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# FORMATIVE ASSESSMENT OF TEENAGE PREGNANCY IN ZAMBIAN PRIMARY SCHOOLS FINAL REPORT

May 2015



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# **FORMATIVE ASSESSMENT OF TEENAGE PREGNANCY IN ZAMBIAN PRIMARY SCHOOLS**

## **FINAL REPORT**

**May 2015**

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## ABBREVIATIONS AND ACRONYMS

AIDS	–	Acquired Immunodeficiency Syndrome
CREATE	–	Consortium for Educational Access, Transitions and Equity
CSE	–	Comprehensive Sexuality Education
CSO	–	Central Statistical Office
DEBS	–	District Education Board Secretary
G&C teacher	–	Guidance and Counseling teacher
HIV	–	Human Immunodeficiency Virus
IRB	–	Institutional Review Board
MCDMCH	–	Ministry of Community Development Mother and Child Health
MESVTEE	–	Ministry of Education, Science, Vocational Training, and Early Education
MOGE	–	Ministry of General Education
MOHE	–	Ministry of Higher Education
MOH	–	Ministry of Health
PTA	–	Parents Teacher Association
RTS	–	USAID Read to Succeed Program
SBS	–	Sexual Behavior Survey
SPRINT	–	School Program IN the Term
SRH	–	Sexual and Reproductive Health
STD/s	–	Sexually Transmitted Disease/s
STI/s	–	Sexually Transmitted Infection/s
UNESCO	–	United Nations Educational, Scientific and Cultural Organization
UNICEF	–	United Nations Children’s Fund
USAID	–	United States Agency for International Development
ZDHS	–	Zambian Demographic and Health Survey
ZSBS	–	Zambia Sexual Behavior Survey

## EXECUTIVE SUMMARY

The report set out to document the reasons why there is an increase of teenage pregnancies in Zambia, to identify causes and provide recommendation to reduce the prevalence as well as to enhance support services provided to school girl mothers during pregnancy and after returning to school. In keeping with the multiple spheres of influence on adolescent sexual behavior, a number of prevention interventions have been instituted in the schools, including school-based sex education, positive peer pressure programs (through Agents of Change), adolescent friendly clinics, as well as community led programs. While the focus of these interventions has primarily been on preventing HIV, they have also helped in providing information on and reducing teenage pregnancy because of their potential impact on sexual behaviors. To prevent pregnancy from being overshadowed by a focus on HIV, a deliberate focus on teenage pregnancy is recommended.

This research study examined the causes of teenage pregnancy in Zambian primary schools with a specific geographic focus on part of the USAID/Read to Succeed Project (RTS) target provinces; Eastern, Luapula, and North-Western Provinces. Perspectives were sought from learners, guidance and counseling (G&C) teachers, and parent teacher association (PTA) members in each participating school. Findings provide recommendations to the Ministry of Education, Science, Vocational Training, and Early Education (MESVTEE), schools, and development partners on how to better understand and prepare for curbing teenage pregnancy in Zambian primary schools. Specifically, the study examined the following specific objectives:

1. to establish the reasons why there is an increase of teenage pregnancies in Zambian primary schools;
2. to identify support services provided to schoolgirl mothers during pregnancy and after returning to school by the school (including staff members, students, and PTAs), health centers, and the community; and
3. to provide recommendations on ways that would assist in reducing teenage pregnancy among school-going children in Zambian primary schools.

The sample size included five female students from each participating school, designated G&C teachers and two members of the PTA, one male and one female representative.

### Summary of Findings

**i) Causes of Teenage Pregnancy:** Among key findings on the causes of teenage pregnancy were peer pressure, poverty and lack of parental support, specifically parents who do not discuss issues related to sexuality with their daughters.

The study findings reveal that most of the teenage pregnancies are unintended and that girls who get pregnant before 15 years are coerced by older males. Most of these sexual abuses that resulted in pregnancies were reported and they happened between the school and home. Power imbalances also play an important role in girls' ability to negotiate safe sex. In the context of high levels of sexual coercion, girls seldom have the power to negotiate sex or condom use in the relationship.

#### Causes of Teenage Pregnancies in Zambian Primary Schools

- ✓ Poverty;
- ✓ Negative peer pressure,
- ✓ Defilement
- ✓ Lack of parental guidance;
- ✓ Loss of cultural values
- ✓ Early Marriage: Girls are often seen as 'waiting mothers
- ✓ Traditional practices;
- ✓ Insufficient treatment of sexual education in primary curriculum;
- ✓ Experimenting with sex after an initiation ceremony;
- ✓ Lack of knowledge of and access to conventional methods of preventing pregnancies
- ✓ Increased migration attracted by mining and road

Almost 70% of the learners in this study cited poverty as one of the causes of teenage pregnancy. Poverty leaves girls susceptible to risky sexual practices, transactional and intergenerational sex and early/child marriages. In relation to this, respondents also feel that mining industry and road construction contributed to teenage pregnancy prevalence. Limited parental guidance on sexual matters with their children aggravated the problem. On the other hand, parents complain about the loss of cultural values among young girls and boys. For example, a parent from Mansa District said “We have noted moral decay among the young girls in recent years. Children no longer respect what the Bible teaches about respecting ones’ body and [they] are no longer listening to the elders. What they see from movies influences their behaviors”.

Moreover, low comprehensive knowledge on sexual and reproductive health (SRH), HIV, low contraceptive usage and poor access to SRH are found to be additional contributing factors to teenage pregnancy in almost all schools. More than 50% of the learners reported that some girls are heavily influenced by negative second-hand stories about methods of contraception from friends and the media. It was also interesting to note that there are still some misconceptions among some learners that using condoms can cause cancer. In summary, findings reveal that majority of the girls lack knowledge and access about pregnancy prevention. Some girls who are in need of contraceptives such as pills or condoms said that they were often too embarrassed or frightened to seek such information from either their guidance teachers, parents, or from health center workers.

**ii) Preferred Prevention Methods from Pregnancy and HIV:** The study findings reveal that the common form of contraception is abstinence. The use of pills or condom was the least preferred. The majority (80%) of teachers, and community members were of the view that distribution of condoms in schools as a prevention measure for teen pregnancy would instead encourage sexual activities among young students. Older respondents felt that education was a key way to help inform learners about prevention of unwanted pregnancy and new HIV infections. However, 42% of learners said condoms should be distributed in schools while 58% opposed it. This figure is significant and calls for considerable attention especially that almost half of the girls interviewed in the study demanded for condoms in schools.

**iii) Where do girls get information and support from?** Learners get to know about teenage pregnancies and HIV in a variety ways, including those which are not part of the formal curriculum. They see and hear from their friends who got pregnant and learn about the consequences. They see about HIV/AIDS when a community member in their villages suffer and die from the disease. In this study, schools and homes are found to be the common places and sources of information about HIV/AIDS and teenage pregnancies. Majority of teachers and a good number of students interviewed consider the school as the most common place and source of information on HIV/AIDS and unwanted pregnancies.

Schools and homes are found to be the main sources of information about HIV/AIDS and teenage pregnancy

Nine out of ten participating learners indicated that HIV and AIDS is discussed with them by their teachers at their schools. Additionally, community members also noted that the home is an important place to get information about HIV/AIDS and unwanted pregnancies. Respondents indicated that parents, Agents of Change, religious leaders, health workers, anti-AIDS clubs/associations, community members, community games, drama, friends, media (e.g., TV, radio, newspapers, etc.), and significant events and holidays (e.g., national independence day, World AIDS Day, youth day, etc.) are all ways in which information about HIV and other life skills is disseminated. “They learn by sharing with friends, peers, and church mates” (C28-35). They “learn through observing those tormented by HIV in the community” a male G&C teacher responded (GC 24-44).

Another male G&C teacher indicated that students learn through “discussions among themselves” and also “under the leadership of the school’s Agents of Change” (G&C 28-44). Most learners responded that they learn about HIV from other learners, friends, and peer educators (Agents of Change). “We learn from our parents and from each other” was a response from a learner (L014-33) and 12 others indicated that they learn about HIV through meetings and interactions with the “Agents of Change” at their school.

