FOCUS on Young Adults

A Program of
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In Partnership with

The Futures Group
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Tulane University School
of Public Health
and Tropical Medicine

Young Adult Reproductive Health in Zambia: A Review of Studies and Programmes

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Young Adult Reproductive Health in Zambia: A Review of Studies and Programmes

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With appreciation,

Rose Zeko Haambayi, FOCUS Consultant
and Lisa A. Weiss, FOCUS Program Coordinator

Executive Summary

This review synthesises findings from relevant studies and information collected on selected programmes that involve young adult reproductive health in Zambia. It is intended to help serve the needs of programme planners and implementers working with and on behalf of young people. The authors have drawn on background data in order to highlight the dimensions of risk for young adults in Zambia and the remaining needs for young adult reproductive health in Zambia. Information is presented that may aid diverse programmes in prioritising young adult reproductive health (YARH) needs and programme criteria, as well as realise common goals and the sharing of experiences and expertise.

Findings demonstrate levels and patterns of sexual activity among young people that place them at increased risk of undesirable consequences such as HIV/AIDS, STDs, unwanted pregnancy, and abortion. Many youths do not have adequate or correct information on sexual and reproductive health, perceive high levels of sexual activity among their peers, and use condoms and/or contraception inconsistently or not at all. The household level impact of HIV/AIDS and worsening economic disparities appear to exacerbate risk-taking and vulnerability; the number of AIDS orphans is increasing as are numbers of street children. Exchange of sex for money or goods appears prevalent among not only the most disadvantaged youth, but also those with access to educational opportunities. Young females are particularly vulnerable to undesirable consequences because they may be more likely to be coerced to have sex or have difficulty negotiating condom use with their partners, who are often older than they are. Health services are under-utilised, and youth have cited both real and perceived barriers that limit their use of services.

A number of programmes are tackling these issues with enthusiasm and innovation, but are tempered by severe resource constraints and an uncertain donor environment. The key informants who were interviewed (and in turn their colleagues) offer a wealth of experience working with and on behalf of youth. It would be helpful to engage such "youth experts," as well as youth leaders, in a more formal process that builds consensus on: (1) priority target subgroups and their needs, (2) the successful elements of programmes –so that efforts can be replicated or extended into underserved areas throughout the country, and (3) new or refined strategies to test. Documentation and sharing of experience is an invaluable resource that should be exploited.

The review begins with a contextual background for Zambia, and current literature is used to illustrate demographic, employment, education, policy and legal issues, as well as the media environment. Then, dimensions of risk are explored, and data are presented on undesirable reproductive health outcomes, behaviours, and factors related to these behaviours. This report also examines over 45 youth-oriented programmes identified during an exercise that took place from February through April 1998.

Following the discussion of what the available data show, there is a listing of possible priority areas to consider for future research. For a synopsis of the studies reviewed, Appendix A provides summary tables of studies arranged by general topic. The programme findings from key informant interviews are followed by suggestions for new programme efforts and programme expansion (the key informant questionnaire is in Appendix B). Tables in Appendices C through K supplement the programme findings, and a full listing of programme contact information is in Appendix L. Appendix M contains profiles of each programme that include programme name, implementing organisations, timeframe, funding sources, staff, geographic area, site types, characteristics of targeted youth, secondary target groups, goals, implementation strategy examples, peer educator background, communication methods, and monitoring and evaluation plans.

Abbreviations

&	and
ADRA	Adventist Development Relief Agency
AIDS	acquired immunodeficiency syndrome
ANC	antenatal clinic
ARC	AIDS related complex
CBD	Community based distributor
CBOH	Central Board of Health
CEDPA	Centre for Development and Population Activities
CSO	Central Statistical Office
CYP	Commonwealth Youth Programme
DEC	Drug Enforcement Commission
DfID	[British] Department for International Development
DHS	Demographic and Health Survey
DSW	District Social Welfare [Officers]
FGD	focus group discussion
FHI	Family Health International
FLE	family life education
FOCUS	FOCUS on Young Adults
FP	family planning
HIV	human immunodeficiency virus
HIVOS	Institute for Cooperation with Developing Countries
IEC	information, education and communication
IPPF	International Planned Parenthood Federation
JHU	Johns Hopkins University
JSI/SEATS	John Snow, Inc./Services Expansion and Technical Support Project
MCH	maternal and child health
MOE/CDC	Ministry of Education/Curriculum Development Centre
MOH/HEU	Ministry of Health/Health Education Unit
MYSCD	Ministry of Youth, Sport and Child Development
N	Total sample size
n	Size of subset of total sample
N/A	not applicable
NGO	non-governmental organisation
NORAD	Norwegian Agency for Development
OPD	Outpatients department
PAGE	Programme for the Advancement of the Girl Child
PCI	Project Concern International
PSI	Population Services International
PLA	participatory learning and action
PPAZ	Planned Parenthood Association of Zambia
PWA	person(s) with AIDS
RH	reproductive health
SAAT	Southern African Training Programme
SFH	Society for Family Health
SIDA	Swedish International Development Authority
SNV	Netherlands Development Organisation
STD	sexually transmitted disease
STI	sexually transmitted infection
TA	technical assistance

UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Education for Scientific & Cultural Organisation
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Fund
UNZA	University of Zambia
USAID	United States Agency for International Development
UTH	university teaching hospital
WAAGS	World Association of Girl Guides
WFP	World Food Programme
WHO	World Health Organisation
YARH	Young Adult Reproductive Health
YMCA	Young Men's Christian Association
YWCA	Young Women's Christian Association
ZARD	Zambian Association of Researchers in Development
ZDHS	Zambia Demographic and Health Survey

Young Adult Reproductive Health in Zambia: A Review of Studies and Programmes

Introduction

Young people between the ages of 10 and 24 comprise more than one third of the population of Zambia, and are increasingly viewed as a critical age group for targeting health messages and services. This review synthesises findings from relevant studies and information collected on selected programmes involved in young adult reproductive health. It is intended to help serve the needs of programme planners, implementers, and researchers working with and on behalf of young people. Background data are presented in order to highlight dimensions of risk for Zambian young adults and remaining needs for young adult reproductive health in Zambia. This report may be helpful to those already familiar with the situation of young people in Zambia, as well as those with a new interest.

The review begins with a contextual background for Zambia, and current literature is used to illustrate demographic, employment, education, policy and legal issues, as well as the media environment. Then, dimensions of risk are explored, and data are presented on undesirable reproductive health outcomes, behaviours, and factors related to these behaviours. This report also examines youth-oriented programmes identified during an exercise that took place from February through April 1998. Information is presented that may aid diverse programmes in prioritising young adult reproductive health (YARH) needs and programme criteria, as well as in realising common goals and the sharing of experiences and expertise.

This review was made possible through the invitation and support of the Central Board of Health and United States Agency for International Development (USAID)/Zambia, and was co-ordinated by FOCUS on Young Adults (FOCUS), a programme funded by USAID.

Methods

The authors synthesised information from available publications to provide a comprehensive description of the issues and factors related to the reproductive health of young adults between the ages of 10 and 24 in Zambia. The information was drawn primarily from documents and quantitative and qualitative studies conducted after 1990. Both published and unpublished documents were identified for the review. On-line computer searches were conducted using POPLINE, AIDSLINE, and MEDLINE. Research studies were located through various libraries, non-governmental organisations (NGOs), government agencies, and donor organisations. A summary section of research studies is included (see Appendix A) as a reference tool for those desiring to identify research studies of particular relevance to their programmes.[1] The summary of research studies provides additional detail that may not always be included in the information cited within the report text, such as location and sampling information. It also includes a table on indicators from the 1992 and 1996 Demographic and Health Surveys (ZDHS). Notably, most of the research studies identified were conducted and/or reported on after 1995.

The review of interventions includes interviews with over 45 key informants representing the government, NGOs, donor organisations, and other entities. Key informants were identified with the assistance of Project Concern International (PCI), USAID, and the members of the USAID Adolescent Task Force. The majority of the key informants and programmes identified are based in Lusaka, though many of the Lusaka-based organisations have multi-district or multi-province interventions.

[1] For additional references the bibliography contains the full list of documents reviewed.

A semi-structured questionnaire[1] was used for each interview (see Appendix B). To collect programme information, FOCUS hired and trained four youth interviewers to assist the lead researcher with the interviews. In a few cases, key informants self-administered questionnaires or portions of questionnaires.

Information from key informant interviews was used to prepare the "programme profile" tables in Appendix M. These profiles include programme name, implementing organisations, timeframe, funding sources, staff, geographic area, site types, characteristics of targeted youth, secondary target groups, goals, implementation strategy examples, peer educator background, communication methods, and monitoring and evaluation plans.

This report provides a great deal of useful information in one place that can be improved and expanded in the future. While every attempt was made to collect relevant documents, report data accurately, and report correct programme information, it is possible that some relevant documents are not included and that the high volume of information and possible errors associated with interviews may have led to some inaccuracies.

Defining Young Adults

There are many definitions for the terms *adolescent*, *young adult*, *youth*, and *young people*. FOCUS on Young Adults (FOCUS), a USAID programme, defines young adults as those individuals between the ages of 10 and 24. Within this age span, FOCUS defines subgroups according to their issues and needs, recognising each group as a diverse population (e. g. some are married, some are parents, others attend school, and others are active members of the labour force). In this report, the terms *adolescent*, *young adult*, *young people* and *youth* will broadly refer to the those from age 10 to 24. However, it should be noted that available data and programme information often refer to other age ranges, with lower or higher bounds than the 10 to 24 age limits.

Most organisations define young people chronologically. The World Health Organisation (WHO) classifies all young people aged 10-14 and 15-19 as "early" and "late adolescents" respectively, and suggests that the terms "youth" or "young people" may be used for persons up to 24 years old. The United Nations (UN) has adopted the youth age category 15-24. The Commonwealth Youth Programme (CYP) refers to the 15-30 age group as youth.

Individual countries also have varied definitions (as shown in the following table). In its Youth Policy, the Zambian government uses the 15-25 youth age category (Republic of Zambia Ministry of Youth, Sport, and Child Development, 1994).[2]

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[1] An international programme survey questionnaire developed by Advocates For Youth (Washington, D.C.) was very useful for design of the inventory questionnaire, as was the input of USAID partners and youth interviewers.
[2] Additionally, in accordance with its December 6, 1991 ratification of the United Nations Convention on the Rights of the Child, Zambia defines a person up to 18 years old as a child.

Definition of Youth Age in Selected Commonwealth Countries in Africa	
Country	Youth Age Range
Botswana	12 - 29
Swaziland	12 - 30
Lesotho	12 - 35
Malawi	14 - 25
Mozambique	14 - 35
Zambia	15 - 25
Namibia	15 - 30
Zimbabwe	15 - 30
Tanzania	15 - 35
South Africa	16 - 30
Uganda	18 - 30
Source: Mkandawire, 1994	

Mkandawire (1994) observes that it is problematic to define youth chronologically, as they are not a homogenous entity. He suggests classifying them by other variables and factors that recognise their diverse needs. For instance, *out-of-school youth*, *unemployed youth*, *urban youth*, and *young mothers* are among the variety of subcategories that have been useful in the design of policies and programmes.

Segmentation of youth by behavioural variables (e.g. *sexually active*, *condom user*, *drug user*, etc.) may also result in better-designed and more successful interventions, as may consideration of social networks and existing relationships among different subgroups.

Defining Reproductive Health

FOCUS uses the term *reproductive health* in a broad sense to refer to the health and wellbeing of young adults in terms of sexuality, pregnancy, birth and related conditions, diseases and illnesses. However, primary attention is given to reproductive health issues related to pregnancy and sexually transmitted diseases, including HIV/AIDS.

The Programme of Action of the 1994 International Conference on Population Development defined reproductive health broadly as:

> A state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. It implies that people are able to have a satisfying and safe sex life, and that they have the capacity to reproduce and the freedom to decide if, when, and how to do so.

Implicit in this last condition are the rights of men and women to be informed, and to have access to safe, effective, affordable, and acceptable family planning options, as well as other methods of their choice for fertility regulation that are not against the law. Also implicit is the right of access to appropriate health care services that will enable women to safely experience pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

These reproductive health rights extend to young people as well. This UN definition of reproductive health differs from previous approaches as it includes both men and women, is not just limited to childbearing ages, and works on the premise that --to address reproductive health issues successfully-- there is a need to also address relevant behaviours and cultural practices.

