



REPUBLIC OF ZAMBIA  
MINISTRY OF HEALTH



**Knowledge and use of Sexual  
Reproductive Health and HIV services  
among Adolescent Girls and Young Women  
in Central and Western Provinces:  
A Qualitative Knowledge Attitudes and Practices Study**



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## ACRONYMS

AFP	Adolescent focal point
AGYW	Adolescent girls and young women
ANC	Antenatal care
ART	Antiretroviral therapy
CHA	Community health assistant
CSO	Central Statistics Office
CWAC	Community Welfare Assistance Committee
DHS	Demographic and Health Survey
DHD	District Health Director
DHO	District Health Office
FGD	Focus group discussion
GRZ	Government of the Republic of Zambia
HIV	Human immunodeficiency virus
HMIS	Health management and information system
IDI	In-depth interview
IEC	Information, education and communication
IRB	Institutional Review Board
KAP	Knowledge, attitudes and practices
KII	Key informant interview
MCH	Maternal and child health
MOH	Ministry of Health
NHCs	Neighbourhood health committees
NHRA	National Health Research Authority
PHO	Provincial Health Office
PMTCT	Prevention of mother-to-child transmission
SDG	Sustainable development goal
SGBV	Sexual and gender-based violence
SMAG	Safe Motherhood Action Group
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health rights
STIs	Sexually transmitted infections

# EXECUTIVE SUMMARY

## BACKGROUND

Adolescents and young people aged 10–24 comprise about a third (33 per cent) of the Zambian population (Census Population and Demographic Projections: CSO, 2013). This group faces several challenges in accessing sexual reproductive health (SRH) services. Further, adolescent girls and young women (AGYW) aged 15–24 are disproportionately affected by poorer sexual and reproductive health (SRH) outcomes. Although significant structural and legal reforms in addressing sexual and gender based violence (SGBV) have been undertaken, Zambia continues to record a very high rate of physical violence against women. The Demographic and Health Survey 2018 indicate that 21 per cent of adolescent girls (15–19 years) and 34 per cent of young women (20–24 years) report have experienced physical violence and 12 per cent and 18 per cent respectively report having been subjected to physical violence in the last 12 months (often or sometimes) (CSO, 2018). Socio-cultural norms, the status of women, and attitudes and acceptance of SGBV have all been highlighted as underlying causes.

This study aimed to gain an in-depth understanding of the knowledge, attitudes and practices around SRH and HIV, focusing on the prevention of mother-to-child transmission (PMTCT) of HIV among adolescents and young women of reproductive age (15–24 years old) to inform interventions to improve the uptake of SRH/PMTCT/HIV/SGBV services.

## METHOD

The study employed a qualitative approach involving key informant interviews (KIIs), focus group discussions (FGDs) and in-depth interviews (IDIs). The participants included provincial, district and facility-level health officials, HIV support groups, Safe Motherhood Action Groups (SMAGs), and HIV-free and HIV-positive adolescent girls and young mothers aged 15–24 years. The study covered a total of 84 participants contributing through 17 KIIs, 10 FGDs and 4 IDIs. The study was conducted in two districts in Western and Central provinces. Specifically, the study covered the following sites: the Provincial Health Offices in Western and Central provinces; the District Health Office and four health centres in Senanga District; and three health centres and the District Health Office in Kabwe District.

## SUMMARY OF KEY FINDINGS

### FACTORS THAT INFLUENCE ACCESS TO SRH/PMTCT/HIV SERVICES FOR ADOLESCENT GIRLS AND YOUNG WOMEN

- *Low socio-economic status continues to affect access to SRH and SGBV services for adolescent girls and young women (AGYW). A reported barrier to access is the informal fee<sup>2</sup> charged to young girls who do not attend antenatal care (ANC) with partners or spouses.*
- *Continued engagement in transactional sex due to poverty increases the risk of contracting STIs and HIV, and of unwanted pregnancies. Poverty and a lack of the means to pay for key needs and other expenses are linked to greater vulnerability to poor SRH outcomes of adolescents, particularly for girls.*
- *The lack of action or delayed action against the perpetrators of SGBV discourages survivors/victims from reporting such cases. The findings reveal concerns that many cases go unreported. Even after reporting SGBV, it was reported that sometimes no action is taken*

<sup>2</sup>The study found that some health facilities required women attending ANC to be accompanied by a spouse and if this was not possible, to bring a letter from a village headman/chief. This letter has to be paid for.

by the institutions responsible for punishing offenders. GBV survivors often prefer to use customary approaches to deal with GBV rather than the formal legal system.

- *Lack of spousal or partner support discourages the use of SRH services, including ANC and family planning services, among AGYW. Community-level education campaigns on SRH, including family planning, need to target both men and women to allay fears and address misconceptions around family planning.*
- *Religious practices around HIV, such as faith-healing, particularly in urban areas, prevent the continued uptake of antiretroviral therapy (ART).*
- *The lack of privacy at health facilities, combined with a perceived lack of confidentiality and judgmental attitudes, discourages the use of SRH and HIV services.*
- *The findings suggest that orientation and training in adolescent health needs to be targeted not only at health workers but also at a range of other non-clinical workers in health facilities, and at community workers who interact with AGYW such as Community Welfare Assistance Committees (CWACs) and Neighbourhood Health Committees (NHCs).*
- *High attrition rates of peer educators and a lack of funding to support their work disrupts service provision; lack of training among peer educators also leads to loss of confidence in the messages they communicate to this group.*
- *Health education and illustrative information, education and communication (IEC) material is key in improving awareness of SRH. Educational talks during ANC provide adolescents with useful information, such as the importance of good nutrition. However, the presence of older women makes adolescents uncomfortable and discourages their full participation. Language is also a barrier; while educational materials are readily available in most health facilities, the content is mostly presented in English.*
- *Radio and social media are effective communication platforms from which IEC initiatives can reach out to young women on SRH and HIV issues. The use of social media for information and discussion of SRH matters is also increasingly gaining popularity among adolescents, particularly in urban areas.*

#### **ATTITUDES, BEHAVIOURS AND PRACTICES THAT INFLUENCE AGYW ACCESS TO SRH/PMTCT/HIV SERVICES**

- *Adolescents and young mothers are generally aware of the importance and benefits of ANC – but there is limited understanding of the importance of first trimester ANC visits. The study also found that awareness of family planning options is lower among young adolescents and particularly those pregnant for the first time.*
- *While awareness of the existence of HIV is near-universal, misconceptions around transmission mechanisms still exist in this age group.*
- *Some HIV-positive adolescent girls and young women lack a general understanding of how to prevent transmission from mother to child after birth, or the appropriate time to take ARV medication.*
- *AGYW prefer to disclose their HIV-positive status to their parents rather than partners or peers. The study found low disclosure of HIV status to partners for fear of stigma, abandonment and neglect of children.*
- *Stigma and discrimination within communities continues to be a barrier to accessing SRH and HIV services.*



## HEALTH WORKERS AND INTEGRATED SRHR/HIV/SGBV SERVICES

- *Integrated SRH and HIV services are on offer to adolescent girls and young women but they have concerns about the current approach to service delivery. For instance, providing HIV services during a child health clinic may have a negative influence on a mother's adherence to ART.* While the majority indicated that they are comfortable with integrated family planning and HIV services, the majority were not comfortable with integrated HIV and child health services. There may be an issue with a lack of privacy because it is obvious to all the clients present when an HIV-exposed or infected child is given medication while others are not. The need to ensure privacy is thus critical.
- *Integrated health service delivery is challenging in cases where there are few staff, and/or a lack of infrastructure and equipment.* This study found that, in some cases, facilities may not have the equipment to offer integrated HIV and SRH services, or they may not be accredited as an ART clinic. When clients tested for HIV at one facility are referred to another, there is a danger that they will be lost between the two.

## ATTITUDES, BEHAVIOURS AND PRACTICES AMONG AGYW THAT CONTRIBUTE TO LOSS OF HIV-EXPOSED OR INFECTED INFANTS TO FOLLOW-UP SERVICES

- *Self-perceived stigma and lack of disclosure of HIV-positive status to partners or family are among the key contributing factors to non-adherence to HIV treatment and mother-infant loss to follow-up services in this group.* The study also found that more HIV-exposed or infected infants are lost to follow-up services when immunization is complete. This suggests the need for innovative approaches to revitalize the growth monitoring of children at facility level beyond vaccination programmes.
- *Lack of disclosure of HIV status to spouses or partners affects ART adherence and contributes to infant loss to follow-up care.* The study showed that most AGYW found it difficult to disclose their status for fear of marital problems, rejection or stigma. The lack of disclosure of HIV status was more pronounced among those not adhering to ARV treatment than among those who consistently used the medication. Ensuring the support of intimate partners is crucial for preventing onward transmission of HIV.

## RECOMMENDATIONS

### INFORMATION, EDUCATION AND COMMUNICATION (IEC) MATERIALS

- There is a need for less technical, more accessible IEC on SRH, family planning and SGBV to ensure wider readership and understanding among adolescents and young people. The materials and programmes need to be simplified and presented in local languages for each target area, using a range of communication channels including radio, TV, social media and digital platforms such as U-Report, Internet of Good Things and Tune Me which have adolescent audiences in Zambia.

### MALE INVOLVEMENT AND PARENTAL ENGAGEMENT

- There is a need to target adolescent boys and young men on the importance of supporting their partners to access SRH, HIV and family planning services.
- Male engagement programmes that focus on youth mentorship to promote the use of SRH services among adolescents and young people need to be prioritized.
- Interventions should focus on parental training and establishing community dialogue to build a supportive environment that encourages adolescents and young people to access SRH services.

## AWARENESS-RAISING CAMPAIGNS AND CONTINUOUS DIALOGUE WITH KEY STAKEHOLDERS

- Awareness-raising campaigns on family planning and SRH that target younger adolescents (under the age of 15) in school and out of school are recommended as a preventative measure to combat early pregnancies and HIV infection. Younger adolescents particularly lack understanding of family planning, including matters such as the right age to start using contraceptives and how to deal with their side effects. Awareness campaigns should be supplemented with long-term life skill programmes that target adolescents in and out of school and also address family planning issues.
- Awareness campaigns also need to dispel mistaken cultural beliefs and concerns among AGYW and their communities about the side effects of modern family planning methods.
- Awareness campaigns need to emphasize the need for dual protection through the use of condoms and contraceptives to reduce the risk of HIV transmission and HIV acquisition among AGYW. There is a need to demystify the belief that other forms of contraceptives, other than condoms, can also prevent one from contracting HIV.
- Community awareness campaigns targeted at AGYW (aged 15–24) and younger adolescents (aged 10–14) need to emphasize the importance of starting ANC visits in the first 12 weeks of pregnancy.
- Continuous HIV awareness campaigns are needed to improve the understanding of HIV prevention and transmission among AGYW and dispel misconceptions and false beliefs around HIV.
- Community HIV awareness interventions are needed to decrease the levels of stigma faced by HIV-positive AGYW.
- Community awareness campaigns are needed to increase the awareness of physical and sexual gender-based violence, and to sensitize communities to the need to allow official investigation of SGBV cases.
- Given that awareness-raising campaigns are short-term measures, longer term measures need to include ongoing dialogue with adolescents, community leaders and members. The aim should be to identify and address the factors that contribute to poor adolescent SRH outcomes.

## DISTRICT, PROVINCIAL AND NATIONAL LEVEL RECOMMENDATIONS

- There is a need to review and revisit the informal fees charged to adolescents and young women seeking ANC care who present without partners. Informal fees deter them from using the services.
- Committees should be set up to focus on formulating adolescent-targeted communication strategies.
- Provincial Health Offices (PHOs) and District Health Offices (DHOs) need to intensify supervision to ensure that all staff provide supportive services for adolescent health.
- Indicators to track adolescent health service delivery and SGBV in the Health Management Information System must be put in place swiftly. Since school platforms are expected to provide adolescents with the knowledge and skills they need to protect themselves, there is also a need to advocate for the inclusion of adolescent SRH and HIV prevention-related indicators in the Education Management System.

- Community activities aimed at increasing SRH and HIV awareness among adolescents need more funding. This includes support for the training of peer educators and the orientation of other community groups on adolescent SRH.
- There is a need for more health staff and non-health staff who have been oriented or trained in adolescent SRH to increase uptake of services.
- Peer educators need to be fully trained if they are to be an effective link to adolescent SRH services at the facility level.
- The study found that there is lack of clarity, particularly among the peer educators, about the age at which adolescents can start using family planning methods. This gap requires policy guidance.

## **MULTI-SECTORAL APPROACHES**

- Continuous community sensitization is needed to increase awareness of SGBV and to encourage community members not to withdraw SGBV cases.
- The courts of law and police need to stiffen punishments for SGBV offenders. This should entail applying maximum penalties for SGBV-related crimes and being consistent in the application of the law as a deterrent to would-be offenders.
- Long distances between police posts in rural areas deter those with SGBV complaints from reporting their assaults. These services need to be brought closer to communities, especially in rural areas, by decentralizing them so that coverage across remote settings can be maximized, particularly for the better protection of AGYW.
- Given the level of interaction of traditional leaders and traditional initiators, particularly in rural areas, efforts should be made to support and review the content taught during the initiation of boys and girls. The aim should be to provide age-appropriate information on how the body works and SRH; and to address the gender norms underpinning GBV through teaching about safe and unsafe touch, consent, the right of a boy or girl to say no to something they may not want to do or be part of, positive masculinity and discussions on transformed gender expectations of the roles of boys and girls. There is a need for ongoing dialogue to correct religious beliefs or practices that encourage individuals, including adolescents, to stop taking ARVs.

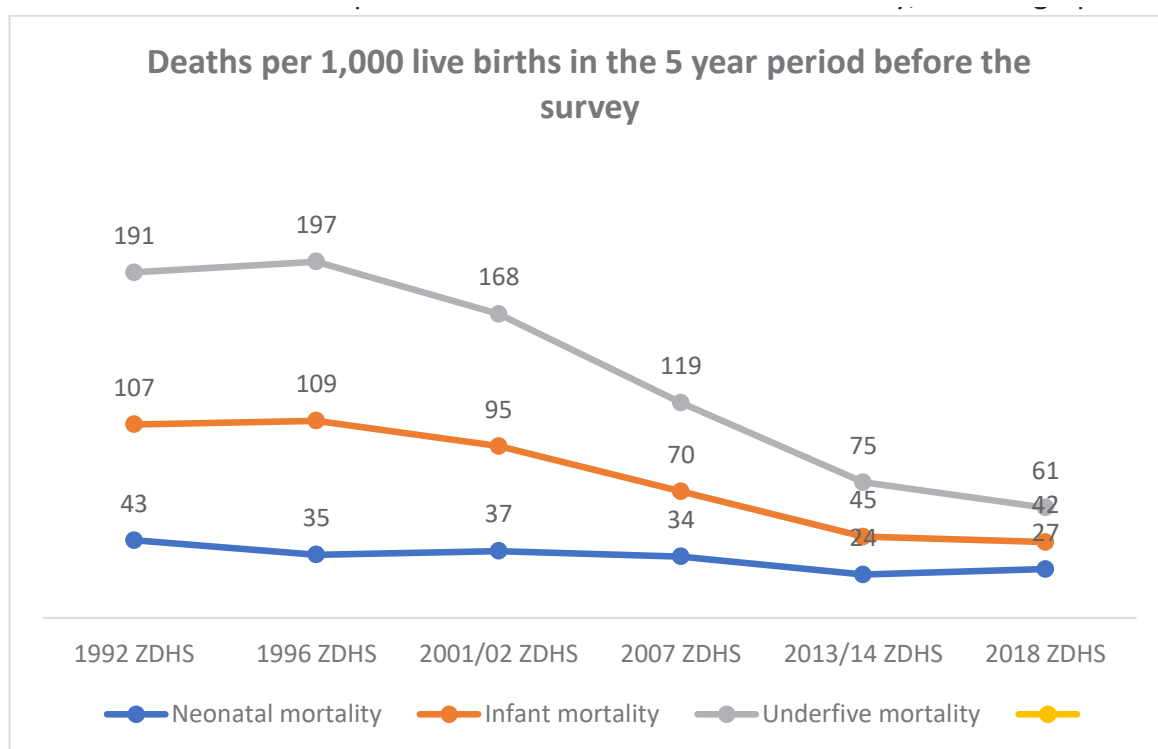
# 1 INTRODUCTION

## 1.1 BACKGROUND

### 1.1.1 STATUS OF MATERNAL, NEWBORN AND CHILD HEALTH IN ZAMBIA

Zambia continues to record steady improvement in key developmental indicators such as maternal and child mortality over recent years, although neonatal mortality did record an increase between 2014 and 2018 (ZDHS, 2018). The figure below summarizes trends in childhood mortality between 1992 and 2018.

**Figure 1: Trends in childhood mortality**

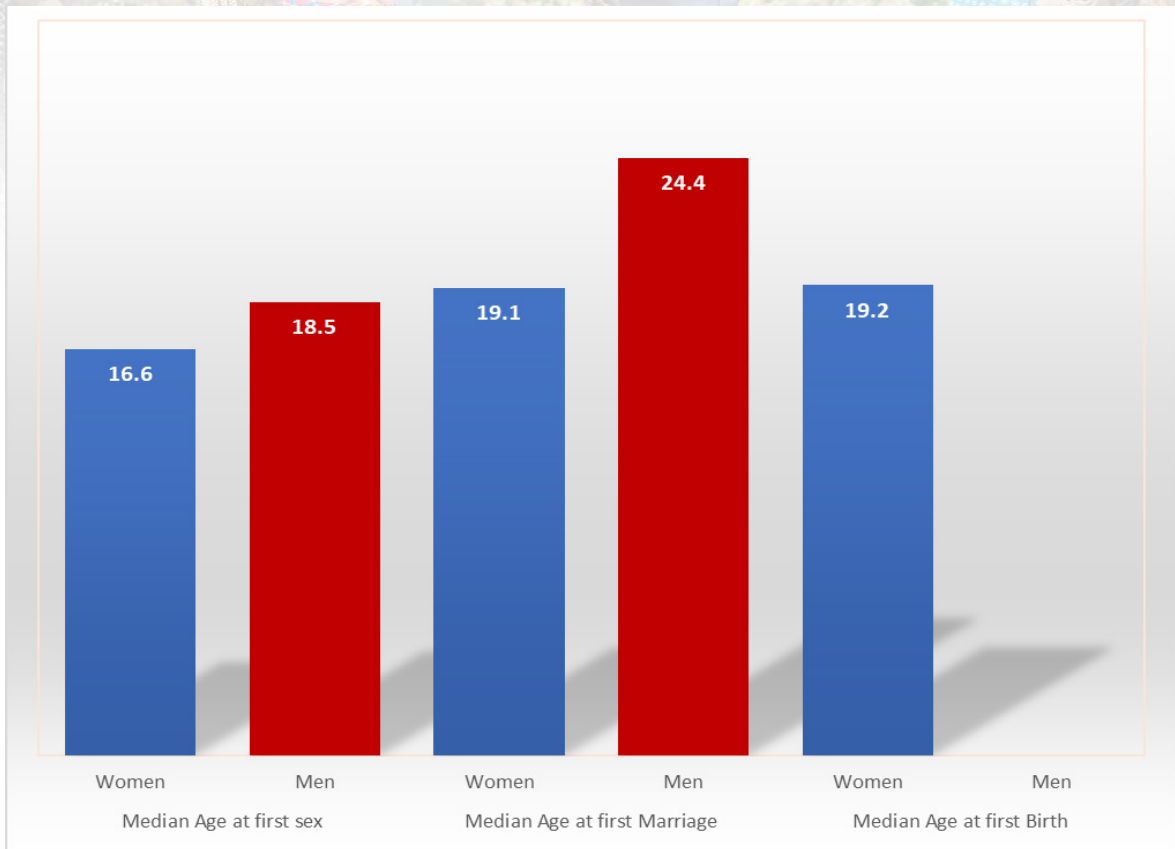


Source: 2018 Zambia Demographic & Health Survey

The total fertility rate declined from 6.5 children per woman in 1992 to 4.7 children per woman in 2018, although there are variations by educational and household wealth. Women with higher education have an average of 2.4 children compared with 6.4 children per woman among those with lower education levels.

Early sexual debut may predispose AGYW to poorer health outcomes related to pregnancy at a very young age and to increased risk of sexually transmitted infections such as HIV. The 2018 ZDHS showed that 17 per cent of women began sexual activity before the age of 15 years, and 69 per cent before 18 years. The statistics for childbearing show 34 per cent of women give birth before the age of 18 while teenage pregnancy (ages 15–19 years) is 29 per cent.

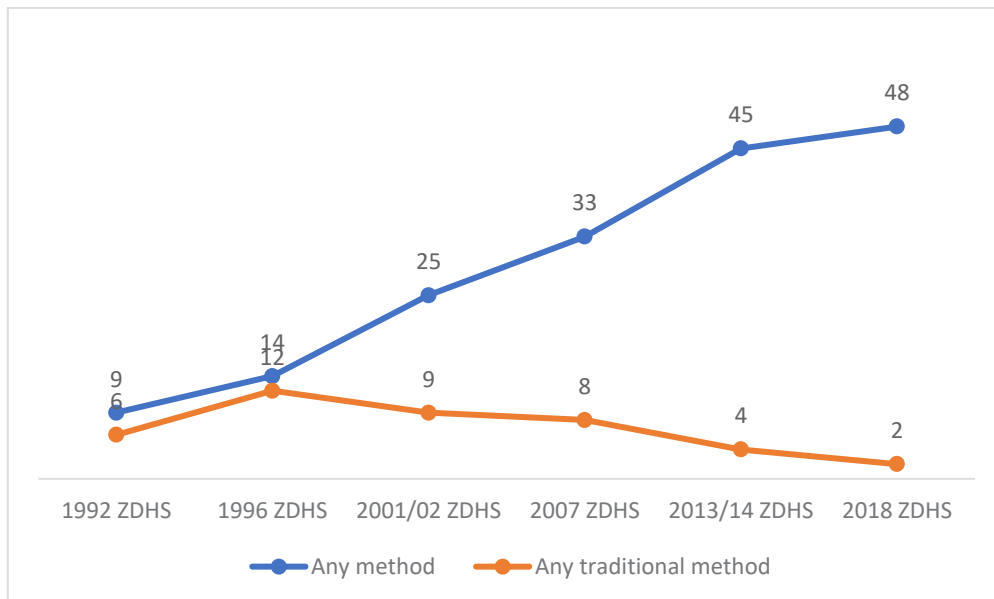
**Figure 2: Median age at first sex, marriage and birth**



Source: 2018 Zambia Demographic & Health Survey

Use of family planning (any method) among married women increased from 15 per cent in 1992 to 50 per cent in 2018. Of sexually active unmarried women aged 15–49, 43 per cent use a modern method of family planning. The unmet need for family planning among married women has decreased from 30 per cent in 1992 to 20 per cent in 2018. Figure 3 shows trends in demand for family planning.

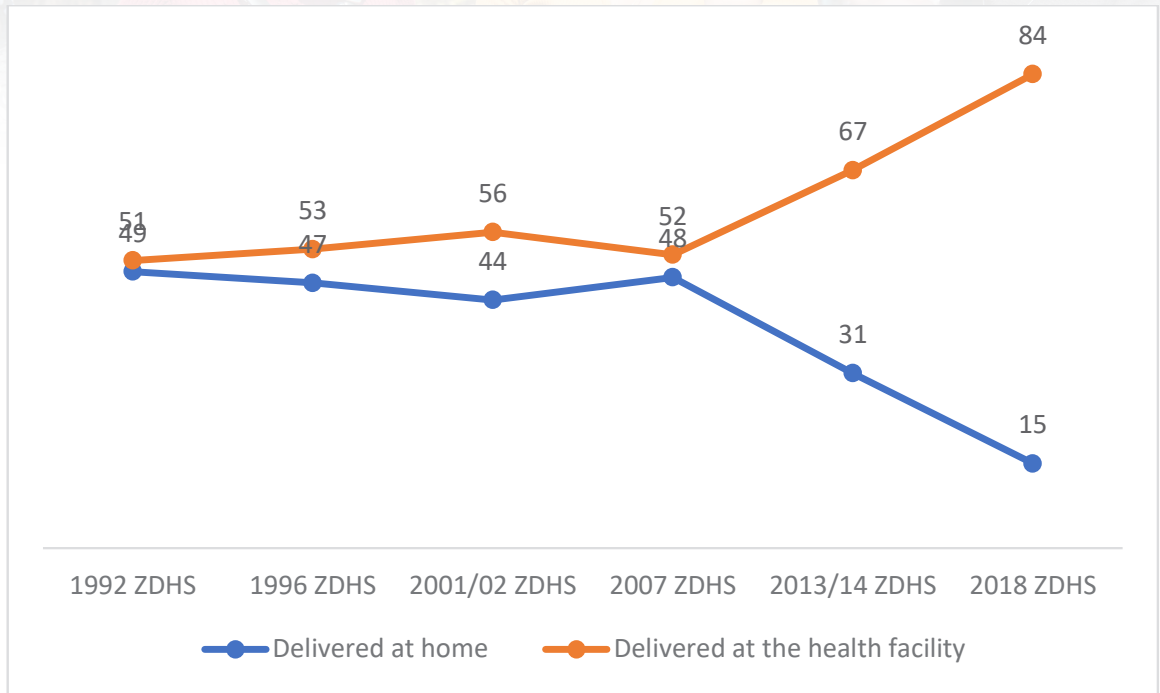
**Figure 3: Married women currently using a contraceptive method, 1992–2018 (%)**



Source: 2018 Zambia Demographic & Health Survey

Maternal mortality declined from 591 births per 100,000 live births in 2007 to 252 per 100,000 live births in 2018, with in-facility deliveries increasing to 84 per cent in 2018 compared to 51 per cent in 1992.

**Figure 4: Trends in place of delivery, 1992–2018**



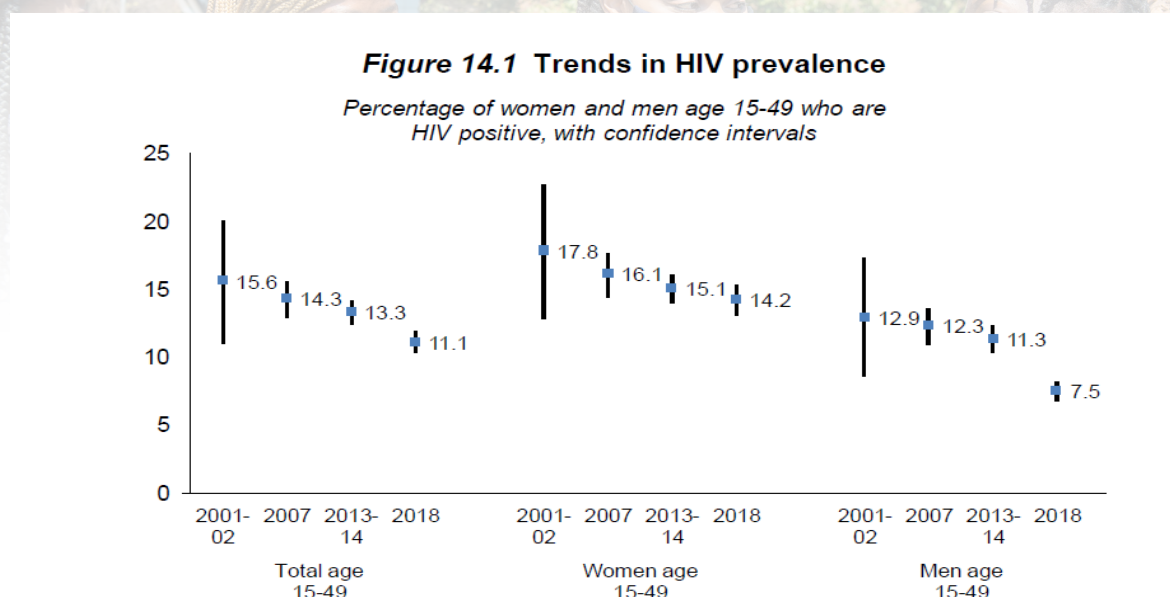
Source: 2018 Zambia Demographic & Health Survey

### 1.1.2. STATUS AND CONTEXT OF THE HIV AND AIDS RESPONSE IN ZAMBIA

The policy, legal, institutional and strategic frameworks for the multi-sector HIV/AIDS response have been strengthened. Further, the provision of free anti-retroviral (ARV) drugs in public facilities has contributed to the reduction in HIV/AIDS morbidity and mortality.

Overall, 11.1 per cent of adults aged 15–49 are living with HIV. The prevalence is higher among women (14.2 per cent versus 7.5 per cent in men). Over the years, the country has continued to record declines in HIV prevalence though the rate remains high with a generalized epidemic.

**Figure 5: Trends in HIV prevalence (2001 to 2018)**



Source: 2018 Zambia Demographic & Health Survey

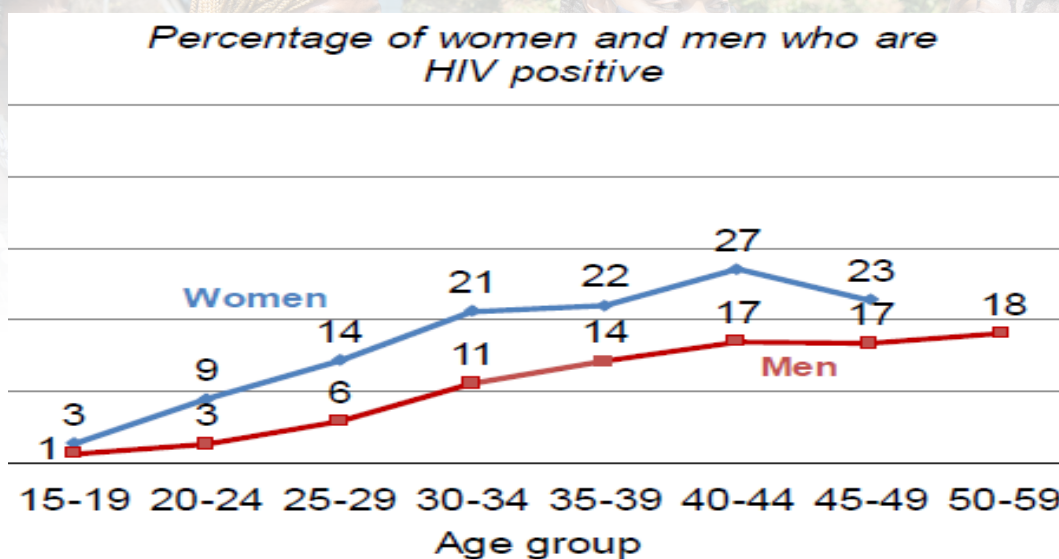
The ZDHS 2018 also showed that over 80 per cent of pregnant women received HIV testing in ANC clinics. Programme data shows that 95 per cent of women with an HIV-positive test are initiated on the lifesaving anti-retroviral therapy (ART) for life, preventing mother-to-child-transmission of HIV and keeping mothers alive.

The high uptake of HIV testing and ART initiation among pregnant women provides a valuable opportunity to offer integrated services that include other sexual and reproductive health (SRH) services such as family planning and counselling for those who test negative on how to maintain their status.

Young people aged 10–24 make up a third (33 per cent) of the Zambian population (CSO, 2013) and are disproportionately affected by poorer SRH outcomes. In particular, the upper age range in this group, 15 to 24-year-olds, account for a little under half of all new HIV infections in Zambia; that is, an estimated 19,000 of 45,000 new cases in 2019 (UNAIDS, 2019). This is partly accounted for by behavioural and cultural vulnerabilities and their often limited knowledge of available services. More importantly, however, they also face restricted access to such services due to the legal and policy framework, such as the age of consent to access some SRH services (Ministry of Health, 2017).

For instance, the proportion of sexually active adolescent girls having sexual intercourse with older men (an age gap of 10 years or more) increased by more than 60 per cent between 2007 and 2014 (CSO, 2014). While the pattern across all age groups is that HIV prevalence is generally higher among women than men (see figure 6), it is more pronounced among the 20–24 age group; HIV prevalence is three times higher among women in this group (9 per cent) than men (3 per cent) (CSO 2018).

**Figure 6: HIV Prevalence by age**



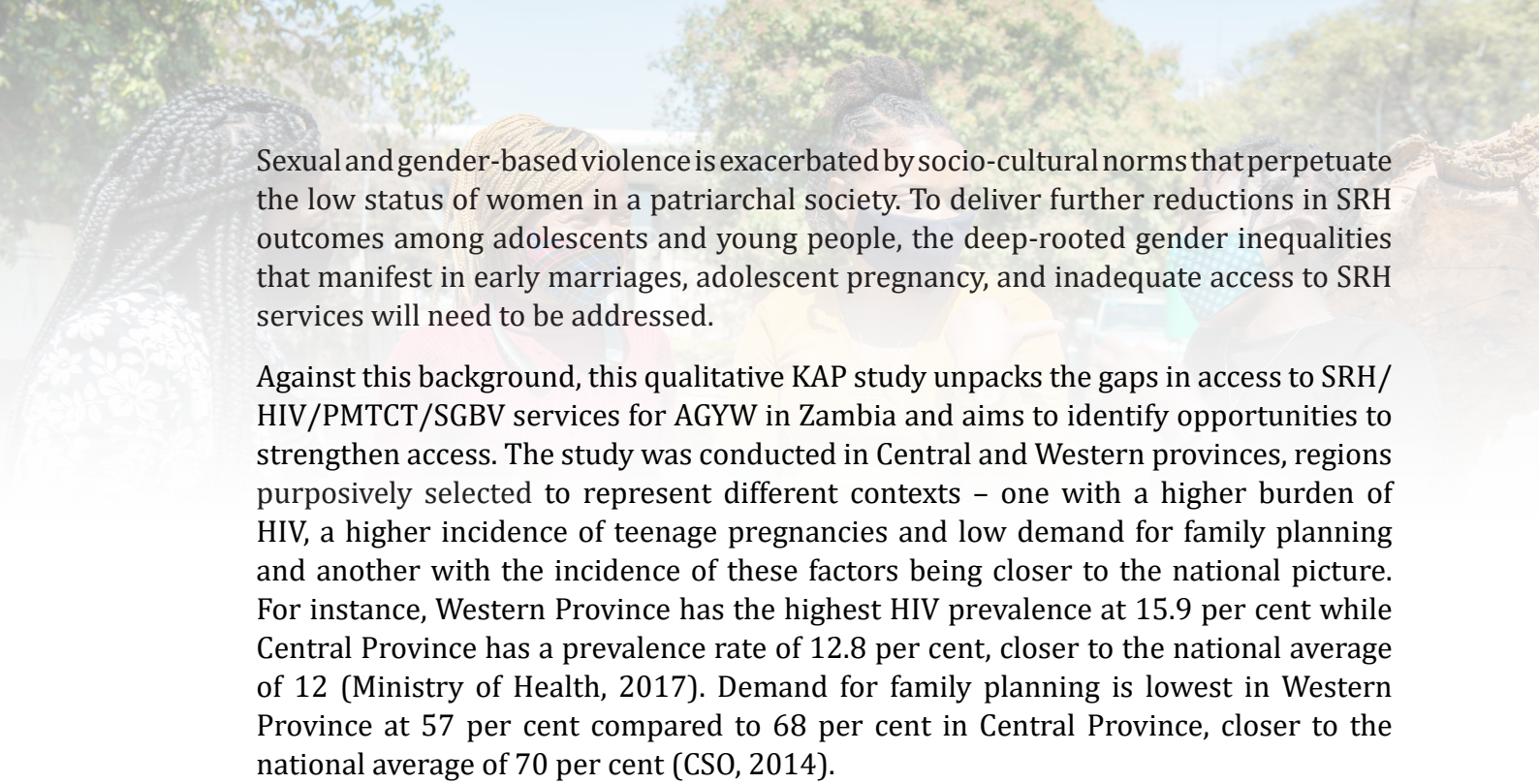
The significant increase in HIV prevalence as adolescent girls move to young womanhood (i.e. from HIV prevalence of 3 per cent among girls 15-19 years old to 9 per cent and later 14 percent among young women aged 20-24 and 25-29 respectively) demonstrates the vulnerabilities of adolescence and highlights certain gaps in service delivery during this transition period that need to be addressed. Young women aged 20 to 24 are both of childbearing age and likely to be marrying, and this is therefore a critical age at which strengthened access to a comprehensive range of sexual health services and SGBV advice would be highly beneficial.

