of conflicting messages and service delivery.

While the Zambia family planning policy empowers every service provider to provide services to everyone, including teenagers, the study showed that because of lack of regular, up–to-date training some providers still held the view that teenagers have no right to walk into a centre and ask for contraceptives. Clearly, sexually active teenagers found this attitude a big draw back in their quest for answers and services.

As stated earlier, there are many problems with service delivery and access and one is that there are too few centres or delivery points. While Lusaka youth, being from an urban centre, recorded about 60 service points for the youths, no centres were found in Sesheke. Ignorance on where to get the service was greater in Sesheke (90 per cent) than in Lusaka.

Societal values and beliefs as barriers

Societal values and beliefs are barriers to contraceptive services as without proper education about methods of contraceptives, myths continue to guide people's lives. There was a clear cultural and societal belief that still played an important role in the life of most teenagers and parents. In group discussions both talked about what contraceptives can do to the human body and reproduction; this was especially so for teenage girls. Some still held views that there are serious consequences if one uses these methods, especially the pill and injectables. These myths and beliefs as stated earlier form our everyday social practices and as such they become part of what informs our decisions.

During a group discussion in both Lusaka and Sesheke, it was clear that these beliefs are strong and would not go away without proper programmes of sex education and communication for both teenagers and parents. One teenage boy in Lusaka reiterated this position when he said:

'I have heard from friends that pills cause cancer, a disease that has no cure just like HIV/AIDS.'[39]

Myths form beliefs which influence social practice. Teenagers are growing up in a society where norms, values and beliefs are re-enforced through different structures and institutions of religion, family and other sub-groups. Speaking to teenagers in this study revealed that they were receiving different messages from the churches, from their own parents and from their peers. Clearly there was a lot of misinformation about sexuality, contraceptive use and when to start having sex. Having sex was often related to prostitution especially for girls although these girls were just teenagers and in some cases sleeping with men old enough to be their fathers. In a study by Malambo (1999)[40] the author encourages parents to teach their children while they are still young yet most parents in this study showed a negative attitude towards teenage sexuality and contraceptive access citing that they are too young to start engaging in sex. Annie Lene Staib (2000)[41] talks of changing patterns of sexuality and sex education information in an era where parents were still holding to what was appropriate when they were growing up, which in practice is no longer possible.

Myths surrounding contraceptive use go beyond what people speculate to what they think is true giving an example of how some women could not have children because of contraceptive use while they were still young. This it would seem needs to be tackled because it will further disadvantage sexually active teenagers.

Communication between parents and children

The moral panic from adults in this study showed that there was lack of understanding, reflection and acceptance from most parents in managing change. Parents still thought that the way they were brought up should be the way their children should grow up not appreciating the fact that there are socio-economic, changes which affect society as the years go by. Teenagers no longer spend their time in the confines of their homes.

Religious beliefs and positions

Religious and institutional stands and beliefs were found to be an inhibiting factor in this study. In both Lusaka and Sesheke teenagers were exposed to different messages both from churches, non-governmental organizations and from traditional structures. For example, while line ministries were encouraging teenagers to visit service providers to access contraceptives, churches were preaching abstinence, non-usage of condoms and chastity. As such the religious beliefs raise the issue that up to this time, reproductive health for teenagers remains a controversial issue. For example, in January 2001, the Zambian government suspended a television advertisement campaign promoting the use of condoms as a protection against HIV, particularly among young people.

[39] Comment from a teenage boy in Lusaka.
[40] Malambo, R (1999)Teach them while they are still young.
[41] Staib, A.L.(2001) Women's Human Rights and Reproductive Autonomy.

Indeed this tended to give teenagers conflicting views on the issue of sexuality and the promotion of teenage sexuality. The Bishop's Conference spokesperson said:

> 'The adverts are offensive and in bad taste. They suggest to children and youth that sex is something nice to have provided it is done with a condom.'[42]

So teenagers are confronted by religious values that impact negatively on their access to contraceptive services because of conflicting statements and doctrines. This is also supported by one female counselllor who spoke as a believer and not on the position of the church:

> 'Contraceptives can encourage the young ones to have sex.It defeats God's purpose for a family and sex within marriage.'