Young Adults in Zambia

Youth in Africa and Zambia, in particular, live in a society that is changing from a traditional to more modern one, undergoing dramatic socio-economic transformations and urbanisation. According to Mkandawire (1994):

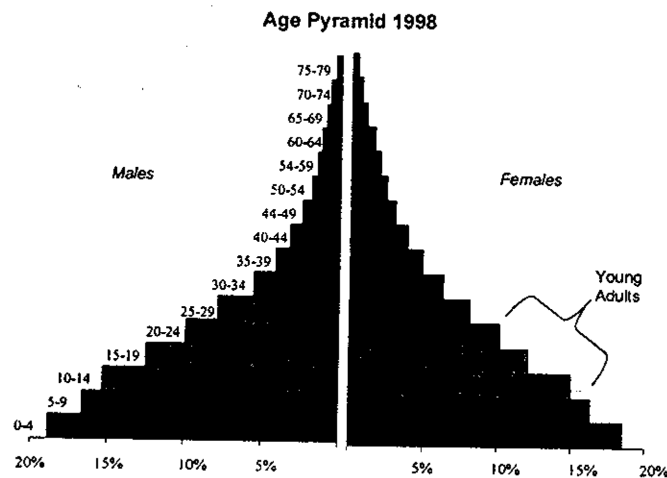
> [Youth] no longer subscribe to the values and norms of their parents' ethnic groups. Through the influence of the western media, radio and television as well as the print media, the youth of the region are now part of a global culture, a culture that is radically different from that experienced by their parents at independence nearly three decades ago. At the root of all these changes is the changing role of the family, which is now far less important in the individual development of young people. The parents are finding it increasingly difficult to fulfil their role of providing advice and nurturing the young into society. The absolute nature of their authority is attenuated by the authority of other institutions, including the media.

Mkandawire adds that most young people in Africa are caught in a crisis of growing up in economies that are not able to fulfil their expectations, and are living in a culture of poverty. The World Bank (1997) estimates that 70% percent of the Zambian population lives in absolute poverty.

The Demographic Situation

In mid-1998, the Zambian population was estimated to be 9.5 million and growing at an annual rate of 1.9%. At this rate, the population will double in 36 years. Despite the high fertility rate of 6.1, population growth is slowed by the devastating impact of HIV/AIDS, which is reflected in the mortality rate of 23 per thousand. Infant mortality is also high, at 109 per thousand, and life expectancy at birth is just 37 years. Forty percent of Zambians live in urban areas. Notably, 45% of the population is under the age of 15 (PRB, 1998). As the following population age pyramid demonstrates, the younger cohorts are a sizeable proportion of the population. Young adults aged 10-24 comprise more than one-third of the total population.

Age Pyramid 1998



Source: UN Population Division, "World Population Prospects as Assessed in 1996" Projection Software

The 1996 ZDHS found that youth aged 10-24 comprise more than one-third (37%) of urban residents and one-fourth (25%) of rural residents. The size of the 10-14 year age group, as well as the number of children under age 10, means that more young people as a proportion of the total population are entering the young adult age group than in previous years.

Employment

A 1996 report prepared for UNICEF suggests that levels of formal employment in Zambia are very low, estimated as approximately 350,000 people (GRZ, UN 1996 quoted in Webb et al., 1996). The report further suggests that this figure may be higher with the advent of economic restructuring, which has resulted in retrenchments with no corresponding growth in employment.

As shown in the following table, the 1996 ZDHS found that three out of four young women aged 15-19 were not currently employed.[1] Male unemployment among this age group is similar. Among 20-24 year olds, unemployment drops considerably among males but a majority of females remain unemployed.

Percentage of Young People Not Currently Employed		
Age Group	Female	Male
15–19	76.2	70.4
20–24	57.3	28.2

Source: ZDHS 1996

The 1990 census estimated urban unemployment for young people between 12-19 years old as 61% for females and 65% for males. In rural areas, unemployment was 59% for females, and 67% for males. It has also been estimated that 70% of 15-24 year olds that have a secondary school education are unemployed (Webb et al., 1996). This implies very high competition for formal jobs. Additionally, the educational requirements to get a formal job are much higher than they were in the last decade. These competitive conditions automatically disqualify most young people, as will be noted in the following section on education.

These circumstances mean that young people are primarily engaged in the informal sector, including subsistence farming and seasonal work (Webb et al., 1996). Studies have also shown that females, particularly those who are not in school, engage in sex for economic gain.

Sixteen is the legal age of employment in Zambia. In recent years, probably as a consequence of economic adjustment, there has been an increase in child labour. This is reflected by a change in the definition by the Central Statistics Office (CSO) of the economically productive age group. In the past, CSO defined this age group as those twelve years and above, but recent data on the labour force in the 1993 Priority Survey No. 11 has lowered it to seven years (Webb et al., 1996).

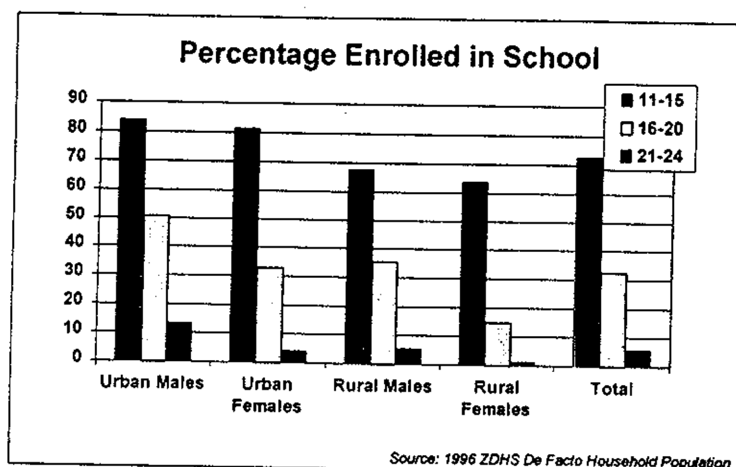
Education

Zambia's formal education is based on a three-tier system. Primary education begins when a child is seven years old (though this is not necessarily followed in private schools) and continues for seven years. Secondary school requires an additional five years (two in junior, and three in senior grades). Tertiary education consists of two to seven years if one goes to college or university (ZDHS, 1996).

Studies have shown that, although the rate of enrolment is the same at grade one for both males and females, more females than males tend to drop out of school as they get older, resulting in wide differences at tertiary levels. The ZDHS (1996) indicates that males generally receive more education than females. Although males and females ages 10-14 and 15-19 reported similar median years of schooling, beginning with the 20-24 cohort the trend is for males to have reported a higher number of years of schooling.

[1] Only about 2-3% reported any employment in the last 12 months.

The following bar chart demonstrates the gender gap and rural-urban differentials in school enrolment according to age group.[1] Enrolment decreases dramatically after age 15, more so among females than males and rural than urban residents.



Until recently, the Ministry of Education had a strict policy toward girls that became pregnant while attending school: they were asked to leave or were expelled without a possibility of re-entry. The new education policy initiated in September 1997 has addressed this issue, and proposes that pregnant adolescents continue with their education (ZARD Youth Committee, 1997). The Ministry of Education's Programme for the Advancement of the Girl Child (PAGE) has since been put in place to address this and other education-related problems that put young girls at a disadvantage. However, the policy lacks legal enforcement and some young girls continue to be expelled.

An opinion poll survey conducted in 1997 by the Zambian Association of Researchers in Development (ZARD) Youth Committee in rural and urban areas of six districts found that most of the respondents (including pupils, teachers, religious group representatives, politicians, NGOs, traditionalists, and pregnant girls) supported the policy declaration. However, both those who opposed the declaration and many of the supporters felt the policy contributes to immoral behaviour. Because almost half of parents interviewed did not support the declaration, there is less likelihood that parents will allow daughters to continue with school even if daughters want to return.

Policy and Legal Issues

There is national recognition of the importance of positive development of young people. Goals of the National Youth Policy issued in August 1994 by the Ministry of Youth, Sport, and Child Development (MYSCD) are as follows:

a. promoting the welfare of the youth and safeguarding the rights of the youth to exist, develop, and meet his/her life needs in accordance with international requirements:
b. highlighting the youth problems and designing programmes or projects with a view to improving the quality of life of the youth in accordance with national development aspirations; and
c. creation of the much-needed environment conducive to the development of the youth socially, culturally, spiritually, politically, economically, as well as to other areas of human development.

To move toward these goals the MYSCD has prioritised youth unemployment in its National Programme of Action for Youth. A primary thrust is to rehabilitate and expand youth skills training centres to become "Youth Resource Centres" (with a curriculum that includes family life education (FLE)), and

[1] Note that the ZDHS reported current enrolment according to the age groups 11-15, 16-20, and 21-24.

also to continue and improve administration of youth enterprise loan schemes (Republic of Zambia MSYCD, 1997). Within the National Programme, specific components of the MYSCD youth health and welfare action plan are as follows:

1. Renew discussions with the Ministry of Education and Ministry of Health to promote the reinforcement of sex and personal relationship education in schools, with special emphasis on contraception, and link this effort closely with clinical services for adolescents.
2. Discuss with the Ministry of Health the reinforcement of family planning associations' activities for youth, and with the Ministry of Information extensive media coverage of topics such as contraception, STDs, especially HIV/AIDS, in formats appealing to the young.
3. Provide support and grants to young people's organisations concerned with youth education on sex, STDs, and HIV/AIDS, particularly those using innovative techniques such as street theatre.
4. Continue to introduce FLE as an integral part of its skills training in all Youth Resource Centres.
5. Develop further plans with NGOs...to create awareness amongst youths and adults of adolescent problems and health hazards.

The Ministry of Health's (MOH) 1997 Family Planning in Reproductive Health Policy Framework includes young people in the following manner:

> Recognising that the family is "the natural unit" and that "each person has duties towards his/her family," there is need to emphasise the importance of instilling moral values in the youth from an early age at school, in order to strengthen the bonds of responsible and caring family life on a more firm and long term basis. Consequently, family life education in the schools needs to place the biological aspects of the sexual reproductive system within the wider framework of human sexuality, human relationships, responsible parenthood and individual human rights and their corresponding social responsibilities. There is also a need to address the dangers and risks involved in early sexual activities.

A supportive measure with special implications for young people that the MOH describes in the Policy Framework is:

> Men and women of reproductive age shall be eligible for using family planning methods without the consent of their spouses, parents, or relatives. Spousal/guardian counselling is, however, strongly recommended. Specific concern should be given to the counselling of young adolescents under 16 years of age. In case they are, after counselling, unwilling to involve their parents/guardians, care should be taken to ensure that these adolescents have the mental maturity to understand what is involved in their decision along with possible consequences.

Policies are important, especially when they are supported by action and enforced by law, if necessary. The Zambian legal system is dual in nature because it allows for both customary and statutory law, a situation that can be disadvantageous for young girls and women.

Marriages in Zambia can be contracted in either system of law, and the majority are contracted under customary law. Even people who contract civil marriages may go through formalities required under customary law, such as payment of bride price or seeking consent from parents or elders, and this may still be done when the couple is of legal age under statutory law (16 years or older). Zambian husbands have total authority over their spouses, as customary laws govern family relations (Mabula, 1994).

Mabula (1994) identifies legal situations that have serious implications for young women as follows:

1. Consent to marriage
Customary marriage is a union of two families rather than two people. Sometimes marriages are arranged without the consent of the woman. This is the case more often in rural areas, where traditional practices are stronger than in urban areas.

2. Minimum age of marriage
Under statutory law, the minimum age for contracting a marriage is 16. Under customary law this is as soon as a girl attains puberty, which often occurs much earlier, as young girls aged 10 or even younger can begin menstruating.

3. Marital rape[1]
This concept does not exist in Zambia's legal system.

4. Abortion
Unlawful abortion is a criminal offence under the penal code. The 1972 Termination of Pregnancy Act permits abortion in certain cases and specific procedural requirements must be met.

5. Access to contraception
There is no official law governing the sale or use of contraceptives. The one-time age and parity requirements have been removed. However, major problems such as shortages of contraceptive supplies, lengthy distances to service points, unaffordable service costs, and poorly trained staff still remain, as do provider biases against providing contraception to young people, unmarrieds, or couples without children.

6. Employment
The law protects individuals from discrimination based on sex, race, or gender. It also gives young women a right to maternity leave. However, it does not adequately address sexual harassment.

The aforementioned abortion law makes it very difficult for women, and young women in particular, to obtain an abortion. The Termination of Pregnancy Act specifies that abortion is permitted:

> ...if continuation of pregnancy involves risk to the life or injury of the physical or mental health of the woman, or if there is substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be severely handicapped. A legal abortion can also be obtained if continuation of the pregnancy involves a risk of injury to the physical or mental health of any of her existing children. Section 3(2) of the Act further stipulates that the woman's actual or foreseeable environment or age may be taken into account in determining whether the pregnancy poses any risk to her life or her mental or physical health, or poses a risk of injury to the mental or physical health of any of her existing children.[2]

A woman inducing her own abortion may be prosecuted by one to seven years of imprisonment. Performing an illegal abortion on someone else is punishable by one to fourteen years in prison. Three physicians must provide consent for an abortion, and a licensed physician must perform the procedure (Folsom et al., 1998). One of the signing physicians must be

[1] Though prevalent, date rape is not recognized as a problem by younger or older men (Lubilo, 1998).
[2] As cited in Folsom et al., 1998: United Nations, *Abortion Policies: A Global Review. Vol. III, Oman to Zimbabwe* (New York: Department for Economic and Social Information and Policy Analysis, Population Division, United Nations, 1995), p.187.