In Zambia, the focus and resources for PMTCT has mainly been on the prevention of vertical transmission of HIV and on treatment, care and support for children, adolescents and adults with HIV. Less attention has been given to prevention, particularly primary prevention of HIV and prevention of unintended pregnancies among women living with HIV.

### **1.1.3. STATUS AND CONTEXT OF THE SEXUAL AND GENDER-BASED VIOLENCE RESPONSE IN ZAMBIA**

Despite the Government of the Republic of Zambia (GRZ) making significant structural and legal reforms to address SGBV, such as the anti-GBV act of 2011 and the Penal Code, Zambia continues to record a very high rate of physical violence against women, with 43 per cent of women aged 15–49 years reporting having experienced physical violence. Among adolescent girls, 29 per cent reported having experienced physical violence, with 13.2 per cent of them reporting physical or sexual violence in the last 12 months (often, sometimes, or combined). In terms of sexual violence, 10.4 per cent of women aged 15 to 49 and 10.2 per cent of young women aged 20 to 24 had experienced sexual violence in the previous 12 months. Among women aged 15 to 49, 17 per cent reported having experienced sexual violence at some time since the age of 15 (CSO, 2014), while the 2018 ZDHS results showed that 47 per cent of women who had ever been married had experienced physical, sexual, or emotional violence from their current or most recent husband or partner.





Sexual and gender-based violence is exacerbated by socio-cultural norms that perpetuate the low status of women in a patriarchal society. To deliver further reductions in SRH outcomes among adolescents and young people, the deep-rooted gender inequalities that manifest in early marriages, adolescent pregnancy, and inadequate access to SRH services will need to be addressed.

Against this background, this qualitative KAP study unpacks the gaps in access to SRH/HIV/PMTCT/SGBV services for AGYW in Zambia and aims to identify opportunities to strengthen access. The study was conducted in Central and Western provinces, regions purposively selected to represent different contexts – one with a higher burden of HIV, a higher incidence of teenage pregnancies and low demand for family planning and another with the incidence of these factors being closer to the national picture. For instance, Western Province has the highest HIV prevalence at 15.9 per cent while Central Province has a prevalence rate of 12.8 per cent, closer to the national average of 12 (Ministry of Health, 2017). Demand for family planning is lowest in Western Province at 57 per cent compared to 68 per cent in Central Province, closer to the national average of 70 per cent (CSO, 2014).

## 1.2 CONTEXT AND RATIONALE

The 2016 Zambia population-based HIV impact assessment study (ZAMPHIA) indicated that among 15–19-year-old adolescents who gave birth in 2015, 85 per cent knew their status; and of the 20–24 age group 94 per cent knew their HIV status. Among all women aged 15–49, 93 per cent knew their HIV status. These gaps in coverage need to be addressed. Furthermore, with 12 per cent of females and 18 per cent of males aged 15–19 reporting sexual initiation by age 15, the current age of 16 and above for access to some SRH and HIV services, including testing without parental consent, suggests some significant challenges for younger adolescents, especially in an environment where HIV infections are high among young people. UNAIDS estimates for 2019 indicate that there were 8700 new HIV infections among adolescents aged 10–19. Asked whether clinic staff talk to them about sex, 63 per cent of young people said they did, but not about ways to prevent pregnancy or PMTCT of HIV (MOH, 2017).

This qualitative KAP study provides evidence on what factors enable and prevent AGYW aged 15 to 24 from accessing SRH services, including PMTCT and SGBV services, from both the clients' and the service providers' perspectives.

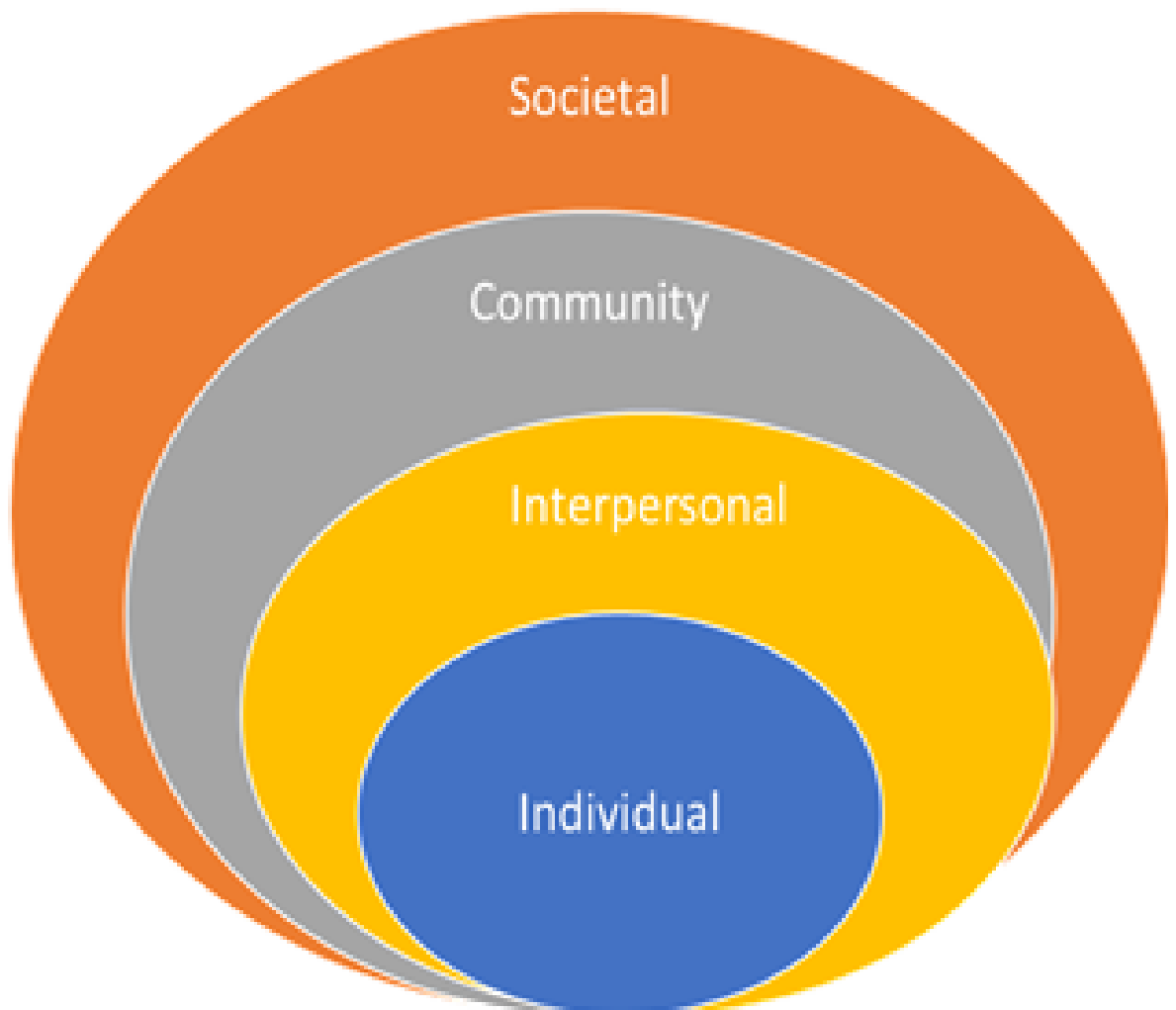
The findings from the study are critical for the improvement in SRH and HIV service delivery, particularly among AGYW. Specific programming areas to be informed by the research findings include interventions for the development and implementation of community-based, differentiated, and targeted interventions aimed at social and behaviour change, and communication strategies to help create demand for SRH, HIV and SGBV services for AGYW.

The findings will also influence the planning and decision-making of the provincial and district managers of the two target provinces and encourage dialogue between the service providers and AGYW.

### 1.3 CONCEPTUAL FRAMEWORK

The purpose of this KAP study is to gain an in-depth understanding of the knowledge, attitudes and practices around SRH and HIV among adolescent girls and young women aged 15 to 24. To achieve this goal, the study collected and analysed data on knowledge, attitudes and practices around SRH among AGYW based on the key elements that shape adolescent SRH at four levels adapted from the socio-ecological model and structural model of health behaviour (Cohen et al., 2000; Svanemyr et al., 2015; Krug et al., 2002; Garbino, 1985; Sommer and Mmari, 2015) (see Figure 6 and Table 1). The model is based on four guiding principles: 1) it identifies the role of factors that exist at the individual, interpersonal, community and public policy or societal level; 2) it hypothesises that these factors interact across the different levels; 3) it requires the need to focus on specific health behaviours and outcomes, and the need to identify the factors that have the greatest influence on these behaviours at each level; and, 4) posits that interventions that deal with factors at multiple levels may be more effective than those that address only one level.

**Figure 7: Conceptual framework**



Source: Adapted from Sommer and Mmari (2015)

**Table 1: Key elements that shape adolescent sexual and reproductive health**

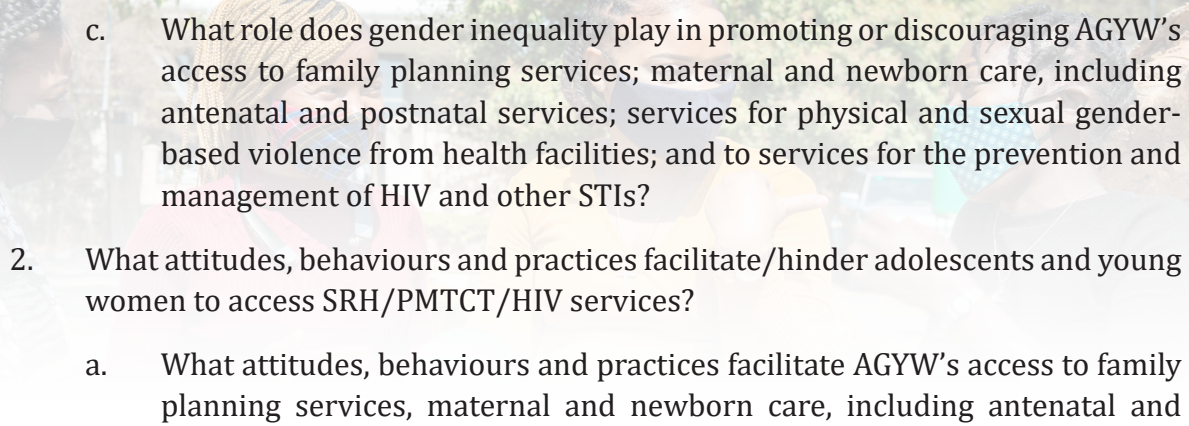
Level	Approach
Individual	<p>Focus on empowering adolescents by using approaches that build their economic and social assets as well as the resources of adolescents.</p> <ul style="list-style-type: none"><li>• Focus on interventions that increase knowledge and self-efficacy to elicit demand for appropriate interventions</li><li>• Creating safe spaces for adolescent girls to ensure their safety, to build their assets and to connect to social networks</li><li>• Economic empowerment of girls</li></ul>
Interpersonal or relationship	<p>Build relationships that support and reinforce positive health behaviour of adolescents.</p> <ul style="list-style-type: none"><li>• Interventions include those that influence sexual and reproductive experiences of adolescents, such as parents, intimate and other sexual partners and peers</li></ul>
Community level	<p>Create positive social norms and community support for adolescents to practice safer sex behaviours and access SRH.</p> <ul style="list-style-type: none"><li>• Interventions are targeted at community members and institutions outside the family such as neighbourhoods, schools and workplaces.</li></ul>
Societal level	<p>Promoting laws and policies related to the health, social, economic and educational spheres and to build broad societal norms in support of SRH and helping adolescents realize their human rights.</p> <ul style="list-style-type: none"><li>• Availability and accessibility of resources such as SRH services, education, recreational activities, employment.</li><li>• Social structures and policies, which includes laws and policies that relate to adolescent SRH, that limit high-risk behaviours and provide a framework for low-risk behaviours such as a legal age for marriage, education policies.</li><li>• Level of exposure to media and cultural messages: including mass media (print, video, internet, films), cultural beliefs and myths.</li></ul>

Source: Authors' adaptation from ecological and structural models of health behaviour; Cohen et al., 2000; Svanemyr et al., 2015; Krug et al., 2002; Garbino 1985; Sommer and Mmari., 2015.

## 1.4 RESEARCH QUESTIONS

The study addresses the following research questions:

1. What factors (structural, policies, socio-economic) promote or discourage access to SRH/PMTCT/HIV services by 15–19-year-old adolescent mothers and mothers aged 20 to 24?
  - a. What national-level laws and policies promote or discourage AGYW's access to family planning services, maternal and newborn care including antenatal and postnatal services, services for physical and sexual gender-based violence from health facilities and prevention and management of HIV and other STIs?
  - b. What socio-economic factors promote or discourage AGYW's access to family planning services; maternal and newborn care, including antenatal and postnatal services; services for physical and sexual gender-based violence from health facilities; and prevention and management of HIV and other STIs?

- 
- c. What role does gender inequality play in promoting or discouraging AGYW's access to family planning services; maternal and newborn care, including antenatal and postnatal services; services for physical and sexual gender-based violence from health facilities; and to services for the prevention and management of HIV and other STIs?
  2. What attitudes, behaviours and practices facilitate/hinder adolescents and young women to access SRH/PMTCT/HIV services?
    - a. What attitudes, behaviours and practices facilitate AGYW's access to family planning services, maternal and newborn care, including antenatal and postnatal services, services for physical and sexual gender-based violence from health facilities and to services for the prevention and management of HIV and other STIs?
  3. Why are health workers not providing integrated SRHR/HIV/SGBV services?
    - a. What level of service integration exists at the facility level for AGYW seeking access to family planning services; maternal and newborn care, including antenatal and postnatal services; services for physical and sexual gender-based violence from health facilities; and services for the prevention and management of HIV and other STIs?
    - b. In addition to health care, what type of support is provided for SGBV to AGYW?
    - c. What are the challenges associated with providing integrated SRHR/HIV/SGBV services for AGYW?
  4. What attitudes, behaviours and practices prevent adolescents and young mothers from bringing back their HIV-exposed or HIV-positive infants for regular HIV follow-up?
    - a. What are the attitudes and behaviours of AGYW towards safe sex practices and family planning?
    - b. What are the perceptions of AGYW towards HIV services?
    - c. What factors contribute to the loss of AGYW mothers and their infants to follow-up services in rural and urban areas?
    - d. To what extent are spouses/partners of AGYW with HIV-exposed infants involved in ensuring adherence to PMTCT?
    - e. Is the failure to disclose status to partners/family a major contributing factor to lack of adherence among AGYW to PMTCT and mother-infant loss to follow-up services?

# 2 METHODOLOGY



## 2.1 SURVEY ADMINISTRATION

The survey to assess the knowledge, attitudes and practices of adolescents' and young mothers' use of SRH (family planning, antenatal care services, delivery and postnatal care), PMTCT and HIV services was conducted in Central and Western provinces. The provinces were purposively selected based on their contrasting SRH indicators, such as HIV prevalence and family planning use. Western Province has the highest HIV prevalence at 15.9 per cent, while Central Province has a prevalence rate of 12.4 per cent (MOH, 2017). Further, Western Province has the lowest proportion of women aged 15–49 using any method of family planning at 33 per cent compared to a national average of 49 per cent and the Central Province average of 42.8 per cent (CSO, 2015). To ensure a rural-urban balance in the selection of districts to be surveyed, the study was conducted in Kabwe, an urban district in Central Province, and in Senanga, a rural district in Western Province. The data was collected over a three-week period from late December 2018 to mid-January 2019.



The survey tools were prepared by the research team and reviewed by the UNICEF country and regional team. Four female research assistants were recruited to undertake the field work with support from two researchers. The research assistants were trained for data collection during a two-day training session to ensure a common understanding of interview guides as well as the general techniques of administering face-to-face interviews and FGDs. During the training, ethical considerations were reviewed including: review of the consent forms and requirements and emphasising the need to allow the potential respondent to decide if they want to participate or not; the need to maintain confidentiality; being open-minded and non-judgemental, and to listen carefully to the participants.

Following the training of research assistants, a pilot study was conducted in Lusaka District at the UTH Adult Centre for Excellence, PMTCT section. The feedback from the pilot study on the clarity and sequencing of questions was used to refine the tools for the actual field work.

The team of research assistants consisted of women who were young and experienced in collecting qualitative data and could speak the local languages in either one of the districts fluently.

## 2.2 ETHICAL CONSIDERATIONS

The study obtained ethical approval from the ERES Converge Internal Review Board (IRB) and national authorisation from the National Health Research Authority (NHRA). National level authorisation to visit the selected provinces was obtained from the Ministry of Health. We obtained informed consent from all participants and assured confidentiality. For adolescents aged less than 16, informed consent and assent was obtained from the parents or health providers and the adolescent, respectively. To ensure that confidentiality was maintained, the research team handled all data in accordance with the procedures and protocols approved by the ethics board.

## 2.3 SAMPLING OF HEALTH FACILITIES

In each district, three health centres were purposively sampled, in consultation with the District Health Director (DHDs) and district adolescent focal point persons. Table 2 shows the sampled health facilities in the two districts in Western and Central provinces. The main criteria for selection of the health centres were the availability of HIV clinics and presence of an adolescent-friendly space. In Senanga District, a peri-urban facility was also purposively included in the sample to be able to capture the HIV-positive adolescents who were either pregnant or had a child, given the relatively lower proportions of this age group in rural areas.

**Table 2: Sample provinces, districts and health facilities**

Province	District	Health Facility
Central	Kabwe	Kasanda
		Makululu
		Ngungu
Western	Senanga	Lui River
		Liangati
		Litambya
		Senanga Urban

## 2.4 DATA COLLECTION APPROACH

The study employed three main approaches to qualitative data collection: key informant interviews (KIIs), focus group discussion (FGDs) and in-depth interviews (IDIs). At provincial and district level, KIIs were conducted with maternal and child health (MCH) coordinators or an adolescent focal point person.

At the facility level, KIIs were conducted with the in-charge or adolescent focal point, representatives of the Safe Motherhood Group Action Groups (SMAGs) and HIV support groups, peer educators and community health assistants (CHAs) (available only in rural health facilities). FGDs were conducted with the HIV-free and HIV-positive 15–19 and 20–24-year-



old pregnant women and mothers. IDIs were conducted with adolescents and young mothers who are non-adherent or have a poor record of adherence to PMTCT interventions. These non-adherent adolescents and young mothers were tracked to their communities using the facility PMTCT registers and local knowledge from health providers or peer educators.

A total of 31 interviews and FGDs were conducted in both Kabwe and Senanga districts; 17 KIIs, 10 FGDs and 4 IDIs. Table 3 at the end of this chapter summarises the data collection approaches and respondents interviewed.

Two researchers accompanied the research assistants for the data collection to ensure that the sampling procedure was adhered to and that interviews were conducted in a standardized manner. The researchers conducted the KIIs at the provincial and district level. The data collected by the research assistants was reviewed by the field researchers to ensure quality and consistency.

## 2.5 DATA ANALYSIS

A team of three researchers led the data analysis process. All the data from the KIIs, IDIs and FGDs were coded and analysed using the NVivo<sup>3</sup> qualitative software. A preliminary coding plan based on the conceptual framework, research questions and data collection tools for the study was generated. The coding plan guided the organization and subsequent analysis of the information collected in the interviews and FGDs. The plan was modified as new themes and findings emerged during the data analysis. During the analysis, the researchers analysed the common responses, examined the differences among groups and identified the key findings addressing the research questions.

<sup>3</sup> NVivo qualitative data analysis software; QSR International Pty Ltd. Version 12, 2018



## 2.6 PROFILE OF RESPONDENTS

The profile of respondents is presented in Table 3. At the provincial level and district level, key informants provided their perspectives on existing policies, successes and challenges faced in delivering services on SRH/PMTCT/HIV/SGBV for adolescents. At the health centre level, the key informants gave the providers perspectives on some of the challenges and successes around providing integrated SRH/PMTCT/HIV/SGBV services to adolescents and young mothers. The providers also gave insights into their understanding of the policy on integrated SRH/PMTCT/HIV/SGBV services, whether they are providing these services and the associated challenges with providing the integrated services.

The KIIs with the CHAs, peer educators, and representatives from the SMAGs and HIV support groups provided community perspectives on the factors that encourage or discourage adolescents and young mothers from accessing SRH/PMTCT/HIV/SGBV services, and insights into the behaviours and practices that contribute to mother-infant pair loss to follow-up among the HIV-positive adolescents and young mothers with infants aged up to 18 months. Whereas all facility managers or focal adolescent persons at each sampled facility were interviewed, interviews with CHAs, SMAGs or peer educators depended on whether they were available at the facilities. All the key informants were purposively selected due to their existing roles.

Within each district, FGDs of five to 10 participants were conducted by a trained research assistant/facilitator. FGDs were conducted with 1) HIV-positive and HIV-free adolescent mothers aged 15 to 19; and 2) HIV-positive and HIV-free young mothers aged 20 to 24. The respondents were purposively selected, with the assistance of health care providers, to avoid any breach of confidentiality and privacy during antenatal visits.

The total number of respondents aged 15–19 covered in the FGDs was 63. Other respondents were tracked to the community using the PMTCT register with support from the peer educators or community health workers. In one of the sampled facilities, about six peer educators were available on the day of the interview and an FGD was conducted with them. At the facility level, we rotated the FGD groups for HIV-positive and HIV-free adolescents and young mothers based on availability of respondents at a health centre. The FGDs provided a deeper understanding of adolescents' and young mothers' perceptions of SRH/PMTCT/HIV/SGBV.



In each district, in-depth interviews (IDI) were conducted to explore the perspectives of adolescents and young mothers who are non-adherent or have a poor record of adherence to PMTCT. These interviewees were tracked to communities using the facility PMTCT registers. The study team relied on assistance from community groups such as HIV support groups, SMAGs, CHAs and those in charge of health facilities to identify target respondents (either an adolescent mother or a young mother) in each facility catchment area. A total of four in-depth interviews with adolescents and young mothers lost to follow-up were conducted in Kabwe and Senanga districts (see Table 3).

The instruments used for each respondent are set out in Annex 2.

**Table 3: Study respondents by data collection approach and type**

Method	Respondent(s)	No.	Gender	Ages
Provincial and district level-key informant interviews	Provincial MCH Coordinator, Mongu	1	F	
	Provincial MCH Coordinator, Kabwe	1	F	
	District Adolescent Focal Point person, Senanga	1	M	
	District Adolescent Focal Point person, Kabwe	1	F	
Facility level-key informant interviews	In-Charge, Lui River Centre	1	F	
	Acting In-Charge, Litambya	1	F	
	In-charge, Liangati Health	1	M	
	Acting In-Charge, Kasanda Health Centre	1	F	
	Adolescent Focal Point Person, Ngungu	1	M	
	Adolescent Focal Point Person, Makululu	1	M	
	Community Health Assistant, Liangati	1	F	
	SMAG member, Liangati	1	F	
	SMAG member, Lui River	1	F	
	SMAG member, Makululu	1	F	
	HIV support group member, Makululu	1	F	
	HIV support group member, Litambya	1	M	
	Peer educators, Makululu	2	M,F	M22,F23
	Focus Group Discussions	HIV-free adolescent pregnant/mothers (15–19) Lui River	8	F
HIV-free adolescent pregnant/mothers (15–19) Kasanda		6	F	15,15,16,16,17,19
HIV-positive adolescent pregnant/ mothers (15–19) Senanga Urban		7	F	17,17,18,19,19,19,19
HIV-positive adolescent pregnant/ mothers (15–19) Makululu		5	F	19, 18, 19, 17, 17
HIV-positive Young Pregnant/ Mothers (19–24) Litambya		5	F	19,20,21,24,24
HIV-positive young mothers (20–24) Litambya		5	F	21,22,22,23,24
HIV-positive young mothers (20–24) Makululu		6	F	24, 24, 22, 23, 23, 23
HIV-free young mothers (20–24) Lui River		10	F	20,20,20,21,21,21,23,24,24
HIV-free FGD young mothers (20–24) Kasanda		5	F	20,20,20,21,24
Peer educators, Litambya		6	M,F	M21, F20, M19, F21, M22, M22
In-depth interviews	Non- adherent adolescent mother, Litambya	1	F	21
	Non- adherent young mother, Liangati	1	F	19
	Non- adherent adolescent mother, Makululu	1	F	15
	Non- adherent young mothers, Ngungu	1	F	22
	Sub Total KIIs	17		
	Sub Total FGD (N=63)	10		
	Sub Total IDIs	4		
	<b>Total</b>	<b>31</b>		

# 3 FINDINGS



## 3 FINDINGS

This chapter describes the knowledge, attitudes and practices around SRH, HIV and SGBV, drawing on the findings from KIIs with facility, district and provincial officials, SMAGs and HIV support group members, FGDs with AGYW, and IDIs with non-adherent HIV-positive AGYW. The analysis is presented at four levels, as described in the conceptual framework: individual; interpersonal or relationship; community, and societal level.

### 3.1 INDIVIDUAL LEVEL

This section describes the role of factors that exist at the individual level that influence the knowledge, attitudes and practices around SRH, HIV and SGBV among AGYW. The analysis draws largely from the responses presented by AGYW and perceptions of the key informants at facility, district, provincial and community level.

#### *Awareness of benefits of antenatal care services*

In general, AGYW are aware of the benefits of ANC services for the unborn child and the wellbeing of the pregnant mother. Most AGYW reported that seeking ANC services for routine check-ups was necessary to prevent complications with the baby at the time of delivery. Some participants also indicated that seeking ANC services early enables pregnant women to be tested for HIV and, if found positive, to be provided with drugs to prevent the mother from passing on the HIV virus to the unborn child. One HIV-positive adolescent stated that: *“When I came to the clinic, I was also tested for HIV and I found out that I was positive. I was then told how to take care of myself and I was given medication to prevent my baby from getting infected.”* [FGD 15–19 HIV-positive]. Other AGYWs indicated that it is important for pregnant mothers to register for ANC early to be given supplements such as folic acid and iron tablets. *“You have to come and register early so that you start taking those pills that they give us, because some people get sick, and have blood problems. That’s why we come and register early.”* [IDI - adolescent, 19].

#### *Knowledge of appropriate timing for first antenatal visit*

There are mixed perceptions regarding the appropriate timing for the first ANC visit. In general, AGYW indicated that the first ANC visit should be made as soon as possible after becoming pregnant, with some indicating that they started ANC in the first trimester. One adolescent reported the following: *“You are supposed to come early for antenatal. If you are HIV-positive, you are supposed to come to the clinic so that the baby can be prevented from getting infected. You are supposed to come when the pregnancy is three months or below so that the health workers can assist you.”* [FGD 15–19 HIV-free]. This finding suggests that some adolescents understand the benefits of starting ANC in the first trimester. However, some adolescents were not aware of when the first ANC visit should be made, and state that a woman can decide when to start ANC.

The study found that even among those who knew about the importance of starting ANC services at the earliest possible time, some reported that they still delayed because they did not know that they were actually pregnant until after five months or more: *“At first I didn’t notice that I was pregnant until my mother mentioned it to me. I was sure that I was pregnant at five months and that’s when I started coming for antenatal”* [FGD 15–19 HIV-positive]. Other AGYW delay in making the first ANC visit for fear of being tested and getting to know their HIV status early in the pregnancy. They prefer to wait

a little longer. Others delay in making the first antenatal visit to be sure that they are actually pregnant, for fear of disappointing their husbands in case it turned out that they were not actually pregnant. *“You might think that you are pregnant [when in fact you are not] ...That’s why you are supposed to wait a bit and not rush into telling your husband and find that you are actually not pregnant.”* [FDG 19–24 HIV-positive]

### **Educational talks during antenatal care**

A number of respondents highlighted the importance of the educational talks presented by health workers during ANC visits, where issues such as the importance of good nutrition during pregnancy are discussed. AGYW also reported that health workers always emphasized the need for pregnant women to pay close attention to their diet and to adhere to instructions when taking medications. The HIV-positive AGYW seemed to be aware of the additional nutritional needs to promote good health. An HIV-positive adolescent stated: *“When we came [for ANC], we were tested for HIV. We were also shown some pictures of what we would look like if we did not take our medication. We were told that if we take our medication we will not look like we are infected. We were also told to eat healthy food and eat a lot of vegetables so that we can have enough blood. We were told to eat food that has a lot of vitamins so that we can have enough strength.”* [FGD 15–19 HIV-positive]



### **Knowledge of family planning**

In general, AGYW expressed an understanding of the importance of using family planning methods. AGYW explained that family planning is necessary to prevent unwanted pregnancies. One young woman reported: *“Family planning helps us not to conceive but most of us rushed into having children because we used to like unprotected sex and marriage.”* [FGD 20–24]. AGYW recognise that family planning helps to effectively space children and to increase their own and their children’s health and well-being. AGYWs indicated that delaying the childbearing process by using family planning enables them to focus on completing their studies at school. An adolescent

stated: *“You can’t concentrate at school if you have a child so it’s better to go for family planning so that you don’t conceive so that you concentrate on school.”* [FGD 20–24]. Another common understanding was that family planning enables AGYW to have more opportunities for work, be it paid employment or women’s daily living activities. An adolescent reported that: *“We should concentrate on school and not have children until we find jobs so that we are able to take care of our children... if you don’t have a job, how are you going to take care of your child? Your child may end up suffering. That is why they encourage us to use family planning so that we can complete our education and find jobs. The time to have children will come later.”* [FGD 15–19 HIV-positive].

The levels of understanding of various family planning methods is different across AGYW, but all of them seemed to have a general understanding that family planning is key to helping them prevent pregnancy and to space their children. Many AGYW know about the existence and availability of modern methods of family planning such as male condoms, female condoms, contraceptive pills and injectable contraceptives. The key informants indicated that women and men in the community have been using family planning for a long time and as such many people have come to know about them. Some older adolescents and young mothers seemed to have greater understanding of the contraceptive pill and injectable contraceptives. *“From what we are taught, what I get is that when we are injected we are supposed to abstain for seven days or one week, after one week is when you can be intimate with your boyfriend otherwise you might get pregnant but if you wait (for after seven days) you will not get pregnant. And that injection does not protect from HIV, it just prevents us from getting pregnant.”* [FGD 19–24 HIV-positive] However, it was also evident that some respondents, particularly younger adolescents with a first pregnancy, have limited understanding of family planning and the options that are available for them to use. *“We haven’t yet started going to seek for family planning services. We just hear about it from people and also when we come for antenatal, so we would like to learn more about it.”* [FGD 15–19]

### **Sources of family planning services**

In general, the majority of AGYW know where to go if they want to access contraceptives in their communities. Most AGYW access contraceptives from the health centre, as explained by one adolescent: *“Here at the clinic is where we can find the contraceptives. We might get information from our communities, but the actual contraceptives are found here at the clinic.”* [FGD 15–19 HIV-positive] A few respondents indicated that they obtain contraceptives from the chemists and grocery shops though it was also mentioned that the clinic is the safer option: *“And we sometimes buy from the shops (safe plan), almost all the contraceptives are sold in the shops, apart from the injections.”* [FGD 19–24 HIV-positive] *“Some of them even sell in the shops and at stands but the ones they sell at the stands are not very safe because of how they are kept. That’s why some people prefer to get them from the clinic.”* [FGD 15–19 HIV-positive] These responses suggest that adolescents are aware of the risks involved in buying contraceptives from shops. However, it is also probable that some adolescents resort to buying contraceptives from the shops due to unavailability in clinics.

### **AGYW’s awareness of the benefits of antenatal care and family planning**

Understanding the benefits of the SRH services such as antenatal and family planning enhances demand. Many adolescents explained that they seek family planning services to avoid having a lot of children that they cannot provide for, and for child spacing. One

young mother explains the benefits of family planning: *“What encourages them is the desire not to have many children in a short period. If you don’t go for family planning, you will find that maybe one child is one year old and then you get pregnant. So that encourages us.”* [FDG HIV POS 20–24] Another young mother explains that: *“When women have many children, the man will run away and propose to another woman who doesn’t have a child while she is left suffering with the children so that’s why they encourage us to be on family planning.”* [FDG HIV POS 20–24] In relation to ANC services, most of the interviewees indicated that understanding the benefit of the service encourages them to take it up. An HIV-positive adolescent explained this: *“As for me, what encourages me to come for antenatal is because my baby is innocent and does not deserve to get infected.”* [FDG HIV POS 15–19].