**iii) Guidance and Counseling Services at School:** G&C teachers provided mentorship to the “Agents of Change”<sup>1</sup> on a monthly basis and other services such as psychosocial support, counseling and referral services on a regular basis. Level of services provided showed mixed response. Results show that there was adequate support to learners by G&C teachers who were trained by RTS if they are still in their schools (if they have not been transferred). On the other hand, in schools with newly recruited and transferred G&C teachers, support was found to be less effective. When children are referred to G&C teachers due to an illness or any other problem, the most common action taken was to send the learner to a local health center or to send them home. G&C teachers rely heavily on external health professionals to help diagnose and treat ill learners. When asked what the common illnesses children suffer from at their schools, G&C teachers reported abdominal pains and frequent headaches.

**iv) Implication for future actions;** Schools need to provide learners with an effective CSE program and a protective and supportive environment. In addition, there is need for MESVTEE, the Ministry of Health (MOH), and the Ministry of Community Development Mother and Child Health (MCDMCH) to strengthen linkages and work together. Future interventions should be targeted on learners in the most-affected grades and provinces, including providing Comprehensive Sexuality Education (CSE). There is also a need to work with traditional leaders to address harmful cultural practices (especially on influencing initiation curricula) and support vulnerable girls with conditional cash transfers and practical financial or entrepreneurial skills to empower them to be economically self-sufficient and less susceptible to transactional sex or early marriages.

**Report Structure:** The first section of this report is about the preamble of the project context and snapshot about the importance of the study. Section two provides background information and summarizes the literature review relevant to teenage pregnancy. It summarizes literature that exist on the subject and relates it to sexual and reproductive health. The third section is about the purpose of the study and research questions. Section four outlines the study methodology while sections five and six are on study findings and conclusions respectively.

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<sup>1</sup> Agents of Change” are selected students trained by RTS to serve as volunteer facilitators of discussions in small groups on socially relevant life skills on a monthly basis. RTS trained 5 girls and 5 boys learners in each project beneficiary schools

## 1.0 INTRODUCTION

Read to Succeed (RTS) is a USAID-funded initiative that aims to improve school effectiveness in a way that schools provide the environment and services for students to acquire essential academic skills with particular focus on early grade reading. Accordingly, the main outcome of the project is improved student performance in reading. RTS works in eighteen (18) selected districts in six provinces: Eastern, Luapula, Muchinga, Northern, North-Western, and Western Provinces namely: Chipata and Lundazi in Eastern Province; Mansa, Mwense, Chembe and Chipili in Luapula Province; Chinsali, Isoka and Shiwang'andu in Muchinga Province; Mporokoso and Mungwi in Northern Province; Solwezi and Mufumbwe in North Western Province; and Mongu, Sesheke, Mwandu, Mulobezi and Limulunga in Western Province. RTS assists MESVTEE by strengthening the implementation, accountability, and institutionalization of these initiatives to create systemic changes and ensure the delivery of quality instruction leading to better reading skills and thereby better learner performance. Since RTS uses the whole school, whole teacher and whole child approach, learner support provision is regarded essential in its implementation.

One of the most pressing health, socioeconomic, and human rights issues that affects learners at primary and secondary levels is teenage pregnancy. It remains one of the top reasons that causes school dropout, especially among girls and young women (Grant and Hallman 2008; Basch 2011; Campero et al. 2014). Therefore, prevention of teenage pregnancies is an important issue for educators, parents of students, learners, researchers, and government policy makers.

Part of the key to successful teenage pregnancy programs in schools is ensuring there is a strong link between schools, communities, and families. Parents and community members need to get involved in their children's education, especially on topics of such importance as sexuality (Taylor et al. 2014). Parents, community members, teachers, and school administrators need to show an increased awareness and love for expectant mothers and those who have already given birth (Bhana et al. 2010). Males who engage in high-risk sexual behaviors and impregnate girls or young women should be held equally accountable for child bearing, but too often this is not the case (Sathiparsad 2010). Increasing female literacy rates is also a recognized and documented strategy in helping to curb teenage pregnancies in sub-Saharan Africa (Odejimi and Bellingham-Young 2014). It is essential to have support from multiple sources to provide learners with sufficient support and empowerment (Jewkes, Morrell, and Christofides 2009).

Effective government policies supporting a comprehensive STI prevention campaign that recognize cultural influences are important in establishing an enabling environment necessary for overcoming AIDS and helping to reduce teenage pregnancies (Odejimi and Bellingham-Young 2014). Such policies build upon national strategic framework and national policy documents that help guide government planners, educators at all levels, and other stakeholders in the national response to HIV and teenage pregnancies (Nsubuga and Jacob 2006; Osewe 2009).

Some of the most important policies that can help reduce and prevent teenage pregnancies include helping to ensure schools are safe havens for all learners, and especially for those who are pregnant or who have already given birth. The reality, however, is that often policies fall short from what is realized in practice (Ngabaza and Shefer 2013). Re-entry policies are essential to help ensure teenage mothers can re-enter schooling following birth.

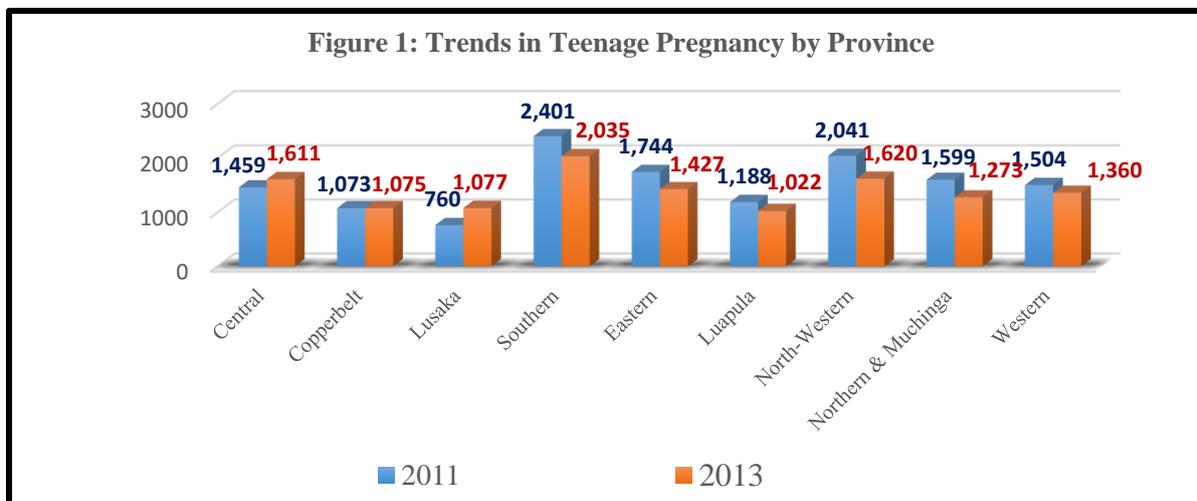
Elaine Unterhalter (2013) argues that it is necessary to ensure that young women who have concerns with the risk of pregnancy are often given adequate attention. This can hopefully help offset the negative stigma which prevent young women from participating in schooling opportunities.

To respond to some of the policy challenges highlighted above, the RTS research team designed the study on causes of teenage pregnancies in Zambian Primary Schools. Data was collected in June and July 2014 shortly after Institutional Review Board (IRB) approval. The study examined multiple issues related to the causes of teenage pregnancy, prevention strategies and practices, HIV and teenage pregnancy, awareness levels of key stakeholder groups regarding teenage pregnancies, guidance and counselling support, and support services available for schoolgirl mothers during pregnancy and afterwards.