> ...a specialist in the branch of medicine in which the patient is specifically required to be examined. Thus, a woman seeking an abortion for mental health reasons must be examined by a psychiatrist, while one with a specific medical condition must be examined by a specialist in that area of medicine. This requirement may be waived if the performance of an abortion is immediately necessary to save the life of the pregnant woman.[1]

As will be discussed later, incest is another situation that primarily impacts women. There is a law against incest, but it is weakly enforced. Zambia Penal code, CAP 146, Section 159, states:

> Incest occurs when a male person has carnal knowledge of a female person, who is to his knowledge his granddaughter, daughter, sister, or mother. Also, it occurs when a female person of above 16 years, who with consent, permits her grandfather, father, brother, or son to have carnal knowledge of her (YWCA, 1997).

If she decides to seek legal recourse, a woman over age 16 is put in the difficult position of having to prove she did not consent to sexual relations with a relative.

Media Environment

As Mkandawire (1996) has noted, the media are one of the more dramatic influences on youth today. As a result of this decade's economic liberalisation policy, more privately owned papers, magazines, radio and television stations have appeared in Zambia. However, these information channels are most accessible to people living in urban areas along the line of rail in the Copperbelt, Central, and Lusaka Provinces (van den Borne et al., 1996).

In 1996, Zambia had two dailies, one biweekly, and four weekly newspapers. The number has since increased with several local and international periodicals. A notable development with respect to reproductive health has been the introduction of *Trendsetters*, a newspaper for youth by youth; the quarterly *Zambia Reproductive Health Newsletter* produced by the Central Board of Health (CBOH); and the *Zambia AIDS Newsletter*.

As shown in the following table, the ZDHS 1996 found that more than half of youth aged 15-24 were exposed to some type of media on a daily or weekly basis. In both the 15-19 and 20-24 age cohorts, more males than females had exposure to media, with the exception of radio listenership at 35% for females 15-19 compared to 34% for males. The gender gap is widest for newspaper reading.

Exposure to Mass Media, 15-24

Type of Media	15-19		20-24	
	Females	Males	Females	Males
No mass media	48%	39%	49%	37%
Read newspaper weekly	27%	42%	24%	42%
Watch TV weekly	32%	39%	31%	41%
Listen to radio daily	35%	34%	36%	47%
All three media	12%	18%	11%	25%

Source: ZDHS 1996

A study that examined effects of a *bemba*-language radio drama about AIDS that was broadcast weekly in Copperbelt and Northern Provinces during a nine-month period in 1991-1992 reported that 40% of those under age 26 owned a radio, and 25% of those under 26 listened to the weekly radio drama very

[1] As cited in Folsom et al., 1998: United Nations, p.187.

often or all of the time (Yoder et al., 1996).[1] The same study found that more urban than rural residents, and more males than females, reported listening at all to radio.

A survey to determine the media preferences of youth in urban areas (N=578) found that radio was the most preferred source (though television was seen as conveying information better than any other source), and a large majority preferred messages presented to them in form of pictures, especially cartoons (Nzima, 1995). Radio and TV have become more frequently used channels for reproductive health messages. Radio enjoys a wider range of listeners and coverage (Radio 1 and 2 transmit to both rural and urban areas in different vernacular languages).

Dimensions of Risk

Understanding the dimensions of risk for young adult reproductive health requires reflecting on the following basic questions:

- What are the undesirable health outcomes?
- What does available data say about these outcomes?
- Who is at risk (which subgroups)?
- What are they doing? Who are the 'doers' and 'non-doers'?
- How many are there (prevalence levels)?
- What are possible influencing factors and reasons for risk-taking behaviours?

Unfortunately, it is easier to ask the questions than to get the answers, particularly where data are scarce. There is no simple way to connect the many internal and external factors that drive adolescent risk-taking behaviour, and some factors are beyond the influence of any programme. However, as more information on these determinants becomes available, programmes can prepare, segment, and strategize for this target population. Using this information to identify those behaviours that a programme has the potential to influence is crucial, as is transferring the information in an effective manner to those working with youth so that they may better serve them.

The undesirable reproductive health outcomes considered here are:

- HIV/AIDS
- Sexually transmitted diseases (STDs)
- Unwanted pregnancy
- Abortion and harmful/fatal abortion complications
- Maternal morbidity/mortality
- Infant morbidity/mortality

HIV/AIDS and Young Adults

It has been estimated that almost 20% of the adult population (those over age 15) is infected with HIV, with 300 new infections each day. An estimated 700,000 of those under age 14 are infected, the majority in the under-4 age group (reflecting high rates of perinatal transmission). HIV prevalence is twice as high in urban areas than rural. In 1997, North-Western Province had the lowest adult prevalence (11%)

[1] Baseline and follow-up study results did not demonstrate attributable impact of the radio drama on AIDS knowledge and risk-reduction measures.

and Lusaka Province the highest (26.5%). Lusaka Urban District had the highest prevalence of any district, with an estimated 30% of those age 15 and older infected (MOH/CBOH, 1997[1]).

AIDS and AIDS related complex (ARC) cases as of July 1997 show that most (84%) of cases are adults between 20 and 49 years old, with an equal number of male and female cases. However, there are age variations that point to important gender differentials. Young women ages 15 to 19 are more than *five times* as likely to have AIDS/ARC than men of the same ages. AIDS/ARC cases peak for women from 20 to 29 years old, and for men from 30 to 39 years old, indicating the earlier transmission of HIV in women, probably during late adolescence or early adulthood. Population-based surveys in 1995 and 1996 reflect similar patterns, though urban and rural rates for women show higher proportions of infection. As with AIDS/ARC cases, women's peak ages for HIV infection are 20-29, and men's are 30-39, and women aged 15-19 are more likely to be infected than men --particularly urban women (MOH/CBOH, 1997). It is probable that infection rates are better known for the older cohorts than those under 20, so transmission of the virus may be more likely during the ages 10-19 and into the early 20s. Thus, it appears that women younger than 15 are at more risk than men of the same ages, while men become more susceptible in their late teens/early 20s.

A 1994 sentinel site survey of childbearing women (N=11,517, 15-44) carried out in 27 areas throughout the nine provinces found that 20% of urban females aged 15-19, and 32% in the 20-24 age group were HIV-positive. For rural women, 8% of those aged 15-19 and 15% of 20-24 year olds were HIV-positive. The age distribution of infection for urban 15-19 year olds was steeper than for those in rural areas, rising from 11% for 15 year olds to 28% for 19 year olds in urban areas, compared to an increase from 4% for 15 year olds and to 11% for 19 year olds in rural areas. For all age groups the urban-rural ratio was 2:1. The study found no significant relationship between educational attainment and infection for the 15-19 age group, although in an analysis that included all ages infection was significantly associated with educational attainment (infection rates rose with higher levels of educational attainment). Overall, unmarried women were more likely to be infected than married women, though separate analysis of the 15-24 age group showed no differences between unmarrieds and marrieds (Fylkesnes et al., 1994).

Despite these high numbers, there may be encouraging signs of a decrease in prevalence in young people. Surveillance data in Lusaka for 1993 and 1994 showed a downward trend in HIV prevalence among 15-19 year olds, from 28% in 1992 to 23% in 1994 (Fylkesnes et al., 1994). Prevalence dropped further to 17% in 1996 (Sichone et al., 1997, cited in Webb, 1997).

The Orphan Crisis

Concerted efforts are greatly needed to address the increasing number of orphans that constitute one of the many devastating impacts of AIDS. The Ministry of Health defines AIDS orphans as children under 15 who have had one or both parents die from AIDS (described as maternal orphan, paternal orphan, or double orphan). The associated social ramifications of the large number of AIDS orphans increasingly impact the young adult age group, as family structure changes and economic support systems strain to keep up with the growing orphan population. The rising number of under-educated youth and destitute street children will greatly affect urban areas and further stretch resources of the programmes already struggling to aid those groups. Already, the estimated number of children living on the street has increased from 35,000 to 90,000 from 1991 to 1998 (Daley, 1998).

Several authors have documented the various coping strategies used by extended families after the death of one or both parents. For example, in Katete, more than half of AIDS orphans are cared for by their grandparents (St. Francis AIDS Department, 1998). Another study of orphans in Matero East found that most children go to live with relatives, and 58% of the children surveyed were split up among family members and 92% receive no community support (Kongwa et al., 1991). Similar situations are found in

[1] Some data reflect revisions that occurred after first printing of the MOH/CBOH document.

other areas of Zambia, as noted by Rossi and Reijer (1995), Mulenga (1993), and Webb (1995). Widowers usually remarry quickly after the death of a mother, but if they do not remarry, their children will often go live with other relatives rather than remaining with their father. However, most orphans in Zambia are paternal orphans, and widows do not often remarry and are left alone with the responsibility of caring for their children.

The most pressing issues facing those adolescents orphaned by AIDS are food security, schooling, protection, and health. Thirty two percent of all school-age orphans living in urban areas are out of school, compared with 25% of non-orphans. In the rural areas, the corresponding figures for orphans and non-orphans are 48% and 68%, respectively (Webb, 1995). Even when orphans are taken in by relatives, they often do not receive an adequate level of care. If food is scarce, they are fed after the other family members. They are also the last to receive clothing, are at higher risk for sexual and physical abuse, and are more likely to enter the child labor market. In rural areas, girls may be married off as early as 12 or 13 so their families can collect a bride price and has one less person to feed (Daley, 1998). The number of AIDS orphans is estimated to be between 600,000 and one million by the end of 1999, and the complex issues of strategies for caring for these children must be addressed at the community and national level (Phiri, 1998; Chifuwe, 1998).

Sexually Transmitted Diseases and Young Adults

STDs are an important concern not only due to the illnesses and potential fertility problems they cause, but also because resulting open sores and lesions can increase chances of HIV infection by allowing for easier viral transmission. Prevalence of STDs among young people is difficult to gauge, as many seek treatment outside of the formal health sector (e.g. from traditional healers). Some infected individuals (particularly females) may be asymptommatic. Self-reported levels may be incorrect. Clinic records may be incomplete or not always show accurate ages.

Self-reported STD levels were low in the 1996 ZDHS (see following table), with only about 1% of females 15-19 and 3% of females 20-24 having had an STD in the last 12 months. Males reported slightly higher levels, at 3% for 15-19 and 8% for 20-24.

Self-reporting of Sexually Transmitted Diseases in the Last Year

STD	% Female		% Male	
	15-19	20-24	15-19	20-24
Any STD	1.3	2.8	3.3	7.6
Syphilis	0.6	1.2	0.3	1.8
Gonorrhoea	0.6	1.3	2.0	4.3
HIV/AIDS	0.0	0.2	0.0	0.0
Genital Warts	0.2	0.1	0.0	0.4
Discharge from penis	NA	NA	2.2	3.6
Sore/ulcer on penis	NA	NA	1.3	3.5

Source: ZDHS 1996

According to a 1997 study, adolescent STD cases averaged 40% (range of 21%-57%) of the total STD cases at the out-patient department (OPD) clinics reviewed, with higher proportions of females than males (Webb, 1997).[1] This study also looked at antenatal syphilis levels for females 10 to 25 years old at five antenatal clinics in five different districts, and found the lowest level was 3.8% and the highest 14.5% (for December 1996-June 1997).

[1] The study's author cautions that age reporting at clinics may not be reliable.

When asked whether they had ever had an STD,[1] a large sample of students aged 10-19 reported as illustrated in the following table. The highest percentage of self-reported STDs was among 15-19 year old females.

Percentage of Students that Ever Had an STD (N=1,100)		
Age	Male	Female
10-14	6.4	7.4
15-19	9.5	13.7
		Source: Webb, 1997

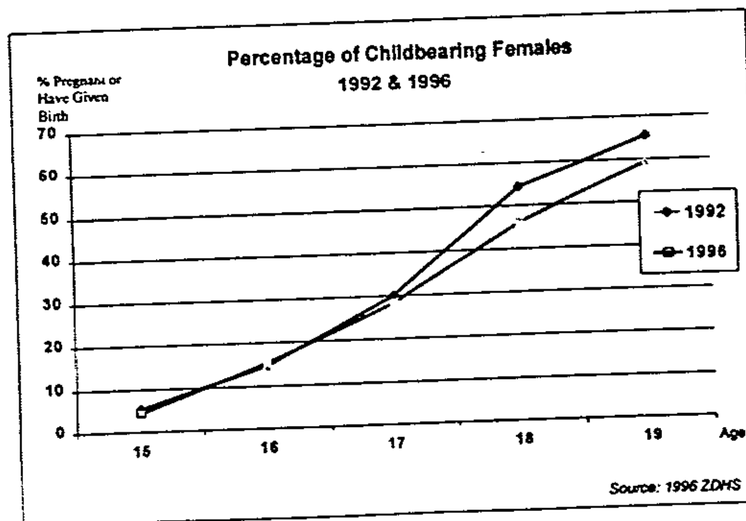
A convenience sample survey of youth 10-19 in four peri-urban Lusaka compounds found that, among sexually active youth, 8% of boys and 4% of girls reported ever having had an STD (n=656 male, n=440 female; Fetters et al., 1997). Another survey of youth 8-21 in six different Lusaka compounds found that among the sexually active adolescents (n=362 female; n=519 males), 5% of boys and 4% of girls reported ever having had an STD (Kambou, 1998).