### ***Attitudes and behaviours of AGYW towards safe sex practices and family planning***

In general, the study found that many AGYW who are sexually active, engage in unprotected sex and are aware that they are at a high risk of contracting HIV and usually go to the facility to get tested. Some persistently engage in risky sexual behaviour, partly due to lack of confidence to negotiate safe sex, and repeatedly go to the facility to check their status. An adolescent explains: *“Most of them come to get tested because they sleep around without using condoms, so they think that they might be at risk.”* [FDG HIV POS 15–19]



With regard to family planning, the study found that some adolescents visit the clinics for family planning services. At one facility, the in-charge narrated that many of the recipients of condoms they distribute are adolescents: *“The rate at which adolescents are getting condoms, it’s overwhelming.”* [KII, Facility in-charge] AGYW are also said to get condoms from the facility although they tend to access more of the other family planning methods. Other forms of family planning such as the injectable contraceptives are misperceived as serving a dual function of protecting one from acquiring HIV/AIDS and prevention of pregnancy. This has contributed to them engaging in unprotected



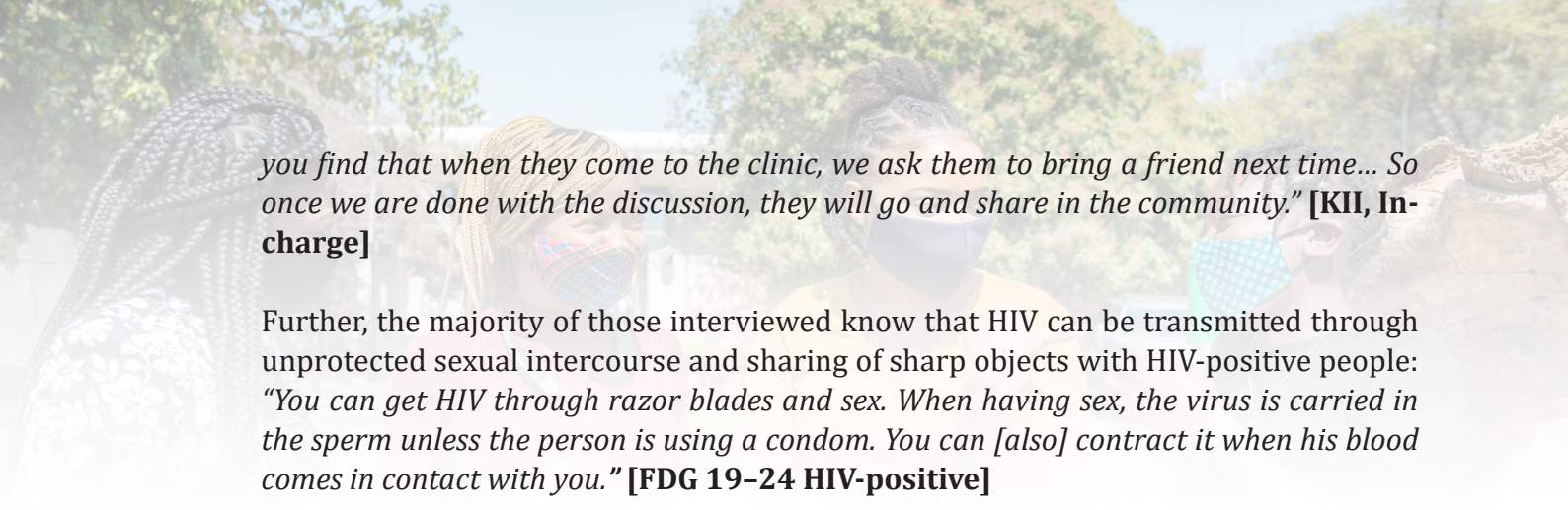
sex. A health worker explained: *“What they [AGYW] believe is that family planning also protects one from HIV, so most of them when they come, they say... if I am injected then it means I am also protected from HIV.”* [KII, Facility in-charge]

Beliefs around family planning deter AGYW from accessing the family planning service. A common belief is that the use of family planning could lead to infertility. An adolescent said: *“Some people are told by their friends that if they use family planning, they will fail to have children in the future. They tell them that once they use family planning, they won’t be able to have children. Some of them listen to this advice and end up not using family planning method.”* [FGD 15–19] When asked whether they could inform their parents that they are using contraceptives, most of AGYW indicated that they would not do so. One adolescent said: *“No, I can’t, it’s a secret I cannot tell my parents.”* [FGD 15–19]

### ***Knowledge of transmission and prevention of HIV***

The study found that knowledge of HIV among AGYW is generally high, as all those interviewed were aware that HIV/AIDS exists. One adolescent explained that: *“A lot of people know about HIV because the health workers usually go around the communities to teach people about HIV. They usually put up sketches to teach people about the virus and how to prevent themselves from getting infected.”* [HIV-positive 15–19] Another explained: *“They get it from the clinic because the health workers are serious about teaching people about HIV. They also go around the villages and teach people through sketches. They also go around testing people. They have different days in which they target specific villages.”* [HIV-positive 15–19] One health provider indicated that awareness of the existence of HIV among adolescents has increased over time: *“Most adolescents are aware of HIV. In the past, they would ask what HIV is but now many people know so*





*you find that when they come to the clinic, we ask them to bring a friend next time... So once we are done with the discussion, they will go and share in the community.” [KII, In-charge]*

Further, the majority of those interviewed know that HIV can be transmitted through unprotected sexual intercourse and sharing of sharp objects with HIV-positive people: *“You can get HIV through razor blades and sex. When having sex, the virus is carried in the sperm unless the person is using a condom. You can [also] contract it when his blood comes in contact with you.” [FDG 19–24 HIV-positive]*

### ***Understanding mother-to-child HIV transmission***

*“We are told that we are supposed to wean the child at six months. They don’t allow us to breastfeed for more than six months because once the child has teeth, then he or she can bite and contract the virus.” [FDG 19–24 HIV positive]*

### ***Understanding of the modes of HIV transmission***

Although many respondents demonstrated knowledge of several routes of transmission of HIV, there are still some misconceptions around HIV as indicated by the incomplete or erroneous responses provided. For example, mosquito bites, sharing plates and spoons are still being reported as a way of contracting HIV. One adolescent responded as follows: *“One can get infected by a mosquito bite, e.g. if the person is positive and is bitten by a mosquito, and it bites the person who is negative, that person will get infected.” [FGD 15–19, HIV-free]* A few adolescents correctly reported that if health workers come into contact with blood of an HIV infected person, they are at risk of getting infected. Knowledge about preventing HIV infection was generally good. Almost all of adolescents responded that HIV infection can be prevented by using a condom during sexual intercourse and reducing the number of sexual partners. Some also mentioned that having sex with a partner that you do not know well enough increased the risk of getting infected with HIV.

### ***Knowledge of mother-to-child transmission of HIV***

When discussing awareness and knowledge of mother-to-child transmission (MTCT), the majority of respondents were aware that an HIV-positive mother can transmit HIV to her baby. Most knew that the virus can be transmitted from the mother to the child at birth and through breast feeding.

They were also asked to describe ways in which the baby can get the virus from the mother. A common response indicated a lack of understanding of the correct practice as illustrated in this quote: *“...we are told that we are supposed to wean the child at six months, they don’t allow us to breastfeed for more than six months because once the child has teeth then he or she can bite and contract the virus.” [FGD 19–24 HIV-positive]*

A few of the HIV-positive respondents were not aware of how a mother can transmit HIV to her child after birth and the precautions they could take to prevent this. One respondent stated: *“I would really like to know about caring for my child, because I am HIV-positive and my child is negative. I don’t know much because my child is kept by relatives but now I want that child to live with me so when I think about it, where am I going to start from because I haven’t lived with this child.” [FGD, 15–19 HIV-positive]*



Other HIV-positive adolescents did not fully understand the consequences of not taking ARVs at the scheduled time: *“I would like to know more about the time at which we are supposed to take our medication. If you are supposed to take your medicine at 20 hours but you take it at a later time, will it still work? Some people have their supper very late and end up taking their medicine later than 20 hours. So the following day are they supposed to take their medicine at the same time or at 20 hours?”* [FGD HIV-positive, 15–19]

This seems to suggest a lack of understanding of how to prevent transmission of HIV to the child or about how to take the ARVs among the HIV-positive individuals.

#### ***Adherence to HIV treatment***

Acceptance of HIV-positive status remains a key factor in AGYW’s access to HIV services. Many of the adherent adolescents and young mothers said that they had accepted their positive status and so were able to continue the uptake of HIV services. One adolescent explains: *“Some of us encourage ourselves to follow what we are told at the clinic. There is nothing you can do. You just have to encourage yourself to take your medication on time. You don’t have to wait for your parents to remind you. You just have to encourage yourself.”* Many AGYW who had adhered to HIV treatment also reported having family support which encourages them to continue taking the medication. *“After I was tested, I was found to be HIV-positive. I went home and told my mother about it and she told me to stop crying. I felt so alone but my mother kept on encouraging me to be strong and accept my status.”* [FGD HIV-positive, 20–24] The study found that all HIV-positive adolescents who have accepted their status also reported taking their medication consistently.

#### ***Desire to have children among HIV-positive AGYW***

The majority of the HIV-positive adolescents indicated their desire to have more children. They were aware of what they should do to prevent any child they might have contracting HIV. One adolescent reported: *“We too are human and we have access to*

health centres where we can get help. We will have more children in due time.” [FGD HIV-positive 15–19] However, others are hesitant for fear of losing their children, based on past experiences: “As for me, I am not sure, since when I was found positive I thought my child was too. So I don’t want to kill an innocent child.” [FGD HIV-positive 15–19]

### **Awareness of SGBV**

Generally, AGYW expressed awareness of SGBV. A considerable number understood SGBV as a sexual or physical act forced on a victim without their consent. When they were asked to give examples of SGBV cases, some of them mentioned GBV cases that occur in their families. One young mother stated that: “These sexual cases happen even in our homes because there are times when your husband wants to be intimate but you do not want to. So he might force you in the process, even when you are walking, you might be raped. So even your husband can rape you and not only strangers.” [FDG 19–24 HIV-positive] Most were aware that cases of SGBV must be reported to the police. In addition to reporting to the police, a number of respondents also mentioned the importance of reporting the cases to the clinic for a medical check-up and to receive medication to reduce the risk of contracting sexually transmitted infections. “At the clinic they can also test you to see if you have been infected with HIV. If you have been infected, you will be counselled on how to take care of yourself and you will be given medicine. They will tell you that you are not the only one and that if you don’t take your medication, you will get sick. If you take your medication, you can carry on with the work that you used to do before you got infected.” [FGD 15–19 HIV-positive]

### **Socio-economic barriers to accessing antenatal and sexual health services**

“They are afraid that if they are found positive, they will be given medicine to take including medicine to prevent the baby from getting infected. They are afraid of taking a lot of medicine. They are also afraid because they have to pay a 100 kwacha to deliver at the clinic.” (FGD 20-24 HIV positive, Senanga)

“Some are scared of paying a fee when they don’t have a card.” (FGD 20-24 HIV, Senanga)

“The challenge that most young women face these days is their partners. Their partners refuse to escort them for antenatal. When they come to the clinic, they are turned away and told to go and bring their partners or they should come with money. Most of them don’t have money to pay and just end up staying at home.” (FGD 15-19 HIV positive, Senanga)

### **Socio-economic status, SRH and SGBV**

Low socio-economic status of adolescents can be a barrier to accessing SRH services. Whereas the health facility may not charge a fee for accessing the SRH services, some reported that pregnant adolescents who cannot bring their partner for ANC are required to pay to get a letter before being attended to. As such, some tend to forego or delay seeking ANC services because they do not have the money to pay.

“Some men deny that they have made you pregnant. When you come for antenatal alone you are told to bring a 20 kwacha so that you get a letter. Your parents may refuse to help you with the money and tell you that it is your own fault. This can make someone to delay and end up coming at nine months.” [FGD, 20–24]. A health provider explained: “Some [AGYW] can even give birth without coming for antenatal.” [KII, In-charge]

HIV-positive respondents report that coping with HIV can be challenging for the poor, given that one is required to eat before taking the drugs and at times they do not have food in their homes. *“Sometimes you can go to the clinic to collect medicine and yet you don’t have food at home.”* [FGD 15–19 HIV-positive] It was also noted that some youths engage in transactional sex due to poverty in homes. One peer educator told of one adolescent who visited the Adolescent-friendly Space (AFS): *“I don’t know what to do, I stopped schooling and am living with my grandmother, I have nowhere to go look for money to buy the things I need, so that’s what has led me to engage myself in these sexual activities.”* The peer educators and adolescent girls also reported that in some cases, young women are told by their parents or guardians that they are old enough to take care of themselves. One peer educator indicated that in some homes girls would be told: *“You’ve grown up, you need now to look after us. Then these girls go to these pubs to make money.”*

The study also found that survivors of SGBV who are of low socio-economic status may fail to report the assault or access help for related services. In cases where the perpetrator is a breadwinner for the family, the victims find it difficult to report such cases for fear that the perpetrator may be arrested and the family would have no other means of survival: *“Others, it’s a situation whereby you are a dependent and have no other help. So if your brother-in-law was to rape you or it’s your stepfather, and you decide to go and report the violence, they threaten to throw you out of the house. So others are just afraid.”* [FDG HIV POS 20–24]

AGYW also report that, in some instances, SGBV victims from poor households are given money to keep them quiet and for fear of losing money they may decide to remain silent. To avoid being asked to reveal who the perpetrator is, victims avoid going to the clinic altogether: One young mother explained that: *“At the clinic they usually ask who raped you so others are scared to mention any names. Also, if one is raped, and the man who raped that person gives her money, the girl may make plans to spend the money even though she feels the pain. To avoid the possibility of the money being taken back, the person might conceal the incident.”* [FDG HIV POS 20–24]

Some HIV-positive AGYW report that ensuring that their children have good nutrition is a challenge as they do not have adequate food. One HIV-positive adolescent said: *“As for me, my child has a good appetite. So when I asked the doctor why it’s so, he said it’s because of the medication he was given. Septrin gives appetite so your child will never lose appetite and he doesn’t breast feed, he was weaned a long time ago. Feeding is a challenge so they need to help us in the feeding of these children.”* [FGD HIV-positive, 20–24]

## 3.2 INTERPERSONAL OR RELATIONSHIP LEVEL

This section describes the role of factors that exist at the interpersonal or relationship level. These factors relate to close relationships of AGYW such as parents, sexual partners and peers that influence the SRH experiences. The analysis draws largely from the responses of AGYW themselves and the perceptions of the key informants.

### *Disclosure of HIV status to partners, family and peers*

There were mixed views on the ease of disclosure of the HIV status to family members. Generally, adolescents said they found it difficult to disclose their positive HIV status. However, some stated that it was easier to disclose to their parents than their friends.

Many who had disclosed their status felt that it was easier to tell family members, particularly their mothers and sisters, as they tend to be more supportive. Other distant family members are most often not trusted to keep such information to themselves. One adolescent explained: *“When it comes to your relatives, it’s not all of them that you can tell about your status. If possible, your parents are the only ones that you should tell. Some of your relatives may start telling other people if you disclose to them. You may even end up feeling bad.”* [FGD, 15–19 HIV-positive adolescent]

*“When I came to the clinic I was told to go back and bring the person who impregnated me. The father of my child refused to escort me and there was nothing I could do about it. I just had to find money to pay for a letter to allow me to come for antenatal.”*

*(FGD 15-19 HIV positive, Senanga)*

*“Some men deny that that they have made you pregnant. When you come for antenatal alone you are told to bring a 20 kwacha so that you get a letter. Your parents may refuse to help you with the money and tell you that it is your own fault. This can make someone to delay and end up coming at 9 months. Some of them can even give birth without coming for antenatal.”* (FGD 15-19 HIV positive, Senanga)

Adolescents indicated that some parents were supportive to the extent that they collect medication on their behalf from the health facility. One adolescent explained that: *“It is better to tell your parent so that they can even go and collect your medicine on your behalf if you are too sick to do it.”* On the other hand, a few of the respondents indicated that some parents had strict rules of conduct for their children, and they regarded being HIV-positive as a sign that one has been misbehaving. One adolescent said: *“Others are afraid to tell their parents because they will think that they sleep around.”* [FGD, HIV-positive 15–19]

The majority reported that it was not easy to disclose one’s HIV-positive status to friends and peers, as they tend to share this confidential information with others. Adolescents added that: *“It is not easy to disclose to your friends because they might go and tell other people. It’s much better to disclose to your family members though not all of them.”* [FGD, 15–19 HIV-positive]

A supportive family environment is highly influential in ensuring that adolescents seek SRH services. However, some adolescents reported that they face stigma from within their families: *“We are usually discriminated against by the people we live with. Once they find out that you are positive, they will tell you not to use the same things as everyone else in the house. You can even end up being depressed.”* [FGD 15–19 HIV-positive]

It was reported that disclosure of HIV status to the partners or spouse could result in marital problems. One young mother explained: *“Some [AGYW] are scared that if she is positive and given those drugs and the husband is negative, then there will be trouble at home because the husband will ask her why she didn’t tell him her status before they got together. This creates problems.”* [FGD 20–24 HIV-positive] Some AGYW could not disclose their HIV status to their partner because they felt that their partners would not continue to support them, especially their child. One key informant indicated that:

*“Some of them [AGYW] may be afraid to ask their partners to escort them because they already know that they are HIV-positive and they don’t want their partner to find out. They are afraid that their partner may refuse to help them with the baby.” [KII, HIV support group member]*

### ***Lack of disclosure and adherence to ART***

Some adolescents attributed their failure to access HIV services to fear of family members and friends finding out that they are HIV-positive. The evidence suggests that fear of disclosure of HIV status to family and friends can act as a barrier to accessing SRH services from the health facility. In cases where adolescent girls did not disclose their status to anyone in the household, they explained that they were not able to freely take medication even at their home. One adolescent explained: *“Sometimes it is because the people you stay with don’t know that you are on medication. Sometimes you might have a visitor at home and you will be afraid that they will find out especially if you are sleeping in the same bed. You can try and wait for them to go to sleep before you take your medicine but you might fall asleep. This can keep happening over and over again and you might feel ashamed to go back to the clinic because you are not taking the medicine.” [FGD 15–19 HIV-positive]*

Lack of disclosure to partners/spouses was also said to contribute to non-adherence to ART by adolescents. One adolescent who had not disclosed her status explained how this affected her adherence to ART: *“Sometimes you may be hiding your status from your partner and you find it difficult to ask them to escort you. So you just end up staying away from the health facility.” [FGD 15–19 HIV-positive]* Lack of disclosure was reportedly common among non-adherent adolescents. When asked whether they disclosed their HIV status to anyone, only a few said they had disclosed their status to their parents and none had disclosed their status to their friends and partners. This suggests that disclosure of HIV status could help improve adherence to ART.

### ***Other reasons for non-adherence to ART***

Some adolescents are unable to adhere to treatment due to discrimination and stigma from the community. One non-adherent adolescent said: *“After I was found positive, someone from here started telling everyone that I am positive and every time I came here they would treat me badly, so I felt really bad and stopped coming until the in-charge came back.” [HIV-positive adolescent]* Some health providers reported that some HIV adolescents do not bring their exposed or infected children because they may not have fully understood the correct procedure. One provider stated: *“When we ask them why didn’t you bring the child for this and this? They will tell you to say, I was thinking maybe it’s just the initial test that you did, I mean the PCR test. So if we don’t continue giving them information that is supposed to be given to them, definitely they won’t bring their child to this facility.” [KII, AFP]*

Health providers also indicated that others do not come back if they are not comfortable with the service provision. The health provider explained that community members now understand the coding on the cards indicating ‘exposed’ or ‘not exposed’ and at times, some mothers try to delete that information. One health provider noted: *“If we are not careful in terms of handling them, especially when they come for under-fives clinics, if we do not become very professional in the way we want to counsel them, it alerts [scares] them. For instance, instead of coming to this facility where they are registered*

*and their child is supposed to be followed, they go somewhere else, and when they are asked about the ART programme by the staff at the other facility, they often lie that they still do it at this facility.” [KII, AFP]*

### **Spousal support and use of SRH services**

The majority of AGYW explained that their partners or husbands provided little support, and particularly were unlikely to accompany them during their visits to the health centre during pregnancy and delivery. To encourage couples to come for antenatal services, some health facilities send away women who do not come with their partners. *“The challenge is that we young women face these days is our partners. Some partners refuse to escort their women for antenatal. When they come to the clinic, they are turned away and told to go and bring their partners or they should come with money. Most of them don’t have money to pay and just end up staying at home.” [FGD 15–19 HIV-positive]* Key informants indicated that SMAGs are able to provide referral letters to females without partners. One SMAG member explained: *“We’ve got those referral letters that we write for them and sign. If that person doesn’t have a husband, we write on a paper like this one and they can register with the SMAG.” [KII, SMAG]*

In some cases, male partners’ insistence on having many children makes it difficult for women to seek family planning services. For fear of being found out by their husbands, some women indicated that they take family planning medication in secrecy: One young mother noted that: *“Some men are difficult and don’t allow their wives to be on family planning, but some are supportive, but you have to discuss and agree. Some men just insist on having more children, so sometimes it’s just better to do what’s best for you.” [FDG 19–24 HIV-positive]*

Further, it was reported that some adolescents are unable to access services as they are required to bring along the partner for ANC. In cases where the adolescent is not in a relationship with the person who impregnated her, it becomes a challenge. *“Some of them stay very far from the clinic and it may take them a long time to get here. When they get here, they are told to go back and come with their partner. Sometimes that person may not be in a relationship with the person who impregnated them or they may have been impregnated by somebody’s husband.” [FGD HIV-positive]*

HIV support group members also indicated that lack of a supportive environment from spouses also leads to non-adherence to ART. One member stated that *“It could be psychological because we have some experiences whereby the husband takes the medicine and throws it away, that is GBV.” [HIV support group, member]*

## **3.3 COMMUNITY LEVEL**

*“The person who impregnated me denied the pregnancy. My mother refused to assist me. She told me that it is my own fault and that I should go and look for the person who impregnated me. I was not doing anything to make money at the time. When I came to the clinic I was told to go back and bring the person who impregnated me. The father of my child refused to escort me and there was nothing I could do about it. I just had to find money to pay for a letter to allow me to come for antenatal.”*

**[FGD 15-19 HIV-positive]**

This section describes the role of factors that exist at the community level. These factors relate to social norms and community behaviours that tend to support or discourage the use of SRH. The analysis draws largely from the responses presented by AGYW and perceptions of the key informants.

### ***Discrimination and stigma in the community and non-adherence among AGYW***

One of the frequently reported barriers to accessing HIV services is community discrimination and stigma<sup>4</sup>. The majority of adolescents interviewed reported that they frequently experience stigma from members of the community they live in and this has contributed to some of them not returning to the facility or even bringing back their child. In many instances they were labelled as sick or ‘overweight due to drugs’. The fear of being discriminated against by community members tends to deter seeking HIV services and is a major contributing factor to non-adherence to ART in this group. An adolescent explained: *“Once you are found positive, then you are supposed to start taking medication and some stop because of the mockery or ridicule that they go through. There is a lot of stigma in the community, people are afraid of being stigmatised and that is why they don’t come to get tested.”*

Further, the study finds that AGYW may not access some of the services offered at the facility because they fear being found HIV-positive. One health provider said: *“Some of them are scared of being found HIV-positive because people may laugh at them and they will feel bad. That’s why some people are afraid of coming to the clinic and end up staying at home.”* [KII, AFP] The study also found that self-stigma acts as a key factor in delaying or not accessing HIV and SRH services. This self-stigma includes embarrassment and shame to be seen taking ARVs from the clinic. One health provider reported: *“I think it is self-stigma, people still stigmatizing themselves. Those that have disclosed their status really don’t mind but others are still self-stigmatizing. You find that they are not able to even adhere to instructions given, such as giving nevirapine to the baby at home because they have not disclosed to other family members, so as a result you find that some end up defaulting.”* [KII, AFP]

### ***AGYW experiences of community discrimination and stigma***

*“Discrimination is there because these people can gossip, even when you walk around, they point at you and tell everyone that you are sick. They tell all the guys that try to date you. That’s why the others even fail to come and collect medication from the clinic because they are scared of being the laughing stock of the community.”* [FDG 19–24 HIV-positive]

*“Ever since I started taking my medication people have been laughing at me saying that my body is not improving because it’s probably not compatible. So these things are happening in our community.”* [FDG 20–24 HIV-positive]

<sup>4</sup> Stigma can be defined as “an attribute or label that sets a person apart from others and links the labelled person to undesirable characteristics” (Fortenberry 2002; Lewis 2005). Stigma that occurs in the public sphere manifests at a community or society level. Self-stigma occurs at an individual level and has been defined as a negative emotion having to do with the experience of failure in relation to personal or social standards and the feeling of responsibility for such failure (Lewis 2005).



Related to self-stigma, some adolescents were unable to access health services from the health facility for fear of being tested and found to be HIV-positive. One young mother noted that: *“It’s just fear that we have. When you are found positive, people fear dying early so it’s difficult. So people are scared, when you’re found positive, people think they will die there and then.”* [FDG, HIV-positive 20–24]

The health providers indicated that in some communities the people are becoming more knowledgeable and accept that HIV/AIDS is just an illness like any other and ARVs are just like any other medicine. One health provider explained that: *“When I compare where I came from to this place, I have found that community stigma here is reducing. Clients are able to come to the facility with the card in their hand and walk past the other patients, without hiding, and openly stating that they have come to collect ARVs. So to me it’s like they are leaving stigma behind.”* [KII, AFP]

### **Community beliefs and misconceptions about family planning**

Health providers indicated that, in some cases, the sexually active shun contraceptives due to the belief, particularly among AGYW who had never had a child, that using contraceptives may lead to infertility. One health provider said: *“For family planning, some they don’t want to be on family planning because there is misconception there in the community to say if you have never had a child and you’re on family planning, then you won’t be fertile. So that one is a very big challenge if we want to promote the use of contraceptives among the adolescents.”* [KII, AFP]

### **Community beliefs and practices around SGBV**

Despite a high level of knowledge of what constitutes SGBV, there are still sections of the community that consider SGBV a normal occurrence, particularly when it is perpetrated by a family member. The study found that some community members lack knowledge on what constitutes SGBV and that SGBV needs to be reported. One health provider reported: *“People can know that they have been sexually abused but, in this community, ... you will find that when someone is sexually abused, because there is lack of knowledge about that, they will just see it as normal.”* [KII In-charge]

Other health providers also noted that in some cases, adolescents are not able to disclose that they have been involved in physical violence and would find other reasons for their injuries. For instance, one health worker explained: *“They lie that they just fell and would not agree that they have been beaten.”* [KII, In-charge] Health providers also noted that the main challenge is that people who face some violence, will often disappear and not follow up the matter. One health provider said: *“I think the challenge, when you*

*identify such a case and you start going through it, by the time you end those people may disappear. They will never come back.”* [KII, In-charge] Health providers observe that parents often tend to state that the case involving an adolescent will be dealt with at home or within the family: *“Even for adolescents, their parents will come in and say no, we will just discuss this thing at home. Maybe that person will be made to pay something then they forget about the case.”* [KII, In-charge] Similarly, support group members also note that most cases are not reported: *“Most of these SGBV cases are hidden,”* said one. [KII, HIV support group]



*“They will start asking you where you are going with a bag. They will even pretend as if they want to escort you and so you act as if you were going somewhere else. By the time you get to the clinic, you might find that they have knocked off.”*

**[FGD 15–19 HIV-positive]**

*“If you go to the general hospital you might find a lot of people that know you and so you just pretend as if you went there for something else. If they see you collecting medicine, they will start talking about you even though they also came to collect medicine.”*

**[FGD 15–19 HIV-positive]**

### ***Cultural beliefs and practices around SRH***

Culture, social norms, and beliefs related to adolescent sexuality were described as barriers by both AGYW and health care providers.

Cultural norms and beliefs in communities that surround adolescents and use of SRH services frequently affect AGYW’s use of these services. Participants in this study revealed several beliefs of this kind. For example, community members believe that children born of parents who use family planning look unhealthy. Some young mothers reported: *“Family planning helps us. But when you deliver, a baby whose mother doesn’t take family planning looks healthier than one whose mother has been on family planning ... if the health workers advise us to start family planning after delivering, we just do it so that we don’t get pregnant, but I think the children look sick.”* **[FDG 19–24 HIV-positive]**

Similarly, adolescents generally expressed a fear of side effects that would arise from the use of modern family planning methods. Perceived side effects such as miscarriage and difficulty in conceiving after use of contraceptives mentioned by the participants were, however, accounts of other women’s experiences in the community, and not personal experiences: *“If you start taking contraceptive and you have never given birth before, chances of getting pregnant are slim.”* **[FGD HIV-free]**

Other cultural practices encourage women to prove that they are fertile and confirm that they can have children at an early age, thus thwarting family planning efforts. *“Some adolescents, most especially female adolescents, when it comes to reproductive health, some few individuals ask me ‘how will I know that I am fertile and can conceive, I am 15/16 years and you’re saying that I should not be pregnant, so how will I know that I am a normal lady? How do I confirm that I can bear children? I need to prove that I am normal.’”* **[KII, AFP]**

Further, there are still beliefs that relate to the cure of HIV. Participants mentioned that there are still sections of the community, which believe that traditional medicines for curing HIV are available. Several people believe that church leaders or prophets have the ability to cure HIV and encourage their members to discontinue with ART and focus on prayers. The following are quotes from the adolescent FGDs.

*“Some people are told that if they take traditional medicine such as moringa they will be healed, and they won’t need to go to the clinic. Some of them would rather believe what their traditional healers tell them instead of them going to the clinic.”* **[FGD 15–19 HIV-positive]**

*“The prophets are the ones who mostly deceive people because they tell them that once they are prayed for, they will be healed. If you believe them, you might end up dying.” [FGD 15–19 HIV-positive]*

However, district officials indicated that such beliefs have been on the decline and that most people no longer believed such statements. One district official said: *“In terms of religious or cultural beliefs with regards to HIV, it’s not much in this district, but we have beliefs around family planning that affect service use.” [KII DHO]*

### **Current approaches to dealing with stigma in the community**

The study found that work to raise community awareness on SRH, HIV and stigma is often done through community health workers and community-based volunteers. In some areas, approaches used include drama groups, which may take place twice a year. One community health worker said: *“We have a drama group which talks about how to take care of those who are HIV-positive and to encourage those who have never tested for HIV so that they know their status. We conduct a school health programme where we mobilize a lot of teenagers to help us in giving health education and condom distribution so that everyone can receive, because some children don’t feel okay to have those things being discussed in the presence of their parents, so that’s why we normally conduct school health programmes.” [CHA]* Other activities include outreach work in schools and the wider community. However, the main challenge is funding for such community activities to provide resources such as transport and logistics.

## **3.4 SOCIETAL LEVEL**

This section describes the role of policies and social structures that tend to support or discourage the use of SRH and SGBV services among AGYW. This analysis draws largely on responses from key study informants such as the facility, district and provincial officers and perceptions of AGYW.

### **Lack of privacy at health facilities and inadequate infrastructure**

Lack of adequate privacy at health facilities is a key barrier that affects adolescents’ access to SRH services. Health providers attributed this lack of privacy for patients to inadequate infrastructure which forces health providers to combine SRH services such as ANC, family planning and, at times, ART services in the same room. *“The challenge is the structure is just too tiny, but services are many... you find that maybe two services or three services are conducted in one room, so it’s just because the structure is just too small.” [KII, AFP]*

Further, the location of ART clinics can discourage AGYW from accessing HIV services. One adolescent explained: *“...in case someone comes to pick [up] medication and they meet their neighbour who has brought in a sick child, and meaning they will know that she is positive, and that discourages people from coming.” [FGD HIV-free, 15–19]* Another young mother noted: *“There is no privacy [at the facility]. That’s why some people from this community prefer to go to the hospital instead because they just give you a specific date to go and people won’t know why you are going there.” [FGD 20–24]*

One of the contributing factors in the failure to collect medication at the health centres is the lack of privacy. One adolescent girl said: *“I think that they should be giving us*

medication for our children at a separate location that is more private. It is very embarrassing to be called to go and get medicine for your child in front of everyone. It is not good.” [FGD 15–19 HIV-positive] Some turn away even after reaching the facility. One adolescent said: “The other day I saw someone who failed to collect the medicine from there. The lady didn’t collect the medicine. She looked very embarrassed.” [FGD 15–19 HIV-positive]

One official said it was important to create private spaces for adolescent patients: “We should ensure that there should be space available and created in our facilities because these are young ones who sometimes wouldn’t want to be seen by other members of the public, so privacy must be considered. Let’s encourage spaces in our facilities where we are seeing these adolescents.” [KII, Province] Adolescents also report that, in some cases, their age group is not comfortable to be accessing services or sharing space alongside older patients. One adolescent reported: “Maybe just looking for a place for those who are not comfortable in mixing with the elderly. When they come they have to mix with the elderly, [and] maybe finding a place where they don’t have to mix will make them more comfortable.” [FGD 15–19 HIV-free]

### *Improving HIV testing and service delivery*

*“I think we have to open more HIV testing points. We should train the HIV counsellors in the communities who could even conduct some HIV tests as well as distribute condoms.”*

*[KII, AFP]*

### *Mode of service delivery for HIV services*

The study found that the mode of HIV service delivery contributes to lack of adherence to ART treatment. Interviewees said that the process of being singled out at the time of collecting ARVs and being separated from the other mothers receiving a similar service is uncomfortable. Some AGYW also complained about their discomfort at being dealt with by older health workers who they perceived to be judgmental. This factor was highlighted as a potential cause of mother-infant loss to follow-up HIV services at the facility. A health provider said: “Adolescents and young mothers tend to shun away from accessing these [HIV] services from probably someone who is like their mother; they would feel a bit uncomfortable. But where we have a young nurse and clinical officers, we see them participating.” [KII, AFP]

Some health workers reported that it would be better to provide separate services for HIV-positive and HIV-free mothers.