## 2.0 BACKGROUND AND OVERVIEW OF TEENAGE PREGNANCIES IN ZAMBIA

Zambia has over the years recorded a high rate of fertility, at an average rate of 6.2 in 2007 (Central Statistics Office [CSO] 2007, p. 56). The 2013 Zambia Demographic Health Survey (ZDHS) reported a reduction in the total fertility rate to 5.3 (CSO 2014, p. 7). This means that, fertility is gradually declining in Zambia (6.5 births per woman in the 1992 ZDHS to 5.3 births per woman in the 2013-2014 ZDHS). It further means that, on average, a Zambian woman who is at the beginning of her childbearing years would give birth to 5.3 children by the end of her reproductive period if fertility levels remained constant at the level observed in the three-year period prior to the survey. Reproductive health challenges facing young people in Zambia include low use of contraception. MESVTEE policy does not allow distribution of condoms in lower institutions of learning, including Zambian primary schools. Sexual activity begins early and is often unprotected and is associated with risks such as HIV/AIDS, pregnancy, unsafe abortions, economic hardships, and school drop-out.

The country experienced an increase in the number of pregnancies among teenagers over the past decade. In 2002 for example, the country recorded 3,663 teenage pregnancies among school-going teenagers at primary and secondary school levels; in 2004, the number doubled to 6,528; in 2007 the figure rose further to 11,391 and to 13,634 in 2009. In 2013, MESVTEE (2013, p. 43) reported 14,922 cases of teenage pregnancy. As per the graph below, it would seem like the teenage pregnancy incidences went down in all provinces except Central and Lusaka Provinces. Figure 1<sup>2</sup> has more details.



<sup>2</sup> Sources: MESVTEE (2011; 2013).

It should be noted, however, that a slight reduction was recorded at the primary school level from 13,929 pregnancies in 2011 to 12,753 pregnancies in 2012 (MESVTEE 2013, p. 43). A further reduction was also reported in 2013 to 12,500 representing reductions of 8.4% and 2.0% in 2012 and 2013 respectively.

In 2012, Restless Development Zambia conducted a study and found that discussion of subjects such as SRH and HIV are still regarded as inappropriate by some stakeholders in the country, particularly among those who reside in rural communities. It is for this reason that some young people in Zambia do not get appropriate guidance on how to avoid pregnancies. In terms of adolescent health, teenage pregnancy is associated with higher morbidity and mortality for both the mother and child and also has potential adverse social consequences. According to the 2007 ZDHS, girls have earlier sex debuts than boys and they are less likely to use condoms which predisposes them to higher risk.

Due to easy access, SRH services are better delivered in urban areas than in rural areas. This problem is further compounded by the fact that the capacity to provide these services on a sustainable basis is low, especially in rural areas that make up 60.5% of Zambia's population (Kapungwe 2003). This leads to an increased risk of young people in rural communities not accessing relevant information regarding their SRH. Surveys conducted in recent years within Zambia suggests that youths are becoming sexually active at a young age, a risk factor for sexually transmitted infections (STIs) including HIV, reproductive health complications, and a lack of girl child retention in school (CSO 2008).

The Zambia Sexual Behavior Survey (ZSBS) of 2009 revealed that the median age at first penetrative sex among young people aged 15-24 was 17.5 years for female respondents and 19.5 years for males, an increase since 2000 of two years among males and one year among females. Among respondents aged 20-24, 86% have had sex, a decline of about 5% since 2000 before age 15 (CSO, 2009). This survey is consistent with the findings in the 2003 ZSBS which reported that 14% of female respondents and 16% of male respondents between ages 15-24 had sex before age 15. The proportion of young people engaging in sex with a non-regular partner has also increased, while condom use during sex with a non-regular partner has decreased. A substantially larger proportion of young men aged 15-24 reported sex with a non-regular partner than did their female counterparts (72% males compared to 28% females) (CSO 2009). This literature indicate increased sexual activities which entail higher risks for younger people.

The dropout rate for girls due to pregnancy has however not matched by re-admissions, especially in primary schools, where there are higher numbers of teenage pregnancy dropouts than in secondary school (or high schools. The Ministry of Education *Statistical Bulletin* reports that from 2002 to 2009, the readmission rate remained low at an average of 38%. This means that 62% of the girls who dropped out of school as a result of pregnancy were not readmitted into schools during this period.

### 3.0 PURPOSE OF THE STUDY

This study sought to document factors associated with rising teenage pregnancies in Zambia. It was guided by the following specific

1. Establish the reasons why there is an increase of teenage pregnancies in Zambia;
2. Identify support services provided to schoolgirl mothers during pregnancy and after returning to school by the school, health centers, and the community; and
3. Make recommendations on ways that would assist in reducing teenage pregnancy among school-going children in Zambian primary schools.

#### Key Research Questions

Even though several questions were asked in the respective respondent questionnaires, the following were the key research questions:

1. What are the key drivers of pregnancies among teenagers in Zambian primary schools?
2. What kind of support exists in primary schools for teenagers that fall pregnant?
3. To what extent are learners, teachers and community members aware of the relationship between teenage pregnancy and HIV/AIDS?
4. What policies guide implementation of sexual and reproductive health activities in primary schools?

### 4.0 METHODOLOGY

This study design is a combination of both quantitative and qualitative methods. Secondary data was used from the Ministry of Education's Annual Statistical Bulletin, and the Central Statistical Office. Data from learners were collected using a structured quantitative questionnaire which was administered by a trained researcher. In the case of G&C teachers and members of the community, researchers facilitated a focus group discussion where both groups participated in one sitting. Responses from focus group discussions were recorded in qualitative form.

#### 4.1 Sample Design

A total of 54 primary schools in Eastern, Luapula and North Western Provinces of Zambia participated in this study. To select the provinces, the following criteria was considered following a trend analysis from 2009 to 2012:

1. Province with highest nominal figures: **North-Western**
2. Province with lowest nominal figures: **Luapula**
3. Province with lowest proportion (i.e. pregnancies/enrolment): **Eastern**

Primary schools were randomly selected from a list of all Zambia primary schools. The school selection was stratified by (a) geographic region, and (b) urbanicity (*urban*, *rural*, and *remote*) (see Table 1). The reason for classifying school in the three categories was to identify different

**Table 1: Number of sample primary schools by province/districts**

Province	District	# of schools
Eastern	Chipata	3 Urban, 3 Rural, 2 Remote
	Lundazi	3 Urban, 3 Rural, 2 Remote
Luapula	Mansa	3 Urban, 3 Rural, 2 Remote
	Mwense	6 Rural, 2 Remote
Northwestern	Mufumbwe	6 Rural, 2 Remote
	Solwezi	3 Urban, 3 Rural, 2 Remote

salient issues that may be contributing to rising number of pregnancies. These are standard classifications used by Ministry of Education, Science, Vocational Training and Early Education (MESVTEE) as per Circular No. B.7 of 2010. The implication is that depending on where the school is located, it is likely to have or not have access to adequate support from MESVTEE. In addition, the location of a school (urban, rural or remote) may explain factors that are contributing to teenage pregnancies. For example, schools in urban areas have more access to SRH information leading to lower numbers of pregnancies and vice versa. It was therefore important to disaggregate data by this criteria.

## 4.2 Participant Groups

Once primary schools were selected, contact was made initially with the District Education Board Secretary (DEBS). We then obtained consent from each head teacher before we approached the three groups of participants in each school: learners, guidance and counselling (G&C) teachers, and PTA members. We sampled five female learners from each participating school (n=239 total learner participants, 88.5% response rate). Designated G&C teachers (n=48, 88.9% response rate) were also interviewed as were two members of the PTA, one male and one female representative (n=95, 88.0 response rate) (see Table 2).