In addition to transmission to other partners, health complications may arise from untreated STDs, so those who do not seek health care are at risk of further discomfort and fertility problems. If left untreated, STDs may be transmitted from mother to child during delivery.

Teenage Pregnancy and Childbearing

There are no data available on the prevalence of unwanted pregnancy in Zambia, but certainly some proportion of the children born to teens are unplanned and unwanted (particularly to those that are unmarried). The ZDHS data on pregnancy and childbearing demonstrates the high rates among teenagers.

Young people in rural areas and those with little or no education are more likely to begin early childbearing. Traditionally, men prefer to marry younger women as early marriage, along with having a child, enhances one's status. The 1992 ZDHS found that 34% of teens 15-19 had begun childbearing (already had a child or pregnant with first child), and by age 19 about two-thirds (66%) had begun. As shown in the following graph, the 1996 ZDHS showed a slight decrease overall, with 31% of teens aged 15-19 having begun childbearing. By age 19, 59% had begun (a decrease as well from the 1992 figure of 66%).



[1] The study's author notes that 8.2% of respondents that claimed never to have had sex also claimed they had an STD.

Starting childbearing as a younger teen increases the chance of having subsequent births during the teen years. Both the 1992 and 1996 ZDHS found that 15% of 19 year olds had two or more children.

Certain provinces have more childbearing teenage mothers between 15 and 19 years old. The 1996 ZDHS found that the highest proportion was in North-Western Province (38% of girls 15-19), and the lowest was in Luapula Province (23% of girls 15-19), as shown in the following table.

Percentage of Childbearing Females 15-19 by Province, 1996

Province	% Pregnant or Have Given Birth
North-Western	38.0
Eastern	35.0
Southern	33.4
Western	33.0
Central	32.3
Northern	31.4
Copperbelt	29.9
Lusaka	28.6
Luapula	22.6

Source: ZDHS 1996

Overall, there has not been much change between 1992 and 1996 in median age at first birth, which also shows most childbearing begins in the teen years. As shown in the next table, urban women had a slight increase from 18.8 to 19.1 between the two ZDHS surveys, while rural rates remained virtually the same.

Median Age at First Birth Among Women 15-49, 1992 & 1996

Location	1992	1996
Urban	18.8	19.1
Rural	18.6	18.5

Source: ZDHS 1992 & 1996

A convenience sample survey of youth aged 10-19 in four peri-urban Lusaka compounds found that 9% of sexually active males (n=656) claimed they had made a girl pregnant and 21% of sexually active females (n=440) had been pregnant at least once (Fetters et al., 1997a).

Webb (1997) found that 12% of male students and 9% of female students claimed to have made someone pregnant or been pregnant, respectively (N=1,100; 10-19).

Pregnancy and Health for Mothers and Infants

Obtaining adequate pregnancy monitoring and care is an issue for young women. Antenatal clinic (ANC) records have shown that most young women delay going to the ANC until the second trimester, and a sizeable proportion delay a visit until late in their pregnancy. For example, records reviewed on 10-25 year olds in selected clinics in Lusaka District showed that 16% attended the ANC during the first trimester, 63% during the second, and 21% during the third (Webb, 1997).

The 1996 ZDHS looked at the type of antenatal provider for mothers under age 20 at birth, and found that 93% had been assisted during pregnancy by a nurse/trained midwife, 2% by a doctor, less than 1% by a traditional birth attendant, and 4% were unassisted. Mothers under age 20 were assisted during delivery as follows: nurse/trained midwife (45%), relative/other (45%), traditional birth attendant (4%), doctor (4%), and unassisted (1%) (ZDHS, 1996).

Place of delivery may add risk to childbirth, particularly if there are complications. For mothers under age 20 at birth, 49% delivered at a health facility and 51% at home. For the same cohort, 14% of their babies were smaller than average and almost 5% were very small.[1]

The 1996 ZDHS also found:

- The infant mortality rate for children born to women that received both antenatal and delivery care was 98 per 100,000 births, compared to 160 for those that received neither type of care. Low levels of education were also associated with higher infant mortality rates for every age group.
- For all age groups, children born less than two years after the previous birth were twice as likely to die in infancy than those born after an interval of four years or more.
- The infant mortality rate for children of mothers under age 20 was 141 per 1,000 --70% higher than for children whose mothers were 30-39 at time of birth.
- The maternal mortality rate (deaths per 1,000 woman-years of exposure) is highest for the 25-29 age group at 2.14. (15-19: 0.75, 20-24: 1.40)

Abortion and Young Adults

It appears that most abortions occur among young adults and that legal abortions are rare, often resulting in complications and dangers to the girl's health. A legal, safe abortion is not always easily accessible and young girls do not have easy access to services and information. Though abortions are legal, some providers are not willing to perform them for religious or personal reasons. Additionally, hospital administrators may impose a policy that legal abortions may not be performed at their hospital. Furthermore, much of the public, and even health care providers, are unaware of the 1972 Termination of Pregnancy Act[2] or are misinformed about it, or believe abortion is illegal (Folsom et al., 1998). With such barriers, it is not surprising that younger as well as older women resort to self-induced, dangerous methods of abortions.

Who is Having Abortions and What is the Prevalence?

While there is some evidence of high prevalence among younger women, the number of unsafe abortions performed and resulting complications or deaths are not adequately captured in hospital or other records. Qualitative studies have revealed some perceptions of the levels of unsafe abortion --generally that levels are high and that school girls are more likely to induce an abortion that out-of-school girls.

Available data suggest that young women are more likely than are older women to undergo illegal, unsafe abortions. One study found that 80% of women with induced abortion related complications admitted to hospitals were under 19 years old (Likwa, 1989). Another study to determine socio-demographic differences between 199 women who obtained legal abortions and 65 who were hospitalised with complications after illegal abortions revealed that women who succeeded in obtaining legal abortions tended to be between 20-29 years of age (55%), had some secondary education (60%), and had children (71%). By comparison, most women having illegal abortions were between the ages 15-19 (60%), 55% had some secondary education, 80% were unmarried and 63% had had no prior pregnancies (Likwa & Whittaker, 1994). One study found that some girls believed younger girls (e.g. under 14) would be more likely to choose to have an abortion than older girls (Chambeshi et al., 1997).

Another study (Castel et al., 1990, cited by van den Bourne, 1996) also observed that many adolescents and women of lower socio-economic status delayed abortion procedures until the second trimester. This may be a result of lack of information, fear, or hesitation due to religious beliefs. For young girls, this delay could result from a failure to recognise signs of pregnancy, refusal to face the situation, or hope for spontaneous abortion.

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[1] These data are a weak measure of low birth weight, as 81% were recorded as don't know/missing.

[2] See Legal & Policy Issues section for more detail on the 1972 Termination of Pregnancy Act.

During a recent assessment of postabortion care in Zambia, participating health care providers indicated that most of the postabortion patients are younger teens who are unmarried and in school. The six hospitals visited during the assessment cited more than 9,000 emergency cases due to abortion complications in the past year. The assessment also found that postabortion care services lack follow up counselling on family planning methods and linkages to relevant services (Folsom et al., 1998). Notably, a UNICEF study found that the proportion of maternal deaths due to abortion increased from 13 percent to over 30 percent between 1974 and 1993.[1] It may be inferred that the majority of these emergency complications and deaths were to young women.

Interviews with health care workers (N=175) revealed that 64% of health care workers considered abortions very common or common in their communities (Webb, 1997). Boys and girls in Ng'ombe Compound, Lusaka, thought abortion was common in their area (Chambeshi et al., 1997). Chibbamulilo (1997) found that youths in one Lusaka community perceived that more than half of girls under 18 that get pregnant abort, and that girls in school were more likely than out-of-school girls to have an abortion.

Harmful Methods and Consequences

Methods used to abort are generally unsafe and dangerous for the girl. Some methods include taking red and black capsules bought at the market, drinking *Muleza* (a traditional drink made from roots), overdosing on 12 tablets of chloroquine, drinking washing powder solution, drinking *Chindulo* (ash solution), and drinking a soaked leaf solution called blue gum (Nkwemu et al., 1997). Numerous qualitative studies have identified a variety of methods used by girls in different areas, often self-induced (including pushing objects like cassava stem through the vagina to scrape out the foetus) and sometimes with advice or treatment from a traditional healer (Webb, 1997; Shah et al., 1996; Mupela & Fetters, 1997; Chambeshi et al., 1997; Fetters et al. 1997b).

In the group of 65 women with complications from illegal abortion described earlier, the most common method used (33%) was insertion of a cassava root into the cervix. Four deaths occurred among women in this group. None occurred in the group receiving legal abortions. Only 12% of the women resorting to illegal abortions and 27% of those who received legal abortions had ever used modern contraceptives (Likwa & Whittaker, 1994).

Why Abortion?

Likwa and Whittaker (1994) found that, of the 65 hospital patients with abortion complications in their study, 81% were students who wanted to continue with their education. Several qualitative studies have also identified the desire to continue school as a primary reason why girls have an abortion (Webb, 1997; Chambeshi et al., 1997; Mupela & Fetters, 1997). Other leading reasons found through qualitative research are as follows (Chambeshi et al., 1997; Mupela & Fetters, 1997, Shah et al., 1996):

- They do not want to disappoint parents
- Boy refuses to take responsibility
- Boys tell girls to abort so they can avoid marrying them
- They want to continue having fun and do not want responsibility for a baby
- They fear parents' anger
- There is no support for the child, either from boy's or girl's family

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[1] As cited in Folsom et al., 1998: UNICEF, *Safe Motherhood in Zambia: A Situation Analysis*, Monograph No. 3 (New York: Family Care International and UNICEF, 1994). Note: this figure has since decreased (Ahmed, 1998).

Exposure to Risk and Risk Behaviours

Undesirable reproductive health outcomes may be linked to a variety of behaviours and factors that increase exposure to risk, such as early marriage, sexual activity, sexual initiation, contraceptive method use, types and number of partners, and higher-risk sexual practices like dry sex.

Early marriage

Marriage among young people in Zambia, as in many other cultural systems, is an example of a life event that symbolises the psychological transformation of a person from childhood to adulthood (Webb 1996). The 1996 ZDHS shows that women are now marrying at a later age. The median age at first marriage[1] reported by women 25-49 increased from 17.4 years in 1992 to 17.7 years in 1996. There are also significant differentials in the median age at first marriage by province; women in Lusaka and Western provinces marry at an older age than women in other provinces (in Lusaka Province the median age of marriage is 18.5 years, compared with 17 years in North-Western and Luapula Provinces).

There has been an increasing trend among women in urban areas to spend longer periods in the educational system, thus raising their age at marriage. For example, the 1996 ZDHS found that women who have secondary or higher education marry more than four years later than women with no education. Urban women also generally marry one year later than their rural counterparts.

Women marry much earlier than men. A 1998 survey in Lusaka conducted by Population Services International (PSI) found that for those aged 15-24, 40% of women were married, compared to 9% of men (Agha, 1998). Mushingeh and Kurz (1997) also found that among women aged 14-24 in their sample (n=75), 40% were married.

Early marriage increases the likelihood of early and repeated pregnancies that may not be wanted, or undesirable health consequences to the mother and/or child. The strong traditional link between marriage and childbirth means that childbirth is seen as an immediate expected outcome of a marriage. It has been estimated that, at current age-specific fertility rates, a woman will have a total of 6.1 children in her reproductive period. Although this indicates a decline from 6.5 in the 1980's and early 1990's, it is still high compared to other sub-Saharan countries (e.g. Botswana 4.9, Namibia 5.4, Tanzania 5.8, and Zimbabwe 4.3) (ZDHS, 1997).

Sexual Activity

The gap between numbers of sexually active[2] and inactive youth decreases quickly with age. Though available data present varying estimates, it appears that about two-thirds are sexually active by their late teens, with more boys than girls having ever experienced sexual intercourse at all ages.

Magnitude

How many young adults are sexually active and who are the most sexually active? ZDHS data show high levels of sexual activity among young adults age 15 and above. The proportion that has never had sex decreases sharply with age. While 42% of 15-19 year old females are virgins, only 5% of those aged 20-24 have not yet had sex. Only 34% of males 15-19 and 11% of those 20-24 are virgins.

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[1] The ZDHS did not indicate whether the reported marriages were contracted under customary or statutory law.

[2] Sexually active = those who have ever had sexual intercourse.

It appears that by age 18 more than two-thirds of both males and females are sexually active. Those in the 15-19 and 20-24 age groups at the time of the 1996 ZDHS reported they had had sex by exact ages as shown in the following table:

Percentage Who Had First Sexual Intercourse by Exact Age, According to Current Age						
	Exact Age of First Sexual Intercourse					
	15		18		20	
Current Age	% Female	% Male	% Female	% Male	% Female	% Male
15-19	21.7	39.3	NA*	NA	NA	NA
20-24	21.7	31.9	69.1	70.2	86.2	82.6
*NA=not applicable						
						Source: ZDHS1996

Another survey of youth 10-19 in four peri-urban Lusaka compounds (N=1,634) found that 78% of males and 56% of females had ever had intercourse (Fetters et al., 1997a). Feldman (et al., 1997) found that 77% of male and female adolescents aged 14-20 surveyed in Lusaka were sexually active (N=276; average age 17). Another study with a smaller sample in Lusaka and Mansa found 63% of females aged 14-20 were sexually active (n=75; Mushingeh & Kurz, 1997). The PSI Lusaka survey found that 76% of female and 75% of male respondents aged 15-24 (n=394) had had sex (N=806; 15-49; Agha, 1998).