The youth-friendly centres in Lusaka were trying their best to reach out to the teenagers. It was noted however that the availability of contraceptives was erratic which further disadvantaged teenagers as supplies were not found at all times. As for the teenage girls it was found that the most available contraceptive was a male condom in both Lusaka and Sesheke. While a female condom was not available in Sesheke, it was noted however that this was given at a fee within the maternal and child health centres in Lusaka. This explains why female condoms were not known to many teenagers in this study. It was noted that only 10 teenage girls had seen a female condom. There was clearly discrimination in service provision because despite teenage girls being biologically more disadvantaged, no special attention was paid to them. This study indicated little attention was paid to the reproductive and sexual health of teenagers in general but that teenage girls were found to be in a more precarious position. Further, there was less attention paid to the supply of physical and material resources in this centre. One teenage girl in Chilenje area complained that resources seem to be free for teenage boys but not for the teenage girls:

> 'Why do we have to buy condoms when the boys are given freely?'[43]

There was a clear position of unmet needs for the teenagers as especially teenage girls seemed to have a wider range of reproductive health needs than those usually dealt with at most maternal and child health or youth-friendly centres.

Most information on contraceptive services as well as knowledge of reproductive health was absent in centres, except the Lusaka youth-friendly centre which had a comprehensive reproductive health curriculum. It was found through group discussions that 70 per cent of teenagers in Lusaka and 65 per cent in Sesheke needed knowledge that went beyond accessing a condom or pill and answers to questions they had regarding their bodies. One teenage girl in Sesheke had this to say when asked what she would like to see happening concerning contraceptive information and access:

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[42] Pastoral letter -Zambian Catholic bishops Conference (2001)
[43] Comment from a teenage girl in Lusaka

> 'I want to see that one is taught more on how our bodies function. So that I know what is right and wrong for me. Not, *No, don't do this, don't do that*, we need to know as teenagers what is best for our bodies.'

Accepting change and managing change was found to be a major issue for both Lusaka and Sesheke parents. Although times are changing and children's movement cannot be monitored step by step, adults still have reservations about teenagers being given leeway to access contraceptives.

Concluding the story of sexually active teenagers' lives

Barriers to positive change: in the light of HIV/AIDS

While teenagers in this study have shown that they are interested in accessing contraceptives many barriers still stand in their way. These barriers can be classified as age restrictions for those teenagers who are not married, attitudes of service provider staff, conflicting messages, negative expectations of different stakeholders, lack of policy direction and inconsistencies in the law regarding how teenage rights are supposed to be tabulated and implemented. Lack of co-ordination and planning for youths' activities means that they are vulnerable and at higher risk. It becomes a vicious circle. Once you deny a teenager a service, the teenager is left to source answers to the questions from what that teenager thinks is the only way out which can be from unreliable sources.

Communities in Zambia cannot afford to cling to traditions which are no longer relevant to the present scenario when the same teenagers are being infected with STDs. Communities in Lusaka, Sesheke and the whole of Zambia cannot afford to sit and observe from the sidelines. Concerted efforts and programmes have to be put in place to improve the lives of teenagers.

Denial of services puts teenagers at risk in the wake of the HIV/AIDS pandemic through exposure to STDs. What must be realized is that times have changed and there is need to take stock of the present situation, make plans and be able to answer the question of the middle generation gap. Teenage rights can not at this moment be ignored as daily, teenagers are contracting the virus due to a lot of factors like poverty, lack of service, negative service provider attitudes, hostile and unfriendly environments and lack of supplies of contraceptives.

Actors for positive change

In this study, there was a positive position in the key people who were heading both government institutions. Consequently there is need to use their influence and position of standing to bring about change. Key actors for positive change could be instrumental in enabling communities to do a self examination of their beliefs, attitudes and negative

taboos. The actors for change, who in this case include government workers, could be used effectively, not only to plan but also to holistically co-ordinate activities in their own communities. Traditional and religious leaders, other key people las diverse as musicians and traditional birth attendants could also be used as actors for change. These might need to be trained and offered initial support to put comprehensive programmes in place.

Policy and legal measures

The needs of teenagers are often left out of the planning process and neglected. In this study, it showed that various barriers contribute to teenagers lack of access to contraceptives. The ZDHS 2001-2002,[44] as earlier stated, showed that by the age of 15 to19, 17 per cent of teenagers have already started sexual activity. This shows the importance of planning to meet with interested groups as this relates to the youths' rights to reproductive health and development.