*“It’s better to separate them from the others. Because for these mothers, they are supposed to be getting their treatment through MCH until the child is about one year six months, somewhere there. That’s when they start mixing with the others. So, if they are treated as a separate group, they are free.” [KII, In-charge]*

The study established that an approach in which ARV drugs are provided to HIV-positive clients after health education and during MCH led to loss of clients, because some women would not

stay behind to collect the drugs. A district official observed: *“What used to happen is after, maybe, health education, the other services which everyone is receiving they all receive. Now there is an issue of collection of drugs, maybe samples, then they would be told to ... remain for extra services. So now that issue of remaining has been affecting us so much because they would [leave]. So now what we are doing is, when we are providing all these other services, we are also doing the same activities for HIV clients. It’s only maybe we would just tell them go the other side, but everything is happening at once, so that we do not miss out anyone.”* [KII, District]

Health providers and district officials felt that singling out women seeking SRH such as ANC, asking them to remain to receive ARV drugs after the other clients have left, raises issues of stigma. One key informant noted: *“For those that are HIV-positive, it’s a challenge for them to remain to pick up the drugs because of the set-up of our facilities. We need to try to make sure that the other people do not know what type of drugs they are collecting, it would be better. In the current set-up, after receiving health education, the HIV-positive clients are singled out to remain specifically for collection of drugs or collection of samples.*

*However, most of them don’t remain, because it becomes obvious to the others that there is a problem with the child or the client. We should be able to make sure that there is no segregation of clients, but we should be able to provide the service informally. For instance, during one-on-one counselling, at the same time you are giving counselling you should be able to give the drug and collect samples. Asking AGYW to remain after everyone else has been attended to has been problematic.”* [KII, District]

### **Spreading the message**

*“Let’s try to look at a material which is produced in local language, so that even the people who are less educated can read if the material is in their local language. [If] it’s just in English, we automatically exclude those who are not able to read English.”*

**[KII, District]**

### **Adherence among adolescents and young mothers**

Health providers indicated that the usual practice is to encourage adherence to ART for those found HIV-positive and to teach clients how to stay healthy so that they can avoid getting opportunistic infections, and to explain the need to continue taking the ARVs. One health provider said: *“We are encouraging them that, once they know their status, if they are HIV-positive they need to start treatment immediately and they need to be on treatment for life; they need to check their viral load after every six months to ensure that they keep the viral load low. And issues of health, we encourage them to prevent infections, to use mosquito nets so that they don’t get malaria from the mosquito bites.”* [KII, In-charge]

The health providers also noted that the default rates are higher where the child has completed immunization. One health provider noted: *“When they finish the vaccines, that period, that’s when they are reluctant to bring their children for following up or the final test, so we follow them up in the community.”* [KII, In-charge]

### **Lack of confidentiality**

Some of the respondents reported being afraid of going to the health facility for fear that the health worker would spread the word that they have sought services for SRH or STIs. *“Sometimes they are afraid because we come from the same place with the health workers and usually mingle at functions and bars ... They are afraid of being exposed to be on treatment,”* said one health worker [FDG 19–24 HIV-positive]. Reports of high levels of stigma in communities were also highlighted by health workers in some of the facilities as shown by this comment: *“I think from what I have observed, even from where we are coming from in our community, it’s like certain parts of our community haven’t accepted HIV as just a mere disease ... there is still stigma at some point.”* [KII, In-charge]

### **Sound and factual information**

*“Here at the clinic, they provide accurate information on family planning and how to use it. Sometimes you can know about family planning but you don’t know how to use it. That is why some people come to the clinic to get more information on how it works.”* [FGD 15–19 HIV-positive]

### **Designated days for offering family planning services; availability of commodities**

In most cases, the facilities have designated days or scheduled times for offering services such as family planning. The general perception among adolescents is that offering the services on designated days may limit their opportunities to access the service. However, health providers indicated that, in some instances, adolescents are attended to whenever they visit the facility for such services. *“We offer [AGYW] family planning services on a daily basis though we have [scheduled] times and days. Like at this facility, we just attend to clients in the afternoon in terms of family planning but there are those that come from very far places, we have got catchment areas that are not within our reach. So if those people come and say we want to access family planning, we offer it right there and then.”* [KII, In-charge] Another health provider reported: *“Yes, even for the young people we had made a policy to say when that young person makes a decision that ‘I want to be on family planning’, then we defer them [to] come in the afternoon. What we discovered is that most of them were not coming back, the only coming back we would see is a pregnancy. So ... we’ve agreed that let’s just offer the services right there when they come into our facility. But the normal way we usually do it is in the afternoon, the reason being we have got a lot of activities in terms of MCH.”* [KII, AFP]

Adolescents also reported that sometimes there are medication shortages and they are asked to come back later. One adolescent said: *“We would at times find that they have run out of family planning injections then send us back and tell us to go back next week. And most of the times they are difficult when it comes to the one for five years. I have heard a lot of people complain that when they insert it in you (on the shoulder), and maybe it gives you problems, like you don’t stop bleeding. When you go back to have it removed, they refuse.”* [FGD 15–19]. However, some district and provincial officials reported that some facilities do not have equipment to remove long-term reversible contraceptive implants such as the Jadelle implant.

### **Challenging cultural beliefs and practices**

*“We hear about family planning on the radio. They tell us that we should go for family planning. Sometimes you can get pregnant and yet your parents want you to complete your education. They encourage us to go for family planning because a lot of youths misbehave a lot these days.” [FGD 15–19 HIV-positive]*

*“Some of them learn from their parents. Their parents may bring them to the clinic for an injection to prevent them from getting pregnant even as early as 15 or 12 years.”*

**[FGD 15–19 HIV-positive]**

### **Information sources on SRH**

AGYW identified health centres, peers, parents, teachers, radio and television as sources of information on SRH and HIV. The findings showed that health facilities were considered the main source of information. They also said that sometimes health facilities reach out to the community with information rather than waiting for them to come to the clinic. One young mother reported: *“There are times when information is brought from the health centres to the community. You can find they have a drama group so that they call many people. They dance, then teach us on HIV.” [FDG HIV POS 20–24]* In interviews, health providers and district officials talked about radio and TV programmes initiated by health facilities to raise community awareness on HIV and SRH. One health provider had this to say: *“There is awareness, we have a local radio station here ...where I usually go every Saturday at 15hrs. If I am not there, other colleagues usually go there and it’s a live phone-in programme where young people ask about SRH and their rights.” [KII, AFP]*

Untrained peer educators reported that they did not understand some issues around HIV well enough to be able to accurately communicate and answer questions from the community. This may mean that AGYW do not consider peer educators to be a reliable source of information. Asked about information on family planning, adolescents mentioned peers, parents, teachers, radio and television among their sources of information on SRH. However, a number said they relied mostly on their peers for information on SRH. The results also revealed that parents were an important source of information. More than half indicated that teachers are an important source of information on SRH.

Notably, AGYW reported that their friends and family members with previous experience of contraceptive use are a source of information for modern family planning methods. Despite mentioning many sources of information on family planning, many respondents indicated that their preferred source of information was the health facility rather than information from friends, as reported by a young mother: *“Sometimes your friends can mislead you and you end up believing the wrong things. It is better to come to the clinic so that you have correct information.” [FGD 20–24 HIV-positive]*

## Effective peer education

*“For us there is no way we can be answering some of these questions without training; even if we give answers, they are not proper answers, so we too need to be trained so that we can give better responses. It doesn’t mean that when we are trained we shall be doctors or nurses, no, but we will be just there to help the community.”*

**[FDG Peer Educators]**

## Community level involvement

SMAG members reported that, in some cases, young women have been selected to be part of SMAGs so that they can deal with adolescents. One SMAG member suggested: *“When they are picking people to train for SMAG, [if] they also picked young people so that young people can assist their fellow young people, it would be good.”* **[KII, SMAG]**

The community-based volunteers also reported that community programmes that engage young people have been effective in dealing with some of the challenges faced by community workers. For instance, programmes such as DREAMS<sup>5</sup> are seen to be involved in educating adolescents, empowering them by paying for their schooling. One SMAG member said: *“The DREAMS have brought young people together and always teaching them, and tells them that they will pay their school fees. So, they withdraw from sex issues and come to learn, if they come they even say ‘I will be going to school’. Back in the day we used to have challenges; now this time, ever since DREAMS came and the youth friendly corner, it’s good and we are not having any problems.”* **[KII, SMAG]**

## Delays in punishing perpetrators of SGBV

AGYW reported that they are aware of where SGBV cases can be reported. One young woman indicated: *“We can report to the police and the clinic, and even report to the area chairman and the leaders in the community.”* **[FGD 20–24]** Some respondents expressed concern that many cases go unreported. They feel this is because even when SGBV is reported, sometimes no action is taken to punish the offenders. *“When it came to report such cases, our leaders were not taking it seriously. They would tell us that they were waiting for feedback from the Lusaka offices. We are still waiting for feedback on some cases that we had reported.”* **[FGD 15–19 HIV-positive]**

Further, adolescents reported that the action taken by the police depends on the nature of crime. *“If it is a big case, the offender can be arrested. If it is a small case, they will just talk about it and go back home.”*

One adolescent said: *“The challenge is that when you report to the police station, they won’t do anything about it. When you come to the clinic, they will assist you. When it is time to go to the police, you might find that the person who has abused you has more money than you. He might just be arrested for a short time. [The police] will be paid money and that will be the end.”* **[FGD 15–19]**

<sup>5</sup> DREAMS is a global public-private partnership between the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), Bill & Melinda Gates Foundation, Girl Effect, Johnson & Johnson, ViiV Healthcare, and Gilead. It seeks to reduce new HIV infections in adolescent girls and young women (AGYW) across 10 sub-Saharan African countries.



### ***Service delivery for SGBV at facility level***

District officials report that with SGBV, the challenge in delivering services for adolescents arises when they are brought in by their parents or guardians who would prefer not to provide full information on what transpired, and in some cases would attempt to shield the perpetrators, particularly if they are family members. One health provider noted that: *“The only problem that we usually encounter is these young people, especially if they have been brought by their parents or the guardians, opening up is something else, we really struggle to really find out that this is a sexual assault or there is a problem in terms of knowing what happened. Sometimes they always want to shield especially if it was perpetrated by the uncle or maybe the relative. They also come out if maybe the perpetrator is not part of their family. Especially if we mention the Zambia police, it will be something else, they won’t even come back, so that one is a very big challenge.”* [KII, AFP]

Health providers also reported that in most cases, parents or guardians of adolescents tend to withdraw the cases. One health provider noted that: *“I think the biggest [challenge] is where people want to withdraw, especially the guardians, the parents; that one is a very big challenge even if that adolescent was victimized, was raped, you just hear, they just withdraw. Just before you start treating them, they will agree to say, I want the law to take its course but the moment they see that everything is okay to that adolescent, then they will try to pull out.”* [KII, AFP]

Health providers and district officials report that in some cases, the victims would also not be willing to report the sexual or physical violence inflicted on them. One health provider noted: *“When you examine them [clients], and you find something on their body and when you try to probe they will not want to talk and you have to keep probing. You will need somebody with experience to get that information, good counselling, you need to do a good counselling session for you to be able to get that information.”* [KII, District]. The health providers also noted that there is lack of sensitisation of the issue of SGBV in the communities: *“Sexual gender-based violence hasn’t been publicized, maybe people are not much aware about it and just like if you look at community where we are coming from, people they need much information, [the authorities] need to go flat out so that they know what is really happening.”* [KII, In-charge].

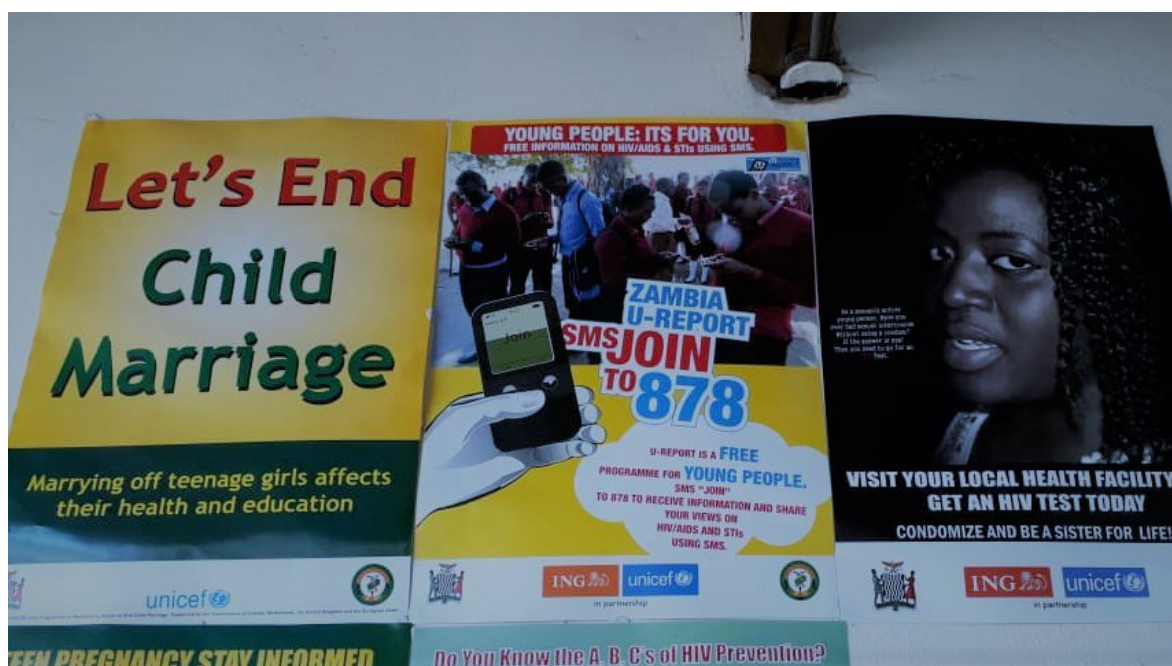
Health providers reported that in urban areas, with NGOs providing support for SGBV cases, there are fewer challenges. However, health providers note that in rural areas, it is more challenging as there are fewer or no active groups that focus on SGBV. One district official said: *“In the rural areas it becomes a bit difficult even when there are SGBV and cases. It will just die a natural death because of the absence of these other active groups specifically looking at GBV. And also, the linkage to relevant authorities like the police, since those facilities are far away, so by the time the health care worker comes and reports that issue, a month would have elapsed when it happened. Then it takes another month for follow up, so really I don’t see a proper link for the [distant] facilities, But those that are near, things are okay.”* [KII, District] The district and provincial officers noted that more attention needs to be given to the issue of gender-based violence.

### **Better information, education and communication**

*“We need to give the adolescents information, education and communication material. Let us focus on those in schools and those who are out of schools. Mainly, I think, of late we have just been concentrating on those who are in schools but we don’t have a lot of activities for those who are out of school. They also need this service.”*

#### **Information, education and communication (IEC) materials**

Health providers reported that an increase in the level of knowledge on SRH among AGYW may encourage the uptake of SRH services. Health providers and peer educators emphasized that education through the use of IEC materials played an important role and that materials translated into local languages are more useful, particularly in rural areas. In one instance, IEC materials in Bemba were sent to a region with different local language. One district official explained that: *“More recently we received a lot of material in Bemba, and now people here don’t understand Bemba.”* [KII, District]



#### **Training of staff on adolescent health standards**

District and provincial officials said inadequate funds meant that few staff in health facilities had training in adolescent health standards. The common practice is to ask health facility staff who have such training to orient others or share what they have learned from training with those who did not attend. However, health providers reported that staff who had not had the formal training were reluctant to deal with certain adolescent health issues and would rather defer to those who had the training. However, in most cases, limited funds mean that only a small proportion of staff have the training. One trained health worker reported: *“Yes, it is the issue of who was invited for that [training] workshop in terms of money. So some, even when we come from the trainings, we tell ... colleagues, we want to debrief you on the training that we underwent. The majority, even when you are giving that talk, they will just be looking at you, like, you just went to get the money – then why are you coming to give me that information? ... When they face a problem, handling that case, they will refer to Mr. XYZ who went for*

*that training. Even if they were oriented they will try to refer the client to another person. 'That programme is not mine, that programme is for Mr. XYZ.' [KII, AFP]* Trained health providers said that district supervision of provision of adolescent health services should be enhanced.

During the field visits, one district reported that it had funds to train additional staff on adolescent health. One district official indicated that: *"...all the staff in the five facilities with adolescent-friendly spaces were trained, but the staff in the rest of the facilities were not trained. But now the funding we have received includes training for the remaining health care workers and we are doing this training actually on Thursday next week."* [KII, District]

*"This year we did not plan for many training sessions at provincial level. What we are doing is more of mentorships right at facility level. We thought it is less expensive and we are not depleting staff from their facilities. We are able to give them the skills within the facility and also plan for reverse mentorships. For instance, we pick three members of staff from one hospital take them to a certain facility and take three members of staff to come and work at that hospital so that they gain the skill without us taking them for a residential training. So we spend less as we only pay their DSA, unlike where we have to pay for the venue, accommodation and food. That is the direction we are trying to take, I hope it works ok."* [KII, Province]

Provincial officers explained that, rather than scheduling training programmes, they have embarked on a mentoring programme at the facility level, where staff from one facility are sent to another facility to learn skills without necessarily being taken for training. The officials explained that this approach is less costly and does not reduce the number of working staff at the facilities.

#### ***Orientation of non-clinical staff and community workers on adolescent health***

Health providers and district officials reported that there is a need to orient not only clinical staff working at the facility but also non-clinical staff. The district officials and health providers explained that as adolescents enter a health facility, they interact with various health and non-health staff, as they often don't know where to go. There is therefore a need to broaden the spectrum of the people trained or oriented on adolescent health needs.

One district official explained: *"I think all members of staff, starting from the CDEs, the security guard, the station handyman – all people – if they are not trained, at least they should be oriented on how to handle the adolescents because these people just come and hang around the facility, they don't know where to go. Sometimes they can even ask the station handyman where to access family planning services. Now if this guard doesn't know how to handle such a client, they just start shouting, you're very young, why do you need family planning ... then two to three months later, this is an adolescent who falls pregnant. So all of us need to be oriented on how to handle these young people."* [KII, District]



Another health provider said: *“We need to put deliberate policies [in place] for how we should handle adolescent health services. If similar training that I was given was provided to the majority of people that handle these young people, not just health workers, even gate keepers out there, I think issues to do with adolescents could be minimized. Because they will be able to know where to go, what to do in health centres.”* [KII, AFP]

In addition, district officials also noted that there is need to train community-based workers, such as the NHCs, to ensure continuity in adolescent service delivery beyond the facilities and into the community. One district official suggested the following: *“We should concentrate at community level as well. We should also train one or two people from the NHCs on adolescent health issues. This will enable us to establish structures at community level to support these adolescents. This will be very helpful.”* [KII, District] Some SMAG members reported that they had been trained in adolescent SRH needs.

### ***Demand creation for use of SRH services among AGYW***

District officials noted that demand creation activities, such as sports activities organized through the AFS, are key in mobilizing adolescents and a useful avenue towards provide SRH services, including HIV testing. The mobilized groups of adolescents are able to participate in sporting activities such as football, netball and volleyball. A health provider noted: *“We bring them together, so we even organized games like football, netball, even indoor games, and we meet every Saturday 9hrs. We’re trying to break the stigma of these adolescents through interacting at gatherings for those who are HIV-positive.”* [KII, AFP].

However, the district officials noted a key challenge; the range of sports activities is limited. One district official said: *“We have seen that sports activities are really yielding so much fruit by bringing [adolescents and youths] together. However, one challenge is that we have very limited sports activities in the adolescent spaces. There is only football, netball, volleyball and adolescents would want other sports activities, especially in town, like playing pool.”* [KII, District]

In rural areas, health providers and district officials noted that the provision of community television centres, where both entertainment and health IEC messages can be shared and HIV testing can be done, is likely to draw a lot of adolescents. One key informant said: *“So, if we are able to put up TVs in the adolescent spaces, with informative IEC material, it would help to bring adolescents together. I have seen that from the time we installed these rural television programmes through satellite, under the Vice President’s office, most of the people who go to the facility just to go and watch TV are the adolescents.”* **[KII, District]** Health providers also reported that having designated days for HIV-free and HIV-positive adolescents’ activities encourages participation and provides comfort to those HIV-positive adolescents, particularly the newly diagnosed.

### ***Implementation of integrated service delivery for SRH and HIV services***

All the respondents reported that they received integrated HIV and ANC services during their first ANC visit. All those with HIV-positive tests were counselled and initiated on ARVs and others with a low CD4 count were given Septrin. One adolescent stated that: *“When I got pregnant, at three months I went for antenatal, they tested me and found me positive. They gave me Septrin. It’s the one I was taking till my CD4 count was high and then I started the actual drug.”* **[HIV-positive 20–24]** Similarly, those who reported seeking family planning services said they were also tested for HIV and the provision of integrated HIV and family planning services ensured that both services are effectively delivered since most people are interested in family planning but are afraid of taking an HIV test. One young mother explained: *“Providing both family planning and HIV services is very convenient. The problem they face at the clinic is that most people don’t want to come and get tested for HIV, but when they hear about family planning they come in numbers.”* **[FGD 20–24, HIV-positive]** Another young mother noted that: *“It’s good to combine these services because when you know your status it helps in prolonging your life.”* **[HIV-positive 20–24]**

The health providers explained that HIV services are offered jointly with family planning, ANC and child health. One health provider explained: *“These who are doing family planning here, they also test for HIV and immediately they come across a person who is HIV-positive, they’ll refer them to the ART clinic. From there again, if at all this is an adolescent, that adolescent will fall in the hands of the adolescent peer group. They will offer counselling and then further referred to the in-charge for initiation of ART.”* **[KII, In-charge]**

District officials indicated that integrated health service delivery reduces the loss of clients who need more than one service: *“... When an adolescent comes, they should be able to access family planning from the same place, like a one-stop centre, not to move from one room to another because like that you can lose them. So within the same building, they should be able to access all the services, such as HIV testing, family planning and if there is also antenatal.”* **[KII, District].**

Lack of privacy was reported in some instances where both HIV and Child Health Services were provided. One HIV-positive young mother reported: *“They can combine us at family planning but not at [the clinic for under-fives]. When they will tell you that here is the medication for your child, it doesn’t look good because some people will start wondering why you are being given Septrin for your child when they are not.”* **[HIV-positive 20–24]** Another noted that: *“When they combine HIV services and family planning it is okay. However, when they combine HIV services with [under-fives clinic] it is not okay.”* **[HIV-positive 20–24]**

*“ ... with so many people and very few health providers ... clients start complaining that they are taking too long at the facility because maybe this other one has come for postnatal, the other one for family planning.” [KII, District*

### ***Integrated service delivery for SGBV and HIV***

The study found that health services have a referral system for the management of SGBV cases. SGBV victims who report to the health centres are given first aid, tested for HIV and referred to the nearest hospital or one-stop facility. Officials explained that health facilities also work with NGOs and other government agencies such as the victim support unit to manage GBV cases. Other types of non-clinical services offered include advice to victims and, where possible, likely perpetrators. One official said: *“We have those facilities that are very far from the hospital and if somebody is injured or molested, maybe it takes time to get there ... we are supposed to offer what we call first aid so that the patient is stable and out of danger, before we can refer them to the next level where they can be examined by the doctor.” [KII, District/province]*

District and provincial officials noted that, in practice, victims of SGBV can visit the one stop facility in places where this is available. They can report to the police and then go to hospital or vice versa. In some cases, health providers are able to identify victims of physical violence. The health providers reported that for clients receiving other services such as antenatal care, the providers may notice possible signs of GBV and can refer the person to the hospital and advise them to visit the victim support unit. One official explained: *“If there is gender-based violence and the client comes to the facility seeking, for instance, antenatal care services and then you as a health provider notice that there could be some gender-based violence, you can take it up and refer that client to the hospital ...you can also even inform them to report to the victim support unit.” [KII, District/province]*

### ***Challenges in providing integrated service delivery***

AGYW reported that some adolescents feel discouraged from seeking family planning services because, said one, *“they are told to also do an HIV test”*. [FGD 15–19 HIV-free] Similarly, AGYW stated that some adolescents and young mothers avoid or delay ANC services because they are required to do HIV testing: *“When you come for antenatal you will have no choice but to be tested for HIV. Some people tend to run away when they are referred to VCT.” [FGD 20–24 HIV-positive]*

District officials reported that providing integrated services can be challenging in cases where there are few staff. Where a facility is run by one person, providing integrated services becomes a challenge and more scheduled days for various SRH services have to be planned for. One district official noted that: *“To provide an integrated service becomes a bit of a challenge if this [one member of] staff has to do a number of things in the same session. So they would prefer to offer, for instance, family planning and not provide antenatal care services because they can’t do everything at once. So that means that these adolescent mothers come more frequently to the facility. But in facilities where we have adequate number of staff, we are providing a supermarket kind of service where all services are provided at once.” [KII, District]*

One district official noted that: *“The staffing levels are few and you need to provide all the integrated services, but with so many people and very few health providers, it poses a challenge because the clients start complaining that they are taking too long at the facility because maybe this other one has come for postnatal, the other one for family planning. There are different activities, but you need to integrate them. But if you have enough members of staff, it is different because each one will be dealing with a different service.”* [KII, District] Health providers at facilities with adequate staff reported that they don’t face any challenges in providing integrated services: *“As at now, we don’t face any challenges because we are a bit many. We even have the peer educators, so we refer them to their peers.”* [KII, In-charge]

Some adolescents reported delays in provision of integrated SRH and HIV services. One noted: *“When I came for antenatal, I was tested for HIV and was found negative. I then had to wait for a long time before I could receive the next service.”* [HIV-free, 15–19] However, other AGYW find the provision of integrated services convenient as it helps them to avoid frequent visits to the facility as they are able to access more than one service on the same day. One young mother said: *“... [integrated family planning and HIV service delivery] is very convenient, the problem they face at the clinic is that most people don’t want to come and get tested for HIV.”* [FGD 19–24, POS]

District and provincial officials also report that providing integrated services is challenging due to lack of infrastructure and equipment. Some services, such as HIV testing or inserting an IUD, require privacy and may not be provided even where there are trained staff because the clinic environment makes confidentiality difficult. One official noted that: *“We still have some challenges in some facilities in equipment and also infrastructure. You will find that some services you really fail to carry out not because you not trained but the environment will not allow. For HIV testing services, and even family planning if you have to insert an IUD, you need an environment where there is enough privacy. Equally for postnatal, pretesting and counselling you need privacy. A room where you can be able to talk to your client – but you find that even our clients at times shun these services because if I am seated here in the next room someone is able to hear what I’m saying. People will not be able to come and access this service.”* [KII, District/province]

Health providers also noted that inadequate infrastructure infringes on the client need for privacy and quality of service delivery is compromised. One health provider reported that: *“I think the quality is the one which is compromised because of lack of infrastructure.”* [KII, In-charge]

Provincial and district officials report that one challenge in providing integrated HIV and SRH/MCH services is that some facilities with HIV testing services do not have ART clinics. Clients who test positive are referred to other health centres and this leads to loss of clients. One official explained: *“In some of the facilities that do not offer ART, it means you are not going to offer a holistic service, meaning you are able to identify this client is HIV-positive when you are offering, say MCH services, you test the mother, and she is HIV-positive. But if the facility is not an ART accredited site, meaning you can’t initiate, so that works as a challenge meaning you have to refer this client to the next level and in the process you lose the client.”* [KII, province]

### **Staff attitudes and confidentiality**

AGYW reported that health providers were mostly friendly. AGYW living with HIV stated that the health workers explain the side effects of the ARVs, such as a typical rash, and the need to adhere to the treatment. One adolescent reported that: *“They encourage us to get tested early and start medication before you get very sick and everyone knows that you are sick, because when you go early no one can notice that you are sick. You can’t even tell by just looking that that person is on medication, that’s if you come early, but if you don’t come then the virus multiplies itself in the body.”* [FGD 15 19, HIV-positive]

Another added that: *“Some choose to come to this facility because the nurses are friendly, and they are able to maintain confidentiality.”* [FGD HIV-positive 20–24]

One young mother noted that: *“They help us a lot, and whatever time you come. And even when you are given the medicines for the first time they explained to us that we would see certain side effects like rash. You just have to adhere to the treatment because it’s something that has been explained.”*

Another explained that the health providers are able to provide support. For those who are not able to collect the drugs on their own, they are able to ask their relatives or someone they know to collect on their behalf: *“They give us everything that we need, even when you need Septrin and other things they give us. And there are times when we fail to come to the clinic, we just give someone we know our cards and then they bring the medicine for us. And then you come and check your viral load in the following month.”* [FGD 20–24 HIV-positive] Another explained that: *“Sometimes the medicine makes one weak. So we come back to explain to them and they also help with ways to regain our appetite, they help us with a lot of things.”* [FGD HIV-positive 20–24]

With regard to staff attitudes, the provincial officials explained that there has been a reduction in complaints from the public on poor staff attitudes. One official said: *“Last year I think we didn’t receive any complaint from the public because people are open to this office. They come and make complaint over the treatment they receive in the facility, maybe during antenatal. Those days they would come and say people want to make us pay. People want us pay maybe for antenatal or family planning. But last year I would safely say we were not getting those complaints anymore we were also doing spot checks in this facility and we were responding complaint from the public.”* [KII, Province]

*“We ensure that anyone who comes to our facility, regardless of the reason, we do offer HIV service. For GBV clients we also offer that service; if they are negative we follow with another test after three months just to be sure if the client contracted the HIV due to sexual harassment.”* [KII, District]

However, some health providers noted that some staff that have not been trained on adolescent health are not keen to learn about what they need or deal with adolescents. One health provider reported: *“The major challenge we have in providing adolescent health services is that there are a few people that are knowledgeable about adolescent health, and there are other members of staff not willing to learn and other people not wanting to deal with adolescents.”* [KII, AFP]



### ***Dedicated days for adolescents and adherence***

Health providers reported that having dedicated days for adolescents has reduced the defaulting rates for ART. *“For now, since they have their own clinic, we don’t experience much of the defaulting but before they used to default. Now they have their own clinics, we do it on a Saturday.”* Another health provider also highlighted that separating adolescents from adults increases satisfaction and participation among adolescents. He noted: *“We even separated them from the adults because previously, we used to have the same clinic day with the adults so we saw that the young ones won’t be happy, let’s make their own day.”* [KII, AFP] Other health providers agreed. One noted: *“At this facility, ART clinic for adolescents, it’s only on Monday then for adults it’s Tuesdays and Thursdays. So, when it’s Monday, there is only adolescents.”* [KII, In-charge]

### ***Policies and planning for HIV and SRH service integration***

The existing policy is that clients seeking health services be offered HIV services, regardless of the reason for the visit. A district official explained: *“We ensure that anyone who comes to our facility, regardless of the reason, we do offer HIV service. For GBV clients we also offer that service, for testing so that they know their status. If they are sexually abused, so we want to establish the status of that client; if they are negative we follow with another test after three months just to be sure if the client contracted the HIV due to sexual harassment.”* [KII, District]

Provincial officials reported that the current practice in service delivery is the integration of HIV services with other SRH, maternal and child health services. The officials indicated that they work closely with Cooperating Partners and have joint meetings to review the activities in various aspects including SRH and HIV. The officials also noted that while some Implementing Partners tend to focus more on HIV, the province tries to ensure that synergies are drawn with other SRH and MCH activities. One official noted: *“We find that some [Implementing Partners] are more into HIV but we are trying to bring them together. We have these partner meetings where we are saying it is better we work together, so that when I am looking at this woman she should be looked at holistically, if we need to find that she has come for antenatal we test her, if she is positive we work together with ART. We have to join hands, it shouldn’t be like you are just here for maternal health, you can’t offer HIV services. So we have to look at this individual holistically in each department.”* [KII, District/province]

### ***Monitoring and Supervision***

Provincial and district officials indicated that one of the challenges in monitoring adolescent girls access to integrated SRHR services is the lack of age disaggregated data and indicators in the Health Management and Information System (HMIS). One official indicated that *“I would say the reports were not adequate this year and the main complaint that was coming from most coordinators was that it was very difficult for them to get information because most of the adolescent health indicators are not in HMIS. The government needs to ensure that the relevant indicators for monitoring adolescent access to SRHR services are included in the tools and HMIS.”* [KII, Province]

### ***Dual role of Peer educators***

District officials noted that in areas where peer educators have been trained as Community-Based Distributors, there has been marked increase in the use of family planning. *“...One thing which have really worked out so well in the adolescent spaces is*

*the issue of training peer educators as Community-Based Distributors (CBDs). We have facilities where we trained one or two peer educators also as CBDs. The data for family planning has improved so much in terms of the acceptors who are in the new group of adolescents...we have seen a very big difference compared to other facilities.” [KII, District]*

*“The challenge here is that our community is far, sometimes we walk about 10 to 15 kilometres [and] some people, especially the young ones, say it is far away to come and get medicine.”*

*[KII, HIV support group]*

### ***Lack of Training of Peer Educators***

Peer educators and health providers explained that peer educators lack the training and sometimes the knowledge to address some of the SRH issues raised by AGYW. The peer educators indicated that AGYW at times ask questions on issues that they are not too conversant with, such as full understanding of HIV transmission mechanisms, and they need to be thoroughly trained to be able to deal with these issues. One peer educator reported that: *“On the question of STIs they always ask on this even on things that we do not know. Even when we bring in a different subject they always go back to asking about STIs. We need more training on these things (STIs) to be equipped.” [FGD, Peer Educators]*

### ***Accessibility and Communication***

The health providers and HIV support group members indicated that, access to SRH and HIV services is a challenge for most adolescents who live further away from the facility. One health provider noted that: *“so you will find that the geographical location of our facilities it has very far communities maybe 30 Kms away from facilities so accessibility becomes a challenge to those adolescents who are far from the centre.” [KII, In-charge]* Similarly, the health providers report that the long distances are also a challenge for outreach services where there are few vehicles. Furthermore, the terrain in areas of Western Province makes it difficult to use some of the bicycles, even when they are available. One district official indicated that: *“when it comes to outreach activities it becomes very difficult...we were supported with bicycles, but you know how the terrain is here, Senanga, specifically it is very sandy so bicycles don’t seem to be very effective in some areas. So the issues of accessibility becomes a challenge in terms of them going out there because numbers are in the communities when they do outreach that’s where they capture a lot of people and that’s how they even create demand.” [KII, District]*

Further, adolescents report that lack of communication services, such as mobile phone services, is a hindrance from getting support from the health providers at the health facilities. Some adolescents indicated that: *“We are unable to communicate with people at the facility because we don’t have network. We have to search around for network to be able to communicate with someone who is at the clinic.” [FGD HIV-free 15–19]*

The HIV support group members reported that one of the key challenges that leads to non-adherence is the distance from the facility. Some clients have to walk long distances to collect drugs from the facility. One support group member suggested ARVs be distributed in the communities: *“the challenge here is that our community is far,*

*sometimes we walk about 10 to 15 kilometres some peoples, especially the young ones, say it is far away to come and get medicine I think they have to introduce that ARVs are taken in the communities.” [KII, HIV support group]*

Other adolescents indicated that collecting the ARVs every three months is a bit challenging given the long distances to be covered, and particularly in the rainy season: *“I would just love to collect medication at once for a long period of time and not frequently visiting the facility for medication every three months, especially now during the rainy season, it’s difficult.” [HIV-positive 15–19]* Respondents from the community-based voluntary groups also indicated that accessibility is a challenge for them as they lack transport to cover the catchment areas that are further from their communities. One health provider stated that: *“Some of them live very far away so we tend to have transportation challenges. We often go without meals. Also, our work is voluntary based. We are appealing for help to assist us carry out our work.” [KII, SMAG]*

### ***Adolescent-friendly spaces***

Health providers and peer educators reported that some SRH and HIV services are provided at adolescent-friendly spaces (AFSs). Services include IEC messages on prevention of early pregnancy, prevention of HIV and STIs, provision of condoms, discussions on family planning, counselling on HIV and, in some cases, counselling on drug abuse. One peer educator said: *“We offer HIV counselling and how to use family planning like the usage of condom. We give them information about HIV/AIDS and how they can prevent themselves from that. And the other thing is we tell them to stick to one partner or just to abstain for them to be safe.”* Another peer educator explained that: *“We also give information about antenatal and postnatal care and encourage [adolescents] on the importance of going there in case of pregnancy.”* Other peer educators reported that adolescents are usually counselled and referred to the main facility to be tested for HIV: *“We usually refer adolescents to those people who can test and give them drugs. And then we try to remove that stigma ... the HIV-positive adolescents, they have stigma and feel that their friends will judge them so they try to isolate themselves from others, so we try to encourage them.” [FGD, Peer Educators]*



Some adolescents would prefer to be tested at AFSs, but the peer educators do not have testing kits: *“They come here looking for advice, some of them want to be tested, then we refer them. We lack testing kits. Others refuse to go to the adult section.”*

Some peer educators also noted that condom provision is the most commonly sought service: *“Most common thing they come here for are, the condoms, family planning and we advise them about HIV/AIDS and knowing their status and why they should know their status.”*



Apart from providing services at the health facility, peer educators report that they also provide outreach services in the community to increase awareness and use of SRH among adolescents.