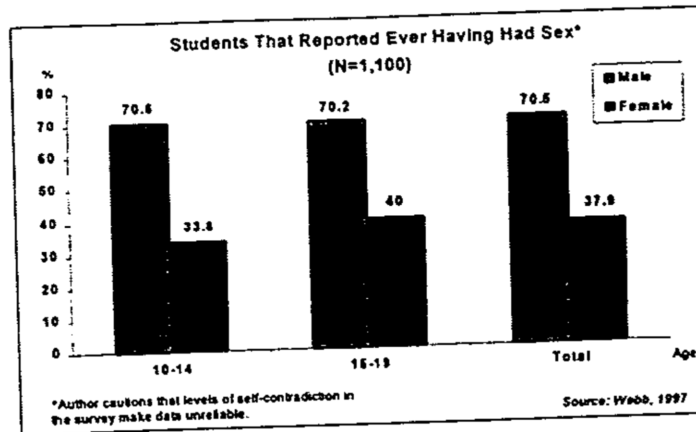
The same survey found that out-of-school youth are more sexually active than in-school youth, and that more males than females are sexually active, as shown in the following table.

Percentage of Young Adults Age 13-18 Who are Sexually Active by Gender and School Status		
School Status	Female (n = 371)	Male (n =353)
In-School	46%	73%
Out-of-School	82%	88%
Total	59%	79%
		Source: Agha, 1998

Feldman (et al., 1997) also found evidence of lower sexual activity among female students when more than half (53%) of schoolgirls (n=62) claimed to be virgins, compared to 21% for the total sample (N=276; males and females).[1]

Webb (1997) surveyed 1,100 male and female students using the narrative research method, and found that 71% of boys and 38% of girls reported ever having had sex. Reported sexual activity by age group and sex is shown in the following bar chart.

[1] Feldman adds that fear of pregnancy is likely to be a primary motivation for schoolgirls, as they do not wish to jeopardize their place in the highly competitive educational system (about one-third of the eighth grade youth pass entrance tests, and only 15% of tenth grade youth pass the exams).



From these data, male students appear to be much more sexually active than females and the levels do not vary greatly between age groups.

Qualitative research has revealed different perceptions regarding in- and out-of-school youth. During participatory learning and action (PLA) exercise in one Lusaka compound (Mtendere) youth felt in-school boys and out-of-school girls were the most sexually active, while in another compound (Misisi) they perceived that both out-of-school boys and girls were the most sexually active (Shah et al., 1996; Fetters et al., 1997).

Recent Sexual Activity

The frequency of sexual activity combined with unsafe practices increases risk of exposure to HIV, STDs and pregnancy. However, little is known about the frequency of intercourse among sexually active youth -- for example, whether they have had sex in the last month, how many times in that period, or how much more frequently boys are having sex compared to girls. The 1992 ZDHS measured sexual activity in the last four weeks and found that 56% of 15-19 year old females had had sex in that period. Interestingly, this percentage decreased substantially to 27% in the 1996 ZDHS, and in comparison, 28% of males aged 15-19 were sexually active in the last four weeks.[1]

Higher levels of recent sexual activity have been found elsewhere. Feldman (et al., 1997) found that almost all (79%) male and female adolescents aged 14-20 with a current boyfriend/girlfriend had had sex in the last four weeks. Differences in the percentages of those sexually active in the last four weeks among youth in the study were as follows: 89% of out-of-school males, 86% of out-of-school females, 79% of in-school males, and 47% of in-school females.

More than half of the youth surveyed (55% of males and 50% of females) in four peri-urban Lusaka compounds[2] had had sex at least once in the three months preceding the interview (n=676 male, n=440 female; Fetters et al., 1997a). In seven other Lusaka compounds,[3] 75% of boys and 64% of girls who had ever had sex were sexually active in the last three months (n=362 female; n=519 male; Kambou, 1998). This study also found that compound of residence was strongly associated with recent sexual activity, as girls residing in two of the compounds[4] were more likely to have been sexually active than girls residing in other study sites, and boys in two other compounds[5] were significantly less sexually active than those in the other study sites.

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[1] The 1992 ZDHS did not include a male survey module.

[2] Mtendere, New Kanyama, Misisi, and Ng'ombe.

[3] Chilenje, George, Chelstone, Kanyama, Chipata, Marapodi, and Mandevu.

[4] Marapodi and George.

[5] Chelstone and Kanyama.

Households and Level of Sexual Activity

Data on the effect of household composition on sexual activity are inconclusive. Notably, household composition is changing more rapidly and with less-understood effects due to the HIV/AIDS crisis (see earlier discussion on AIDS orphans in the "HIV/AIDS and Young Adults" section). PLA methods have revealed that youth perceive household living situations to be related to sexual activity, particularly for girls. This appears to be related to the level of "strictness" associated with a particular type of person living in the household. One perception was that living with both parents reduces chances that a girl will become pregnant because parents are more strict than other relatives (Shah et al., 1996 & Fetters et al., 1997b). Zambezi (et al., 1996) found perceptions that those living with grandmothers are less sexually active, girls living with grandfathers were more likely to have sex with close relatives (especially their grandfather), and those living with uncles were less sexually active than those living with aunts. Fetters (et al., 1997b) reported that boys felt that girls who lived on their own or with single fathers had most likelihood of becoming pregnant. Chambeshi (et al., 1997) noted the perception that pregnancy is more likely if a girl lives with a grandparent, on their own, or with an older sister, and that living with a male relative decreases the likelihood of sexual activity because males are more strict than females.

It has also been perceived that households with extended families living together may encourage sexual activity among relatives, particularly cousins (Chambeshi et al., 1997). Another perception found through PLA was that being a member of a "better-off" household diminishes the likelihood of sexual activity (Shah et al., 1996).

Where Do Youth Go to Have Sex?

Youth are finding places to have sex, typically at night or when others, such as their parents, are not at home. CARE PLA research (Shah et al., 1996; Mupela & Fetters, 1997; Fetters et al., 1997b) revealed the following locations were used most often for sex:

- Bushes
- Toilets
- Homes (when others are out)
- Boy's cabins (behind main house)
- Bars/rest houses
- Homes/buildings under construction
- Fields
- Abandoned cars
- Hotels/motels

Why Have Sex?

In various studies using PLA methodology done by CARE in peri-urban Lusaka with groups of boys and girls as young as 8 and as old as 20, a number of reasons were provided as to why young people have sex (Zambezi et al., 1996; Chambeshi et al., 1997; Shah et al., 1996; Mupela & Fetters; 1997; Fetters et al., 1997b). Webb (1997) found similar reasons in focus group discussions with youth 10-19. Common across the studies is that boys are having sex more for the feeling and to keep up with peer pressure, while for girls the money or gifts provided by boys is the leading motivator.

The main reasons given by boys as to why they (or other boys) have sex are:

- Pleasure or *nyele* (sensational sexual feeling)
- Peer pressure (e.g. competition for most partners)
- Fun
- Love for girls/love growing stronger with sex
- Test functioning of sexual organs
- Prove manhood
- Difficult to refuse when girls request
- Aroused by pornographic films
- Copying elders' behaviour
- Believe penis is supposed to be used when need arises

Girls have said they (or other girls) have sex for reasons that include:

- Money or material benefits (e.g. to buy food, cosmetics, clothes, lotion, for household needs, school materials, etc.)
- Peer pressure (often leads to wanting money for sex to keep with peers)
- Pleasure
- Keep boy from leaving
- To prepare for marriage
- Prove to their boyfriend that they love them
- Curious to try after seeing elders do it in open
- To become pregnant to prove not infertile

Participants in one PLA study provided reasons as to why different types of girls engage in sexual activity (Shah et al., 1996). According to the girls' analysis, poorer girls have sex for money because they desire to have the same things as better-off girls; in-school girls may have sex for curiosity, to get help with schoolwork, to earn pocket money/snacks, etc, and to get copies of exams from teachers; and out-of-school girls have sex more for material gain.

Why Might Youth Not Have Sex?

CARE PLA studies also examined adolescent's reasons for not having sex (Chambeshi et al., 1997; Shah et al., 1996; Mupela & Fetters, 1997; Fetters et al., 1997b). Primary reasons included:

- Fear of STDs/AIDS
- Fear of unwanted pregnancy (often girls more concerned about pregnancy than STDs)
- Fear of parents
- Fear of school expulsion
- Religion (e.g. religion forbids sex unless married; sex prior to marriage is a sin)
- (For boys) Not having money to pay for sex
- Desire to complete/concentrate on studies
- Caring mothers
- No interest

Sexual Initiation

Most notably, it appears that youths' perceived average age of first intercourse among their peers is usually lower than the actual average age. The ZDHS found higher ages of initiation than smaller surveys have.

Data from qualitative research found varying age perceptions, and these data were mostly collected in urban or peri-urban settings. Qualitative findings generally support the urban ZDHS median age data in that girls are perceived to initiate sex earlier than boys. However, other urban studies have found reported age of initiation for boys to be lower than that for girls, and as shown in the ZDHS table in the previous sexual activity section (Percentage Who Had First Sexual Intercourse by Exact Age, According to Current Age), more males in both the 15-19 and 20-24 age groups (39% and 32% respectively) reported being sexually active by age 15 than females (22% for both age groups).

National-level data show little change in median age at first intercourse between 1992 and 1996 for women aged 15-49, as shown in the following table. The 1996 data show the difference between rural males and females is negligible, but the urban males' median age of first intercourse averages a half-year older than the females' median age. According to these data, sexual initiation has occurred earliest among females in rural settings and latest among males in urban settings.

Median Age at First Intercourse Among Those Aged 15-49, 1992 & 1996				
	1992		1996	
Sex	Urban	Rural	Urban	Rural
Female	16.6	16.0	16.9	16.1
Male	NA	NA	17.4	16.0
			Source: 1992 & 1996 ZDHS	

CARE PLA studies have found that youth in peri-urban Lusaka communities perceived that boys as young as seven years old and girls as young as four years old may already be sexually active, though the average age was largely estimated at 10-12 for girls and 12-14 for boys (Zambezi et al., 1996; Chambeshi et al., 1997; Shah et al., 1996; Mupela & Fetters; 1997; Fetters et al., 1997b). However, among in-school youth, initiation has been perceived to be more delayed. In a survey of students aged 10-19, the perceived average age of initiation was 15-16 (Webb, 1997). Health workers that participated in this study perceived the average age of initiation was 18. A supplemental survey (N=1,634; 10-19) to CARE PLA in peri-urban Lusaka compounds found that about 17% of youth had initiated sex before age 10. Most reported initiating sex between 11-14 (slightly higher than the PLA perceived estimates). The younger average age for boys (11.8) than girls (13.3) also differs from PLA perceptions that girls initiated sex at younger ages than boys (Fetters et al., 1997a).

Kambou (1998) reported that another supplemental survey to CARE PLA in Lusaka found that 55% of girls had initiated sexual activity, compared to 81% of boys (N=1,294; 8-21; mean age 14.4). The mean age of sexually active boys was one year younger than the mean age of sexually active girls (14.8 years and 15.7 years respectively). The mean age of respondents who had not yet initiated sex was 13.2 years. There appeared to be compound-specific variations in adolescent sexual activity, as the median age at first sex varied across the six compounds surveyed, ranging from 9 to 12 years old for boys and 12 to 13.5 years old for girls. Compared to these survey results, during PLA in the same sites, boys tended to overestimate age at first sex and girls to underestimate, as shown in the following table.[1]

Compound	Boys Perceived Age at First Sex [PLA]	Boys Median Age at First Sex [Adolescent Survey]	Girls Perceived Age at First Sex [PLA]	Girls Median Age at First Sex [Adolescent Survey]
Kanyama	*12*	11	*10*	13
Chelstone	*15 – 16*	9	*10 - 11*	12
Chilenje	*10*	10	*12*	13.5
Chipata	*14*	12	*12*	14.5
Mandevu	*10 – 12*	12	*10*	14
George	*6 - 9*	11	*8*	13
				Source: Kambou, 1998

The 1996 ZDHS indicates that 22% of 15-19 year-olds had had sex by age 15. The same percentage was found for those in the 20-24 age group. However, this does not correspond with the indications coming from qualitative research that the majority may be initiating sex at younger ages than 15.

It is possible that many adolescents experience first intercourse at a young age, but then a long period of time passes before their next experience. Kambou (1998) reported that surveys found a considerable time lag between age at first sex and age at second sexual experience in six peri-urban Lusaka compounds, with a longer lag for girls than boys. Of the 881 respondents who had initiated sex and 547 who reported age at second sexual experience, the median age at first sex for girls was 13 years and the median age at second sex was 15 years. The median age at first sex for boys was 11 years and median age at second sex was 12 years.