Laws and policies fail to give sufficiently clear guidance and it was found in this study that most service providers did not have enough information about the family planning policy, and had not even seen or read the guidelines. This left service providers to use their own discretion in offering services and whether this was done correctly and to the benefit of the teenager was debatable.

There was a serous problem of counselling young people to make right choices. No counselling was done as the provider indicated that there were other pressing issues which needed to be attended to. So no special care was given to teenage girls who were often frustrated:

> 'I went in the room, and the health provider took one look at me and asked what I wanted. When I told her, she told me that she won't give me the pill because I might forget to take one each day. She suggested to me that the male condom was better as it also prevents STDs including HIV/. I was not happy because I wanted a pill, not a male condom.'

So the providers in this case did not provide counselling but used their own discretion in denying the teenager contraceptives because of their own belief about the correct thing to do.

The policy further indicates that the ministry will support 'any measures and any of their political and service provision implications on behalf of the nation'. This means that the Zambian family planning policy contradicts the law in many ways and gives dual service provision rules depending on who is given the service. For example, the Zambian family planning policy practices which, until now, have not been routinely applied in the delivery of family planning services has done away with certain provisions, for example, it has abolished the need for parental consent.

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[44] Ibid ZDHS 2001-2002

Also, adolescents are now eligible to receive reproductive health care services and be provided with contraceptive methods such as the IUD by paramedical personnel. Trained nurses can insert IUDs even though the general nursing council regulations do not allow this.

Ministry of Health further permit community-based distributors (CBD) to distribute oral contraceptives even though the Medical Services Act[45] would appear to prohibit all physicians and pharmacists from doing so.

This, as can be seen, is creating double standards in the provision of services and so the interpretation is left to the discretion of the service deliverer.

The Zambian constitution and teenage reproductive rights

Under the Zambian constitution, Article 23 [46] gives protection from discrimination, at least on paper as it provides for non-discrimination of citizens based on gender, place of origin, colour, sex, age and tribe. The constitution does not allow different treatment for different citizens or differing political opinions but, as noted in this study, teenagers were discriminated against in information access and in their desire to access contraceptive services. It was found that religion, customs and traditional practices discriminate against teenagers in as far as their access to contraceptive services. Among adults interviewed, 75 per cent could not agree to teenagers as a separate group with reproductive needs that require attention. Equally, service providers were discriminating in their service provision to sexually active teenagers. The service providers were denying teenagers the right to seek contraceptive services. For example, during an interview in Lusaka, one teenage girl reflected on her experience:

> 'I never knew there were youth friendly centres. I decided to go to a family planning centre to seek advice.The provider was not happy with me. She told me *Ukali mufana maningi* (You are still too young to start having sex). I was given a male condom to give to my boy friend. But I was not interested in a male condom but some family planning pills and I did not want my boy friend to know because he might think I also date other boys. I was not happy. But what could I do?'

The Convention on the Rights of the Child further obligates states parties to put measures in place to promote the best interests of the child. Zambia is party to this convention but in practice the best interests of the child are not promoted since not even the definition of a child is articulated in the constitution. What is in place are child-related laws that are specific depending on the occasion. For example, the Convention on the Rights of the Child recognizes a child as one who is 18 years and under while in Zambia this is subject to different interpretations and disadvantages the teenager in service provision as this can be open to manipulation, for example, legal and medical counselling only allows access to those over 21 in the absence of consent by parents or guardians.

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[45]Medical service act 1992.
[46] The Constitution Of Zambia article 23

The Marriage Act, Chapter 50, [47]stipulates that any person below 21 years requires the written consent of a parent or guardian before marriage is contracted. However, customary law allows for contracting of marriage after the attainment of puberty but with parental consent, although in most rural areas this may happen after elopement. In terms of sexual health, the unmarried teenager may be denied services while her married counterpart will be able to access a service. This also may refer to a girl who will have attained adulthood by emancipation. This also was found in this study to be sending different messages to the community. For example, in one group discussion in Sesheke, a nineteen year old with two children was told to join a group discussion of adults although she was still a teen. As such teenage girls were found to be the most disadvantaged.

While Article 2 of the Convention on the Rights of the Child[48] talks of the best interests of the child but the principle of best interests is not expressly stated in the constitution. However, a number of statutory provisions exist which are considered to be in the best interests of the child.