**Table 2. Descriptive Statistics of Participant Groups**

	Learners		G&C Teachers		PTA Members	
	N=239	Percent	N=48	Percent	N=95	Percent
<b>Gender</b>						
Female	239	100.00	18	37.5	52	54.7
Male	0	0.00	30	62.5	43	45.3
<b>Geographic Region</b>						
Eastern, Chipata	40	16.67	8	16.67	16	16.84
Eastern, Lundazi	34	14.58	7	14.58	16	16.84
Luapula, Mansa	40	16.67	8	16.67	15	15.79
Luapula, Mwense	45	18.75	9	18.75	16	16.84
North-Western, Mufumbwe	40	16.67	8	16.67	16	16.84
North-Western, Solwezi	40	16.67	8	16.67	16	16.84
<b>Urbanicity</b>						
Urban	60	25.10	12	25.00	24	25.26
Rural	120	50.21	24	50.00	46	48.42
Remote	59	24.69	12	25.00	25	26.32

### **4.3 Instruments**

The semi-structured questionnaires were designed to examine issues related to teenage pregnancy in Zambian primary schools. The instruments were designed in an effort to collect both quantitative and qualitative data from the participants in this study. The questionnaires were reviewed by content area experts for accuracy of the items and relevancy to the Zambian context. The instruments were then pre-tested in the field at multiple primary schools not included in our sample. Following this pilot study, minor revisions were made to the instruments under the direction of the RTS Project. All instruments were administered by trained members of the research team. See Appendix 1 for details.

### **4.4 Ethics Committee/Institutional Review Board (IRB) and Approval**

This study received permission from a national recognized (ERES Converge IRB) and the University of Pittsburgh IRB. Each member of the research team were trained to meet the highest ethical standards of data collection and analysis throughout the duration of this study.

### **4.5 Data Analysis**

Data analysis included both quantitative and qualitative methods. Participant groups were evaluated and compared with each other to shed light on the current status of teenage pregnancy in Zambian primary schools. Analysis occurred after questionnaires are completed with participant groups. Quantitative data were analyzed using SPSS statistical analysis software; transcriptions of the digitally-recorded oral interviews with participants were analyzed using NVivo and SPSS statistical analysis software.

### **4.6 Limitation of the Study**

The study results are limited to three provinces and six districts in Eastern, Luapula and North Western Provinces only. Hence, findings may not be generalized for national coverage. The study is also limited to the Read to Succeed Project beneficiary schools where Guidance and Counseling (G&C) teachers received training and on-going support and where selected learners served as Agents of Change. It is suggested that the same study be conducted in other provinces covering non-RTS schools in order to expand coverage. The design of this study focused on girls and did not included boys. It is suggested that future studies should benefit from the views of boys on causes and remedies of teenage pregnancies.

## 5.0 FINDINGS

This section provides findings from the sample schools in the three provinces in which the study was conducted. It presents data on key aspects of the study including: causes of teenage pregnancy; prevention of teen pregnancy and HIV and levels of awareness regarding teenage pregnancy; guidance and counseling support in place; and other support services available for schoolgirl mothers during pregnancy and afterwards.

### 5.1 Causes of Teenage Pregnancy

Findings indicate that study respondents still think teenage pregnancies are on the increase despite slight reductions of official statistics as presented in Figure 1. Almost three quarters (n=178, 74.5%) of the learners interviewed from sample schools in the Eastern, Luapula, and Northern provinces reported that teen pregnancy is on the increase compared to previous years. Only 22.6% of the respondents reported a reduction and a marginal 2.9% reported that there was no change. Responses from G&C teachers and community members confirmed the findings from learners.

When the same question was raised to the G&C teachers, nearly all (n=47, 97.9% indicated that it had increased and only 1 (2.1%) reported it had reduced. Similarly, of the 95 community members interviewed, 63.2% reported an increase. The reader is guided that statistics presented in this report show respondents' perceptions rather than actual realities on the ground. As noted in the 2013 MESVTEE Statistical Bulletin, the number of pregnancies in the country marginally reduced from 12753 in 2012 to 12500 in 2013. The incongruence between respondents' perceptions and facts on the ground was paradoxical and is not explained in this report because it is beyond the scope of this study. However, it is worth noting that perceptions may not always be representative of the truth.

The summary of the responses from learners and guidance and counseling teachers on the causes of teen pregnancies include poverty, negative peer pressure, lack of parental guidance, and traditional practices. Other responses include: experimenting with sex after an initiation ceremony, a desire to have their own baby, defilement resulting in an unintended and unwanted pregnancy, and long distance to school. Defilement mostly occurs in the wider community not necessarily in the school environment. Because defilement most often occurs outside of school premises, it is not perceived as a major school responsibility for teachers to address. Apart from reporting the matter to classroom teachers and G&C teachers little is done to address the matter.

Responses from community members are consistent with those responses from learners and teachers. They linked the increased teen pregnancy to high poverty levels, low-value placed on education by girls, and a general lack of positive role models. Community members are also concerned in Mansa District reported the following: "We have noted moral decay among the young girls in recent years. Children no longer respect what the Bible teaches about respecting ones' body and [they] are no longer listening to the elders. What they see from films influences their behaviors" (C54-FN and C58-FN).

In another focus group discussion in Lundazi District, community members reported the following:

*"Here at our school, most of the teachers are male. Therefore girls don't have role models to look up to. Our children have not travelled outside Lundazi, therefore they are not exposed to see the other side of the country. They and [some of our fellow parents] believe that when a girl reaches puberty, she must be married off."*  
(C23-FN and C24-FN)

G&C teachers also attributed increased teenage pregnancy to the lack of parental guidance, which often leads to young girls engaging in immoral activities. Community members attributed the increase to the lack of education on the dangers and consequences of premarital sex in schools.

One teacher in Chipata District reported the following: “Peer pressure is a major cause of premarital sex among teenagers in our school. Most of the schoolgirl mothers are pressurized by friends to engage into sex before the right time” (GC06-FN). Another teacher in Mansa District said:

*“Parents sometimes provide false information about sex to discourage their children from participating in it, such as pregnancy comes after shaking hands with a man. Often girls have so many demands which cannot be met by their guardians and this leads them to go into relationships with older men who give them money in exchange for sex”. (GC07-FN)*

Some parents also believe that the school curriculum is a factor. Community members in Lundazi reported the following, “While young girls are taught morals at home, schools use a curriculum that is not in line with our traditional teachings. Some of the things our girls learn from school make them arrogant and consequently become pregnant” (C96-FN).

Mining industry and road construction have also been mentioned as contributing factors. Almost half (n=17, 43.2%) learners from in Solwezi District reported that most of the girls who got pregnant from their school were impregnated by migrant mine workers. This was supported by views of community members who indicated that the mines in North-Western Province have led to the diminishing of their culture thereby contributing to the increased number of teen pregnancies. Views of learners in Mansa District indicated that most girls were going out with road construction workers whom they perceived to have money in exchange for sex. Some girls cited coercion or forced sex by elderly men and the long distance to school as the primary reasons for increased teen pregnancy. Lack of sensitization on the dangers of teen pregnancy and the importance of education were identified by learners and community members from the three sampled provinces. Another major cause of teenage pregnancies cited by majority of the learners from all provinces was early marriage. Lundazi in Eastern and Mwense in Luapula provinces had the highest number of reported cases of early marriages. G&C teachers attributed the increased number of teen pregnancies to peer pressure and poverty in the target schools.

Table 3 shows the responses of learners, G&C teachers, and community members to the reasons why teen pregnancy has increased in the target schools.

**Table 3.** Causes of Teenage Pregnancy

Participant Group Name	N	Poverty		Peer Pressure		Parental Neglect		Traditional Ceremonies & Traditional Values		Other	
		n	%	n	%	n	%	n	%	n	%
		Learners	239	150	62.7	60	25.2	16	6.7	10	4.2
G&C Teachers	48	10	20.8	30	62.5	6	12.5	2	4.2	0	0.0
Community Members	95	70	73.6	20	21.1	2	2.1	2	2.1	1	1.1

Table 3 shows that 62.7% of the participating learners reported poverty as the primary reason for the increases in teen pregnancies. These responses somewhat differ from those given by G&C teachers, where 62.5% of the respondents cited peer pressure as the main reason for teen pregnancies increases. Generally, G&C teachers seemed to be aware of many of the issues that cause teenage pregnancy among

female students in their schools and in their communities. One male G&C teacher from Mwenze District stated that “Communities do not appreciate the important role schools play [in educating students about teenage pregnancy]. Girls are often seen as ‘waiting mothers.’ Poverty is high and [there is often] no money for school so they drop out to get married and have children. These are very traditional norms” (GC01-25). Another common response given by G&C teachers was lack of positive role models (from their parents and from the community in general). “There exists parental negligence or inadequate supervision from home” (GC14-25).