A health worker reported that AFSs are effective in that adolescents are provided with health education and referred for HIV testing and family planning. Adolescents tend to be more at ease about visiting the facilities and an increase in HIV testing and high uptake of condoms has been observed. One facility in-charge said: *“I think for impact adolescents are free to come for the [HIV] test and there is high demand for the condom uptake.”* **[KII, In-Charge]**

Peer educators reported that they faced challenges in providing the SRH services. One challenge is the lack of clarity on the age at which young girls can start using family planning. One peer educator said: *“We have a challenge because there is no specific age group to say they shouldn’t start family planning... we had a case where a 10-year-old girl was brought for family planning. So we were not sure whether to give her family planning or not. We were not told what ages the clients should be starting family planning.”*

District officials report that even when funding for setting up AFSs is available, one of the key common challenges being faced in rolling these out to other facilities is the lack of infrastructure. The officials report that most facilities lack spaces that can be dedicated to providing or offering adolescent health services. In most cases, in the facilities where AFSs are available, there is co-sharing of the spaces with other services such as MCH or ART clinics. Said one district official: *“Most of our health facilities don’t have enough room to just have a standalone place, meaning that they have to integrate with other services maybe like MCH, so that is one of the biggest challenges so that’s why we have been lobbying for something, even tents.”* **[KII, District]**

Another district official noted: *“We don’t have enough space, but we do have adolescent meeting spaces that are created in such a way that the same place where they do MCH when it is free, then the adolescents come to meet.”* **[KII, District]**

Similarly, a health provider noted: *“We don’t have a space, we just use those if the people are not there, and we use the space for growth monitoring or that shelter once they move out, we move at sixteen hours. We also use the ART shelter when they move out, if they have a meeting we have to wait until they finish because that is not our space.”* **[KII, AFP]**

The respondents at district and facility level reported that the lack of dedicated spaces for adolescent activities is seen as a challenge as this does not allow for the storage of materials that the peer educators may have: *“If they had their own room, then they would have had their own equipment in there, which you can keep and then they come out any time and meet there, but then there are these rooms which are also needed for other services meaning you cannot buy benches tables or drawers that they can use to lock up whatever materials they would like to lock in there, it is difficult...They can also come in the room and no one would disturb them.”* **[KII, District]**

The peer educators also expressed displeasure with the lack of space to provide adolescent-friendly services. One peer educator stated that: *“We need shelter, because it disturbs us a lot, in as you find that if the owners are occupying that space again for a*

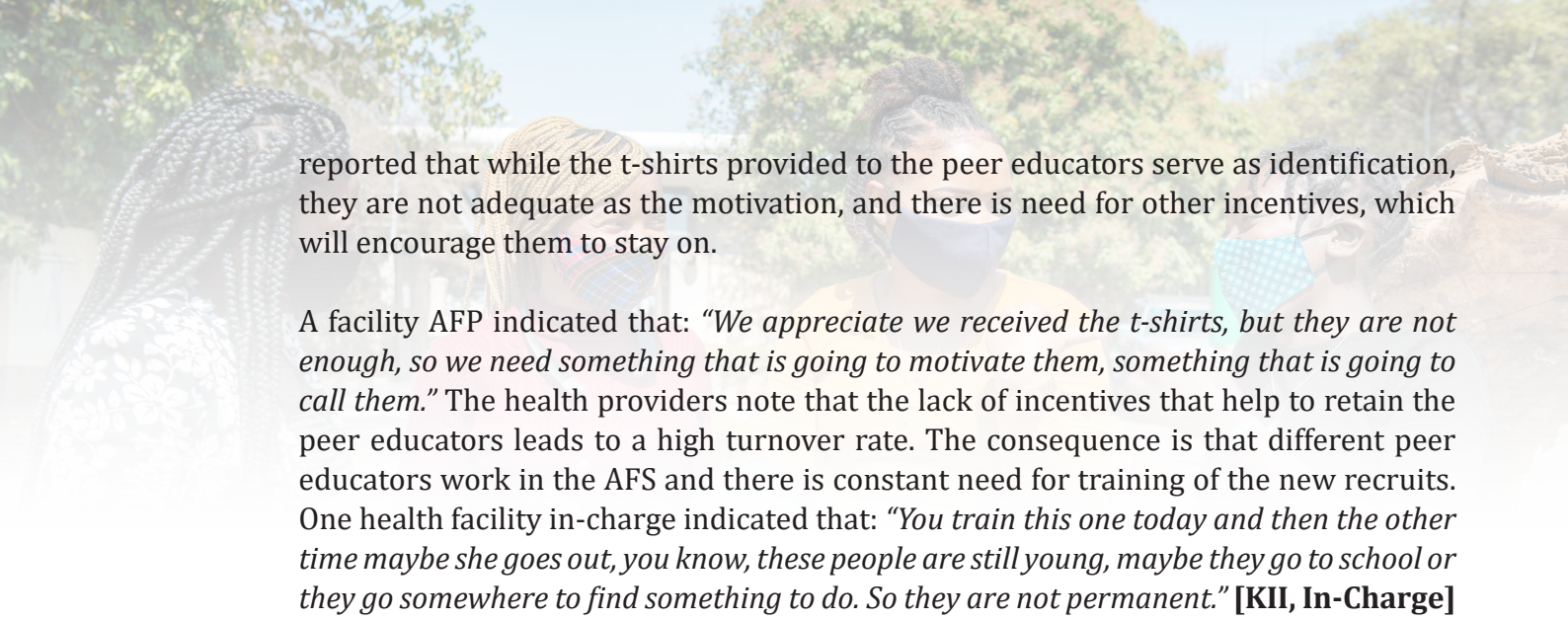
*long period of time, it means we are not going to meet, which is a drawback. I believe in every meeting that we meet as adolescents there is one person who has a problem ... so the more time we spend with each other if we talk to one another it can make a difference. That's our number one challenge."*

*"I believe in every meeting that we meet as adolescents there is one person who has a problem... so the more time we spend with each other, if we talk to one another it can make a difference. That's our number one challenge."*  
**Peer Educator**



Health providers reported that the lack of incentives to motivate the peer educators manning the AFSs was a key challenge. The health providers indicate that at recruitment, the peer educators tend to feel as if they have been offered a paying job and will be provided some compensation. One facility in-charge noted that: *"When they were recruited they were thinking maybe it's like a job, they will be getting something, but it's sort of motivation which comes there and then. So most of them think maybe they'll be getting a salary."* Health providers reported that incentives motivate the peer educators to continue providing the services, and that incentives need not be in monetary form but, rather, in various forms.

One health provider indicated that: *"Motivation comes in different ways, even when we have an exchange visit, it's a motivation; even when we have a road show it's a motivation for them because they will know that we are being recognized, at least we've got a belonging to that clinic, at least we are counted also."* [KII, AFP] The health providers



reported that while the t-shirts provided to the peer educators serve as identification, they are not adequate as the motivation, and there is need for other incentives, which will encourage them to stay on.

A facility AFP indicated that: *“We appreciate we received the t-shirts, but they are not enough, so we need something that is going to motivate them, something that is going to call them.”* The health providers note that the lack of incentives that help to retain the peer educators leads to a high turnover rate. The consequence is that different peer educators work in the AFS and there is constant need for training of the new recruits. One health facility in-charge indicated that: *“You train this one today and then the other time maybe she goes out, you know, these people are still young, maybe they go to school or they go somewhere to find something to do. So they are not permanent.”* **[KII, In-Charge]**

District officials reported that in areas where adolescent-friendly services, peer educator and school outreaches are active, it has been observed that over time, teenage pregnancies have reduced. One key informant at district level explained: *“When you look at our data from 2016 up to now I think the trend has been going down in terms of teenage pregnancies. ... this can be attributed to the fact that we have these active [adolescent] spaces, we have peer educators there who conduct school outreach talks to adolescents and also in the communities so the difference is actually there.”* **[KII, District]** One key informant at facility level indicated that for AFSs to be effective, there is need to have adequate numbers of peer educators, who are provided with some identification such as t-shirts and also some incentives to motivate them to continue providing the services.

# 4 DISCUSSION AND COMPARISON OF KEY STUDY FINDINGS WITH EMPIRICAL LITERATURE



## 4 DISCUSSION AND COMPARISON OF KEY STUDY FINDINGS WITH EMPIRICAL LITERATURE

This section discusses the main empirical findings and compares them with evidence from literature from developing countries. The findings are organized around the research questions and presented at individual, interpersonal, community and societal level.

### 4.1 FACTORS THAT PROMOTE OR DISCOURAGE ACCESS TO SRH/PMTCT/HIV SERVICES AMONG AGYW

We discuss the structural, socio-economic factors and policies that facilitate or prevent access to SRH, HIV and SGBV services among AGYW, structured around the various intervention levels.

#### 4.1.1 INDIVIDUAL LEVEL

***Low socio-economic status continues to affect access to SRH and SGBV services for AGYW. The informal fees AGYW are charged if they fail to attend with partners or spouses when seeking ANC services act as a barrier to accessing these services.***

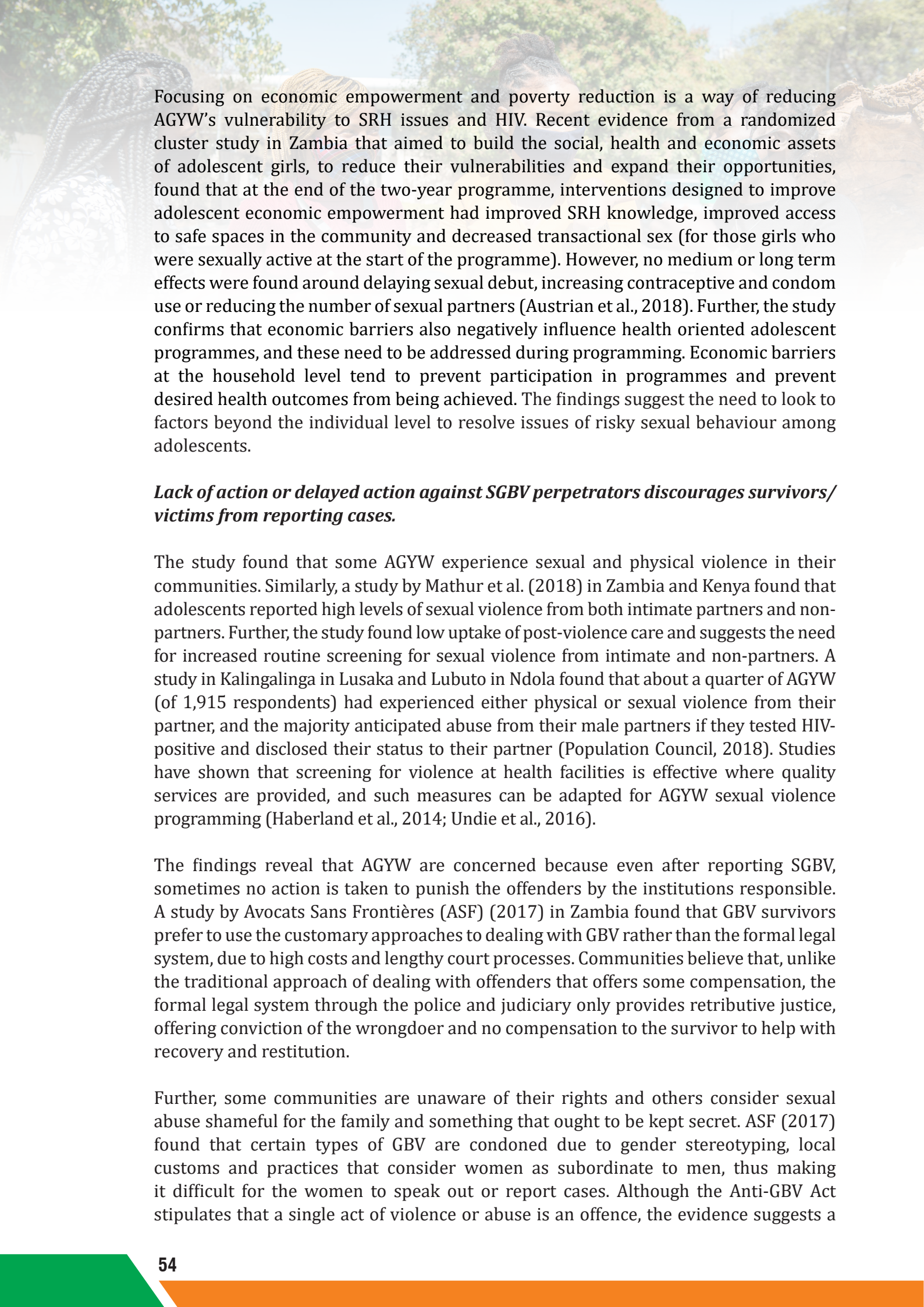
The study established that some facilities imposed a fee on those who attend clinics without a partner, the aim being to encourage women to come with their spouses when accessing reproductive health services. Bwalya et al. (2017) report that some adolescents are still financially supported by their parents or guardians, and these parents may still be in denial or not supportive in the early stages of pregnancy. As such, charging fees to access ANC services is a barrier to access: adolescents who cannot afford to pay shun the services or delay seeking them. The study found that in some communities, AGYW are able to get letters from SMAGs which enable them to access the services.

AGYW who are sexually abused and become pregnant may not have the means to pay to access the services. In some cases, abusers may be bread winners for the survivor's family, making her reluctant to reveal their identity. The evidence in literature shows that informal fees and out of pocket payments are among the greatest barriers to access to maternal health services for pregnant women, including adolescents (Homer et al., 2018; Kyei-Nimakoh et al., 2017). It is clear that informal fees imposed on AGYW deter them from accessing antenatal services and should be removed.

***Some AGYW continue to engage in transactional sex due to poverty, thus increasing the risk of contracting STIs, HIV and having unwanted pregnancies.***

The study found that, in some cases, adolescents engage in transactional sex due to lack of financial resources. The study established that poverty and lack of resources for key needs and expenses are linked to greater vulnerability to poor SRH outcomes of adolescents, particularly girls. Evidence shows that some AGYW are at an increased risk of contracting STIs, HIV and unwanted pregnancies, partly due to taking part in transactional sex in return for money, basic necessities, school fees and other items such as mobile phones (Sommer and Mmari, 2015).





Focusing on economic empowerment and poverty reduction is a way of reducing AGYW's vulnerability to SRH issues and HIV. Recent evidence from a randomized cluster study in Zambia that aimed to build the social, health and economic assets of adolescent girls, to reduce their vulnerabilities and expand their opportunities, found that at the end of the two-year programme, interventions designed to improve adolescent economic empowerment had improved SRH knowledge, improved access to safe spaces in the community and decreased transactional sex (for those girls who were sexually active at the start of the programme). However, no medium or long term effects were found around delaying sexual debut, increasing contraceptive and condom use or reducing the number of sexual partners (Austrian et al., 2018). Further, the study confirms that economic barriers also negatively influence health oriented adolescent programmes, and these need to be addressed during programming. Economic barriers at the household level tend to prevent participation in programmes and prevent desired health outcomes from being achieved. The findings suggest the need to look to factors beyond the individual level to resolve issues of risky sexual behaviour among adolescents.

***Lack of action or delayed action against SGBV perpetrators discourages survivors/victims from reporting cases.***

The study found that some AGYW experience sexual and physical violence in their communities. Similarly, a study by Mathur et al. (2018) in Zambia and Kenya found that adolescents reported high levels of sexual violence from both intimate partners and non-partners. Further, the study found low uptake of post-violence care and suggests the need for increased routine screening for sexual violence from intimate and non-partners. A study in Kalingalinga in Lusaka and Lubuto in Ndola found that about a quarter of AGYW (of 1,915 respondents) had experienced either physical or sexual violence from their partner, and the majority anticipated abuse from their male partners if they tested HIV-positive and disclosed their status to their partner (Population Council, 2018). Studies have shown that screening for violence at health facilities is effective where quality services are provided, and such measures can be adapted for AGYW sexual violence programming (Haberland et al., 2014; Undie et al., 2016).

The findings reveal that AGYW are concerned because even after reporting SGBV, sometimes no action is taken to punish the offenders by the institutions responsible. A study by Avocats Sans Frontières (ASF) (2017) in Zambia found that GBV survivors prefer to use the customary approaches to dealing with GBV rather than the formal legal system, due to high costs and lengthy court processes. Communities believe that, unlike the traditional approach of dealing with offenders that offers some compensation, the formal legal system through the police and judiciary only provides retributive justice, offering conviction of the wrongdoer and no compensation to the survivor to help with recovery and restitution.

Further, some communities are unaware of their rights and others consider sexual abuse shameful for the family and something that ought to be kept secret. ASF (2017) found that certain types of GBV are condoned due to gender stereotyping, local customs and practices that consider women as subordinate to men, thus making it difficult for the women to speak out or report cases. Although the Anti-GBV Act stipulates that a single act of violence or abuse is an offence, the evidence suggests a

widespread perception that the extent or severity of the violence is important and that a slap, hitting or pinching does not constitute GBV. As such, traditional views act as a barrier to the implementation of the GBV Act. The ASF (2017) study recommends that efforts to increase community awareness on GBV through sensitization campaigns in the community should be scaled up. Although the GBV Act provides for counselling services, cultural and religious beliefs, practices and norms often permeate into the counselling approaches and techniques of service providers.

Austrian et al. (2018) argue that given the high level of acceptability and the experience of SGBV among AGYW in Zambia, efforts to address this should take a holistic approach that includes a community level programme. Programmes need to target inequitable attitudes and norms not only among adolescent girls but also in addressing violence at the household, school and community levels. In a systematic review on intimate partner violence and sexual violence, Lundgren and Amin (2014) found that community-based programmes designed to bring about equitable gender norms and decrease tolerance for sexual violence are the most common intervention implemented in low and middle-income countries. Specific types of interventions include group education, community mobilization, social norms marketing, media campaigns, mentorship and identification of safe spaces.

Other programmes that specifically target men and boys include fatherhood programmes that improve gender equality in parenting, build parenting skills and increase paternal involvement in childcare. However, Lundgren and Amin (2014) note that although community-based programmes decreased self-reported perpetration of violence, raised awareness of sexual violence and increased equitable gender norms, the overall effectiveness of community-based programmes is not yet conclusive but is emerging.

#### **4.1.2 INTERPERSONAL OR RELATIONSHIP LEVEL**

***Lack of spousal or partner support discourages the use of SRH services, including antenatal care, family planning services among AGYW.***

The study findings suggest that the lack of spousal support and male partners' unwillingness to accompany AGYW to antenatal and family planning services prevents young women from seeking these services. Among the reasons cited for men's reluctance to get involved in family planning is their demand for more children and a general perception that contraceptives lead to infertility, particularly among women who have not yet had a child. Some AGYW use contraceptives without the knowledge and consent of their spouses or partners. Evidence suggests that inadequate knowledge adversely affects men's involvement in their wives' and their own sexual and reproductive health (Yargawa and Leonardi-Bee, 2015; Ayebare et al., 2015). Reproductive health campaigns at community level which target men would help alleviate the fears men face concerning family planning. The need to educate men on the benefits of family planning has been reported in other studies (Yargawa and Leonardi-Bee, 2015; Ayebare et al., 2015). Community level education campaigns on SRH, including family planning, need to target both males and females to allay fears or misconceptions on family planning.



***Evidence suggests various types of interventions should aim to increase men's involvement in MCH health.***

These include community outreach and education, home visits, facility-based counselling, workplace education programmes and mass media social mobilization. Significant male involvement has been found to support improved MCH outcomes such as improved care-seeking behaviour and home care practices, accompanied by changed couple relationships. Positive and sometimes substantial effects of men's involvement in health care-seeking have been observed but these are often tied to multiple integrated components (Tokhi et al., 2018)

However, there is a need to carefully design interventions to support women's autonomy and avoid reinforcing unequal gender relations. Interventions aimed at increasing men's involvement are often implemented in settings where there are clear power differences between male and female and where gender roles are strongly enforced. In these types of patriarchal settings, MCH is often one of the few spaces where women are empowered (Dumbaugh et al., 2014), and here increasing men's involvement could simply replicate existing gender inequalities and further disempower women (Påfs et al., 2016). Evidence suggests that when men become involved in MCH, their involvement may weaken women's autonomy in the one aspect of their lives where they previously had a degree of authority (Dumbaugh et al., 2014).

#### **4.1.3 COMMUNITY LEVEL**

***Religious practices around HIV, such as faith-healing, prevent the continued uptake of ART among AGYW, particularly in urban areas.***

The study found that AGYW, particularly in urban areas, tend to yield to advice from religious leaders that the HIV-positive should stop taking ARV on the basis that they can be healed through prayer alone. Literature suggests that religious beliefs act both as a facilitator and inhibitor to initiation of HIV treatment and adherence (Ammon et al., 2018). The belief that ART was God-created encourages the use of ARVs, but faith-healing has the effect of discouraging its use (Ammon et al., 2018). The evidence further suggests that faith in a superhuman power helps adolescents living with HIV to gain self-confidence, and they tend to use prayer as a coping mechanism to overcome challenges.

However, faith-healing plays a negative role as it often leads to non-adherence to ART (Nabukeera-Barungi et al., 2015; Denison et al., 2015), promoting the belief that people can be cured by prayers and the use of holy water or oil. A systematic review shows that Uganda, Tanzania and Malawi have reported disruption of ART after spiritual healing ceremonies in adults (Ammon et al., 2018). Given that religious beliefs are a major factor in shaping social attitudes, the evidence suggests the need to include religious authorities in HIV programming to improve ART adherence (Ammon, et al., 2018). This evidence suggests the need for multi-level interventions and multi-sectoral approaches that include religious leaders.

#### 4.1.4 SOCIETAL LEVEL

***The lack of privacy at health facilities, a perceived lack of confidentiality and judgmental attitudes among health workers all act as barriers to accessing SRH and HIV services among AGYW.***

The study found that, due to a lack of infrastructure, some facilities lack privacy and this in turn leads to lower use of SRH and HIV services, particularly among adolescents.

For instance, the lack of privacy in ART clinic location deters adolescents from using the HIV services. Empirical literature suggests that the main reasons that AGYW are less likely to use SRH services such as ANC are lack of privacy, lack of confidentiality and judgmental attitudes from health workers who have not been trained to understand adolescents' needs around SRH (Tunçalp et al., 2017).

The other issue is a lack of privacy during physical examination, where adolescents and older women are attended to in the same space. The literature also shows that adolescents feel that the practice of sharing the same spaces with older women, who may be as old as their mothers, is disrespectful (Bwalya *et al.*, 2017). The lack of specific spaces for adolescents as well as inadequate privacy and confidentiality discourages use of ANC services among adolescents.

Efforts to accommodate pregnant adolescents and young mothers need to be strengthened to ensure continued and increased access to sexual reproductive health services. Some rooms are small and clients outside the room can hear the discussion, and privacy and confidentiality are not guaranteed.

Although most AGYW reported that health staff were friendly, a few talked of unfriendly staff who lacked confidentiality. In several studies, confidentiality has been found to be a contributing factor associated with the lack of use of SRH services among youth and adolescents (Wanyenze et al. 2017). Further, adolescents reported not being comfortable about being attended to by elderly health workers who they perceived to be judgmental. These findings call for the need to have more health staff trained on adolescent-friendly approaches to ensure that AGYW are comfortable with accessing SRH and HIV services and to improve service utilization.

***Orientation and training in adolescent health needs to be targeted not only at health workers but also at non-clinical workers and community workers who interact with AGYW.***

The study found that due to inadequate funds, only a few staff are trained in selected facilities. The expectation is that the trained staff will orient the other facility staff on adolescent health needs. However, in some cases, the untrained staff are reluctant to provide adolescent services and refer such cases to the trained staff. Further, the study found that given that AGYW interact with other non-clinical staff at the facility, these cadres should be oriented in adolescent health. Training and orientation in adolescents' needs should also be targeted at the community level where members, for instance, NHC members are also given orientation on adolescent health. An understanding of the needs of the AGYW group among the non-clinical and community workers that interact with them will ensure continuity in the delivery of adolescent-friendly services from the community to the facility.

***High attrition rates of peer educators and lack of funding to support their activities disrupts service provision. Also, the lack of training among peer educators leads to loss of confidence in the messages they communicate to AGYW.***

The evidence suggests that, in some cases, peer educators lack training and understanding of adolescent SRH and HIV. At the study sites, about half the peer educators interviewed were untrained. Attrition rates among peer educators are high, given that they work on a voluntary basis with minimal or no compensation, and this creates a challenge for facilities that rely on them to provide adolescent services.

The findings show that AGYW, in some cases, prefer to get information from health providers rather than peer educators, as the latter are not able to address some of issues that they raise. In some instances, adolescents do not have confidence in the information provided by the peer educators and shun using the services. Furthermore, the high rate of attrition among the peer educators results in the need for constant training and orienting of replacement peer educators.

A systematic review of studies on youth friendly services (YFSs) finds mixed results on their effectiveness in relation to HIV care and retention (Reif et al., 2018). The study focuses on YFSs to increase linkages to HIV care and or retention including establishing clinics or clinic hours, engaging peer educators and establishing peer support groups, providing additional services likely to be used by young people including STI screening and family planning.

In Kenya, an intervention focusing on providing peer counselling and psychosocial support to young people was associated with a large increase (about 37 percentage points) in linkage to care compared to the pre-intervention period (Ruria et al., 2017). Another study in Kenya implemented provider training in adolescent specific care needs, provided monthly dedicated adolescent clinics, integration of SRH services and peer-led support groups and education programmes (Teasdale et al., 2016). In this case, no significant improvement was observed in retention six months after ART initiation when assessed relative to those same facilities prior to the implementation. In general, Reif et al. (2018) found that YFS may improve outcomes in some but not all steps of the HIV continuum. Efforts to introduce YFS should consider content of education or counselling curriculums and patient materials, approaches to assessing provider competency following training on YFS, and sustainability of the interventions.

In Ghana, Aninanya et al. (2014) examined the effects of SRH interventions on use of SRH services using a community-randomized trial. The authors found that interventions that included targeted school-based and outreach activities increased use of SRH among adolescents more than community mobilization and training providers in youth-friendly service provision alone. The SRH services included STI management, HIV counselling and testing, antenatal or perinatal services.

The range of community activities included community meetings and seminars among community stakeholders, with a particular focus on religious leaders; youth-friendly approaches included adolescent-friendly training workshops for health providers; school-based SRH education involved providing SRH teachings and learning in high schools with the goal of providing accurate information; and peer outreach involved

training peer educators to provide SRH information and peer counselling to out-of-school adolescents. Given that adolescent SRH required a multi-dimensional health services approach, Aninanya et al. (2018) suggest that policy makers develop school and peer-based approaches that increase environmental support and adolescent self-efficacy.

***Health education and illustrative information education and communication (IEC) material is key in improving awareness of SRH among AGYW. However, the IEC material needs to be translated into local languages to cater for AGYW with low levels of education, particularly in rural areas.***

Educational talks during ANC provide adolescents with useful information such as the importance of good nutrition. However, combining these sessions with older women makes adolescents uncomfortable. The study found that AGYW do not feel able to participate fully when the educational groups are combined with older women. They may not feel free to seek clarification where it is needed. However, in the Zambian context, given the limited staffing levels at health facilities, it may not be feasible to have separate talks for AGYW and older women.

While educational materials are readily available in most of the health facilities, the content is mostly presented in English, yet some of the target groups such as AGYW are not able to read English. The findings suggest the need to ensure that IEC materials for rural and remote areas are translated into local languages.

***Radio and social media are effective platforms to reach out to AGYW on SRH and HIV issues.***

Currently, various approaches are used to communicate with adolescents on SRH and HIV such as drama groups or general education talks during outpatient visits. The study found that health education delivered through group settings seem to be a popular approach to engaging with young people. In some cases, facilities are able to mobilize outdoor activities where adolescents are engaged in sporting activities such as football, netball and volleyball. The outdoor activities are particularly beneficial for adolescents and also serve as a platform for health education.

Further, the evidence suggests that the media is an effective means of communication as adolescents and youths are able to listen and ask questions on phone-in programmes. More recently, information shared on social media platforms has been seen to be effective as adolescents are able to ask questions that can be answered by a qualified health provider. Adolescents are able to ask questions and share testimonies of their experiences on social media and other digital platforms. Digital platforms such as U-Report, Tune Me and Internet of Good Things have often provided essential SRHR/HIV information targeting adolescents and young people, especially in urban areas.

Although mass media campaigns can produce changes in behaviour, this does not necessarily mean that any and every mass media campaign can change behaviour. The frequency and amount of messages delivered and received by the target audience, and the quality of message are key determinants of the effectiveness of campaigns. Although Sarrassat et al. (2018) argue that governments must prioritise saturation-based media campaigns, Deane (2018) suggests that saturating the airwaves with health information would result in diminishing returns.



## 4.2 ATTITUDES, BEHAVIOURS AND PRACTICES THAT FACILITATE OR HINDER AGYW ACCESS TO SRH/PMTCT/HIV SERVICES

### 4.2.1 INDIVIDUAL LEVEL

***Adolescents and young mothers are generally aware of the importance and benefits of ANC but there is limited understanding of the importance of having timely ANC visits in the first trimester.***

AGYW know that routine ANC is necessary for health providers to check on the wellbeing of the unborn child and the mother, to mitigate any complications, to get supplements and to be tested for HIV to prevent mother-to-child transmission of the virus. However, some AGYW felt that an individual can decide when best to start ANC. Others shun or delay ANC because they feel they got pregnant too early and want to avoid the judgmental attitudes they fear from health workers, while others delay their first visit because they fear being tested for HIV and knowing their status early. These findings point to a lack of understanding of the importance of timely attendance for ANC services among AGYW.

***Although AGYW understand the benefits, they shun the use of family planning due to cultural beliefs and practices and fear of side effects. Others have the misconception that injectable contraceptives prevent both pregnancy and HIV infection or transmission.***

The study found that sexually active AGYW shun using contraceptives because they share their community's belief that contraceptives may lead to infertility. Others may feel the need to prove their fertility. Existing literature confirms that community norms influence young peoples SRH behaviour and decisions (Plourde et al., 2016). For instance, cultural norms that value fertility contribute to low rates of contraceptive use and high rates of pregnancy among adolescents and youth (Adams et al., 2013).

The literature highlights the need to engage community members to transform norms and create environments that are supportive of adolescents' SRH (Plourde et al., 2016). For instance, in India a programme to delay first birth and improve spacing of births among married adolescents engaged community members in discussions about the health benefits of such practices. The programme resulted in a significant increase in contraceptive use among married adolescents (Rahman and Daniel, 2010)

The study found some misconceptions about injectable contraceptives. The notion that these long-term contraceptives can also prevent HIV transmission contribute to AGYW engaging in unprotected sex. The study also finds that awareness of family planning or of the range of options available is lower among young adolescents. Particularly younger adolescents having their first pregnancy were generally not aware of available family planning methods while older adolescents seemed to know more about the various forms of family planning.

***Awareness of the existence of HIV is near universal. However, misconceptions on transmission mechanisms still exist among AGYW.***

In general, AGYW demonstrated awareness on routes of transmission and prevention of HIV/AIDS. However, some misconceptions still persist. Further, some AGYW demonstrated limited knowledge of transmission routes. For example, some thought that mosquito bites and sharing plates and spoons were ways of transmitting HIV. Some responses about MTCT were incomplete or erroneous, and similar misconceptions are reported in the literature (Akoachere, 2016).

***Some HIV-positive AGYW lack a general understanding of how to prevent transmission of HIV from mother to child after birth and the appropriate time to take ARVs.***

The study found that there is a lack of understanding about how HIV can be transmitted to a child, even among the HIV-positive AGYW. There is also some lack of awareness about administration of ARVs and this lack of knowledge is more pronounced among non-adherent AGYW. These findings suggest the need for reinforcement of educational awareness, particularly among younger adolescents.

***The majority of HIV-positive AGYW hope to have more children.***

In general, most HIV-positive AGYW indicated that they would like to have more children in future. Most were aware of the services provided at the facility that enable a mother to prevent transmission of HIV to their child. However, non-adherent AGYW had less information on this and it seems measures are needed to intensify awareness campaigns in communities that target AGYW.