Having differences in the definition of a child spells and creates disparities in social practice as was found in this study. Best interests of the child was not found to be followed by policy planners and service providers as there were no teenage friendly centres in Sesheke while at Lusaka centres, supplies were found to be erratic.

Respect for views of the child may exist on paper, according to the Convention on the Rights of the Child, but it seems to contradict the roles of parents in Article 5 where state parties are obligated to respect parents' views, responsibilities, rights and duties. Clearly the provision also limits parental rights in that they can be exercised consistent with the evolving capacities of the child.

For example, the Convention on the Rights of the Child Article 12(1) states that state parties shall assume the child is capable of forming his or her own views, and has the right to express those views freely in all matters affecting the child, being duly weighted in accordance with the age and maturity of the child. This right, as Himoonga (1998) writes, relates to participation, freedom of expression and the right to be heard. This rarely happens as was noted during the study – one teenage girl in Lusaka had this say:

> 'I went to the youth-friendly centre because I was pregnant. I wanted them to assist me because I feared my parents. They started telling me about the dangers of abortion and saying it is good to keep the baby. I was unhappy. I went away crying'[49]

Instead of referring the teenager to the doctor, the service provider did not respect the views of the teenage girl in question as they interpreted the situation according to what they knew and their limitation in what service they could offer. This to a Zambian teenager would seem to be a contradiction as most parents in Zambia still have the view

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[47] The Zambian Marriage act Chapter 23
[48] IBD CRC 1990
[49] Comment from teenage girl of Lusaka.

that as long as they still hold parental responsibilities, the teenager can not have the right to decide what is best for her or him.

In social practice traditional structures gave children the rights expressly as (Himonga,1998)[50] writes:

> 'In traditional society Zambian children were seen but not heard.'

As such, even though Article 5 of the Convention on the Rights of the Child gives rights to parents the article also gives the local customs a role in defining parental responsibility and making decisions on behalf of the child. This does not respect the views of children in as far as making decisions about their reproductive and sexual rights. On the other hand although there are all these inconsistencies, between law policy and social practice, adolescents who seek information and services on contraceptives do so because they have evolved the capacity and maturity to seek services that will prevent harm to their bodies

[50] Himonga,C (1998) in Culture Tradition and children's rights.

CHAPTER SIX

Conclusion: Teenage reproductive and sexual rights

Zambia has ratified the following United Nations conventions:

- Convention on the Elimination of all forms of Discrimination Against Women, 1979;
- Convention on the Rights of the Child;
- The African Charter on Human and Peoples Rights;
- The African Charter on the Rights and Welfare of the Child;
- The International Covenant on Civil and Political Rights.

For this research, it would seem that the instruments relate to the promotion of teenage reproductive health but whether these are followed domestically by Zambia is another matter.

One of the key reproductive health needs of adolescents is the need to access contraceptives to prevent unwanted pregnancy and sexually transmitted diseases (STDs), including HIV/AIDS. The international community defines adolescents as people between the ages of 10 and 19, youth as people between the ages of 15 and 24 and young people as people between the ages of 10 and 24 so as to encompass adolescents and youth. The Convention on the Rights of the Child defines a child as a person below the age of 18.

If teenagers are armed with appropriate services and information on contraception and STD preventing they will be better able to guard themselves against early and unwanted pregnancy and exposure to STDs including HIV. Removing the barriers to access will give young people the opportunity to become productive citizens.

Teenagers are exposed to the risk of contracting STDs, including HIV and teenage girls are even at more at risk, with early, unwanted and unplanned pregnancies. These categories in the Zambian population are at higher risk of contracting HIV.Most teenagers are still and receiving conflicting messages about HIV/AIDS from leaders, including top government officials. Although signing an international agreement might not be binding, they reflect commitment through which governments are given detailed guidance to their obligations. But as it has been noted, access to contraceptives in Zambia is inhibited by inconsitencies in policy between the supreme law, government implementation and political statements and decisions. For example, the Zambian Minister of Education[51] recently banned the distribution of contraceptives in schools by non-governmental organizations saying the distribution of condoms to boys and girls in school could, instead of protecting them from HIV/AIDS, encourage them to engage in pre-marital sex. He was supported by his counterpart from the Ministry of Health who supported him and said:

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[51] Comment from the Minister of education.www.post.co.zm.