[1] The author notes that the incongruity may be related to PLA team composition, ability of team members to collect this kind of data, and ability of team to analyze and aggregate this kind of data.

It is likely that contraception is not used at sexual debut, though there is little information on this. Zambezi (et al., 1996) found through PLA that both boys and girls had initiated sex very early with little or no use of contraceptive methods.

Contraceptive Method Use

Low contraceptive use increases exposure to pregnancy and HIV/AIDS/STDs. Although contraceptive prevalence is still low in Zambia, among women aged 15-49 it increased from 15.2% in 1992 to 25.9% in 1996. The use of modern methods has increased from 8.9% to 14.4% during the same time period. Traditional method use also increased in the four-year period, from 6.3% to 11.5% (ZDHS, 1992 & 1996).

The upward trend is evident among young adults as well. The 1992 ZDHS found that 7% of women aged 15-19 and 24% of women aged 20-24 had ever used any modern method of contraception. The 1996 survey showed an increase to 14% among 15-19 year olds and 36% among 20-24 year olds. The 1996 ZDHS also included a male sample, and for men aged 15-19, 24% had ever used a modern method, compared to 55% for those aged 20-24. Though these rates of ever use are encouraging, rates of current use --which imply more continued practice of risk-reduction-- are still low (though have generally increased from 1992 levels, as shown in the DHS indicator table in Appendix A).

The ZDHS 1996 reported current contraceptive method use among young adults as follows:

Contraceptive Prevalence Among Young Adults That Are Sexually Active

Method Type*	Any Partner Status				Currently Married		
	% Female		% Male		% Female		% Male^
	15-19	20-24	15-19	20-24	15-19	20-24	20-24
Any Method	7.4	20.3	13.9	30.4	16.9	24.9	29.7
Any Modern Method	4.7	12.3	12.2	23.6	8.8	14.7	13.5
Pill	1.1	6.4	–	2.5	2.8	8.7	2.3
IUCD	0.1	0.1	–	–	–	0.1	–
Injection	0.1	0.7	–	–	0.3	0.7	–
Diaphragm/Foam/Jelly	0.1	–	–	0.3	–	–	–
Condom	3.5	5.1	12.2	20.8	5.7	5.1	11.2
Any Traditional Method	2.7	8.0	1.7	6.8	8.1	10.0	16.2
Natural FP	0.3	1.7	1.0	3.4	–	1.7	6.7
Withdrawal	1.0	2.8	1.0	1.8	4.0	3.7	5.1
Other	1.4	3.5	0.7	1.6	4.1	4.6	4.4
Not Currently Using	92.6	79.7	86.1	69.6	83.1	75.4	70.3
Total Number of Weighted Cases	*2,003*	*1,830*	*460*	*404*	*498*	*1,207*	*115*

*No users of female/male sterilisation.
^Figures for married men 15-19 based on too few cases & have been suppressed.
Note: No age-specific data for unmarried only.
Source: ZDHS 1996

There are similarities in method use for both age groups of young adults:

- Contraceptive use is low.
- Modern method use is higher than traditional method use, but traditional method use is a notable proportion of total use.
- Condoms and pills are the most commonly used methods.[1]

Ways in which the 15-19 age group is different from the 20-24 age group include:

- Contraceptive use is much lower among 15-19 year olds than 20-24 year olds.
- Condom use greatly increases among males in the 20-24 age group.
- Pill use greatly increases among females in the 20-24 age group.

A survey of youth aged 10-19 in peri-urban Lusaka found that 34% of sexually active males (n=656) and

[1] These are typically the only methods known to PLA participants, based in CARE's work in PLA (Fetters, 1998).

25% of sexually active females (n=440) had ever used a condom, though when asked about ever-use of contraception, only 19% of males and 22% of females reported that they had used a method. Mushingeh and Kurz (1997) reported that among those young women using a contraceptive method,[1] 41% were pill users and 30% condom users (n=75 females 14-20). It is likely that many of the respondents did not associate condoms with contraceptive methods. Interestingly, the data showed that the majority of protected sexual acts (using condoms) occurred in late adolescence, after age 15 (Fetters et al., 1997a).

Pillai and Yates (1993) found that of the urban secondary school females aged 13-20 (N=516) who had heard of modern methods (65%)[2], only 6% had ever used modern family planning methods (note that higher proportions of older ages had heard of modern methods than the younger ages). About 30% of respondents had engaged in sexual intercourse in the two months preceding the survey, presenting a discouraging picture of both lack of information and a high level of unprotected sex (especially when the proportion that ever had sex is likely to be greater than 30%).

Ahmed (et al., 1997) reported results of the first phase of an operations research study on emergency contraception. Emergency contraception services (pills under brand name PC-4) were available in over 21 health care facilities across Lusaka and rural areas in Copperbelt Province. The mean age of emergency contraception users was about 29, with an age range of 19-43.. Youth aged 19 and below made up only 14% of MCH/FP clients at the four MOH clinics in the study, and less than 3% at the PPAZ clinics.

Unmet Need for Family Planning

The ZDHS 1996 reported unmet need[3] for family planning among 15-19 year olds at 25% (24% for spacing, 1% for limiting). Among 20-24 year olds unmet need was almost 28% (26% spacing 1% for limiting). A smaller study by Mushingeh and Kurz, (1997) found that unmet need was 43% among 14-20 year olds, met need[4] 30%, and no need[5] 28% (n=75 females 14-20).

Why Not Use a Contraceptive Method?

One study found that reasons for not using a contraceptive method among never-married adolescent women were infrequent sex and fear of side effects (Mushingeh & Kurz, 1997). One PLA conducted in a Lusaka compound revealed that contraceptives are not used because they are available only at clinics, hospitals or pharmacies. Among the other reasons for non-use noted in this study are that nurses at clinics ask too many questions and often do not approve of young people using contraception; use of contraceptives at young age may cause infertility; and pharmacies are too expensive (Mupela & Fetters, 1997). Other PLA studies have reported that pills may not be used because of the belief that they cause infertility or birth defects, or other side effects (Chibbamulilo, 1997; Shah et al., 1996). Some girls may think pills are only for those that already have children (Chambeshi, 1997).

Condom Use

The prevalence of condom use is important because this barrier method provides protection both from pregnancy and HIV/AIDS/STDs. Several studies have provided information on condom use levels (e.g. ever use, use with partner types, frequency of use) and motivating factors. The ZDHS 1996 found that among 15-24 year olds, males in the 20-24 age group were using condoms the most (21%).[6] The lowest

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[1] Met need reported as 30%, but proportion currently using family planning not reported.

[2] The study did not report a measure of ever had sex.

[3] Unmet need=unmet need for spacing+unmet need for limiting (the number or proportion of women currently married or in union who are fecund and who desire to either terminate or postpone childbearing, but who are not currently using a contraceptive method).

[4] met need=family planning users

[5] no need=do not want to wait at least 2 years before having next child

[6] Current use is defined as method being used at the time of the survey.

level of condom use was among 15-19 year old females (less than 4%). Five percent of females aged 20-24 reported current use of condoms, as did 12% of males aged 15-19.

The ZDHS also found that, among those who had intercourse during the four weeks preceding the survey, a surprisingly high percentage (nearly 18%) of 20-24 year old males reported using a condom at last intercourse with their wife. Notably, there were too few males aged 15-19 who had used a condom at last intercourse to even show a percentage for that age group. Percentages for females were also low, as shown in the following table.

Condom Use at Last Intercourse by Type of Partner, Among those Who Had Intercourse in 4 Weeks Preceding the Survey, 15-24

Type of Partner	15-19		20-24	
	Females	Males	Females	Males
Spouse	7.6%	NA	7.0%	17.5%
Other Partner*	0.8%	–	2.4%	–
Regular Partner^	–	0.0%	–	0.8%
Someone Else^	–	0.0%	–	1.3%
Any Partner	4.1%	0.0%	6.1%	6.4%

*Only for females.
^Only for males.
Source: ZDHS 1996

Other studies that examined condom use show that use is likely to be low and irregular. Feldman et al. (1997) found that of sexually active male and female adolescents 14-20 (n=210) less than half (47%) had ever used a condom, and only a few routinely used condoms. Seven percent had used a condom each time they had sex in the previous four weeks, 33% had sometimes used a condom and 60% did not use condoms at all. The findings were also discouraging for youth with multiple partners: of those having sex with one or more partners other than their boyfriend or girlfriend in the last four weeks (n=109), 4% used a condom every time, 39% sometimes used a condom, and 58% never used a condom. Additionally, Chiboola (1990) reported from a survey of youth 11-25 (N= 160) that only 2% of males and 2% of females who had had sex in the last six months said they always used condoms. Another study revealed that almost all respondents understood that unwanted pregnancy, STDs and HIV are possible consequences of unprotected sex, and 70% acknowledged that condoms provide effective protection against these undesirable outcomes. However, only one third reported that they always use condoms (Mano Consultancy Services, Ltd., 1998).

As mentioned earlier, a survey of peri-urban Lusaka youth aged 10-19 found that 34% of sexually active males (n=656) and 25% of sexually active females (n=440) had ever used a condom, and the majority that had used a condom were over 15 years old (Fetters et al., 1997a). Another survey in different Lusaka compounds found that among the sexually active adolescents (n=881), 37% reported ever using a condom (Kambou, 1998).[1]

A 1997 PSI survey reported the following rates of condom use at last sex as follows:

- 27% of women 15-19 used a condom at last sex, as did 21% of women 20-24 (likely due to higher number of married women in 20-24 age group); and
- 35% of men 15-19 used a condom at last sex, as did 36% of men 20-24.

The PSI survey also found that condom use was significantly higher among males 20-24 than females 20-24. There was some evidence that condom promotion is reaching the younger age groups more; condom use was significantly higher among young adults under 30 than older adults. Condom use was also significantly associated with non-marital sexual activity for both men and women. There was no significant association between schooling and condom use, although men with a secondary or higher educational level were two times more likely to report condom use at last sex (Agha, 1997).

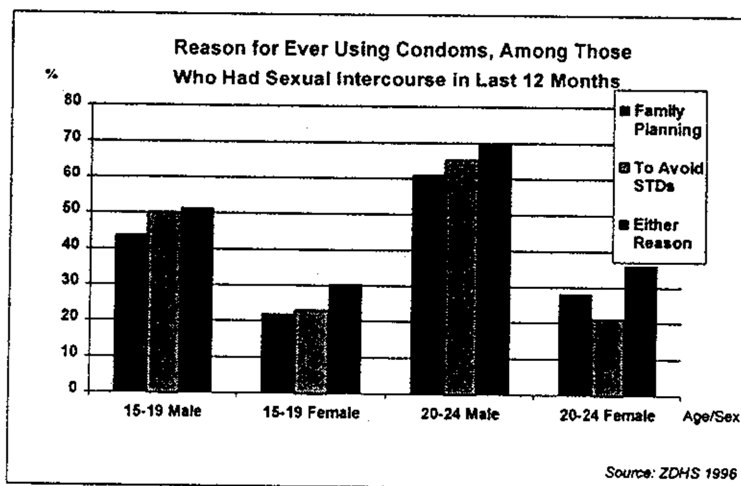
[1] These data not presented by age groups.

Webb (1997) found that among those who reported ever having had sex (n=550), 59% of schoolgirls 15-19 had ever used condoms compared to 36% of schoolboys aged 15-19 (12%).[1] Condom use among the younger sexually active students was even lower. Just 25% of girls 10-14 reported ever using condoms, as did only 12% of boys 10-14.

Among a sample of mostly male college students (n=149 male; n=38 female), 56% had ever used a condom, but regular condom use was low unless with non-regular partners. Condom use with regular partners was reported as follows: never (27%), sometimes (57%) and always (16%), while use with 'other' partners was: never (12%), sometimes (28%) and always (60%) (Mkumba & Edwards, 1992).

Why Use A Condom?

A 1997 PSI survey found that, among condom users aged 15-24 (n=102), 79% reported that they used condoms for pregnancy prevention (more females (93%) than males (76%) reported this), and 99% for HIV/AIDS/STD prevention (Agha, 1997b). Chambeshi (et al., 1997) found that those who used condoms said they did so to protect themselves from disease. Mano Consultancy Services (1998) discovered in FGDs that students (14-25) used condoms because they are easily available and protect against pregnancy and STDs. As shown in the following bar chart, the 1996 ZDHS found that far higher proportions of males than females reported they had used condoms for family planning and/or prevention purposes.



Why Not Use A Condom?

The 1997 PSI survey identified the following as reasons for non-use of condoms (reported by non-users 15-24): do not like condoms (64%), trust partner (55%), partner objected (37%), not available (35%), and cost (5%) (Agha, 1997).[2]

Qualitative research with youth has identified a spectrum of reasons they may not want to use a condom (Webb, 1997; Chambeshi et al., 1997; Shah et al., 1996; Mupela & Fetters, 1997; Fetters et al., 1997b; Chibbamulilo, 1997; Macwan'gi, 1993). Some of the main reasons youth provided as to why they do not want to use condoms are:

[1] The author questioned reliability of this data, as levels of self-contradiction are high in younger age groups.