#### **4.2.2 INTERPERSONAL OR RELATIONSHIP LEVEL**

***AGYW prefer to disclose their HIV-positive status to their parents rather than partners or peers. Family support is critical for HIV-positive AGYW's acceptance of their status and encourages their use of SRH and HIV services.***

It is evident from the various levels of disclosure that many AGYW are more comfortable disclosing information about their HIV status to their parents. They trust parents to maintain confidentiality and not share that information with anyone. In general, the results suggest that adolescents are not comfortable disclosing their status with peers because their peers are more likely to share this information with others. This finding suggests it would be useful to review peer-to-peer campaigns on PMTCT, given that parents seem to be better allies.

The study also found that AGYW are unable to disclose their HIV status to their partner for fear of stigma, abandonment and neglect of their children. Lack of disclosure was most common among non-adherent AGYW, most of whom had only disclosed to parents but not their partner or peers. However, the study finds that some parents are not supportive, viewing HIV-positive status as evidence that someone is promiscuous. The literature suggests that programmes that contribute to positive SRH outcomes include those that strengthen family connections, increase associations with positive peer groups and provide safe spaces for young people to meet with other peers to form meaningful relationships (Plourde et al., 2016). Interventions aimed at improving parent-adolescent communication in developing countries have been found to be effective in improving young people's knowledge about condoms and self-efficacy (Wang et al., 2014).



#### 4.2.3 COMMUNITY LEVEL

***Stigma and discrimination within communities continues to be a barrier to accessing SRH and HIV services among AGYW.***

HIV-positive AGYW reported experiencing stigma not only from family members and friends but also the community. Several studies have reported how the rejection caused by stigma affects access to health care and medication adherence (Siegel, et al. 2015). In some cases, AGYW would rather change their treatment site to avoid stigma from community members or peers. Multi-pronged educational interventions targeting AGYW and communities are needed to decrease the levels of stigma around HIV and to ensure patients continue to seek services and take medication that is vital for improving their SRH and HIV outcomes.

### 4.3 HEALTH WORKERS AND INTEGRATED SRHR/HIV/SGBV SERVICES

***AGYW receive integrated services for SRH and HIV services. However, they have concerns about the current approach to service delivery. Delivering HIV services at the same time as child health services may have a negative influence on adherence to ART among AGYW.***

Integrated service delivery aims to provide clients with convenient access to the maximum number of comprehensive quality services during a single visit. The study found that AGYW receive integrated services for family planning, ANC, child health services and HIV services.

The study found that although AGYW are afraid of taking an HIV test, the provision of integrated HIV and family planning enables most of them to seek the service, since their wish for family planning services outweighs the fear of taking the HIV test.

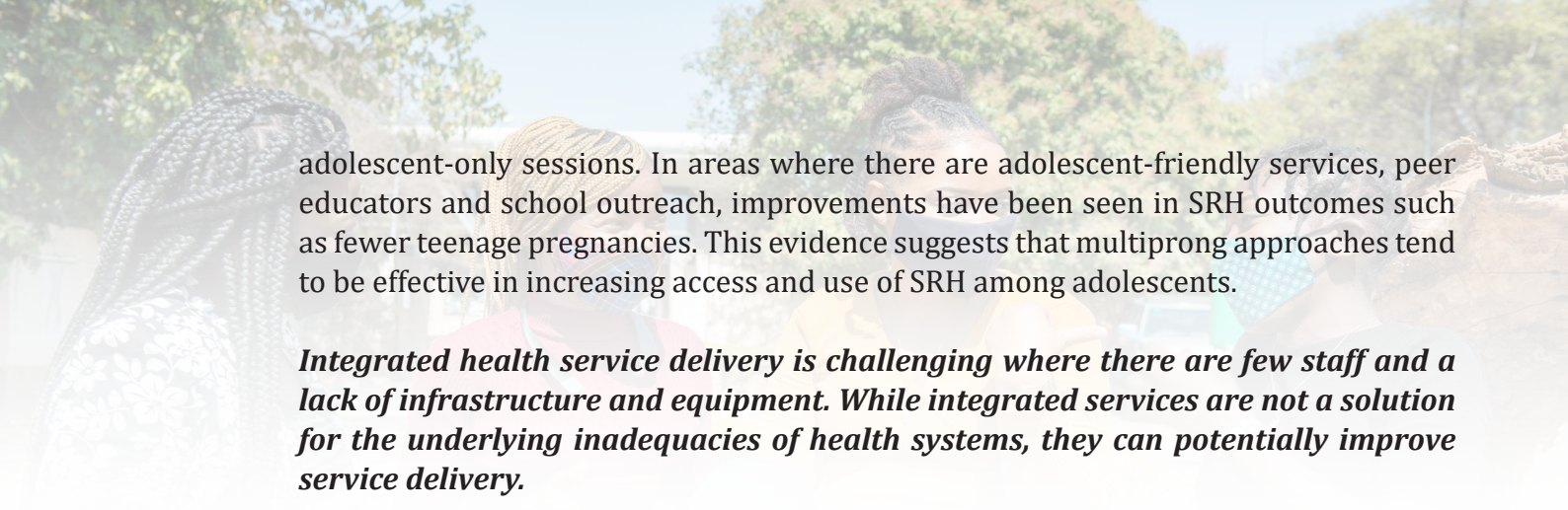
However, in some cases, AGYW will choose not to seek family planning rather than take the HIV test. While most said they were comfortable with integrated family planning and HIV services, the majority were not comfortable with integrated HIV and child health services. Integrated HIV and child services do not offer the privacy they want since all the clients present see if an HIV-exposed or infected child is given medication that other children do not get.

The study found that AGYW living with HIV tend to be uncomfortable with being singled out and separated from other mothers when collecting ARVs during child services. Where women are requested to remain after health education talks to collect ARVs, most AGYW would opt not to remain for fear of being stigmatized.

***Having dedicated facility days for adolescent service delivery improves SRH and HIV service utilisation.***

The study found that in facilities with dedicated days for SRH or HIV services for adolescents, more attend as they feel more comfortable. Furthermore, the study found that modes of distribution of ARVs in ART clinics vary.

In some clinics ARVs are distributed to adolescents and adults on the same day. The findings indicate that defaulting rates are lower where the services are provided separately suggesting service use and adherence can be improved by providing



adolescent-only sessions. In areas where there are adolescent-friendly services, peer educators and school outreach, improvements have been seen in SRH outcomes such as fewer teenage pregnancies. This evidence suggests that multiprong approaches tend to be effective in increasing access and use of SRH among adolescents.

***Integrated health service delivery is challenging where there are few staff and a lack of infrastructure and equipment. While integrated services are not a solution for the underlying inadequacies of health systems, they can potentially improve service delivery.***

The study found that where a facility has few staff or, in some cases, only one health professional, providing integrated services inevitably increases waiting times for clients. When certain services are offered only on certain days because of staff shortages, this places the burden of returning over several days on women and children.

Evidence from a multi-country study on integrating HIV and MNCH services (Kiragu et al., 2017) shows that in Zambia, merging the ART clinic with outpatient services increased the waiting time for ART clients. This was partly due to the integration model used, but also to inadequate staffing and other factors. In Namibia, however, client times reduced after integration of services. Integrated service delivery reportedly reduces stigma and discrimination and loss to follow-up care and treatment, and makes efficient use of resources (Kiragu et al., 2017).

This study also found that inadequate equipment and infrastructure is a hindrance to providing integrated services for HIV and SRH. While in some cases, facilities may not have the equipment, some may not even be accredited to run an ART clinic. This means that clients tested for HIV at one facility may be referred to another, and this can lead to the loss of clients.

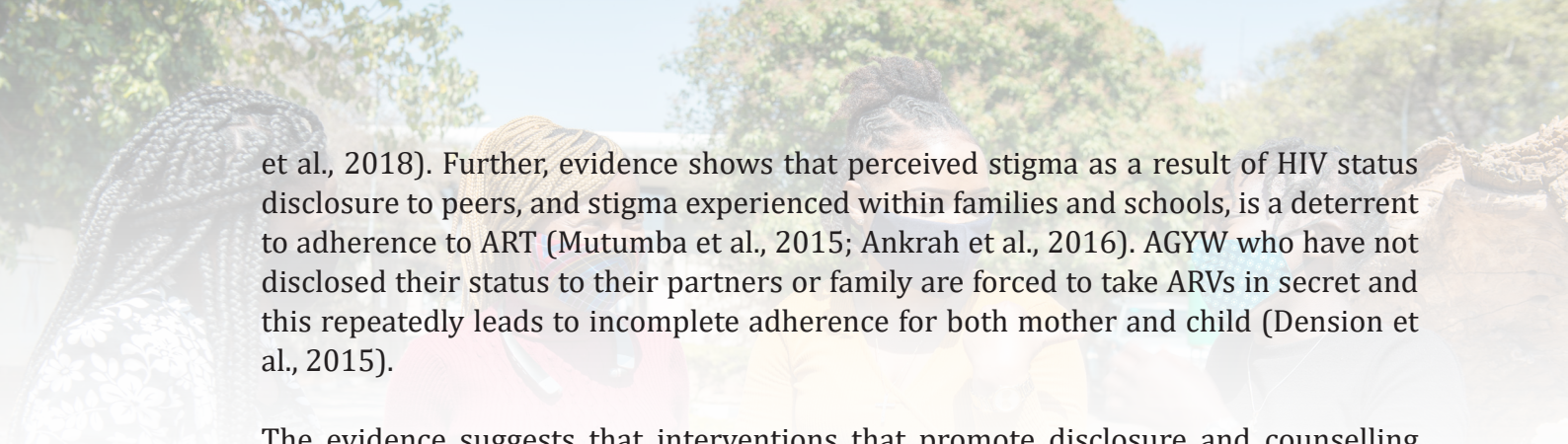
## **4.4 ATTITUDES, BEHAVIOURS AND PRACTICES AMONG AGYW THAT LEAD TO LOSS TO FOLLOW-UP FOR HIV-EXPOSED OR HIV-POSITIVE INFANTS**

### **4.4.1 INDIVIDUAL LEVEL**

***Self-stigma and lack of disclosure of HIV-positive status to partner or family are among the key contributing factors to non-adherence to HIV treatment and mother-infant loss to follow-up among AGYW.***

In the literature, stigma is a key barrier to ART adherence (Ammon et al., 2018). This study found that adolescents who had accepted their HIV-positive status or had told their family members or partners were able to take measures to prevent transmission of HIV to their child. Further, AGYW who had accepted their status were more likely to continue with their own treatment. However, the study found that some HIV-positive AGYW were not sure how to take medication and when and why to give medication to their exposed child.

Findings from this study are similar to those in existing literature which suggest that adolescents who do not know why they take medication are more likely to miss doses. Those who are unable to disclose to their family or spouse their HIV status may hide their treatment, thus making adherence more difficult (Cluver et al., 2015; Ammon



et al., 2018). Further, evidence shows that perceived stigma as a result of HIV status disclosure to peers, and stigma experienced within families and schools, is a deterrent to adherence to ART (Mutumba et al., 2015; Ankrah et al., 2016). AGYW who have not disclosed their status to their partners or family are forced to take ARVs in secret and this repeatedly leads to incomplete adherence for both mother and child (Dension et al., 2015).

The evidence suggests that interventions that promote disclosure and counselling facilitate adherence to ART (Cluver et al., 2015). Studies have shown that while huge resources are spent on viral load tests to assess adherence clinically, much less focus is given to interventions to address root causes of poor adherence (Roberts et al., 2012). Policy interventions also need to be targeted at other levels beyond the individual.

The study also found that the numbers of HIV-exposed or infected infants lost to follow-up are higher where the child has completed immunization, which suggests the need for additional sensitization and support for those AGYW whose children have completed vaccination.

#### **4.4.2 INTERPERSONAL OR RELATIONSHIP LEVEL**

##### ***Lack of disclosure of HIV status to spouse or partner influences ART adherence and contributes to the loss of infants to follow-up care and treatment.***

The study found that most AGYW found it difficult to disclose their status to their partners or spouses for fear of marital problems, rejections or stigma. This lack of disclosure contributes to non-adherence to ART and loss to follow-up for the infected or exposed infant. The lack of disclosure of HIV status was higher among the non-adherent AGYW.

The study found that AGYW found it easier to disclose their status to their parents than to peers or other family members. These findings are consistent with evidence from the literature, which shows that non-disclosure to intimate partners led to ART defaulting and fear of being identified as HIV-positive, and that non-adherence is higher among adolescents who fail to disclose their status (Nabukeera-Barungi et al., 2015; Cluver et al., 2015). The evidence also shows that adolescent girls' partners may not always be other adolescents; some will have intimate relationships with older men and they need the skills, knowledge and confidence to enable them to disclose their status to all potential partners before relationships become sexual (Ammon et al., 2018). Ensuring that AGYW are able to disclose their HIV status to intimate partners is crucial for preventing onward transmission of HIV.

Counselling to explain the link between good adherence and low HIV transmission through reduced risk of infection could decrease fears among AGYW of infecting intimate partners (Ammon et al., 2018). The evidence in existing literature suggests that most adolescents are not aware of the link, and that health workers may not tell them about it for fear of promoting intercourse without condoms (Ammon et al., 2018). There is need for more evaluation of the potential benefit and harm of informing adolescents living with HIV of this link.

## 5 LIMITATIONS OF THE STUDY

The study faced a number of limitations linked to the generalisation of the findings, and sampling of adolescent respondents to facilitate rural-urban comparisons among HIV-positive adolescents.

One key limitation of the study is the **non-representativeness of the findings** to the country context. The targeted districts were purposively selected based on specific characteristics such as high prevalence of HIV and low use of family planning. In each district, the facilities were purposively selected based on predetermined characteristics such as the availability of HIV and adolescent-friendly spaces. At each facility level, a combination of a purposive and a snowballing approach was used to recruit respondents from the different target groups. These groups include the SMAGs, HIV support group members, adolescents aged 15–19, young mothers aged 20–24 and non-adherent adolescents and young mothers. Although this general approach enabled us to engage with a diverse range of respondents, it was not designed to generate a representative sample. As such, the findings from this study may not be generalisable to other contexts in Zambia. However, the findings depict knowledge, attitudes and practices among AGYW in the study areas in Western and Central provinces. The study did not include perspectives from male adolescents and young fathers.

The **target age range** for adolescents in both rural and urban areas was 15–19. However, we were unable to get adequate numbers to conduct a focus group discussion among the HIV-positive mothers or mothers-to-be in the age range 15–19 in the rural facilities that were sampled. The focus group discussion therefore had to be conducted in the peri-urban areas. Furthermore, overall the proportion of adolescents aged 15 to 16 who were HIV-positive and either pregnant or mothers across the sample is relatively lower than the proportion of those aged 17–19. However, this difference would normally be expected across these age groups.

Another limitation of the study is the **reliance on self-reported data**, a common and simple approach to measuring knowledge, attitudes and practices. The pitfall in using self-reported data is that recall bias and reluctance to report socially undesirable behaviours can lead to over-reporting of behaviours that are perceived as desirable. The study strove to reduce this bias by assuring respondents of confidentiality and indicating that there was no right or wrong answer in focus group discussions and open-ended interviews. Further, findings were triangulated across different respondents and existing literature.

## 6 CONCLUSION AND POLICY RECOMMENDATIONS

The KAP study examined AGYW's knowledge and use of SRH and antenatal services in Western and Central provinces in Zambia. While there are several interventions currently being implemented to encourage the use of SRH, HIV and SGBV services among adolescents and young women, there is a need to review and reinforce some approaches to improve effectiveness.

Various approaches to providing effective and efficient SRH and HIV for adolescents have been implemented in developing countries. The evidence suggests that the most successful programmes are those that combine efforts to: 1) train health workers to provide services to adolescents in a friendly manner; 2) adapt health facilities so that they are acceptable and accessible to adolescents and meet their needs; and 3) generate demand for services through disseminating information in schools, communities and mass media.

It is crucial for policymakers to engage adolescents at all the stages of designing, implementing, promoting and evaluating services. This section presents the recommendations for planning and improving of SRH, HIV and SGBV service delivery for adolescents and young mothers, based on the study findings. Although the study does not cover first generation adolescents that are younger than 15, it is clear that most interventions also need to be targeted at the younger adolescent generation for greater impact.

### INFORMATION, EDUCATION AND COMMUNICATION (IEC) MATERIALS

- There is a need for less technical IEC on SRH, family planning and SGBV to ensure a wider readership and understanding among adolescents and young people. Materials and programmes need to be simplified and presented in local languages for respective target audiences, using different channels of communication including radio, TV and social media platforms.

### MALE INVOLVEMENT; PARENTAL AND COMMUNITY SUPPORT AND ENGAGEMENT

- There is a need to target adolescent boys and young men to communicate the importance of supporting their partners to access SRH, HIV and family planning services.
- Male engagement programmes that focus on youth mentorship, to promote the use of SRH services among adolescents and young people, need to be prioritized.
- Interventions are needed on parental training and establishing community dialogues for a supportive environment for adolescents and young people to access SRH services.

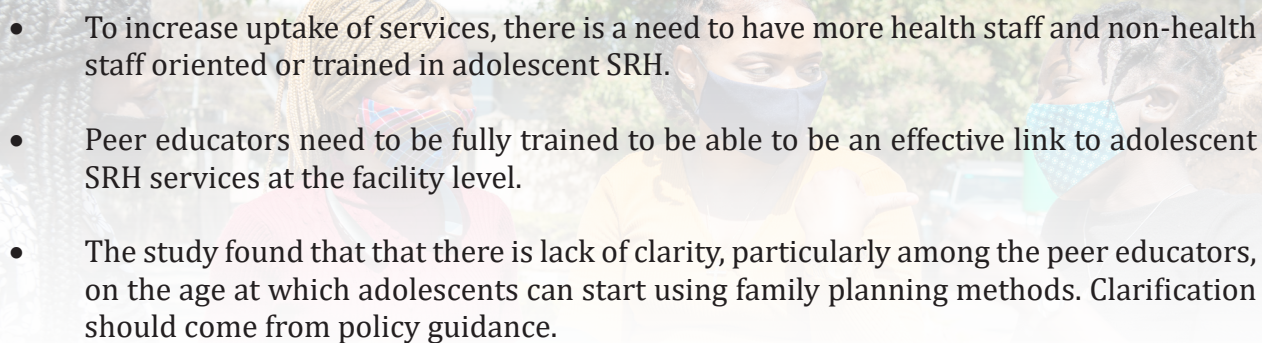
### AWARENESS-RAISING CAMPAIGNS AND CONTINUOUS DIALOGUE WITH KEY STAKEHOLDERS

- Awareness-raising campaigns are recommended on family planning and SRH targeting younger adolescents (younger than 15) in school and out of school, as a preventative measure for early pregnancies and HIV prevention. There is a lack of understanding of family planning, particularly among younger adolescents, such as the right age to start using contraceptives or how to deal with side effects. Beyond awareness campaigns, long-term life skill programmes targeted at adolescents in and out of school should also address family planning issues for younger adolescents.

- Awareness campaigns also need to dispel cultural beliefs and concerns widely held by AGYW and their communities around the side effects of modern family planning methods.
- Awareness campaigns need to emphasize the need for dual protection through the use of condoms and other contraceptives to reduce the risk of HIV transmission and HIV acquisition among AGYW. There is a need to demystify the belief that forms of contraception other than condoms can also protect against contracting HIV.
- Community awareness campaigns targeted at AGYW (15–24) and younger adolescents (10–14) need to emphasize the importance of starting ANC visits in the first trimester (the first 12 weeks of pregnancy).
- Continuous HIV awareness campaigns are needed to improve the understanding of HIV prevention and transmission mechanisms among AGYW. The campaigns also need to focus on dispelling misconceptions and false beliefs around HIV.
- Community HIV awareness interventions are needed to decrease the levels of stigma on HIV-positive AGYW.
- Community awareness campaigns are needed to increase awareness on physical and sexual gender-based violence and to sensitize community members to not withdraw SGBV cases.
- Given that awareness-raising campaigns are short-term measures, longer term measures need to include ongoing dialogue with adolescents, community leaders and members to identify and address the factors that contribute to poor adolescent SRH outcomes.

## DISTRICT, PROVINCIAL AND NATIONAL LEVEL

- There is a need to review and revisit informal fees charged to adolescents and young women seeking ANC care who present without partners, as this practice deters service use.
- Committees that focus on formulating adolescent communication strategies need to be set up.
- The Provincial Health Offices (PHOs) and District Health Offices (DHOs) need to intensify supervision to ensure that staff that are oriented (but not necessarily trained) to provide supportive services for adolescent health.
- The inclusion of indicators tracking adolescent health service delivery and SGBV in the Health Management Information System needs to be expedited. There is a need to advocate for the inclusion of adolescent SRH and HIV prevention-related indicators in the Education Management System, given that schools are expected to provide adolescents with the knowledge and skills they need to protect themselves.
- There is a need for improved funding to support community activities aimed at increasing SRH and HIV awareness among adolescents. This includes support for the training of peer educators and the orientation of other community groups on adolescent SRH.

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- To increase uptake of services, there is a need to have more health staff and non-health staff oriented or trained in adolescent SRH.
  - Peer educators need to be fully trained to be able to be an effective link to adolescent SRH services at the facility level.
  - The study found that there is lack of clarity, particularly among the peer educators, on the age at which adolescents can start using family planning methods. Clarification should come from policy guidance.

## MULTI-SECTORAL APPROACHES

- Continuous community sensitisation is needed to increase awareness of SGBV and to encourage community members to avoid the withdrawal of SGBV cases.
- The courts of law and police need to stiffen punishment for SGBV offenders.
- Long distances to police posts deter victims of SGBV in rural areas from reporting assaults. There is a need to bring the services closer to the communities, especially in rural areas, by decentralizing care into remote communities to maximize coverage across rural and remote settings, particularly for AGYW.
- Given the influence of traditional leaders and traditional initiators, particularly in rural areas, efforts should be made to review the content taught during initiation of boys and girls. The aim should be to provide age-appropriate information on how the body works and SRH; and to address the gender norms underpinning GBV through teaching about safe and unsafe touch, consent, the right of a girl or boy to say no to something they may not want to do or be part of, positive masculinity and discussions on transformed gender expectations of the roles of boys and girls.
- There is a need for ongoing dialogue to correct religious beliefs or practices that encourage individuals, including adolescents, to stop taking ARVs.

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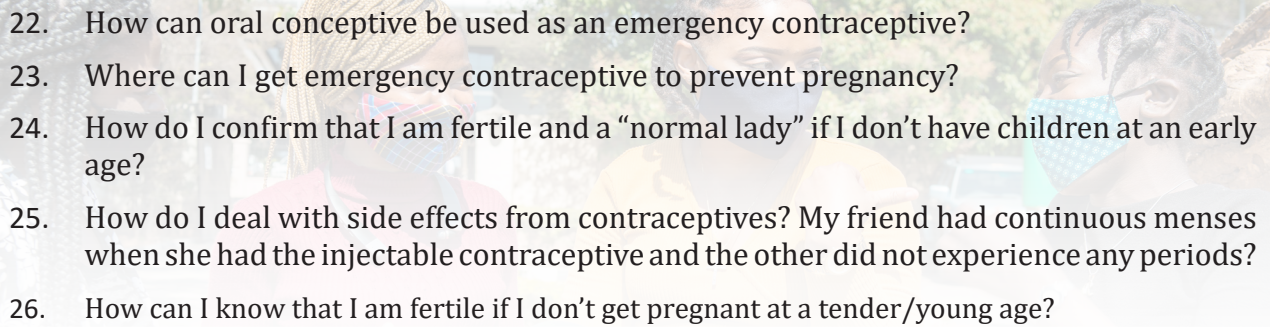
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# ANNEX 1

## COMMON QUESTIONS ON SRH, PMTCT, HIV AND SGBV

### A1.1 FAMILY PLANNING

1. What are the traditional ways of preventing pregnancy?
2. What is the right age to start using contraceptives?
3. How do I deal with side effects of contraceptives?
4. What should we do if the injectable contraceptives give us side effects? Should we remove it?
5. If I get an injection for three months and it makes me sick, how can I be helped?
6. If I start taking contraceptives before I have children, is it true that I will never have a child when I want to? Do contraceptives affect my fertility?
7. Why is it that some people conceive even when they are using some type of contraceptive?
8. I have tried various contraceptives but I am unable to manage the side effects. What other options for family planning do I have?
9. I have heard that the effectiveness of contraceptives reduces overtime. For instance, I have heard that a 5 year implant should only be there for 2-3 years because if it goes beyond that timeframe, one will get pregnant. Should we keep the contraceptive implants for the specified duration or should we remove them earlier?
10. If I get injected with contraceptives, does that protect me from getting HIV?
11. What are the side effects of family planning methods?
12. What family planning methods can use we that can also help to prevent HIV?
13. We have heard that when people are injected with contraceptives several times, then they get complications. Is that true?
14. Can you become infertile after taking family planning pills or injections over a long period of time?
15. Can taking family planning pills terminate a pregnancy?
16. We have heard that when someone uses family planning, then they should not have monthly period. Others say that when you use family planning and get your monthly period, then it is not working? Is this true?
17. The monthly period is a sign that the body is cleansing itself. What happens to those who don't get monthly periods because of using contraceptives? Does that mean that their bodies are not being cleansed?
18. The health providers advise us to go back and have the contraceptives removed if we experience any problems. However, when we go back, the health workers keep postponing to a later date and tell you to give the contraceptive time to work. Why do they refuse to remove the contraceptive?
19. How would you know that the contraceptive is working if you do not get your monthly period after taking it?
20. Some people say that one's body would adjust to the contraceptive after one year. What can I do if it doesn't?
21. What types of contraceptives are available at the health centre?

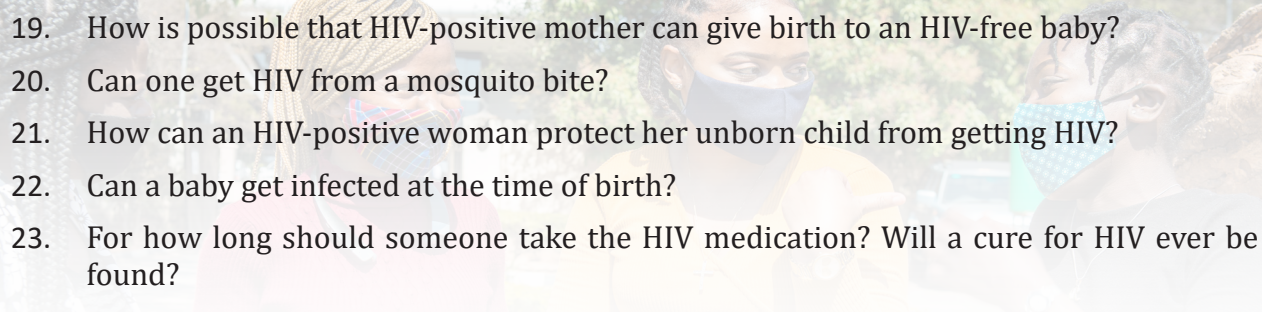
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22. How can oral contraceptive be used as an emergency contraceptive?
  23. Where can I get emergency contraceptive to prevent pregnancy?
  24. How do I confirm that I am fertile and a “normal lady” if I don’t have children at an early age?
  25. How do I deal with side effects from contraceptives? My friend had continuous menses when she had the injectable contraceptive and the other did not experience any periods?
  26. How can I know that I am fertile if I don’t get pregnant at a tender/young age?

## **A1.2 ANTENATAL**

1. Is it really important for me to attend antenatal?
2. Why is it important for me to deliver at a health facility?
3. Why do we have to pay for letters to seek antenatal if our partners refuse to come to the clinic with us?
4. How can I convince my partner to come with me for antenatal care when I am pregnant?

## **A1.3 HIV**

1. How can I have HIV when I am still a virgin? [HIV-positive adolescents infected through vertical transmission]
2. How can I use the HIV drugs to protect my unborn baby from getting HIV?
3. How does the pill that one is given during labour, to prevent the baby from getting infected with HIV work?
4. My friends who sleep around are negative, and yet I do not misbehave as much as they do but I am positive. Why is this so? Why me?
5. In our community, women used to use traditional birth attendants to deliver at home. Why is it not okay to deliver from home?
6. If I am HIV-free and I sleep with an HIV-positive person, will I get infected?
7. How can HIV be transmitted? How can I prevent myself from getting infected with HIV?
8. Does taking the ART medication at a time later than advised affect the effectiveness of the drugs in the body?
9. Can someone get sick if they take ART medication without eating?
10. Can any other STIs apart from HIV be transmitted to the baby if you are not put on medication?
11. I was told that if you don’t take medication, HIV can turn into AIDS? Is this true?
12. How is it possible that an HIV-positive man and woman can have an HIV-free child?
13. How did HIV come about?
14. Taking the ART every day is not easy, will a cure for HIV ever be found?
15. What will happen if I stop taking my ART drugs?
16. How is HIV transmitted? What does HIV look like? What is viral load?
17. How is possible that there are despondent couples?
18. We have heard that when the HIV virus is exposed to air then it dies quickly, is that true?

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19. How is possible that HIV-positive mother can give birth to an HIV-free baby?
  20. Can one get HIV from a mosquito bite?
  21. How can an HIV-positive woman protect her unborn child from getting HIV?
  22. Can a baby get infected at the time of birth?
  23. For how long should someone take the HIV medication? Will a cure for HIV ever be found?
  24. Can I contract HIV from a person who is taking ART?
  25. How is possible that for a married couple, one can be positive while the other one is negative? Then some have children and the partner still does not get HIV and the child is also negative? How is that possible?
  26. Is it true that HIV is curable?
  27. Can the HIV virus be transmitted by mosquito?
  28. Is it possible that a woman who is positive can give birth to a child who is not positive?
  29. How is possible that an HIV-positive woman can give birth to an HIV negative child? What happens?
  30. If you do not take your ARVs at the stipulated time, say 20.00 hrs, but you take them later at 22 hours, are you supposed to change the time to take the medication the following day to 22 hours, or should you take it at 20.00 hrs?
  31. What happens if I don't take my ARVs frequently?
  32. Can HIV be cured through prayers by the religious leaders?
  33. How do I join an HIV support group?

#### **A1.4 OTHER SEXUAL REPRODUCTIVE HEALTH**

1. When it is appropriate for me to have sex?
2. When is it okay for me to have a boyfriend?
3. How does the menstrual cycle work?
4. How do I use sanitary pads?
5. How can you distinguish between 'normal' irritation and a pimple from an STI?
6. When would you know that you have an STI?
7. How can we prevent ourselves from contracting STI?
8. What are the benefits of male circumcision?
9. Can an adolescent who has not yet reached menarche get pregnant?
10. Is it true that circumcised males cannot get STIs?
11. Is it wrong to use traditional herbs to cure genital ulcers or other STIs?
12. The treatment for some STIs is too painful, I would rather stay away. What other options for treatment do I have?



## ANNEX 2

### A2.1 PROTOCOLS FOR KIIS, FGDS AND IDIS

Protocol Focus Group Discussion Guide for 15 -19 year old pregnant adolescents and mothers living with HIV

#### *Introduction*

Good morning. My name is \_\_\_\_\_ and this is my colleague \_\_\_\_\_.

Thank you for coming.

#### *Purpose of the focus group*

We would like to get your views on sexual reproductive health issues as young women living with HIV. Please feel free to express yourself as there is no right or wrong answer in our discussion. To ensure that everyone gets a chance to speak and be heard, we ask that you speak one at a time. It is possible that you may not agree with some statements made by your colleagues, please feel free to express your feelings based on your own experiences.

Please note that all the information that you will share with us today will be useful for coming up with solutions to deal with current problems that youths face around sexual reproductive health. Please be assured that we will not reveal your name with anyone outside this room. My colleague will record the discussion to ensure that we capture your views correctly. Our session will last for about 1 hour. Do I have your permission to proceed with the discussion?

Introduction of participants and ice breaker

Could you please introduce yourselves by telling us your name, age? Please tell me the age of your child (months/years).

Are you currently working, doing business, studying or staying at home?

I would like to ask you some questions on your knowledge and experiences about antenatal care

1. When do young pregnant women in your community most often start going for antenatal? Probe: first trimester (1-3 months), second trimester (4-6 months), third trimester (7-9 months)? What are some of reasons for this? Why are they not able to start antenatal care in the first trimester?
2. Are young women in your community aware of the benefits of seeking antenatal care in the first trimester? What are these benefits?
3. What was your experience at the facility during your first antenatal visit? Probe for: experience with the health care provider. What type of services were you offered during your first antenatal visit? Probe for: educational talks on various issues such as HIV, personal care during pregnancy, child growth monitoring
4. What are the challenges that young pregnant women in your community face in accessing antenatal services?
5. What would you say encourages/discourages young women from seeking antenatal service at this facility or any other facility in the area?

I would like to ask you some questions on your knowledge and experiences about family planning

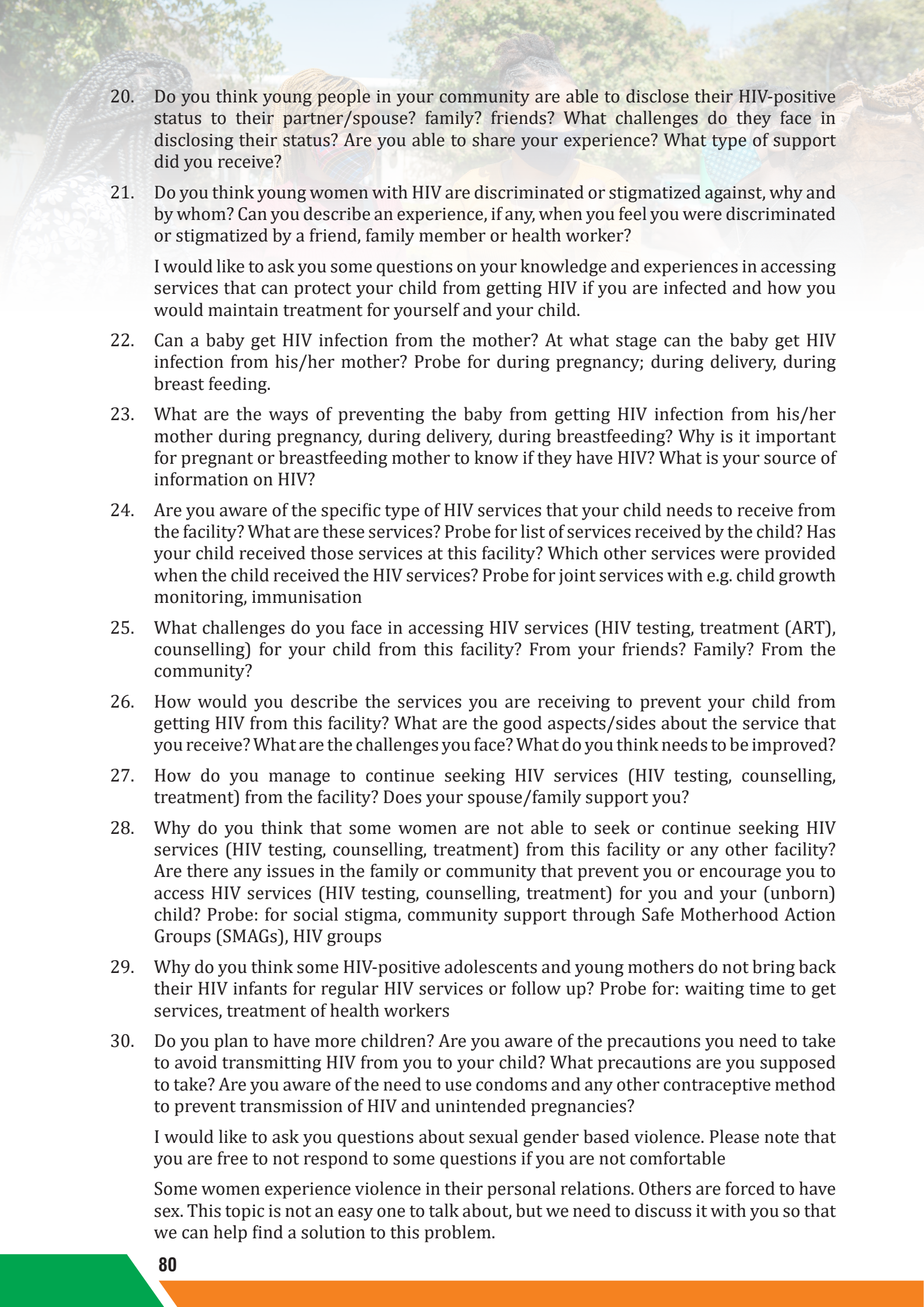
6. Do young women in this community know what family planning is? Please explain.