A few responses included the additional challenge of girls and young women who are members of child-headed households, where perhaps one or both parents have died from AIDS, “poverty combined with child-headed homes often leads to the need to turn to sex for economic survival” (GC21-25). Community members agree to the responses of learners. Almost three quarters (73.6%) of the community member respondents cited poverty as the main reason why teen pregnancies have increased. Results of this study are similar to the findings of the study conducted by Restless Development (2012) in the Central Province, which revealed that poverty and peer pressure were the main reasons for the increasing trend in teenage pregnancy.

While the re-entry policy is a good policy that provides a chance for girls to complete their education after falling pregnant, some community members from the Eastern and North-Western provinces indicated that the policy encourages teen pregnancy as girls no longer fear losing their school places. Community members further reported that girls no longer fear to temporarily dropout due to pregnancy because of the policy which allows them to return to school. However, a G&C teachers indicated that the policy did not contribute to teen pregnancy; “if it did, more girls would have returned to school after giving birth” (GC40-FN). They also said there was ambiguity in terms of how many times a girl can fall pregnant and be allowed to return to school.

When asked to state reasons why some teenagers want to have babies, almost half (n=118, 49.4%) of the learner participants reported that some girls are envious of friends who have babies. The vast majority (n=198, 82.8%) of learners responded that most of the girls were not interested in having babies but were “merely experimenting” (L061-20) or simply want “to taste having sex” (L006-18) based on what they hear from friends and ended up getting pregnant. The response given points to the fact that girls who become pregnant lack general information on sexual reproductive health and prevention of teen pregnancy.

The study findings reveal that in order to protect a close relationship with their mothers, a culture of silence was maintained about sexuality even though there were clear signs that their daughters were sexually active. A learner from one of the districts in North Western Province commenting on teenage pregnancies, also noted the culture of silence around teenage fertility contributes to teenage pregnancies because the reality is girls are sexually active and that is why they fall pregnant.

Several community respondents also warned about the potential dangers of media, internet, and negative peer influence.

Some statements by community members include:

- ✓ Have teenagers stop watching bad movies and pornographic materials. Peers often share information to fellow peers on sex education, and these can lead to negative results including to teenage pregnancy. (C93-22)
- ✓ First the child that is spreading teenage pregnancy awareness must be living as an [positive] example. She must not be found in bad company and must be morally right. (C34-22)
- ✓ Children get things from their peers more than their parents. (C59-22)
- ✓ The number is increasing for teenage pregnancy due to poverty and drunkenness. (C27-21)
- ✓ We had a lot of girls in our areas Mpanga and Kabanse (these are fictitious names to protect the identity of the girls) only two girls have remained in school. (C37-21)
  - We have many [more] people now than before and increased poverty, no fish, and no money. (C58-21)
- ✓ The re-entry policy is encouraging the teenage pregnancy rate to rise. Poverty and the need for money for survival and no proper care from parents. (C68-21)
- ✓ Sexual intercourse among young teenagers is common knowledge “So many [female] children here have known men at a young age. Many children at the age of 12 are doing it” (C63-21)

## 5.2 Prevention of Teenage Pregnancy

More than three quarters of learners (n=183, 76.6%) reported that they have sexuality education in school. The majority of G&C teachers (87.5%) reported that they offer sexuality education. The topics covered in the sexuality education curriculum include delayed sexual debut, HIV and AIDS, reproductive health, dangers of early pregnancy, how to abstain from sex, gender, and handling of peer pressure.

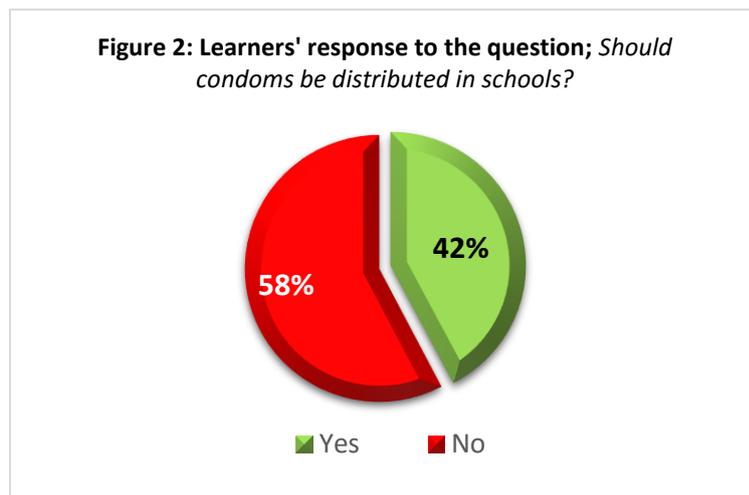
About half of learners (51.1%) indicated that the CSE material content is adequate. According to the learners, topics covered in their CSE training include: abstinence from sex, HIV/AIDS, life skills, delayed sexual debut, reproductive health; the dangers of early pregnancy, early marriages, sex and gender, and peer pressure. The majority of them indicated that topics such as HIV/AIDS take a bigger share of their training than those related to the prevention of teenage pregnancy. On the other hand, there were a good number of students who felt that the CSE material insufficient. This view is for example cited by a learner in Lundazi District who said, “the content of the curriculum is not enough as you know more girls are still engaging in sexual activities” (L076-FN), while another girl stated that “lessons are not enough, more topics should be taught to help girls understand how they can prevent themselves from getting pregnant” (L079-FN).

When G&C teachers were asked if sexuality education is taught in their schools, the vast majority (87.5%) reported affirmatively. Roughly two-thirds of community member respondents (68.4%) reported that they were aware that sexuality education was taught in the school.

On whether the topics covered were sufficient, G&C teachers (n=19, 39.6%) indicated that they were sufficient and 47.9% reported that they were not. This is consistent with the responses from community members and learners. On a more positive note, several learners reported that the topics cover survival skills, teach them consequences of early pregnancy, help them to stay away from boys, help them learn the body system, and how to react to any provocation.

When asked what teenage pregnancy prevention strategies were advocated in school and at the community level, the majority of the community members (89.5%) identified abstinence followed by being faithful (27.4%) and condom use (17.9%) and other birth control methods such as use of pills (15.8%). Similarly the majority of G&C teachers interviewed indicated abstinence as the best option.

In response to whether schools should offer contraceptives pills, only 38.3% of the G&C teachers responded in support while the majority were against it. The communities and learner respondents feel the same way as teachers on the use of pills. The majority community members (69.5%) strongly opposed to the use of contraceptives. Similarly, more than half of the learners (63.6%) reported that contraceptives should not be provided because by doing so girls may be more promiscuous. Learners reported that they do not use contraceptives because they fear that their mothers will discover that they are sexually active.



When asked if condoms should be distributed in schools for those who are sexually active, a good number of learners (42%) indicated that condoms should be distributed. However, the majority (58%) responded negatively. Forty-two percent of the learners in the study indicated that using condoms is a sign of not trusting one's partner. Majority (69.5%) of community members also don't agree with distribution of condoms. Myths that

condoms cause diseases were highlighted by several participants from the community member and learner groups. These findings resonates with earlier studies conducted in Zambia which revealed that myths about sex, and abortion still exist and awareness of the full range of contraception is low (Mwansa 2011; Kabaso 2012).

Positive, open, and frequent family communication about sex is linked to postponement of sexual activity, increased contraceptive use, and fewer sexual partners. Similarly, parent-child communication is vital for the prevention and reduction of teenage pregnancy. Learners feel that it is easier for girls to avoid teen pregnancy if they are able to have more open and honest conversations about these topics with their parents indicating that in most cases parents are not open to discuss issues related to sex.