[2] It is unclear whether use of other contraceptives (e.g. for pregnancy prevention) was investigated as reason for condom non-users not to use condoms.

- Getting excited and forgetting
- Too big/may slip off (especially for young boys)
- Reduces pleasure/skin-to-skin sex feels better
- May burst
- Girls fear boys will prick tip/cut holes in condom
- Girls may be viewed as promiscuous/seen as prostitute
- Religious reasons (e.g. sin)
- Young boys' sperm too weak to make girl pregnant
- Lack of money to buy
- Condom may slip off into girl
- Does not protect against AIDS because has microscopic holes
- Girlfriend does not like
- Causes mistrust

In their survey of college students (N=195), Mkumbo and Edwards (1992) found that those who had never used a condom were more likely to think it reduces sexual pleasure than those who had used them. This survey also revealed that availability of condoms was an issue in the early 1990's, as 43% reported they would use condoms if they were more easily available.

Partner Status

Whether one is in a partnership and the type of partnership may have implications for exposure to risk. Young adults appear actively involved with members of the opposite sex, whether as regular partners (e.g. boyfriend/girlfriend), 'other' or non-regular partners, or married partners. Not surprisingly, married partnership status increases with age, as shown earlier. The following table demonstrates the differences between males and females in partner status, with males having the highest levels of non-regular partners.

Partnership Status by Males & Females Aged 15-24 in Lusaka

Partner Status	Females (n=206)	Males (n=188)
Unmarried, Sexually Active		
Regular partner	27%	33%
No Regular Partner	9%	34%
Married	40%	9%

Source: Agha, 1998

Feldman found that 74% of youth aged 14-20 (N=276), had a boyfriend or girlfriend at the time of the interview (Feldman et al., 1997). In a sample of college students, 34% currently had a regular partner (N=195; ages not specified; Mkumba & Edwards, 1992). Pillai and Yates (1993) found that 71% of female students aged 13-20 (N=516) had a boyfriend, and that almost half (48%) had a high likelihood of sexual intercourse due to their steady or 'close' relationships with males.

Number of Partners

In the context of unprotected sex, higher numbers of partners increase risk of both HIV/AIDS/STDs and pregnancy. Little is known about the number of partners younger people have in a specific time period, though the ZDHS provides some information on the 15-19 and 20-24 age groups. The 1996 ZDHS examined the number of sexual partners for the 12 months preceding the survey among unmarried and married young adults aged 10-24.

Number of Recent Sexual Partners: Percent Distribution of Unmarried Women & Men 15-24										
	Women					Men				
	Number of Partners									
Age	0	1	2-3	4+	DK/M*	0	1	2-3	4+	DK/M*
15-19	68.9	25.0	5.0	0.7	0.4	49.4	21.5	20.4	8.5	0.3
20-24	52.6	36.3	8.5	1.1	1.5	30.6	33.8	21.7	13.7	0.2

*DK/M=don't know/missing

Source: ZDHS 1996

Unmarried men have a notably higher number of partners than unmarried women in both age groups. The pattern is the same among married men and women.

Number of Recent Sexual Partners: Percent Distribution of Married Women & Men 15-24										
	Women					Men				
	Number of Partners									
Age	0	1	2-3	4+	DK/M*	0	1	2-3	4+	DK/M*
15-19	2.0	96.6	1.3	0.2	0.0	**	**	**	**	**
20-24	3.4	94.6	1.8	0.1	0.1	1.6	66.5	19.9	12.0	0.0

*DK/M=don't know/missing
**Figure based on fewer than 25 unweighted men & has been suppressed.

Source: ZDHS 1996

Several smaller studies have looked at number of recent partners as well. One found that 29% of college students had more than one partner in the last year. (N=195; ages not specified; Mkumba & Edwards, 1992). Feldman (et al., 1997) found that 17% of youth aged 14-20 (mostly boys) had TWO or more partners simultaneously. Fetters (et al., 1997a) found that 55% of males (n=376) and 40% (n=229) of females 10-19 had had more than one sexual partner in the last three months.

Characteristics of Partners

Partner type has implications related to locus of control, degree of influence/coercion, and, most importantly, exposure to HIV/AIDS/STDs. Partner type is linked closely to having sex for financial or material gain ("exchange sex"), as will be discussed in more detail later. Partner preferences are also examined in a different section. Qualitative studies have identified a variety of partner types, ranging from classmates and neighbour youth to relatives, "sugar daddies" (older men with money), and teachers. One study looked at the relationship with first sex partner and found that friends and neighbours were the most common types of partners. More females (60%) than males (45%) reported first sex with a friend, and more males (38%) than females (22%) reported first sex with a neighbour (n=675 male, n=447 female). Five percent of males and 5% of females reported first sex with cousins, and 5% with "strangers" (Fetters et al., 1997a).

Perceptions that sex between cousins is common have been found in a number of Lusaka studies (Shah et al., 1996; Chambeshi et al., 1997; Mupela & Fetters, 1997; Fetters et al., 1997b). It may also be fairly common between brothers- and sisters-in-law and stepbrothers and stepsisters (Mupela & Fetters, 1997; Chambeshi et al., 1997; Fetters et al., 1997b). Fathers, uncles, grandfathers, and brothers have also been cited as possible partners (Fetters et al., 1997b; Mupela & Fetters, 1997).

A study of college students found that the male students are involved in "Gold rushing" (finding sexual partners among first-year female students) and "importing" (finding young women from outside the college) (Mkumba & Edwards, 1992). More predatory practices are evident as older men seek out younger girls for sex. Youth perceive that sugar daddies prefer to have sex with girls because they think the girls do not have HIV/AIDS, and girls acquiesce for the financial benefits (Zambezi et al., 1996). Haworth et al. (1996) also found that older men seek schoolgirls as "safe" sexual partners.

Sexual Practices

Sexual practices may enhance risk exposure, such as preferences for dry[1] and skin-to-skin sex. STD and HIV transmission may also occur through unprotected oral or anal sex. Dry sex is commonly practised in Zambia and may increase young people's risk of exposure to STD infections by irritating the vaginal lining. Nyirenda (1991) found in her small study of women 17-41(N=50), the majority of whom were under 30 (n=31), that dry sex was widely practised among respondents (86%), and the practice cut across all social, economic and ethnic backgrounds. Most respondents were not aware that dry sex might increase their risk of HIV infection. Feldman (et al., 1997) reported that 28% of the Lusaka girls surveyed (n=114) had undergone ritual initiation (*chisunga*), which includes instruction on how to dry out the vagina and stretch the labia majora.[2] Twelve percent of girls surveyed had engaged in dry sex; additional probing during FGDs revealed girls and boys prefer wet sex, though they had the perception that adults prefer dry sex. Though youth in those FGDs expressed a preference for wet sex, other qualitative research has found youth prefer dry sex (Zambezi et al., 1996).

There are few data on oral and anal sex practices. Youth may be less aware of the risk of HIV/STDs transmission during these behaviours, and thus may be less likely to use condoms or to decide not to practice oral or anal sex. Feldman (et al., 1997) reported that 25% of those interviewed had engaged in giving or receiving oral sex. Forty-eight percent of out-of-school girls had performed fellatio (14 out-of-school and two in-school girls reported swallowing their partner's semen, and three in-school boys and one out-of-school boy reported they had ejaculated into their partner's mouth). Only 12% (mostly out-of-school girls) reported giving or receiving cunnilingus. Ten percent of respondents had had insertive or receptive anal intercourse (35% of these were out-of-school girls), and few of those who had had anal sex reported using condoms (14%). A few of the out-of-school girls reported giving or receiving anilingus.

Factors and Issues Related to Behaviour

What's behind riskier or safer behaviours? As described earlier, various studies have presented reasons provided by youth as to why they have or do not have sex, and why they do or do not use condoms. Beyond these perceived motivations, there are other factors that may influence youths' behaviour.

Sources of Information for Sexual and Reproductive Health

PLA findings and results from other studies in peri-urban Lusaka indicate that parents are not a main source of sexual and reproductive health information for young people, and that whereas grandmothers and other female relatives feature strongly for girls, friends and media are more likely to influence boys. School is also not a primary source, though sometimes mentioned, and is more likely to be reported as a source by those currently in school (Zambezi et al., 1996; Chambeshi et al., 1997; Shah et al., 1996; Mupela & Fetters, 1997; Fetters et al., 1997b; Chibbamulilo, 1997).

[1] The practice of "dry sex" involves some procedure to dry out the vagina prior to intercourse, such as mopping vaginal secretions, douching, inserting herbs into the vagina, ingesting traditional medicine or taking a cold herbal bath (Nyirenda, 1991). There is evidence that the practice of dry sex increases inflammation and abrasion in the vagina, thus heightening a woman's vulnerability to STI and HIV infection.

[2] Note: The study also found that there is no documentation of the practice of female genital mutilation in Zambia, although stretching of the labia majora is encouraged during *Chisungu*, a three-month ritual initiation for girls (Feldman, et al., 1997).

More commonly cited sources are:

- Friends
- Grandparents, particularly grandmother
- Aunts/female relatives
- Pornographic magazines/films (boys)
- Elders, including traditional initiators (*banachimbusas*) for girls
- *Ng'angas* (traditional healers)
- Radio/TV
- School (teachers/textbooks)
- Practical experience

Fetters (et al., 1997b) noted that adolescents felt they could speak with grandparents more freely, and not at all with parents. Also, youth said it is not uncommon to see animals having sex or adults having sex in their homes and communities. Focus group discussions (Mano Consultancy Services Ltd, 1998) with students showed that many of them believe that health advice is best obtained from health education materials and from health centre personnel. Unfortunately, they were often unsatisfied with the information provided and said that staff would sometimes tell them that they did not need to know the answers to their questions. Parents interviewed for the same study thought that young people should get advice from within the family, however, they acknowledged the difficulty of talking to youth about traditionally taboo subjects such as reproductive health. In another study of service providers almost all participating nurses felt that everyone, including medical personnel, the community and parents, should be involved with the education of adolescents on issues of sexuality and reproduction (Chikotola, 1996).

Chambeshi (et al., 1997) found that girls in one Lusaka compound get most information from initiation ceremonies led by *banachimbusas* (elder women that teach girls how to prepare for marriage, care for husbands, *donsa* (pull labia to certain length), and observe certain rules set by elders). The number of girls that experience initiation ceremonies is not clear; one study found 28% of the in- and out-of-school girls had done so (n=114, 14-20) and another survey of in-school girls found 48% of those 17 and older had done so (n=516, 13-20) (Feldman et al., 1997; Pillai and Yates, 1993).

Fathers are unlikely sources of information for girls. Thirty percent of female students in one study (N=516) said it was easy or very easy to discuss sexual matters with mothers, whereas 77% felt it was not easy to discuss sex with fathers (Pillai and Yates, 1993). Grandmothers, friends, aunts, female neighbours, and traditional healers have been cited as persons most likely to be contacted for abortion information or advice (Chambeshi et al., 1997). The ZDHS 1996 reported that radio was the most common source of information on HIV/AIDS for males 15-24, and whereas females more often consult friends or relatives.

The top five sources by age group were as follows:

Sources of Information on HIV/AIDS	
Females 15-19	*Males 15-19*
▪ Friend/relative (62%) ▪ Radio (47%) ▪ Health worker (33%) ▪ School (31%) ▪ TV (22%)	▪ Radio (65%) ▪ Friend/relative (58%) ▪ School (38%) ▪ Newspaper (31%) ▪ Pamphlet (20%)
Females 20-24	*Males 20-24*
▪ Friend/relative (60%) ▪ Health worker (57%) ▪ Radio (56%) ▪ TV (23%) ▪ Newspaper (12%)	▪ Radio (77%) ▪ Friend/relative (63%) ▪ TV (30%) ▪ Newspaper (26%) ▪ Health worker (26%)
	Source: ZDHS 1996

Knowledge and Beliefs

Though knowledge alone (for example, understanding the existence and health consequences of STDs/AIDS) may not decrease risk-taking, it is essential that youth be adequately informed about sexuality and reproductive health. In general, studies have reported that knowledge related to reproductive health is basic, and often incomplete or incorrect depending on the subject matter. Additionally, many studies have identified erroneous beliefs that may contribute to a false sense of security among younger boys and girls.

The 1996 ZDHS investigated knowledge of specific STDs, and found HIV/AIDS reported by most female respondents 15-19 (86%) and 20-24 (89%), as well as males 15-19 (93%) and 20-24 (94%). A majority cited syphilis and gonorrhoea, though compared to 15-19 year olds, the 20-24 year old group was more knowledgeable. Males were more knowledgeable than females in all categories.

Qualitative research has found awareness of consequences of unprotected sex appears to be fairly high but that knowledge is lacking in areas such as STD symptoms and treatment, specific contraceptive methods, and certain aspects of reproductive health (Zambezi et al., 1996; Shah et al., 1996; Chambeshi et al., 1997; Fetters et al., 1997; Chibbamulilo, 1997; Webb, 1997).