7. Where do they learn about issues on family planning? Probe for sources such as mass media, parents, friends, teachers, religious leaders, health providers etc. What specific type of information do they get? What are the preferred sources of information on family planning among young women in this community? Why?
8. What type of contraceptives are available in this community? What type of contraceptives do most young women in this area prefer to use and why? Where do young women in this community get contraceptives e.g. condoms, pills, injectable contraceptives?
9. Do you think young women in this area are able to discuss family planning issues with their spouses/partners? Please explain.
10. What are the challenges that young women in this area face in accessing family planning services (i.e. contraceptive/condoms) in this area? Probe: services not available, family influence, peer pressure, distance to the facility, unfriendly staff, no supply of contraceptives/condoms
11. What would you say encourages/discourages young women from seeking family planning services at this facility or any other facility in the area? Probe: staff attitude, friendly staff etc.

I would like to ask you some questions on your knowledge and experiences about HIV

12. Do you think young women in this community know what HIV is and how it can be transmitted? What do they know? What are some of the religious and cultural beliefs around HIV in your community? Probe on: myths such as transmission by mosquito, can be healed by religious leaders etc.
13. Where do young women in your community get information on HIV from? Probe for sources such as mass media, parents, friends, teachers, religious leaders, health providers etc. What specific type of information do they get? What do you think are the preferred sources of information on these issues? Why?
14. What are some of reasons that young women in your community decide to go for HIV testing? Why do you think they don't go for HIV testing?
15. Were you tested for HIV during your antenatal visit? What was your experience? Probe for: counselling services offered before getting tested? Did you get the results immediately? Why or why not?
16. What are your experiences with the provision of HIV services with other services such as family planning, antenatal, postnatal during a visit to the facility? Is this type of service convenient for you? What are the good aspects/sides of this type of service provision? What are the challenges you face with this type of service provision? Probe for delay, convenient services, privacy, reduces frequency of visiting the facility, time consuming etc.
17. Did the services you received meet *all* your needs? If not, what was lacking? Probe: friendly staff/unfriendly, peer educators available, adolescent-friendly section available, judgmental staff
18. What would you say encourages/discourages young women from seeking HIV services at this facility or any other facility in the area?
19. What do you think about the location of the HIV services at this facility? Do you think the location guarantees the privacy of those seeking HIV services?

I would like to ask you some questions on how you feel about disclosing your HIV status. Please note that if you are not comfortable with this session, you may choose not to answer.

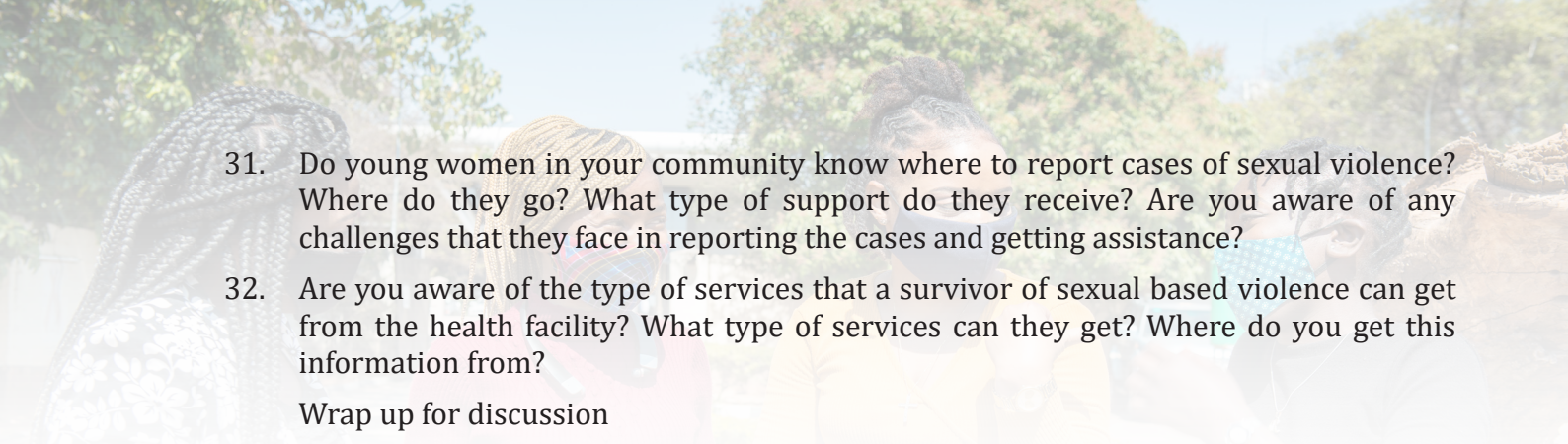
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20. Do you think young people in your community are able to disclose their HIV-positive status to their partner/spouse? family? friends? What challenges do they face in disclosing their status? Are you able to share your experience? What type of support did you receive?
21. Do you think young women with HIV are discriminated or stigmatized against, why and by whom? Can you describe an experience, if any, when you feel you were discriminated or stigmatized by a friend, family member or health worker?

I would like to ask you some questions on your knowledge and experiences in accessing services that can protect your child from getting HIV if you are infected and how you would maintain treatment for yourself and your child.

22. Can a baby get HIV infection from the mother? At what stage can the baby get HIV infection from his/her mother? Probe for during pregnancy; during delivery, during breast feeding.
23. What are the ways of preventing the baby from getting HIV infection from his/her mother during pregnancy, during delivery, during breastfeeding? Why is it important for pregnant or breastfeeding mother to know if they have HIV? What is your source of information on HIV?
24. Are you aware of the specific type of HIV services that your child needs to receive from the facility? What are these services? Probe for list of services received by the child? Has your child received those services at this facility? Which other services were provided when the child received the HIV services? Probe for joint services with e.g. child growth monitoring, immunisation
25. What challenges do you face in accessing HIV services (HIV testing, treatment (ART), counselling) for your child from this facility? From your friends? Family? From the community?
26. How would you describe the services you are receiving to prevent your child from getting HIV from this facility? What are the good aspects/sides about the service that you receive? What are the challenges you face? What do you think needs to be improved?
27. How do you manage to continue seeking HIV services (HIV testing, counselling, treatment) from the facility? Does your spouse/family support you?
28. Why do you think that some women are not able to seek or continue seeking HIV services (HIV testing, counselling, treatment) from this facility or any other facility? Are there any issues in the family or community that prevent you or encourage you to access HIV services (HIV testing, counselling, treatment) for you and your (unborn) child? Probe: for social stigma, community support through Safe Motherhood Action Groups (SMAGs), HIV groups
29. Why do you think some HIV-positive adolescents and young mothers do not bring back their HIV infants for regular HIV services or follow up? Probe for: waiting time to get services, treatment of health workers
30. Do you plan to have more children? Are you aware of the precautions you need to take to avoid transmitting HIV from you to your child? What precautions are you supposed to take? Are you aware of the need to use condoms and any other contraceptive method to prevent transmission of HIV and unintended pregnancies?

I would like to ask you questions about sexual gender based violence. Please note that you are free to not respond to some questions if you are not comfortable

Some women experience violence in their personal relations. Others are forced to have sex. This topic is not an easy one to talk about, but we need to discuss it with you so that we can help find a solution to this problem.

- 
31. Do young women in your community know where to report cases of sexual violence? Where do they go? What type of support do they receive? Are you aware of any challenges that they face in reporting the cases and getting assistance?
  32. Are you aware of the type of services that a survivor of sexual based violence can get from the health facility? What type of services can they get? Where do you get this information from?

Wrap up for discussion

33. Would you like more information on what we discussed today? What specific information would you like to know as young women on 1) family planning 2) antenatal care 3) postnatal care 4) sexual based gender violence 5) HIV services 6) any other related issues?
34. How would you like to learn about these topics? Who would you want to discuss them with?
35. What do you think needs to be done to improve service delivery for the adolescents and young women?

Thank you for sharing your thoughts and experiences.

## A2.2 PROTOCOL FOCUS GROUP DISCUSSION GUIDE: 20–24 YEAR OLD PREGNANT YOUNG WOMEN AND MOTHERS LIVING WITH HIV

### *Introduction*

Good morning. My name is \_\_\_\_\_ and this is my colleague \_\_\_\_\_.

Thank you for coming.

### *Purpose of the focus group*

We would like to get your views on sexual reproductive health issues as young women living with HIV. Please feel free to express yourself as there is no right or wrong answer in our discussion. To ensure that everyone gets a chance to speak and be heard, we ask that you speak one at a time. It is possible that you may not agree with some statements made by your colleagues, please feel free to express your feelings based on your own experiences.

Please note that all the information that you will share with us today will be useful for coming up with solutions to deal with current problems that youths face around sexual reproductive health. Please be assured that we will not reveal your name with anyone outside this room. My colleague will record the discussion to ensure that we capture your views correctly. Our session will last for about 1 hour. Do I have your permission to proceed with the discussion?

### *Introduction of participants and ice breaker*

Could you please introduce yourselves by telling us your name, age? Please tell me the age of your child (months/years).

Are you currently working, doing business, studying or staying at home?

I would like to ask you some questions on your knowledge and experiences about antenatal care

1. When do young pregnant women in your community most often start going for antenatal? Probe: first trimester (1-3 months), second trimester (4-6 months), third trimester (7-9 months)? What are some of reasons for this? Why are they not able to start antenatal care in the first trimester?
2. Are young women in your community aware of the benefits of seeking antenatal care in the first trimester? What are these benefits?
3. What was your experience at the facility during your first antenatal visit? Probe for: experience with the health care provider. What type of services were you offered during your first antenatal visit? Probe for: educational talks on various issues such as HIV, personal care during pregnancy, child growth monitoring
4. What are the challenges that young pregnant women in your community face in accessing antenatal services?
5. What would you say encourages/discourages young women from seeking antenatal service at this facility or any other facility in the area?

I would like to ask you some questions on your knowledge and experiences about family planning

6. Do young women in this community know what family planning is? Please explain.
7. Where do they learn about issues on family planning? Probe for sources such as mass media, parents, friends, teachers, religious leaders, health providers etc. What specific type of information do they get? What are the preferred sources of information on family planning among young women in this community? Why?

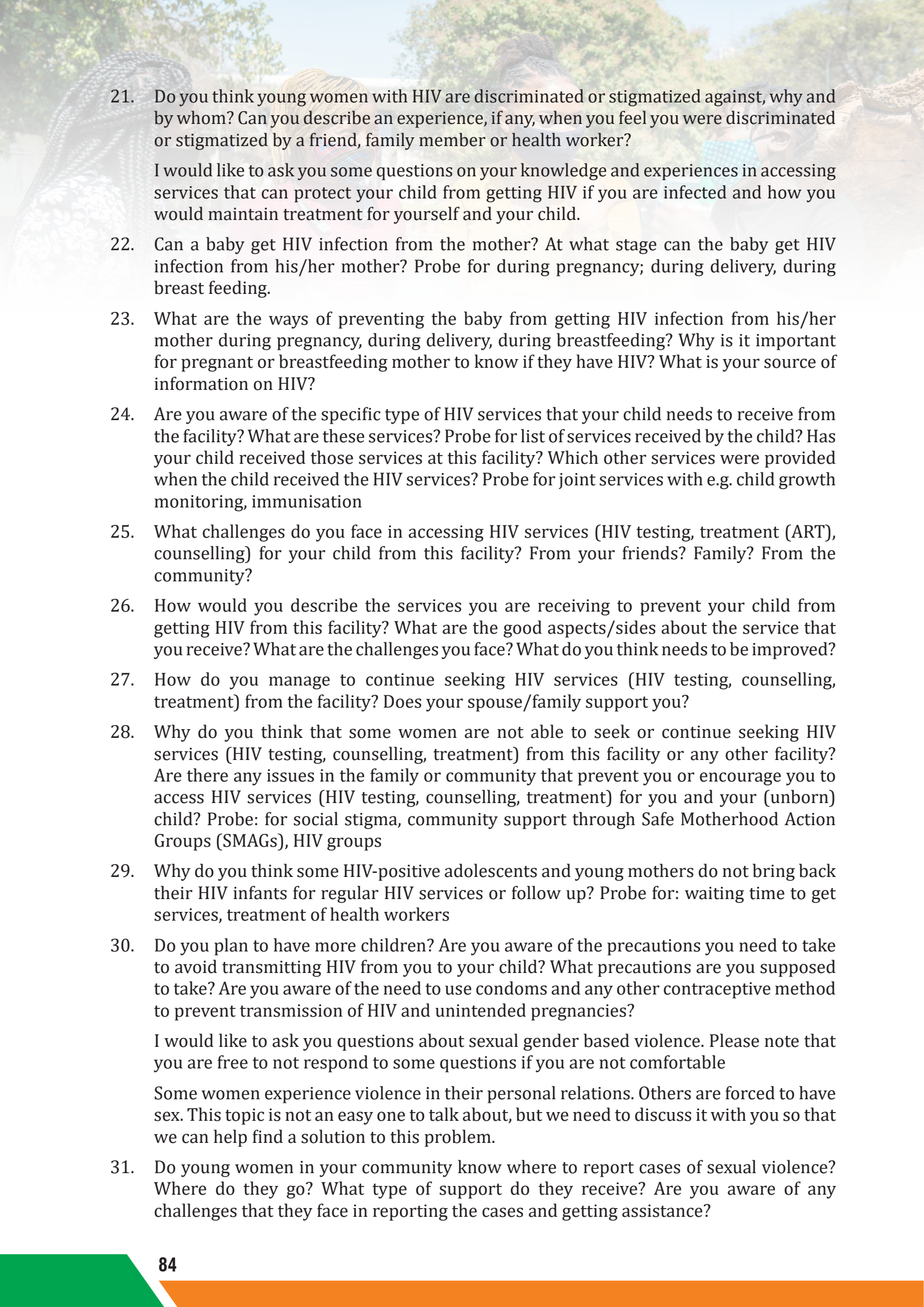
8. What type of contraceptives are available in this community? What type of contraceptives do most young women in this area prefer to use and why? Where do young women in this community get contraceptives e.g. condoms, pills, injectable contraceptives?
9. Do you think young women in this area are able to discuss family planning issues with their spouses/partners? Please explain.
10. What are the challenges that young women in this area face in accessing family planning services (i.e. contraceptive/condoms) in this area? Probe: services not available, family influence, peer pressure, distance to the facility, unfriendly staff, no supply of contraceptives/condoms
11. What would you say encourages/discourages young women from seeking family planning services at this facility or any other facility in the area? Probe: staff attitude, friendly staff etc.

I would like to ask you some questions on your knowledge and experiences about HIV

12. Do you think young women in this community know what HIV is and how it can be transmitted? What do they know? What are some of the religious and cultural beliefs around HIV in your community? Probe on: myths such as transmission by mosquito, can be healed by religious leaders etc.
13. Where do young women in your community get information on HIV from? Probe for sources such as mass media, parents, friends, teachers, religious leaders, health providers etc. What specific type of information do they get? What do you think are the preferred sources of information on these issues? Why?
14. What are some of reasons that young women in your community decide to go for HIV testing? Why do you think they don't go for HIV testing?
15. Were you tested for HIV during your antenatal visit? What was your experience? Probe for: counselling services offered before getting tested? Did you get the results immediately? Why or why not?
16. What are your experiences with the provision of HIV services with other services such as family planning, antenatal, postnatal during a visit to the facility? Is this type of service convenient for you? What are the good aspects/sides of this type of service provision? What are the challenges you face with this type of service provision? Probe for delay, convenient services, privacy, reduces frequency of visiting the facility, time consuming etc.
17. Did the services you received meet *all* your needs? If not, what was lacking? Probe: friendly staff/unfriendly, peer educators available, adolescent-friendly section available, judgmental staff
18. What would you say encourages/discourages young women from seeking HIV services at this facility or any other facility in the area?
19. What do you think about the location of the HIV services at this facility? Do you think the location guarantees the privacy of those seeking HIV services?

I would like to ask you some questions on how you feel about disclosing your HIV status. Please note that if you are not comfortable with this session, you may choose not to answer.

20. Do you think young people in your community are able to disclose their HIV-positive status to their partner/spouse? family? friends? What challenges do they face in disclosing their status? Are you able to share your experience? What type of support did you receive?

- 
21. Do you think young women with HIV are discriminated or stigmatized against, why and by whom? Can you describe an experience, if any, when you feel you were discriminated or stigmatized by a friend, family member or health worker?

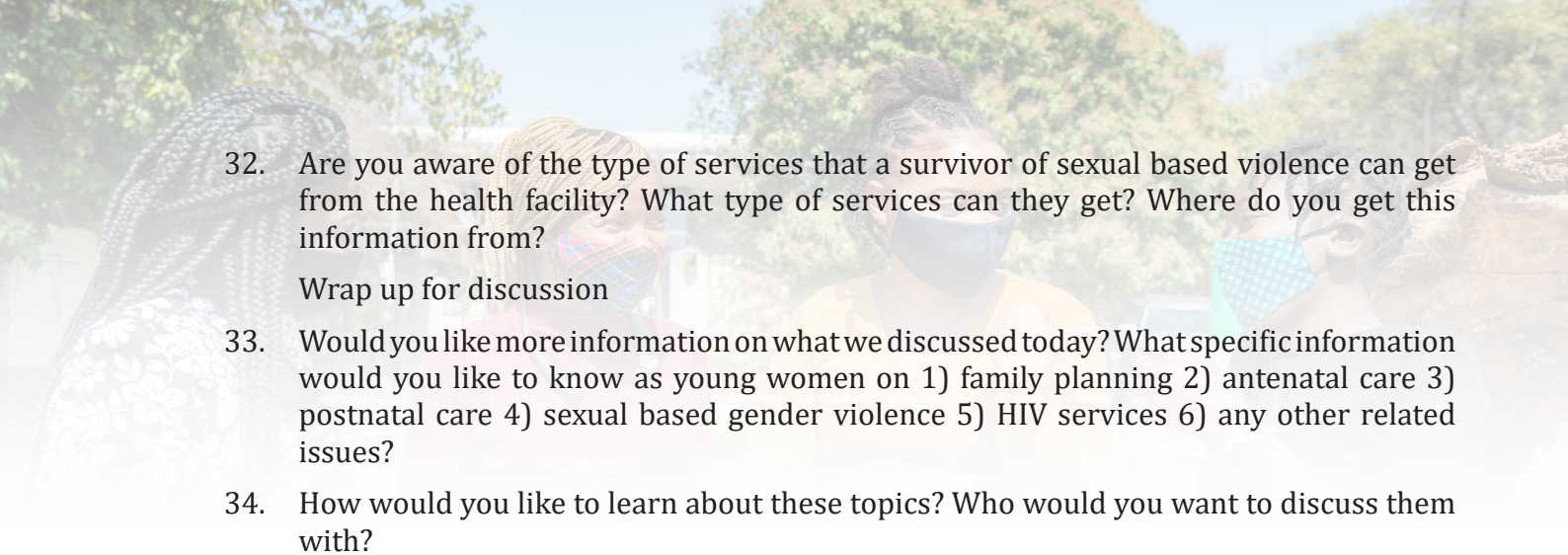
I would like to ask you some questions on your knowledge and experiences in accessing services that can protect your child from getting HIV if you are infected and how you would maintain treatment for yourself and your child.

22. Can a baby get HIV infection from the mother? At what stage can the baby get HIV infection from his/her mother? Probe for during pregnancy; during delivery, during breast feeding.
23. What are the ways of preventing the baby from getting HIV infection from his/her mother during pregnancy, during delivery, during breastfeeding? Why is it important for pregnant or breastfeeding mother to know if they have HIV? What is your source of information on HIV?
24. Are you aware of the specific type of HIV services that your child needs to receive from the facility? What are these services? Probe for list of services received by the child? Has your child received those services at this facility? Which other services were provided when the child received the HIV services? Probe for joint services with e.g. child growth monitoring, immunisation
25. What challenges do you face in accessing HIV services (HIV testing, treatment (ART), counselling) for your child from this facility? From your friends? Family? From the community?
26. How would you describe the services you are receiving to prevent your child from getting HIV from this facility? What are the good aspects/sides about the service that you receive? What are the challenges you face? What do you think needs to be improved?
27. How do you manage to continue seeking HIV services (HIV testing, counselling, treatment) from the facility? Does your spouse/family support you?
28. Why do you think that some women are not able to seek or continue seeking HIV services (HIV testing, counselling, treatment) from this facility or any other facility? Are there any issues in the family or community that prevent you or encourage you to access HIV services (HIV testing, counselling, treatment) for you and your (unborn) child? Probe: for social stigma, community support through Safe Motherhood Action Groups (SMAGs), HIV groups
29. Why do you think some HIV-positive adolescents and young mothers do not bring back their HIV infants for regular HIV services or follow up? Probe for: waiting time to get services, treatment of health workers
30. Do you plan to have more children? Are you aware of the precautions you need to take to avoid transmitting HIV from you to your child? What precautions are you supposed to take? Are you aware of the need to use condoms and any other contraceptive method to prevent transmission of HIV and unintended pregnancies?

I would like to ask you questions about sexual gender based violence. Please note that you are free to not respond to some questions if you are not comfortable

Some women experience violence in their personal relations. Others are forced to have sex. This topic is not an easy one to talk about, but we need to discuss it with you so that we can help find a solution to this problem.

31. Do young women in your community know where to report cases of sexual violence? Where do they go? What type of support do they receive? Are you aware of any challenges that they face in reporting the cases and getting assistance?

- 
32. Are you aware of the type of services that a survivor of sexual based violence can get from the health facility? What type of services can they get? Where do you get this information from?

Wrap up for discussion

33. Would you like more information on what we discussed today? What specific information would you like to know as young women on 1) family planning 2) antenatal care 3) postnatal care 4) sexual based gender violence 5) HIV services 6) any other related issues?
34. How would you like to learn about these topics? Who would you want to discuss them with?
35. What do you think needs to be done to improve service delivery for the adolescents and young women?

Thank you for sharing your thoughts and experiences.



## A2.3 PROTOCOL FOR FGDS FOR HIV-FREE 15–19-YEAR-OLD PREGNANT ADOLESCENTS AND MOTHERS

### *Introduction*

Good morning. My name is \_\_\_\_\_ and this is my colleague \_\_\_\_\_.

Thank you for coming.

### *Purpose*

We would like to get your views on sexual reproductive health issues as young women. Please feel free to express yourself as there is no right or wrong answer in our discussion. To ensure that everyone gets a chance to speak and be heard, we ask that you speak one at a time. It is possible that you may not agree with some statements made by your colleagues, please feel free to express your feelings based on your own experiences.

Please note that all the information that you will share with us today will be useful for coming up with solutions to deal with current problems that youths face around sexual reproductive health. Please be assured that we will not reveal your name with anyone outside this room. My colleague will record the discussion to ensure that we capture your views correctly. Our session will last for about 1 hour. Do I have your permission to proceed with the discussion?

### *Introduction of participants and ice breaker*

Could you please introduce yourselves by telling us your name, age? Please tell me the age of your child (months/years).

Are you currently working, doing business, studying or staying at home? Do you have any social support from family to help take care of your child/pregnancy?

I would like to ask you some questions on your knowledge and experiences about antenatal care

1. When do young pregnant women in your community most often start going for antenatal? Probe: first trimester (1-3 months), second trimester (4-6 months), third trimester (7-9 months)? What are some of reasons for this? Why are they not able to start antenatal care in the first trimester?
2. Are young women in your community aware of the benefits of seeking antenatal care in the first trimester? What are these benefits?
3. What was your experience at the facility during your first antenatal visit? Probe for: experience with the health care provider. What type of services were you offered during your first antenatal visit? Probe for: educational talks on various issues such as HIV, personal care during pregnancy, child growth monitoring
4. What are the challenges that young pregnant women in your community face in accessing antenatal services?
5. What would you say encourages/discourages young women from seeking antenatal service at this facility or any other facility in the area?

I would like to ask you some questions on your knowledge and experiences about family planning

6. Do young women in this community know what family planning is? Please explain.
7. Where do they learn about issues on family planning? Probe for sources such as mass media, parents, friends, teachers, religious leaders, health providers etc. What specific type of information do they get? What are the preferred sources of information on family planning among young women in this community? Why?

8. What type of contraceptives are available in this community? What type of contraceptives do most young women in this area prefer to use and why? Where do young women in this community get contraceptives e.g. condoms, pills, injectable contraceptives?
9. Do you think young women in this area are able to discuss family planning issues with their spouses/partners? Please explain.
10. What are the challenges that young women in this area face in accessing family planning services (i.e. contraceptive/condoms) in this area? Probe: services not available, family influence, peer pressure, distance to the facility, unfriendly staff, no supply of contraceptives/condoms
11. What would you say encourages/discourages young women from seeking family planning services at this facility or any other facility in the area? Probe: staff attitude, friendly staff etc.

I would like to ask you some questions on your knowledge and experiences about HIV

12. Do you think young women in this community know what HIV is and how it can be transmitted? What do they know? What are some of the religious and cultural beliefs around HIV in your community? Probe on: myths such as transmission by mosquito, can be healed by religious leaders etc.
13. Where do young women in your community get information on HIV from? Probe for sources such as mass media, parents, friends, teachers, religious leaders, health providers etc. What specific type of information do they get? What do you think are the preferred sources of information on these issues? Why?
14. What are some of reasons that young women in your community decide to go for HIV testing? Why do you think they don't go for HIV testing?
15. Were you tested for HIV during your antenatal visit? What was your experience? Probe for: counselling services offered before getting tested? Did you get the results immediately? Why or why not?
16. What are your experiences with the provision of HIV services with other services such as family planning, antenatal, postnatal during a visit to the facility? Is this type of service convenient for you? What are the good aspects/sides of this type of service provision? What are the challenges you face with this type of service provision? Probe for delay, convenient services, privacy, reduces frequency of visiting the facility, time consuming etc.
17. Did the services you received meet *all* your needs? If not, what was lacking? Probe: friendly staff/unfriendly, peer educators available, adolescent-friendly section available, judgmental staff
18. What would you say encourages/discourages young women from seeking HIV services at this facility or any other facility in the area?
19. What do you think about the location of the HIV services at this facility? Do you think the location guarantees the privacy of those seeking HIV services?

I would like to ask you some questions on your knowledge of HIV prevention methods

20. Are you aware of the ways in which you can prevent yourself from contracting HIV? Which methods are you aware of? Where do you get information on HIV prevention methods? Why is it important to prevent HIV infection?
21. Why do you think that some young women are not able to seek HIV services (HIV testing, counselling, treatment) from this facility or any other facility?

I would like to ask you questions about sexual gender based violence. Please note that you are free to not respond to some questions if you are not comfortable

Some women experience violence in their personal relations. Others are forced to have sex. This topic is not an easy one to talk about, but we need to discuss it with you so that we can help find a solution to this problem.

22. Do young women in your community know where to report cases of sexual violence? Where do they go? What type of support do they receive? Are you aware of any challenges that they face in reporting the cases and getting assistance?
23. Are you aware of the type of services that a survivor of sexual based violence can get from the health facility? What type of services can they get? Where do you get this information from?

Wrap up for discussion

24. Would you like more information on what we discussed today? What specific information would you like to know as young women on 1) family planning 2) antenatal care 3) postnatal care 4) sexual based gender violence 5) HIV services 6) any other related issues?
25. How would you like to learn about these topics? Who would you want to discuss them with?
26. What do you think needs to be done to improve service delivery for the adolescents and young women?

Thank you for sharing your thoughts and experiences.

## A2.4 PROTOCOL FOR FGDS FOR HIV-FREE 20-24-YEAR-OLD PREGNANT YOUNG WOMEN AND MOTHERS

### *Introduction*

Good morning. My name is \_\_\_\_\_ and this is my colleague \_\_\_\_\_.

Thank you for coming.

### *Purpose*

We would like to get your views on sexual reproductive health issues as young women. Please feel free to express yourself as there is no right or wrong answer in our discussion. To ensure that everyone gets a chance to speak and be heard, we ask that you speak one at a time. It is possible that you may not agree with some statements made by your colleagues, please feel free to express your feelings based on your own experiences.

Please note that all the information that you will share with us today will be useful for coming up with solutions to deal with current problems that youths face around sexual reproductive health. Please be assured that we will not reveal your name with anyone outside this room. My colleague will record the discussion to ensure that we capture your views correctly. Our session will last for about 1 hour. Do I have your permission to proceed with the discussion?

### *Introduction of participants and ice breaker*

Could you please introduce yourselves by telling us your name, age? Please tell me the age of your child (months/years).

Are you currently working, doing business, studying or staying at home? Do you have any social support from family to help take care of your child/pregnancy?

I would like to ask you some questions on your knowledge and experiences about antenatal care

1. When do young pregnant women in your community most often start going for antenatal? Probe: first trimester (1-3 months), second trimester (4-6 months), third trimester (7-9 months)? What are some of reasons for this? Why are they not able to start antenatal care in the first trimester?
2. Are young women in your community aware of the benefits of seeking antenatal care in the first trimester? What are these benefits?
3. What was your experience at the facility during your first antenatal visit? Probe for: experience with the health care provider. What type of services were you offered during your first antenatal visit? Probe for: educational talks on various issues such as HIV, personal care during pregnancy, child growth monitoring
4. What are the challenges that young pregnant women in your community face in accessing antenatal services?
5. What would you say encourages/discourages young women from seeking antenatal service at this facility or any other facility in the area?

I would like to ask you some questions on your knowledge and experiences about family planning

6. Do young women in this community know what family planning is? Please explain.
7. Where do they learn about issues on family planning? Probe for sources such as mass media, parents, friends, teachers, religious leaders, health providers etc. What specific type of information do they get? What are the preferred sources of information on family planning among young women in this community? Why?

8. What type of contraceptives are available in this community? What type of contraceptives do most young women in this area prefer to use and why? Where do young women in this community get contraceptives e.g. condoms, pills, injectable contraceptives?
9. Do you think young women in this area are able to discuss family planning issues with their spouses/partners? Please explain.
10. What are the challenges that young women in this area face in accessing family planning services (i.e. contraceptive/condoms) in this area? Probe: services not available, family influence, peer pressure, distance to the facility, unfriendly staff, no supply of contraceptives/condoms
11. What would you say encourages/discourages young women from seeking family planning services at this facility or any other facility in the area? Probe: staff attitude, friendly staff etc.

I would like to ask you some questions on your knowledge and experiences about HIV

12. Do you think young women in this community know what HIV is and how it can be transmitted? What do they know? What are some of the religious and cultural beliefs around HIV in your community? Probe on: myths such as transmission by mosquito, can be healed by religious leaders etc.
13. Where do young women in your community get information on HIV from? Probe for sources such as mass media, parents, friends, teachers, religious leaders, health providers etc. What specific type of information do they get? What do you think are the preferred sources of information on these issues? Why?
14. What are some of reasons that young women in your community decide to go for HIV testing? Why do you think they don't go for HIV testing?
15. Were you tested for HIV during your antenatal visit? What was your experience? Probe for: counselling services offered before getting tested? Did you get the results immediately? Why or why not?
16. What are your experiences with the provision of HIV services with other services such as family planning, antenatal, postnatal during a visit to the facility? Is this type of service convenient for you? What are the good aspects/sides of this type of service provision? What are the challenges you face with this type of service provision? Probe for delay, convenient services, privacy, reduces frequency of visiting the facility, time consuming etc.
17. Did the services you received meet *all* your needs? If not, what was lacking? Probe: friendly staff/unfriendly, peer educators available, adolescent-friendly section available, judgmental staff
18. What would you say encourages/discourages young women from seeking HIV services at this facility or any other facility in the area?
19. What do you think about the location of the HIV services at this facility? Do you think the location guarantees the privacy of those seeking HIV services?

I would like to ask you some questions on your knowledge of HIV prevention methods

20. Are you aware of the ways in which you can prevent yourself from contracting HIV? Which methods are you aware of? Where do you get information on HIV prevention methods? Why is it important to prevent HIV infection?
21. Why do you think that some young women are not able to seek HIV services (HIV testing, counselling, treatment) from this facility or any other facility?

I would like to ask you questions about sexual gender based violence. Please note that you are free to not respond to some questions if you are not comfortable

Some women experience violence in their personal relations. Others are forced to have sex. This topic is not an easy one to talk about, but we need to discuss it with you so that we can help find a solution to this problem.

22. Do young women in your community know where to report cases of sexual violence? Where do they go? What type of support do they receive? Are you aware of any challenges that they face in reporting the cases and getting assistance?
23. Are you aware of the type of services that a survivor of sexual based violence can get from the health facility? What type of services can they get? Where do you get this information from?