Even though 79% of learners regard parents as a trusted source of information about teenage pregnancy, even more so than friends, only 4% of learner respondents reported learning most about prevention of teenage pregnancy from their parents. The study findings reveal that learners have poor communication with their parents about sexual matters, as was reported by one learner in Mansa District: "parents refuse to engage in conversations about sex, provide only vague indications rather than direct and correct information, and may even punish children for bringing up the topic" (L094-FN). On the contrary, the vast majority of participating community members (n=89, 93.7%) indicated they share information on HIV/AIDS and/or pregnancy with their children at home. Among the most common responses was teaching their children about abstinence and prevention of STIs (including HIV).

A female community leader from Mansa District mentioned “I explain to my children how HIV and AIDS is acquired and how to prevent it. I also talk with them about unwanted pregnancies” (C36-33). Another male community leader from Mufumbwe District indicated how they teach their children “the history of family members who have died of AIDS” and how to prevent the transmission of HIV and early pregnancies (C77-33). These could be good examples, but the general feeling with learners is that parents’ guidance is limited.

Power imbalances also play an important role in girls’ ability to negotiate safe sex. Interviews with learners reveal that most girls fail to negotiate for safe sex for fear that their boyfriends would stop loving them. Despite the increasing availability of condoms at clinics and hospitals, the negative attitude of some health center staff makes it difficult for learners to access them. This was highlighted by a learner in Mansa District: “I would rather send my elder sister to buy condoms for me than go to the youth friendly corner at the hospital because of the attitude of those nurses found there. They are really aggressive. They make you feel bad for asking for a condom” (L093-FN).

### 5.3 HIV/AIDS and Teenage Pregnancy

As it has been noted earlier, abstinence was by far the most common response on what can students do to prevent themselves from contracting HIV and getting pregnant early. Respondents felt that education was a key way to help inform learners prevent themselves and stay safe. For those who are unable to abstain from engaging in sexual relationships, condom use was suggested to prevent HIV/AIDS and early pregnancy. In summary, the following were recommended to avoid new HIV infections and unwanted pregnancy; “Abstinence, avoiding promiscuous behaviors, use condoms if needed, and go for male circumcision”

The authors wanted to better understand from participants where they felt the most appropriate location was for students to learn about STIs (including HIV). Of all 382 respondents, 70.4% felt the school is the most appropriate location, with the home coming in second at 17.3% of all responses (see Table 4).

**Table 4.** Most Appropriate Location for Students to Learn about STIs (including HIV)

Participant Group Name	N	Home		School		Religious Setting		Other	
		n	%	n	%	n	%	n	%
Learners	239	24	10.0	185	77.4	13	5.4	17	7.1
G&C Teachers	48	10	20.8	32	66.7	4	8.3	2	4.2
Community Members	95*	32	33.7	52	54.7	11	11.6	3	3.2

\* Three community leaders indicated two most appropriate locations for students to learn about STIs.

### 5.4 Level of Awareness Regarding Teenage Pregnancy and HIV/AIDS

Students learn about pregnancy and HIV in a variety ways, including many which are not part of the formal curriculum. Community leaders indicated that parents, Agents of Change, religious leaders, health workers, anti-AIDS clubs/associations, community members, community games, drama, friends, media (e.g., TV, radio, newspapers, etc.), and significant events and holidays (e.g., national independence day, World AIDS Day, Youth Day, etc.) are all ways in which students learn about HIV and its effects. “They learn by sharing with friends, peers, and church mates” (C28-35). They “learn through observing those tormented by HIV in the community” a male G&C teacher responded (GC24-44).

Another male G&C teacher indicated that students learn through “discussions among themselves” and also “under the leadership of the school’s Agents of Change” (G&C28-44). Most learners responded that they learn about HIV from other learners, friends, and peer educators. “We learn from our parents and from each other” was one learner response (L014-33) and 12 others indicated that they learn about HIV through meetings and interactions with the “Agents of Change” at their school.

Learners reported a variety of activities that they learn at school. They learn from “health talks given by the guidance teachers” (L001-30a). Poems, debates, role plays, drama activities, sketches that depict teenage pregnancy stories, sports activities, and lessons from interactions with Agents of Change were common responses from learners about what types of activities they participate in at their schools. Peer education activities were also mentioned, including “talks organized by “Agents of Change” (L113-30a).

The majority of learners (209, 87.4%) mentioned that their teachers talk about HIV and AIDS in the classroom. The most common method that teachers use in sharing about HIV with students is through lectures (37 of the G&C teacher respondents, 71.2%; 185 learners, 77.4%). Most learners (153, 64%) and G&C teachers (31, 64.6%) responded that their school has classroom activities related to prevention of teenage pregnancies. The number of responses was higher for both learners (166, 69.5%) and G&C teachers (42, 87.5%) when asked if their school has classroom activities related to HIV and AIDS.

Learners reported a great deal of variance in which sources they obtain information on teenage pregnancy. The responses seemed almost divided, with about half reporting they learn about teenage pregnancy (including HIV) at home and the other at school. A girl said, “We mostly learn about it at school from friends particularly the Agents of Change and G&C teachers. Our parents do also talk about the dangers of pregnancies at a tender age” (L088-35). Learners however, mentioned other sources too including various mass media outlets (e.g., TV, radio, newspapers, etc.), peers, community members, and at church.

Community members provided many good suggestions to help spread awareness to teenagers on teenage pregnancy. Among these suggestions include the need to share correct information through anti-AIDS clubs, youth groups, sports programs, at church, and especially in the home. “Through peer education they should help one another,” a female community leader from Mufumbwe District (C76-22) and another leader from Mansa District suggested “They should intensify the education to their friends so that they become good parents in future” (C33-22). Parents have an important role to play in educating their children about teenage pregnancy. Perhaps the best way a parent can teach their children is by being a positive example and role model, “You should be a good example to others. Just say to teenagers ‘Emulate me’” (C51-22).

**Table 5.** Level of Learner Knowledge on Various Topics Related to Teenage Pregnancy

	No Knowledge		Some Knowledge		Substantial Knowledge	
	n	%	n	%	n	%
Contraceptive Pills*	84	35.1	129	54.0	24	10.0
Condoms†	26	10.9	148	61.9	63	26.4
STIs and STDs‡	68	28.5	131	54.8	37	15.5
Abortion§	68	28.5	121	50.6	43	18.0
Any other contraceptive method**	127	53.1	67	28.0	7	2.9

\* Two learner participants did not respond to this item.

† Two participants did not respond to this item.

‡ Three participants did not respond to this item.

§ Seven participants did not respond to this item.

\*\* Thirty-eight participants did not respond to this item.

Twenty-seven learner participants indicated they had been victims of sexual abuse. Astonishingly, only three of the victims mentioned they complained about the sexual abuse to police. Of the three young women who complained to the police, the following responses were the outcomes of their complaints:

I told my mother and she warned the young man to stay away from me. (L014-37b)

My dad chased the man away. (L015-37b)

The man was taken to court and was given a jail term of three years. (L061-37b)

Only one perpetrator received any formal discipline from judicial authorities. While the other 24 victims did not inform police begs proper reason and we think that it is a research area that needs further study. Perhaps the victims felt threatened or afraid to share with others, which is a common reason why many girls and young women fear to report sexual abuse to the proper authorities (Seloilwe and Thupayagale-Tshweneagae 2009; Yahaya et al. 2013; Foster and Hagedorn 2014; Hindin 2014).

There was no significance in the responses based upon whether learner victims came from an urban, rural, or remote school; however, the findings are significant based on the district from which participants came ( $X^2 = 14.98$   $p < .10$ ). Ten of the 27 victims were from Mufumbwe District and seven were from Mansa District.