> 'We are not teaching the young ones the morality that is required. Children have no business to engage in sex, they have to wait until they are married.'[52]

The political statements are inconsistent with, firstly, international obligations to which the country is party. Secondly, this contradicts Article 23 because the reproductive needs of this age group are clearly discriminated against. Further, the political decision contradicts what the family policy guidelines and strategies are trying to achieve in taking care of the reproductive and sexual health needs of sexually active teenagers. This not only sends different messages to teenagers but also to service providers and adults at the expense of the future of teenagers. This is all being done while government is struggling with the reality of the high number of teenagers being infected with HIV daily. The reality is teenagers are not stopping having sex. This is why we have laws, policies and international obligations which are supposed to guide the welfare of the teenagers rather than lead to political statements that misdirect teenagers.

The Convention on the Rights of the Child strongly supports children's rights, which include the rights to privacy and confidentiality. Article 3(1) states that in all actions concerning children 'the best interest of the child shall be a primary consideration'. Further than being binding to Zambia, the actual promotion of children best interests falls away since there are so many barriers to achieving them, including multiple policy directions coming from different key people in leadership positions.

On parental rights, the Convention on the Rights of the Child still refers to the issue of all stakeholders doing all they can to achieve that which is in best interests of the child. Article 18(1) on parental rights and children's interests says:

> 'As long as parents have the primary responsibility for the upbringing and development of the child, the best interests of the child will be their basic concern.'

The African Children's Charter also points to the same parental protection as well as freedom for the teenagers. International standards of the Convention on the Rights of the Child and African Charter support the interests of teenagers in reproductive and sexual health. Children should be left to seek contraception as this is their protection. Preventive care is the right to information and education which can prevent long-term health problems.

Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), contains most direct specification of reproductive autonomy or freedom. This provides the general right to family planning information and services as a right to health. While the focus is on women and girls, it set standards for a broad-based right to reproductive health information. Article 12 provides that:

> 'State parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.'

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[52] Comment from the Minster of Education.www.post.co.zm

In addition, the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) recognizes information as a prerequisite of effective access to health service. The provisions refer to reproductive health information and services for adolescents or teenagers which should include information on contraception and STD prevention. In the general recommendation, it says that states should:

> 'Ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their rights to privacy and confidentiality.'

CEDAW has repeatedly paid attention to and articulated the right of adolescents to reproductive health care and information. Article 16 refers to the right to decide freely and responsibly on the number of children they have and access to information, education and means to enable them exercise these rights.

With regard to economic, social and cultural rights, Article 13(1) which deals with the right to education says that states must:

> 'Adapt to the needs of changing societies and communities. This is done in the light of promotion and provision of sex education to teenagers.'

The International Conference on Population and Development (ICDP*)* acknowledges that access to reproductive health information is a precondition to fulfilling the right to access family planning services, and it links adolescents' right to information on family planning, including contraception and STD prevention methods to their rights to health and to education. It calls on government to provide appropriate, specific, user-friendly and accessible services to teenagers.

The Beijing Conference reaffirms this:

> 'The right to the enjoyment of the highest attainable standard of physical and mental health protects and promotes the attainment of this right for women and girls.'

It links reproductive health services and information to the right to health as well as the rights to education and information. Stressing the importance of proper dissemination of information to ensure adolescent girls' access to reproductive health free from all forms of discrimination, laws and policies and social practices that discriminate against teenagers based on different specified ground. For example, in social practice an unmarried teenager may be discriminated against by status, age, gender, socio-economic status and marital status.

Regional instruments

The African Charter guarantees that:

> 'Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.'

Article 11 refers to children's rights to education and says that states shall:

‘Develop preventive health care and family life education and provision of service.’

Article (5) relates to the right to respect of the dignity and privacy of individuals.

International and regional instruments are striving to obligate state governments to improve the reproductive lives of the teenagers. It can only be left to the Zambian government to harmonize the pieces of legislation and bring them into harmony with international law. It is also noted in this study that much needs to be done to target the constitution and harmonize the specific child-related laws to make them in line with the Zambian family planning policy, guidelines and strategies, so that there is a clear-cut policy direction when dealing with reproductive and sexual health of teenagers. This could go a long way towards improving their lives.