Wrap up for discussion

24. Would you like more information on what we discussed today? What specific information would you like to know as young women on 1) family planning 2) antenatal care 3) postnatal care 4) sexual based gender violence 5) HIV services 6) any other related issues?
25. How would you like to learn about these topics? Who would you want to discuss them with?
26. What do you think needs to be done to improve service delivery for the adolescents and young women?

Thank you for sharing your thoughts and experiences.

## A2.5 PROTOCOLS FOR IN-DEPTH INTERVIEWS WITH ADOLESCENT (15–19) AND YOUNG MOTHERS (20–24) LIVING WITH HIV AND WITH POOR RECORD OF ADHERENCE TO ART

### *Introduction*

Greetings, self-introduction and affiliation

### *Purpose*

The purpose of this interview is to get your views on sexual reproductive health issues of adolescents/young mothers living with HIV. I am particularly interested in your experiences and recommendations so that we can help improve access and quality of sexual reproductive health services for the community. Please note that everything that we will discuss will be treated as confidential and you will remain anonymous. You can choose to answer any question and should you feel unable to proceed with the interview at any stage, please let me know and we will end the discussion.

If it is ok with you, I will record our interview to make sure that I accurately capture all that we shall discuss. Our session will last for about 30-45 minutes. Do I have your permission to proceed with the discussion?

### Background characteristics

Interview no. \_\_\_\_\_

Age \_\_\_\_\_

Place of residence (locality) \_\_\_\_\_

Marital Status \_\_\_\_\_

Living arrangement (who do you live with) \_\_\_\_\_

School attendance \_\_\_\_\_

Employment status \_\_\_\_\_

Membership to a support group \_\_\_\_\_

I would like to ask you some questions on your sexual reproductive (family planning, antenatal, postnatal) needs as a young person living with HIV.

1. When did you first visit the health facility when you realized that you were pregnant? Probe: first trimester (1-3 months), second trimester (4-6 months), third trimester (7-9 months)? If not until the 4th month or later, ask: Why were you not able to start antenatal care in the first trimester?
2. What was your experience at the facility during your first antenatal visit? What type of services were you offered during your first antenatal visit? Probe for: educational talks on various issues such as HIV, personal care during pregnancy, child growth monitoring
3. Did you receive any HIV services (HIV counselling and testing) during your antenatal visits? If the person received an HIV test, ask: Was this the first time you were doing the HIV test? How do you describe the HIV counselling and testing services you received? Did the staff explain what it means for you and your child? What specific information did you receive? Probe for prevent transmission of HIV to your child during pregnancy, correct feeding practice, care for the baby after delivery to prevent infection
4. Did you receive any medicine for you and your child to take after delivery? What did the staff say about the medicine for you and your child? Which staff (cadre) provided you with the information on the medicine? Do you have any concerns about the service that you received from the health facility?

5. Where do you get most of your information on HIV (e.g. ARVs, testing)?
6. How do you feel about disclosing your HIV status? Were you able to disclose your HIV status to your partner/spouse? Family? friends? What was your experience? How do you describe the support you receive from your spouse/partner in accessing HIV services for you and your child? How does that affect your access to HIV services for you and child?
7. We notice that you have not been coming to the health facility regularly, why is that so? What would enable you to go to the facility regularly? Is there anything specific at the facility level? Is there anything specific at community level?
8. What specific challenges do you face in taking ARVs every day?
9. What challenges do you face in giving medicines to your child? What challenges do you face in bringing your child for testing?
10. Do you belong to any support groups in the community? If not, ask: Why not? Probe for community volunteer, HIV support group. If yes, ask: What specific type of support do you receive from this or other community groups?
11. Are there any issues in the community that prevent you or encourage you to getting an HIV test or taking your ARVs? Are there any issues in the community that prevent you or encourage you from giving your child ARVs or bringing your child for an HIV test? Probe: for social stigma, community support through SMAGs, HIV groups
12. Do you plan to have more children? Are you aware of the precautions you need to take to avoid transmitting HIV from you to your child? Are you aware of methods to prevent unintended pregnancies? Probe for double protection using both condom and other contraceptive methods to prevent transmission of HIV and unintended pregnancy

Wrap up for interview

13. What other information would you like to know as a young person living with HIV on 1) family planning 2) antenatal care 3) postnatal care 4) HIV services 5) any other related issues?
14. How would you like to learn about these topics? Who would you want to discuss them with?

Ask the respondent if there is anything else she would like to add

Thank you for your time



## A2.6 PROTOCOLS FOR KII FOR HEALTH FACILITY IN-CHARGE/ADOLESCENT HEALTH FOCAL POINT

### *Introduction*

### *Greetings, self-introduction and affiliation*

### *Purpose*

The purpose of this interview is get your views on sexual reproductive health issues of adolescents and young mothers who are living with HIV and those who are HIV-free. I am particularly interested in your experiences and recommendations on how the access to and quality of sexual reproductive health services can be improved particularly for the adolescent girls and young mothers. Please note that everything that we will discuss will be treated as confidential and you will remain anonymous.

If you have no objection, I will record our interview to make sure that I accurately capture all that we shall discuss. Our session will last for about 30-45 minutes. Do I have your permission to proceed with the discussion?

### Background characteristics

Interview no. \_\_\_\_\_

Date of interview \_\_\_\_\_

Position of Interviewee \_\_\_\_\_

Gender \_\_\_\_\_

1. What are some of your responsibilities as the in-charge of this facility?
2. What kind of sexual reproductive health and HIV services are offered at this facility?
  - a) Family planning
  - b) Maternal and newborn care including antenatal care
  - c) STI prevention, treatment and care
  - d) HIV counselling and testing
  - e) ART and PMTCT services
  - f) Prevention and management of gender-based violence
  - g) SRH information and education
  - h) Community care and support programmes
  - i) Prevention of unsafe abortion and post-abortion care
  - j) Others specify
3. How does this facility offer SRH/ HIV/SGBV services to adolescents and young women?
  - a. How does your facility offer HIV and family planning? (E.g. offered on the same day, referred to a different service site within the facility etc.)
  - b. How does your facility offer HIV services (i.e. HIV testing, counselling, treatment) within prevention and management of STI services (e.g. offered on the same day, referred to a different service site within the facility etc.)
  - c. How does your facility offer HIV services (i.e. HIV testing, counselling, treatment) within maternal and newborn services (e.g. offered on the same day, referred to a different service site within the facility etc.)
  - d. How does your facility offer HIV services (i.e. HIV testing, counselling, treatment) management of sexual gender based violence (SGBV) (e.g. offered on the same day, referred to a different service site within the facility etc.)

4. What challenges does the facility face in providing integrated SRH/HIV/SGBV services to adolescents and young women?
5. In relation to the staff that provide adolescent SRH and HIV programmes, what are the biggest challenges? How are you coping with these challenges? Probe: Lack of training on adolescent health, quality of services? Retention?
6. To what extent does supervision for delivery of SRH and HIV support effective integration? Prompt: is there a tool/checklist for integrated supervision
7. Are all the staff at this facility trained on adolescent health standards and HIV and SRH peer education package? Why not? What challenges does the facility face in delivering sexual reproductive health services and HIV services to meet the needs of the adolescents and young women?
8. Does this facility have an adolescent-friendly section/space? (Ask to see) Is the adolescent-friendly section well equipped to meet the SRH and HIV counselling needs of the adolescents and young women? What are the gaps?
9. What needs to be done to improve service delivery for the adolescents and young women?
10. What approaches does the facility use to increase adolescent and young mothers' awareness of the availability of sexual reproductive health services and HIV services at this facility? How can these approaches be improved to make them more effective?
11. What clinical and non-clinical support/services are provided to victims of Sexual Based Gender Violence (SGBV)? Who provides these services? Does the facility provide both the clinical and non-clinical services on the same day of the client visit? Is there any special support provided to adolescents who are victims of SGBV? What challenges does the facility face in providing SGBV services to adolescents and young women?
12. Why do you think adolescents and young mothers may have challenges in adhering to ART? What is the experience at this clinic? What does the clinic do to address this?
13. From your experience, what beliefs and behaviours prevent adolescents and young mothers living with HIV to bring their HIV exposed or positive child for HIV services (testing and treatment)? Probe on:
  - a. Perceptions and belief i.e. religious and cultural
  - b. Education/Knowledge
  - c. Attitudes
  - d. Service related factors i.e. health worker treatment, attitudes
  - e. Stigma
14. What do you think are some of the ways to make SRH, HIV (testing, treatment) services more accessible to adolescent girls and young mothers and their HIV exposed/positive children?
15. From your experience, what type of questions are the adolescents and young women still asking that they need answers to on SRH/HIV (counselling, testing and treatment)? What do you think is the best way to communicate the responses to these questions to the adolescents and young mothers?

Probe for specific questions that adolescents and young mothers need answers to

Thank you for your time

## A2.7 PROTOCOLS FOR KII FOR DISTRICT ADOLESCENT HEALTH FOCAL POINT/MCH COORDINATOR

### *Introduction*

### *Greetings, self-introduction and affiliation*

### *Purpose*

The purpose of this interview is to get your views on sexual reproductive health issues of adolescents and young mothers who are living with HIV and those who are HIV-free. I am particularly interested in your experiences and recommendations on how the access to and quality of sexual reproductive health services can be improved particularly for the adolescent girls and young mothers. Please note that everything that we will discuss will be treated as confidential and you will remain anonymous.

If you have no objection, I will record our interview to make sure that I accurately capture all that we shall discuss. Our session will last for about 30-45 minutes. Do I have your permission to proceed with the discussion?

### Background characteristics

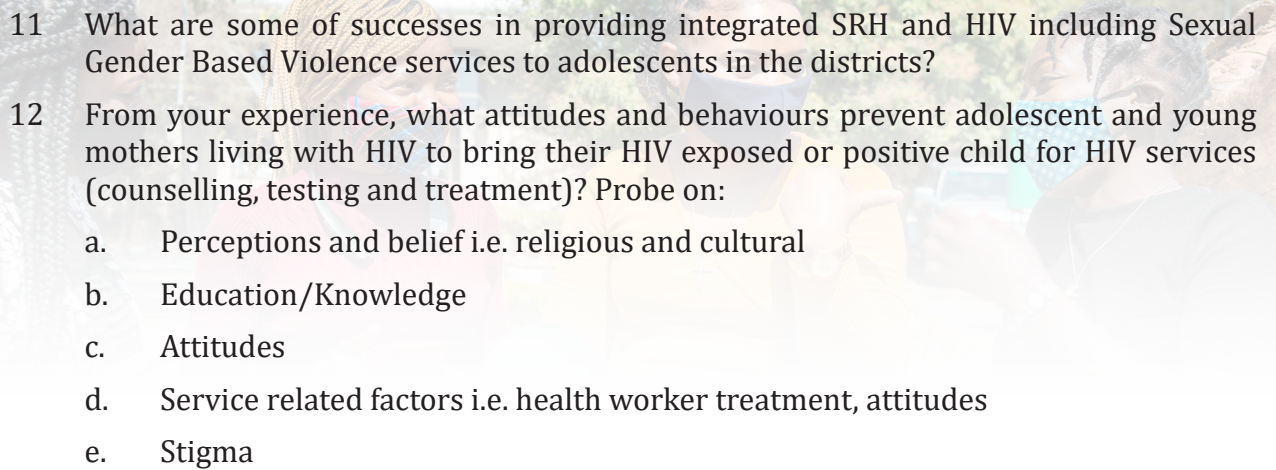
Interview no. \_\_\_\_\_

Date of interview \_\_\_\_\_

Position of Interviewee \_\_\_\_\_

Gender \_\_\_\_\_

- 1 What are some of your responsibilities?
- 2 Did you receive training as a trainer on adolescent health standards and on HIV (counselling, testing treatment) and Sexual Reproductive Health (SRH) peer education package? When did you receive this training?
- 3 What proportion of the facilities in this district have an adolescent-friendly section? Are all the staff at these facilities trained on adolescent health standards and HIV and SRH peer education package? Why not?
- 4 What challenges does the district face in rolling out adolescent-friendly sections to most facilities in the district?
- 5 Are the Youth Friendly Section/Spaces in the health facilities well equipped to meet the SRH and HIV counselling needs of the adolescents and young women? What are the gaps?
- 6 What are the common challenges that facilities in this district face in delivering sexual reproductive health services and HIV services to meet the needs of the adolescents and young women?
- 7 What do you think are some of the ways to make SRH, and HIV services more accessible to adolescent girls and young mothers?
- 8 What policy guidelines govern the provision of integrated SRH and HIV (counselling, testing and treatment) services to adolescents?
- 9 Are there any policy guidelines on integrated services for SRH and SGBV? To what extent are these being implemented? Are there supervisory tools/checklist to track the performance of integration of SRH and SGBV at the facility level?
- 10 What challenges do facilities in the district face in providing integrated SRH and HIV including Sexual Gender Based Violence services to adolescents?

- 
- 11 What are some of successes in providing integrated SRH and HIV including Sexual Gender Based Violence services to adolescents in the districts?
  - 12 From your experience, what attitudes and behaviours prevent adolescent and young mothers living with HIV to bring their HIV exposed or positive child for HIV services (counselling, testing and treatment)? Probe on:
    - a. Perceptions and belief i.e. religious and cultural
    - b. Education/Knowledge
    - c. Attitudes
    - d. Service related factors i.e. health worker treatment, attitudes
    - e. Stigma

Thank you for your time

## A2.8 PROTOCOLS FOR KII FOR PROVINCIAL HEALTH OFFICE - MATERNAL NEO-NATAL AND CHILD HEALTH COORDINATOR/ ADOLESCENT HEALTH COORDINATOR

### *Introduction*

#### *Greetings, self-introduction and affiliation*

#### *Purpose*

The purpose of this interview is get your views on sexual reproductive health issues of adolescents and young mothers who are living with HIV and those who are HIV-free. I am particularly interested in your experiences and recommendations on how the access to and quality of sexual reproductive health services can be improved particularly for the adolescent girls and young mothers. Please note that everything that we will discuss will be treated as confidential and you will remain anonymous.

If you have no objection, I will record our interview to make sure that I accurately capture all that we shall discuss. Our session will last for about 30-45 minutes. Do I have your permission to proceed with the discussion?

#### Background characteristics

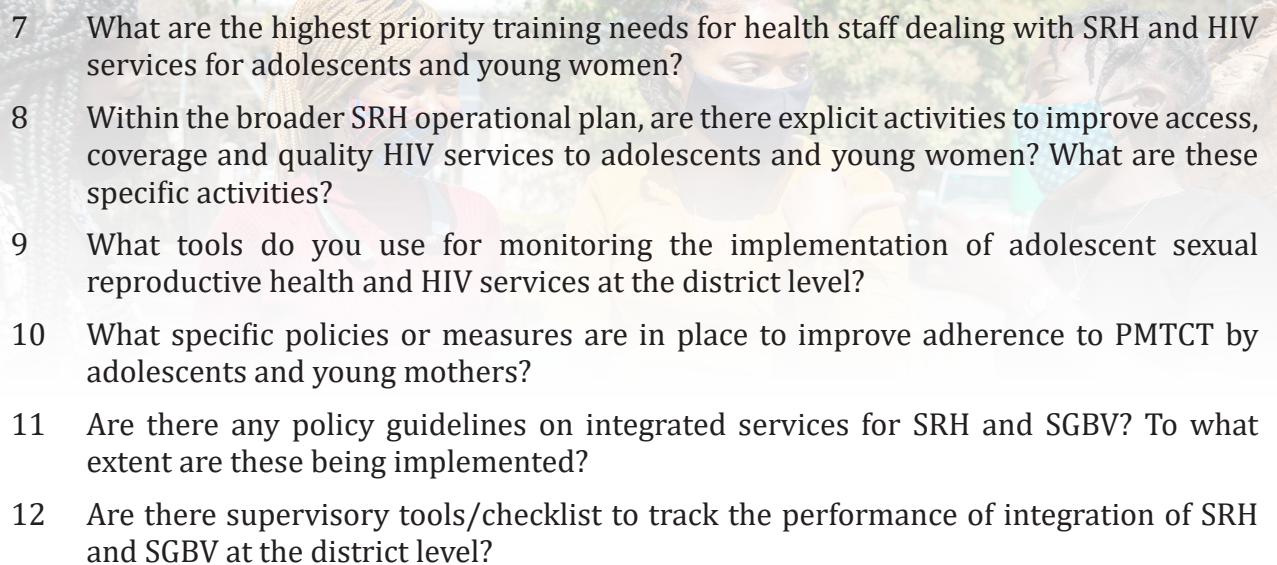
Interview no. \_\_\_\_\_

Date of interview \_\_\_\_\_

Position of Interviewee \_\_\_\_\_

Gender \_\_\_\_\_

- 1 Please tell me your position and what are some of your responsibilities?
- 2 Who are the main funders for the SRH (family planning, antenatal, post-natal) and HIV programmes in the province?
- 3 Are there any joint planning mechanisms for HIV and SRH at the provincial level? If yes, how is joint planning of SRH and HIV undertaken? Is there a collaboration between SRH and HIV programme management?
- 4 Are there any linkages between SRH and HIV in service delivery/implementation? If yes, could you please provide examples (Prompts: coordination of activities, monitoring activities, integrated supervision of activities, integrated budgets). What specific policy guidelines exist for service integration?
- 5 What do you believe are some of the most important policies and procedures in place that facilitate the strengthening of integration between SRH and HIV services?
- 6 What do you believe are some of the policies and procedures in place that serve as the most important challenges and constraints to strengthening integrated services between SRH and HIV? Probe for
  - a. Shortage of equipment
  - b. Shortage of space for offering private and confidential services
  - c. Shortage of staff time
  - d. Shortage of staff training
  - e. Inappropriate/insufficient staff supervision
  - f. Low staff motivation
  - g. Any other, specify

- 
- 7 What are the highest priority training needs for health staff dealing with SRH and HIV services for adolescents and young women?
  - 8 Within the broader SRH operational plan, are there explicit activities to improve access, coverage and quality HIV services to adolescents and young women? What are these specific activities?
  - 9 What tools do you use for monitoring the implementation of adolescent sexual reproductive health and HIV services at the district level?
  - 10 What specific policies or measures are in place to improve adherence to PMTCT by adolescents and young mothers?
  - 11 Are there any policy guidelines on integrated services for SRH and SGBV? To what extent are these being implemented?
  - 12 Are there supervisory tools/checklist to track the performance of integration of SRH and SGBV at the district level?

Thank you for your time

## A2.9 PROTOCOLS FOR KII FOR PEER EDUCATOR

### *Introduction*

### *Greetings, self-introduction and affiliation*

### *Purpose*

The purpose of this interview is to get your views on sexual reproductive health issues of adolescents and young mothers who are living with HIV and those who are HIV-free. I am particularly interested in your experiences and recommendations on how the access to and quality of sexual reproductive health services can be improved particularly for the adolescent girls and young mothers. Please note that everything that we will discuss will be treated as confidential and you will remain anonymous.

If you have no objection, I will record our interview to make sure that I accurately capture all that we shall discuss. Our session will last for about 30-45 minutes. Do I have your permission to proceed with the discussion?

### Background characteristics

Interview no. \_\_\_\_\_

Date of interview \_\_\_\_\_

Position of Interviewee \_\_\_\_\_

Gender \_\_\_\_\_

### Background characteristics

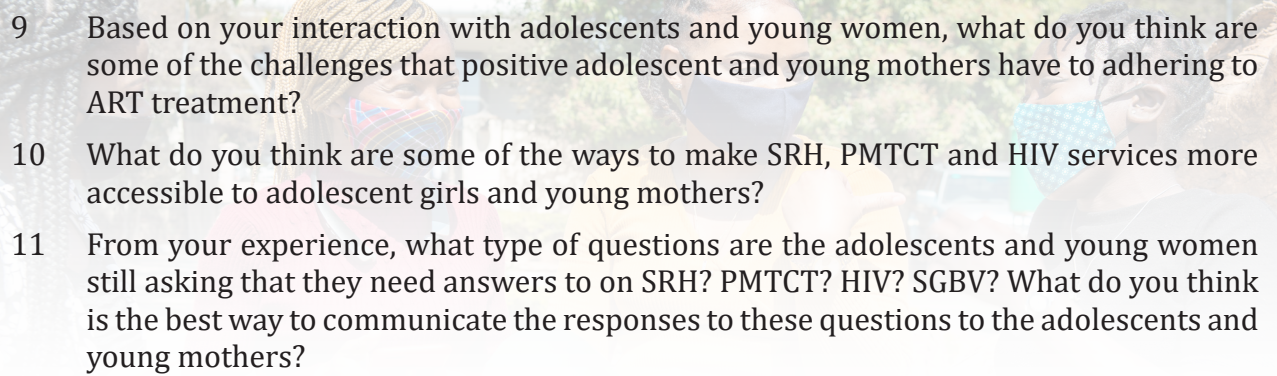
Interview no. \_\_\_\_\_

Date of interview \_\_\_\_\_

Position of Interviewee \_\_\_\_\_

Gender \_\_\_\_\_

- 1 What are some of your responsibilities?
- 2 Are you a trained peer educator? When were you trained and how long was the training?
- 3 Do you think the training equipped you to deliver sexual reproductive health (family planning, health education) and HIV services (HIV counselling and testing) to adolescents and young women? If not, what are the gaps you experience?
- 4 What kind of sexual reproductive health and HIV services do you offer at the adolescent-friendly section?
- 5 What is the average number of adolescents and young people that you see in a day/week?
- 6 Is the adolescent-friendly section able to meet the needs of the adolescents seeking SRH and HIV services? What are the challenges you face in providing services at the adolescent-friendly section? What needs to be improved for you to provide better services to the adolescents?
- 7 Does the adolescent-friendly section also provide any support to victims of Sexual Gender Based Violence? If yes, what type of support? What are the difficulties you face in providing this service to victims of SGBV?
- 8 What are the most common SRH and HIV services that adolescents seek from the adolescent-friendly space?

- 
- 9 Based on your interaction with adolescents and young women, what do you think are some of the challenges that positive adolescent and young mothers have to adhering to ART treatment?
  - 10 What do you think are some of the ways to make SRH, PMTCT and HIV services more accessible to adolescent girls and young mothers?
  - 11 From your experience, what type of questions are the adolescents and young women still asking that they need answers to on SRH? PMTCT? HIV? SGBV? What do you think is the best way to communicate the responses to these questions to the adolescents and young mothers?

Probe for specific questions that they need answers to

Thank you for your time



## A2.10 PROTOCOLS FOR KII FOR HIV SUPPORT GROUP LEADER/MEMBER

### *Introduction*

### *Greetings, self-introduction and affiliation*

### *Purpose*

The purpose of this interview is to get your views on sexual reproductive health issues of adolescents and young mothers who are living with HIV and those who are HIV-free. I am particularly interested in your experiences and recommendations on how the access to and quality of sexual reproductive health services can be improved particularly for the adolescent girls and young mothers. Please note that everything that we will discuss will be treated as confidential and you will remain anonymous.

If you have no objection, I will record our interview to make sure that I accurately capture all that we shall discuss. Our session will last for about 30-45 minutes. Do I have your permission to proceed with the discussion?

### Background characteristics

Interview no. \_\_\_\_\_

Date of interview \_\_\_\_\_

Position of Interviewee \_\_\_\_\_

Gender \_\_\_\_\_

### Background characteristics

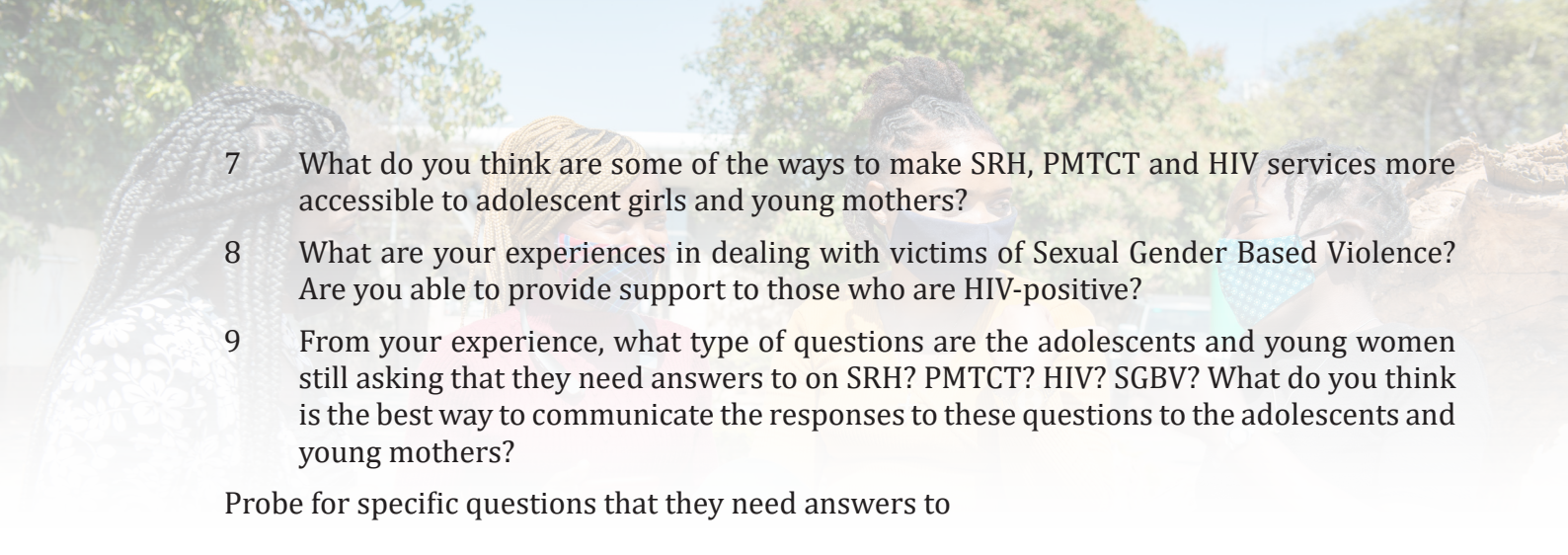
Interview no. \_\_\_\_\_

Date of interview \_\_\_\_\_

Position of Interviewee \_\_\_\_\_

Gender \_\_\_\_\_

- 1 What are your responsibilities in this group?
- 2 What type of support does your HIV support group provide to adolescents and young women living with HIV? What specific activities do the HIV support group members living with HIV engage in?
- 3 How effective is the support that you provide to the members? Could you please share some actual experiences of some adolescents that are part of this group? How has being part of this group helped to change and shape the lives of adolescents and young women's living with HIV?
- 4 How are members to the support recruited and retained? Does your group follow-up on adolescents and young women who have poor adherence to ART treatment and prophylaxis for their child? What have been your experiences in tracking down the non-adherent PMTCT adolescents and young women?
- 5 What are some of the challenges that the support group faces in dealing with SRH (family planning, antenatal care) and HIV treatment issues for adolescents and young women?
- 6 Based on your interaction with adolescents and young women, what do you think are some of the challenges that positive adolescent and young mothers have to adhering to ART treatment and PMTCT?

- 
- 7 What do you think are some of the ways to make SRH, PMTCT and HIV services more accessible to adolescent girls and young mothers?
  - 8 What are your experiences in dealing with victims of Sexual Gender Based Violence? Are you able to provide support to those who are HIV-positive?
  - 9 From your experience, what type of questions are the adolescents and young women still asking that they need answers to on SRH? PMTCT? HIV? SGBV? What do you think is the best way to communicate the responses to these questions to the adolescents and young mothers?

Probe for specific questions that they need answers to

Thank you for your time

## A2.11 PROTOCOLS FOR KII FOR COMMUNITY HEALTH ASSISTANT

### *Introduction*

### *Greetings, self-introduction and affiliation*

### *Purpose*

The purpose of this interview is to get your views on sexual reproductive health issues of adolescents and young mothers who are living with HIV and those who are HIV-free. I am particularly interested in your experiences and recommendations on how the access to and quality of sexual reproductive health services can be improved particularly for the adolescent girls and young mothers. Please note that everything that we will discuss will be treated as confidential and you will remain anonymous.

If you have no objection, I will record our interview to make sure that I accurately capture all that we shall discuss. Our session will last for about 30-45 minutes. Do I have your permission to proceed with the discussion?

### Background characteristics

Interview no. \_\_\_\_\_

Date of interview \_\_\_\_\_

Position of Interviewee \_\_\_\_\_

Gender \_\_\_\_\_

Background characteristics \_\_\_\_\_

Interview no. \_\_\_\_\_

Date of interview \_\_\_\_\_

Position of Interviewee \_\_\_\_\_

Gender \_\_\_\_\_

- 1 What are some of your responsibilities at this facility?
- 2 Do you participate in educating adolescents on HIV prevention methods and preventing unintended pregnancies, antenatal care, family planning, child growth monitoring?
- 3 Have you received any training on dealing with adolescent sexual reproductive health (antenatal, HIV testing and counselling, family planning)? When were you trained and how long was the training? Do you think the training equipped you well enough to deliver SRH and HIV services to adolescents and young women at this facility? If not, what are the gaps you experience?
- 4 One of the main deterrents in accessing SRH and HIV services at the health facility is stigma from the community. Are there activities that the facility organizes to sensitise the community on HIV? How often are these done? How effective are these approaches?
- 5 Based on your interaction with adolescents and young women, what do you think are some of the challenges that positive adolescent and young mothers have in adhering to ART treatment?
- 6 What do you think are some of the ways to make SRH, HIV services (HIV counselling, testing and treatment) more accessible to adolescent girls and young mothers?
- 7 From your experience, what type of questions are the adolescents and young women still asking that they need answers to on SRH? HIV (counselling, testing, treatment)? Sexual Gender Based Violence? What do you think is the best way to communicate the responses to these questions to the adolescents and young mothers?

Probe for specific questions that they need answers to

Thank you for your time

## A2.12 PROTOCOLS FOR KII FOR SAFE MOTHERHOOD ACTION GROUP LEADER/MEMBER

### *Introduction*

### *Greetings, self-introduction and affiliation*

### *Purpose*

The purpose of this interview is to get your views on sexual reproductive health issues of adolescents and young mothers who are living with HIV and those who are HIV-free. I am particularly interested in your experiences and recommendations on how the access to and quality of sexual reproductive health services can be improved particularly for the adolescent girls and young mothers. Please note that everything that we will discuss will be treated as confidential and you will remain anonymous.

If you have no objection, I will record our interview to make sure that I accurately capture all that we shall discuss. Our session will last for about 30-45 minutes. Do I have your permission to proceed with the discussion?

### Background characteristics

Interview no. \_\_\_\_\_

Date of interview \_\_\_\_\_

Position of Interviewee \_\_\_\_\_

Gender \_\_\_\_\_

### Background characteristics

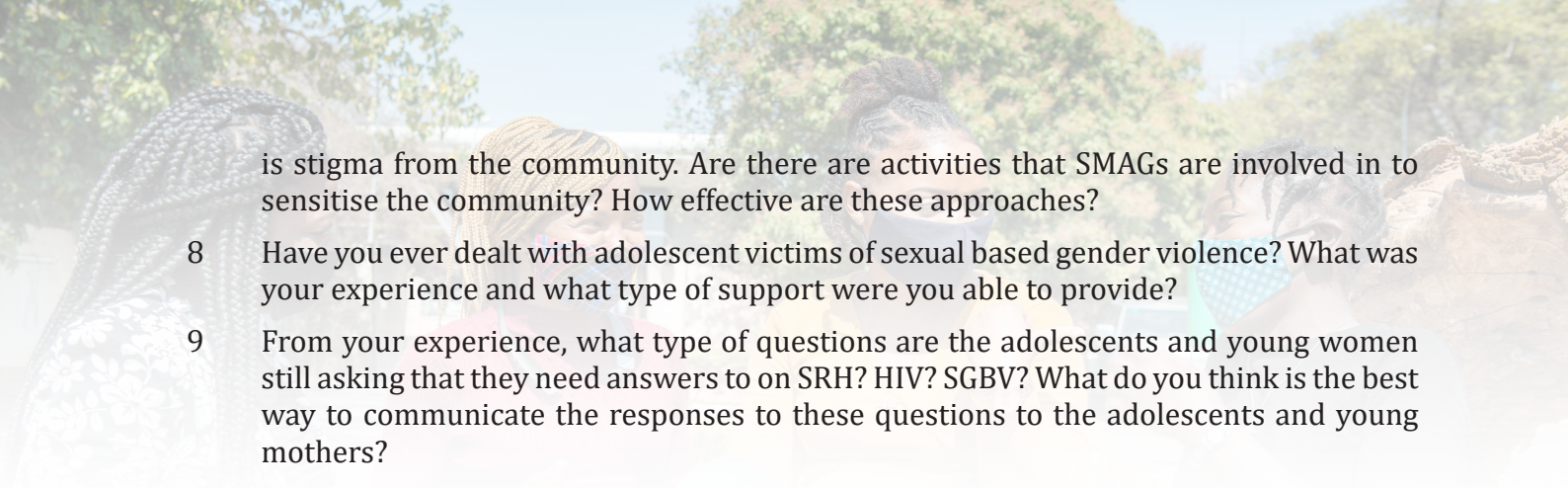
Interview no. \_\_\_\_\_

Date of interview \_\_\_\_\_

Position of Interviewee \_\_\_\_\_

Gender \_\_\_\_\_

- 1 What are some of your responsibilities?
- 2 As SMAG member, have you received training on how to deal with adolescents and young mothers on sexual reproductive health issues such as family planning, HIV testing and counselling, antenatal care? What specify training did you receive? Was it adequate to ensure that the services you provide meet the needs of the adolescents and young mothers?
- 3 Does the SMAG offer any special support towards adolescents for antenatal care and follow up?
- 4 Could you share some of the experiences you have had in dealing with adolescents who may delay in seeking antenatal care when they are pregnant? What challenges do you face in dealing with other SRH issues among the adolescents and young women?
- 5 Does your SMAG offer any support to adolescents and young women who are living with HIV? What type of support?
- 6 Do the SMAGs play any role in educating the adolescents on HIV prevention methods and preventing unintended pregnancies?
- 7 One of the main deterrents in accessing SRH and HIV services at the health facility



is stigma from the community. Are there are activities that SMAGs are involved in to sensitise the community? How effective are these approaches?

- 8 Have you ever dealt with adolescent victims of sexual based gender violence? What was your experience and what type of support were you able to provide?
- 9 From your experience, what type of questions are the adolescents and young women still asking that they need answers to on SRH? HIV? SGBV? What do you think is the best way to communicate the responses to these questions to the adolescents and young mothers?

Probe for specific questions that they need answers to

Thank you for your time