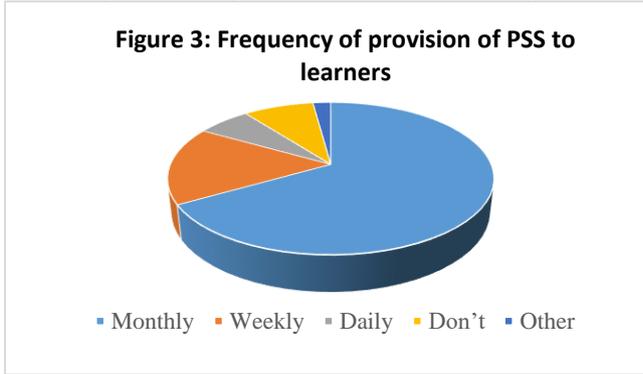
## **5.5 Guidance and Counselling Support**

Guidance and Counseling teachers provide mentorship to the Agents of Change on a monthly basis and other services such as psychosocial support, counseling and referral services on a regular basis. In addition, they also provided guidance with regards to preparing for examinations and career choices. These are two distinct inter-related tasks of the guidance and counseling teachers. Academic guidance is usually provided once per term or at the least once in a year. The psychosocial support is an on-going responsibility.

Services are limited at school according to G&C teachers. When children are referred to G&C teachers due to an illness, the most common action taken by G&C teachers was to send the learner to a local health center (24, 50.0% of the time) or to send the child home (15 times, 31.3%). This shows that G&C teachers rely heavily on external health professionals to help diagnose and treat ill students. The majority of the schools do not even have first aid kits. When asked what the common illnesses children suffer from at their schools, G&C teachers reported some symptoms related to potential teenage pregnancy, such as suffering from abdominal pains and frequent headaches.

There was great variance in the frequency of guidance support provided by G&C teachers at the participating schools. Figure 3 has more details.

The majority of guidance and counseling teachers (N=32 66.6%) reported that they provided psychosocial support at least on a monthly basis. Further, 16.6% indicated they provide the service on a weekly basis. The support provided to Agents of Change has been seriously affected by inter-district transfers of G&C teachers. It was found that many of the G&C teachers who were trained by RTS have been transferred to other districts and were replaced by new teachers who have not been trained. Surprisingly, 53% of the G&C



teachers are not familiar with the Agents of Change activities as they were newly transferred teachers to RTS target schools. Only about 47% of the G&C teachers confirmed they provided support to the Agents of Change in preparing for their monthly group meetings.

There is variance noted in the number of cases that G&C teachers receive from other teachers and administrators. About a third (35.4%) of G&C teachers reported receiving cases at least once in a month, another third (33.3%) once every six months, and the remaining either once in a year. The figures were similar in the number of cases Agents of Change (or other learners) were referred to G&C teachers. It is worth noting that Agents of Change in RTS target schools receive regular mentorship from G&C teachers at least once a month.

Variance on the frequency in giving health and other related topics by G&C teachers and those reported by the learners. Roughly one-fourth of respondents indicated they give talks on a regular basis, at least once a week. Learners (30%) on the other hand reported that G&C teachers don't give health related topics in class except when assisting the AOC prepare for monthly meetings. Other than the regular mentorship offered by G&C teachers to Agents of Change in RTS target schools, the majority of G&C teacher respondents in this study indicated that they are less active. They do not refer students to specialized institutions quite often unless student report problems to them. It is worth noting that the kind of referral the G&C teachers referred to in this study relate to girls who fall pregnant during the year only and not necessarily other emotional, health and social issues.

Health workers from local health centers visited the majority of participating schools (58.3%) at least once every six months, with several indicating they receive visits once a term (5, 10.4%), once a month (5, 10.4%), fortnightly (3, 6.3%), and once a week (4, 8.3%). Only, eight schools (16.7%) reported receiving visits from health center workers less than once a year and four schools (8.3%) have never received a visit. A similar trend was observed between urban, rural, or remote school. The differences were significant between districts ( $X^2 = 51.13 p < .05$ ).

When health workers visited participating schools, they generally led one of the following activities: child health week/immunizations (26, 54.2%), de-worming (27, 56.3%), physical screening (13, 27.1%), giving presentations to learners (12, 25.0%), blood donations (8, 16.7%), HIV and AIDS training (12, 25.0%), and HIV testing (6, 12.5%). Other reported trainings provided by local health centers include bilharzia screening, bathroom hygiene, family planning, malaria screening, and cervical cancer testing. They hardly address the problem of teenage pregnancies thereby further reducing the opportunities for learners to receive correct information from professionals.

## **5.6 Support Service available for schoolgirl mothers during pregnancy and afterwards**

Access to and utilization of Sexual and Reproductive Health (SRH) services plays a pivotal role in the sexual practices and SRH of young people. It includes counseling on sex, sexuality and reproductive issues, treatment for STIs, contraceptives, abortion and post abortion care, pre- and postnatal care, as well as HIV/AIDS counseling and testing. These constitute the main support services to schoolgirl mothers during pregnancy and afterwards.

In each of the sampled provinces more than half of the G&C teachers indicated that they provided counseling services to schoolgirl mothers before they go on maternity leave. However, there seems to be no follow-up counseling services when these girls return after giving birth. To some extent, the school environment becomes unfriendly in this scenario. Further guidance given to schoolgirl mothers before they take their maternity leave is to assist them fill in the forms and advise them on the date when they are expected to return to school. In all sample schools, there was no evidence of schoolgirl mothers being provided with information on parenthood, different physiological and emotional changes that occur during pregnancy, when they should go for antenatal clinic checkups, and general tips on how to take care of their babies.

Less than half of the G&C teachers indicated that they provided referrals to learners to nearby hospitals and clinics. With an exception of the Eastern Province, Luapula and North-Western province participants reported less access to referral health facilities by schools than G&C teachers. Learners from the Eastern Province reported more access to referrals than their G&C teachers reported. This study concurs with earlier studies conducted in Zambia (Vinogradova 2014), which identified that more students at primary and secondary schools accessed more referral services than school administrators reported. With regards to SRH services, in the three participating provinces, fewer schools reported referring learners to SRH services than the general medical facilities. Only 12% of the urban schools reported that they refer learners for SRH services. The Eastern Province had the largest proportion of schools providing SRH services. However, the other two provinces had less than 40% of the schools reported that they refer learners to SRH services.

When G&C teachers were asked what school-based SRH services were available to learners, they reported the following: health talks by nurses or counselors, referrals to local health facilities, and provision of counseling services to learners on HIV and teenage pregnancy. However, learners did not have access to contraceptives. Similar to the findings of the G&C teachers, most learner participants reported that they did not have access to contraceptives or condoms through the school.

Analyses by province showed access to SRH information education services is uneven. While more than 70% of the learners in the Eastern Province responded that they knew where SRH information and services were nearby, less than 40% of the learner respondents from Luapula and North-Western provinces had such knowledge. The majority of the learners interviewed indicated that they preferred to use SRH facilities outside their school and community due to privacy concerns, confidentiality, and the quality of the facilities. Another important reason included the desire to meet friendly nurses who would not judge or reprimand them.

The USAID RTS Project provided intensive training to selected learners as Agents of Change. Trained Agents of Change in target schools conducted life skills-based HIV and sexuality education, which uses a participatory approach to teach behaviors of young people particularly in assisting them to identify and assess the individual social, economic, and environmental factors that may arise and lower the risk of teenage pregnancy and HIV transmission.

The comprehensive life skills-based HIV and sexuality education program covers the following topics: generic life skills such as decision making, communications and refusal skills, while sexuality education covers human growth and development, family life, reproductive health, sexual abuse, and STIs and HIV transmission and prevention. Effective life skills-based HIV and sexuality education can have positive effects on learners' behavior, including delaying sexual debut and reducing the number of sexual partners. According to the internationally recognized indicators, for a school to be categorized as providing comprehensive HIV and sexuality education, a school should teach all the 16 essential topics (which are in alignment with the 17 CSE criteria) on life skills, SRH, sexuality, and HIV/AIDS.

Although few participants from some sample schools self-reported that they provided CSE, the majority of schools (78.6%) did not, in fact, the majority do fall below international standard when data was analyzed using the definition of comprehensive life skills-based HIV and sexuality education as defined in the UNESCO guidelines. Results from the study varied considerably across provinces. In the North-Western and Eastern provinces, very few schools reported providing CSE. Luapula Province was the only one in this study where more than 60% of the schools reported that they provide CSE.