Conclusion

Lastly teenagers are a group within one generation which cannot be ignored; they need to be put on today’s and tomorrow’s plans. They are sexually active and they need protection, education as well as information that will empower them to take care of their reproductive and sexual needs. The combination of sexually active teenagers’ experiences and the current approaches to service delivery revealed that a lot needs to be done. Service providers should be able to offer a service regardless of who comes into their centre looking for assistance.

Information should target all areas, especially rural places which were found to be lacking in terms of information and service provision. Sex education and imparting knowledge should involve and target parents and all adults. Government and societal views at large were found to be barriers affecting teenagers’ access to contraceptives. It is not enough to assume that decrees by circulars or policies will guide the process of service delivery or that a policy will be easy to implement without the monitoring of activities and providing financial support.

When teenagers start to ask questions relating to their reproductive health, in effect they are asking for what needs attention to improve their lives. No amount of religious piety preached or traditional expectations of what is morally correct will make teenagers stop having sex as that is a response to both physiological and social needs. In this era of HIV/ AIDS, parents and policy makers need to realize that the less they talk about abstaining the more they can implement programmes that will improve the lives of teenagers.

Plan of action

Search for a better solution and approach

Clearly, in this study several issues have been highlighted as inhibiting teenagers’ access to contraceptive services and use.

Access to contraceptives

There is need to raise awareness on the special needs of teenagers by defining clearly what their reproductive and sexual health needs are, especially in relation to physical delivery of services and emotional as well as social counselling.

There is need to decide exactly where these services for teenagers, especially those targeting the girl child, should be. Influencing access also requires advocacy which means different areas need to design reproductive and health messages that are culturally and socially appropriate, practical, relevant and promote the positive elements for the benefit of sexually active teenagers.

There is need to design intervention programmes that will cover education that encourages responsible sexual behaviour in teenagers with increased knowledge and availability of guidance and counselling services.

Coordination of services

There should be holistic co-ordination of services that should target not only teenagers but their parents. Evidence of sexual activity among girls of 12 and even younger points to the need to develop appropriate intervention programmes for teenagers.

Reproductive health as a human rights issue

Clearly teenagers are living and navigating their way through confusion and so continuous advocacy on reproductive health as a human right by both international non-governmental organizations and local ones should continue (this as it relates to teenagers, especially girls).

The role of non-governmental organizations, churches, parents and traditional structures

Condemning outright the question of contraceptive access by categorizing the issues to teenagers as unbiblical without dealing with the realities of life will not save the lives of teenagers who continue to have sex. There is need for different churches to put measures and plans into place that reflect the reality of sexuality in society.

There is need to put in place comprehensive sex-education programmes in churches so that teenagers receive not only spiritual messages but also messages that give them life skills and empowerment.

Curriculum for parents' education should be put in place and strengthened so that parents are able to accept change and manage change as it occurs. This parent education should enhance communication between parents and their children.

Churches, non-governmental organizations and other traditional groups should work at changing negative norms and beliefs that do not enhance human development, especially for vulnerable groups like teenagers.

There is need to promote the training of church, non-governmental organizations and other community service providers, including peer educators, in different locations where they have a representation.

There is need to promote the issue of human reproductive and sexual health, especially that related to girls, within the doctrines of the churches, activity of non-governmental organizations and traditional groups as it relates to norms and beliefs.

Youth friendly services need to be created countrywide using existing structures.

Research

Continuous research to assess contraceptive access, service delivery, and changes in attitudes by communities should be promoted.

Laws and policies

Clearly the Zambian government needs to harmonize the various laws and policies concerned that act as barriers to teenagers, especially girls, accessing contraceptive services. These pieces of legislation should be put into one comprehensive body of child-related laws to be able to send one legal message to the whole community.

Supervision and co-ordination of family planning would ensure a comprehensive, multi-sectional implementation throughout the country.

Laws and policies should be disseminated to all stakeholders so that teenagers are not prohibited from accessing contraceptive services.

There should be clarity in the law and policies with similar terminology so service providers comply with and implement practices in line with international obligations.

The definition of a child should be put into the constitution as a guide to all future policies and regulations.

There should be a specific budget to cater for the teenagers' reproductive and sexual health in relevant ministries.

A national plan needs to be implemented to train service providers to educate teenagers, document issues but maintain teenagers' right to confidentiality.

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