## **6.0 CONCLUSION AND RECOMMENDATIONS**

It was evident from the study that there are different and complex factors contributing to teenage pregnancies. The major ones are; poverty, peer pressure, parental neglect and traditional ceremonies. The study findings reveal that: almost half of learners agreed to condom distribution in schools; schools and homes are the main sources of information about HIV/AIDS and teenage pregnancy; learners have low substantial knowledge levels on topics like abortion, condoms, STIs and contraceptives; and SRH in general. In addition, there is poor support of motherhood for girls who fall pregnant in schools.

Given the multiple levels of influence on adolescent sexual behavior, single intervention strategies by single sectors of society will not be adequate to solve the multifaceted issues that lead to teenage pregnancy. Ideally a comprehensive approach should be taken that includes support from home, school, community, and health care settings. In addition, while each social sector line ministry acts within its mandate, it is highly recommended that linkages with other sectors be fostered to promote an integrated strategy to ensure that all sectors act towards achieving a common goal. Universal access to information and skills are required early enough to enable young people to make informed choices.

Based on the formative assessment of teenage pregnancy in the Eastern, Luapula, and North-Western Provinces, and after a review of literature, the following recommendations are made for education interventions and other sectors with the aim of achieving a comprehensive and integrated approach to adolescent reproductive health.

Sex education should form a critical component of a comprehensive strategy towards teenage pregnancy. A number of steps need to be taken to improve the quality and level of implementation of the program in primary schools.

1. Ensure that activities meet most or all of the seventeen (17) characteristics identified for an effective curriculum-based sex education program outlined by Douglas Kirby and colleagues (see Kirby et al. 2005; Senderowitz and Kirby 2006). The characteristics include (a) five items related to the process of developing the curriculum, Note that these are fictitious names to

protect the identity of the girls<sup>3</sup>. (b) Eight items related to the curriculum content,<sup>4</sup> and (c) four items regarding the implementation of the curriculum.<sup>5</sup>

2. Include a definitive focus on pregnancy (rather than only HIV) by addressing knowledge and beliefs about contraception, conception, pregnancy, and focusing on responsibilities of parenthood, knowledge, and skills required for successful parenthood, together with an understanding of the importance of planning for the timing of parenthood.
3. Adopt a comprehensive approach that addresses both abstinence and safe sex practices rather than an abstinence-only focus. The focus of the activities (abstinence or safe sex) should be dependent on the stage of development and age of the learner rather than grade level. This will ensure that learners who are older for their grade receive developmentally-appropriate messages.
4. Focus on both biological and social risk factors (such as gender power relations, poverty, and early-school dropout) that lead to early pregnancy.
5. Conduct an assessment of the availability of condoms in the community, as a support to CSE in schools.
6. Support advocacy work to ensure that the gatekeepers of education—head teachers, teachers, and fellow learners—buy into the policy to reduce the stigma that often turns young mothers away from the doors of learning.
7. Ensure the prompt return of post-pregnancy girls into the schooling system. The suggestion of “up to a two-year waiting period” before returning to school in the MESVTEE learner pregnancy guidelines may be counterproductive to both maternal and child outcomes.
8. Strong referral networks are also required with relevant social sector line ministry support and other community structures that can support learners with child care arrangements, access to reproductive health services (including access to contraceptives), child support grants, and to develop appropriate parenting skills to mitigate the intergenerational transmission of early parenthood. While a mass-based system is effective for the prevention of pregnancy, teenage mothers benefit more from intensive, individualized support. Setting up a one-on-one relationship with a G&C teacher or community members will assist teen mothers in negotiating the range of new economic, educational, and social imperatives that they face.
9. Given the inextricable link between adolescent motherhood, poverty, and socioeconomic disadvantage, efforts to empower young women through skills development and opportunities

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<sup>3</sup> The process of developing the curriculum is comprised of (1) involving multiple people with different backgrounds in theory, research, and sex/HIV education to develop the curriculum; (2) using a logic model approach to develop the curriculum that specify the health goals, the behaviors affecting those health goals, the risk and protective factors affecting those behaviors, and the activities addressing those risk and protective factors; (3) assessing relevant needs and assets of target groups; (4) designing activities consistent with community values and available resources (e.g., staff time, staff skills, facility space, and supplies); and (5) pilot testing the program (Senderowitz and Kirby 2006, pp. 50-51).

<sup>4</sup> The eight characteristics that comprise the content of the curriculum include: (1) creating a safe social environment for youth to participate; (2) focusing on clear health goals – the prevention of STI/HIV and/or pregnancy; (3) focusing narrowly on specific behaviors leading to these health goals, give clear messages about these behaviors, and addressing situations that might lead to them and how to avoid them; (4) addressing multiple sexual psychosocial risk and protective factors affecting sexual behaviors (e.g., knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy); (5) including multiple activities to change each of the targeted risk and protective factors; (6) employing instructionally sound teaching methods that actively involve participants, that help participants personalize the information, and that are designed to change each group of risk and protective factors; (7) employing activities, instructional methods, and behavioral messages that are appropriate to the youths’ culture, developmental age, and sexual experience; and (8) covering topics in a logical sequence (pp. 50-51).

<sup>5</sup> The four characteristics that comprise the implementation of the curriculum include (1) whenever possible, selecting educators with desired characteristics and then train them; (2) securing at least minimal support from appropriate authorities such as ministries of health, school districts, or community organizations; (3) if needed, implementing activities to recruit youth and overcome barriers to their involvement (e.g., publicizing the program, offering food, or obtaining consent); and (4) implementing virtually all activities with reasonable fidelity (pp. 50-51).

for developing sustainable livelihoods may assist in minimizing trade-offs between health and economic security. Interventions that create synergy between health and development goals, may offer promising approaches for pregnancy and HIV risk reduction.

10. Despite significant advancements at policy and programmatic levels to improve the availability and accessibility of health services to young people, usage is compromised by a lack of acceptability of services. Even with the roll-out of the Child Friendly Corners at health centers, young people are still confronted with the negative and stigmatizing attitudes of many health clinic staff members. Thus many young women would rather not use contraception, delay accessing antenatal care when they are pregnant, or resort to illegal means for termination of pregnancy. Much more rigorous effort is required to roll out adolescent-friendly services and to entrench its key principles among the custodians of health care. In addition, the full range of preventative services for pregnancy should be made available and accessible to young people. In particular, emergency contraception, that is considered safe and effective, and that *does not increase sexual activity* among young people, should be deregulated to increase availability and usage.
11. As the primary socializing agents of change, parents are a trusted source of information about sexuality for young people. Yet this represents a missed opportunity because most parents lack both knowledge and skills to talk openly about sex and often feel disempowered to parent their children in an environment that emphasizes a rights-based culture for children. In this regard, we recommend programs that empower parents with correct information on pregnancy and SRH in general which they can use to educate their children
12. There is also a need to work with traditional leaders to address harmful cultural practices (especially on influencing initiation curricula) and support vulnerable girls with such schemes as conditional cash transfers and practical financial or entrepreneurial skills to empower them to be economically self-sufficient and less susceptible to transactional sex, intergenerational sex or forced into early marriages.

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## APPENDICES:

### Appendix 1: Members of the Research Team

S/N	Name	Position	Institution
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10	Mwazona Mwanza	G&C Coordinator	MESVTEE- Chipata
11	Stanley Munene	Provincial Team Leader	RTS- Northwestern
12	Edgar Chaamwe	M&E Officer	RTS - Northwestern
13	Douglas Kangugu	G&C Coordinator	MESVTEE - Mufumbwe
14	Alice Kindalo	G&C Coordinator	MESVTEE - Solwezi
15	Lee Kambanikwao	Provincial Team Leader	RTS - Northern
16	Betwell Mushitu	G&C Coordinator	RTS - Luapula
17	Cosmas Mukobe	Provincial Team Leader	RTS - Luapula
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