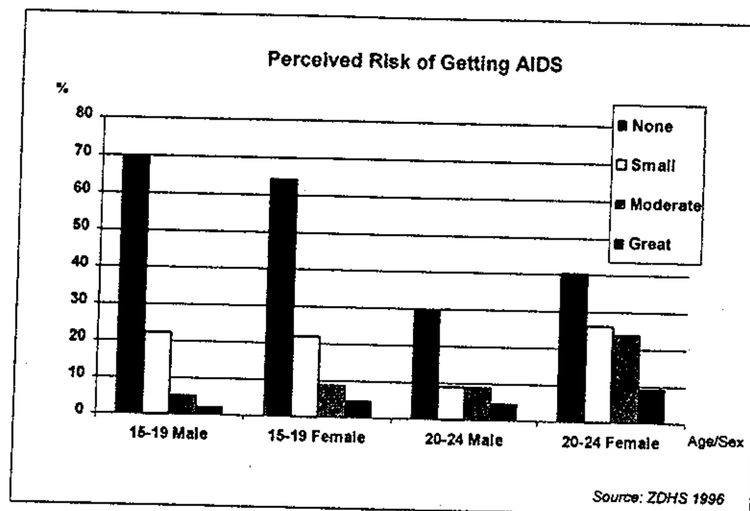
These studies have identified a variety of beliefs that may influence adolescent risk-taking behaviour:

- There is no danger of pregnancy or STIs for 'skin-to-skin' sex between younger girls and boys (e.g. under 14-15), as it is only the older ones who are fertile or that transmit or carry infections (*"sperms not strong enough [to get a girl pregnant]"*-Misisi PLA participant) (Fetters et al, 1997b; Zambezi et al., 1996; Shah et al., 1996; Chambeshi et al., 1997).
- Boys believed that girls are the main carriers of STIs and that it is normal for a boy to be infected as part of growing up (Zambezi et al., 1996).
- Girls believed condoms may move from vagina up into the womb (Chambeshi et al., 1997).
- Using condoms may lead to impotence (Chambeshi et al., 1997).
- Contraceptive pills cause sterility or birth defects (Shah et al., 1996; Chibbamulilo, 1997).
- Contraceptive pills are only for those who already have children (Chambeshi et al., 1997).
- Use of contraceptives at a young age may cause infertility (Mupela & Fetters, 1997).
- A beautiful and healthy appearance eliminates the need for protection (Fetters et al., 1997b).

The ZDHS 1996 found relatively low levels of knowledge of ways to avoid AIDS. In fact, about 10% of girls 15-19 and 9% of girls 20-24 thought there was no way to avoid AIDS (compared to 3% and 4% of boys, respectively). Furthermore, a high percentage of girls (23% of 15-19 and 14% of 20-24) said they did not know any way to prevent AIDS. Though using condoms, abstaining from sex, and having only one sex partner were the most popular prevention strategies cited, overall proportions were low (the highest was for males who said using condoms (55% 15-24)). Additionally, just 6% of boys aged 15-19 and 11% of boys aged 20-24 said they avoid sex with prostitutes (ZDHS, 1996).

Perceived Susceptibility and Risk

The 1996 ZDHS found that the majority of young adults did not believe they were at any risk for AIDS, though older youth were more likely to have some perceived risk than younger (see bar chart that follows). However, other studies have reported higher levels of perceived risk.



Source: ZDHS 1996

Many young people that participated in PLA studies did not see themselves at risk of sexually transmitted infections. As described earlier, a belief exists that younger girls and boys are not susceptible to STDs or pregnancy, and this weakens perceptions of the risk of having skin-to-skin sex. However, youth are generally concerned about possible consequences. Webb (1997) found that boys' main worry concerning sex was the risk of acquiring STDs and AIDS, and for girls it was pregnancy.

Feldman (et al., 1997) reported that 57% of youth 14-20 (N=276) were very worried about getting AIDS, and this concern was more prevalent among the out-of-school youth. While 55% felt they had little or no chance of getting AIDS (especially in-school youth), 25% (mostly out-of-school females) thought their chance was high or very high. Health workers have noted that young people are more worried about HIV and request tests for HIV, however, this does not seem to affect behaviour. The incidence of STDs is increasing and sexual behaviour seems unchanged despite the fear of HIV (Mano Consultancy Services, Ltd., 1998).

Youth in different Lusaka compounds have emphasised several negative consequences of sexual risk-taking (Chibbamulilo, 1997; Fetters et al., 1997b):

- Unwanted pregnancy
- Illegal abortions (and possible death)
- Discontinued education for girls
- HIV/AIDS/STDs

Knowing someone who has experienced a health problem or severe consequences may prompt personal risk-assessment and behaviour change. For example, whether youth in Zambia that know someone with AIDS are more likely to modify their own behaviour is an important question. A study based on a small sample of mostly male college students (N=195) found that 33% reported not knowing anyone with HIV, 9% had a relative with HIV/AIDS, 30% had a friend/relative who died from AIDS, and 43% knew an HIV positive co-worker/friend who has died (Mkumba & Edwards, 1992). Six percent of youths in this study reported ever using a condom. Feldman (et al., 1997) found that 76% of youth 14-20 (N=276) knew someone with AIDS or who had died of AIDS. Perhaps indicating that knowing someone with AIDS is not a primary motivation to have protected sex, less than half (53%) of those who were sexually active (n=210) had ever used a condom.

Locus of Control: Who Makes Decisions That Affect Risk?

Qualitative research has shown that males are the primary sexual initiators and decision-makers in most relationships, and females are unlikely to be assertive in negotiating for safer sex practices such as condom use. However, girls may sometimes propose sex to boys, as well as refuse to have sex with a

boy (Webb, 1997; Shah et al., 1996; Chambeshi et al., 1997; Fetters et al., 1997b). Chambeshi (et al., 1997) notes that decisions to have sex appeared to be more commonly made by those girls sent out to obtain money for the household, or orphans and girls working as sex workers. Decisions to use condoms, however, are most often made by men and boys.

Shah (et al., 1996) found that boys usually make the decision to buy and use a condom, though girls may suggest it sometimes. Girls were sceptical that, although a boy may agree to use a condom, he will cut holes in it --thus girls often feel that using condom is no safer and not worth requesting. Girls may also feel that suggesting condoms implies unfaithfulness or that they have an STD, or lack of trust/love (Zambezi et al., 1996; Fetters et al., 1997b). Webb (1997) found that, while girls may sometimes suggest condom use, boys are responsible for obtaining one, and girls rarely initiate condom use for fear the boy will think they are sick or they do not trust or love them.

Self-Efficacy

There are little data on self-efficacy (the belief that one has the ability to successfully perform a behaviour). Feldman (et al., 1997) reported that 86% of youth 14-20 (N=276) felt they were capable of changing their behaviour to prevent AIDS (the lowest self-efficacy was among out-of-school boys). One qualitative study found that boys were sceptical of anyone having the ability to use a condom every time (Fetters et al., 1997b).

Macwan'gi (1993) reported that youth in FGDs specified not knowing how to use a condom correctly as a barrier to condom use. Among a sample of 195 mostly male college students, 27% reported condom breakage during use (Mkumba & Edwards, 1992).

Intention

Intention to change a behaviour may lead to safer practices, and is a desirable outcome of an intervention, but typically studies have no follow-up to check this association. Feldman (et al., 1997) found that 55% (N=276) agreed they needed to change their behaviours to prevent AIDS. Of the 59% who had not yet modified their behaviour to prevent AIDS (n=156), 40%[1] intended to do so in the future (Feldman et al., 1997).

As part of her study of dry sex practices among women 17-41 (N=50; n=31 aged 17-30), Nyirenda (1991) found dry sex to be popular. However, after a brief counselling session on HIV/AIDS, more than half of the participating women spontaneously decided to stop dry sex behaviour. It is not known whether this intention became a reality for these women.

Partner Preferences

Partner preferences have been investigated in several studies, and depending on the location and sample, the preferences vary.

PLA study in New Kanyama Compound, Lusaka, found that girls' partner preferences are related to their motivation for money, social status, and material gifts. For example, the girls might prefer *ntemba* owners (vendors) and bus/minibus drivers if their motivations are centred around money and material gifts (Mupela & Fetters, 1997). The same study found that boys favoured girls for physical appearance (e.g. light-skin, well-built buttocks, small breasts, coloured (mixed blood), and some favoured educated girls and/or girls from rich families (Mupela & Fetters, 1997).

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[1] Author reported that proportion intending to change is low because those who were not sexually active were likely to have had no need to change their behaviour.

Similarly, in Misisi Compound, Lusaka, girls in the PLA study preferred boys that have money (e.g. working boys) and dress well. *Yos* (boys who wear low-waisted baggy trousers) are popular, as may be 'gangsters' or *galagata* (boys that wear certain types of shoes). *Kawalalas* (thieves) are also preferred because they dress well and give girlfriends money. Schoolboys were least preferred. Some boys preferred younger girls for their small body size and *cadets* (vaginas), while others preferred good looking, medium-build girls (Fetters et al., 1997b).

Shah et al. (1996) reported in PLA findings from Mtendere Compound in Lusaka that most youth preferred to have age-mates as sex partners, though out-of-school girls preferred older boys or men (because they can pay well in return for sexual favours). Some boys mentioned that they go for younger girls (they ask for less money and are more likely to be free of any infectious diseases). Additionally, girls that participated in the study related that their most preferred types are friends, "gangsters" (well dressed, have money), drivers, minibus conductors, *wenges* (wear high-waisted trousers), and *yos*.

Using the narrative research method, Webb (1997) found students aged 10-19 thought it most likely that a first sexual intercourse experience would be with age-mates. PLA research in Ng'ombe Compound, Lusaka (Chambeshi et al., 1997), found that boys preferred to have girls younger than them as sex partners because they believe their chances of a resulting pregnancy are lower. They also preferred schoolgirls because they are smart, clean, not too expensive, and do not have STDs. In-school girls preferred schoolmates and boys from well-off families, as well as teachers. Out-of-school girls preferred minibus conductors and vendors because they always have money to give them.

Exchange of Sex for Money or Gifts

Partner preferences for girls appear to be strongly related to exchange sex. Girls have reported receiving, and boys have reported giving, money or gifts for sex. Power imbalances and the greater earning potential of males may influence this phenomenon. Females, possibly more so those who have been orphaned, may be forced to live on the street and become commercial sex workers to survive economically.[1] Males who live on the street may also exchange sex to survive from day-to-day. Exchange of sex for some material gain appears common among young sexually active females, and small proportions of males have reported receiving something in exchange for sex as well. However, findings have varied considerably across studies.

The 1996 ZDHS found that 38% of sexually active unmarried females 15-19 and 28% of those aged 20-24 had been involved in sex for money, gifts, or favours in the last 12 months. To further substantiate these figures, 39% of sexually active unmarried males 15-19 and 36% of those 20-24 had been involved in sex for money, gifts, or favours in the last 12 months.

In four peri-urban Lusaka compounds, 65% of girls (n=440) and 2% of boys (n=656) aged 10-19 reported having received money or a gift the last time they had sex, while 35% of boys and no girls said they had given someone money or a gift (Fetters et al., 1997a). Another study (Feldman et al. (1997a)) revealed that nearly all (90%) of the sexually active females surveyed had received money or gifts for sex on at least some occasions. Seventy-one percent of sexually active compound boys reported having given money or gifts for sex, while only 6% (3 of 51) of girls had given money or gifts to a boy for sex. Thirteen boys reported they sometimes received money or gifts for sex from females. Focus groups also revealed that sometimes a boy that is considered handsome or very poor will be given money or gifts from the female sex partner.

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[1] No studies were identified on young commercial sex workers. It may be possible to obtain additional information on the subject from Tasintha, an NGO focusing on sex workers that is located in Lusaka, Zambia.

Fetters (et al., 1997b) found that girls may initiate sex and give boys something in return. However, they do not typically pay boys for sex because this might imply that they are *hules* (prostitutes) or that they are not disease-free. In their study of youth trainees aged 15-17 at seven different youth skills training centres (N=208), Mukuka and Tembo (1996) found that girls were having sex for material benefits, and that for both males and females poverty and unemployment emerged as the strongest factors in influencing sexual behaviour.

Some studies described payment amounts. Chibbamulilo (1997) found that girls are offered Kw50-Kw10,000 or other types of payment for sex, and sometimes parents 'indirectly' send daughters out to have sex for money due to poverty. Chambeshi (et al., 1997) noted that reported amounts paid for sex varied depending whether a condom was used. While amounts paid for sex ranged from Kw100 to Kw15,000, boys reported different payments for sex with a condom (Kw5,000) and for sex without a condom (Kw10,000). Another study also found reports that girls receive more money for sex without condoms (Kw30,000-45,000 with condom and Kw50,000-60,000 without). In the same study, in-school girls were estimated to get Kw500-1,500, and out-of-school girls were thought to charge according to status of the man (e.g. up to Kw10,000 per hour). In another study (Fetters et al., 1997b) one group of girls reported the following payments by partner types: *Kawalala* (thief)-Kw10,000; *Kantemba* (vendor)-lotion/soap/biscuits/sweets; unemployed-Kw2,000; teacher-past papers; schoolboys-homework/test answers; and footballers-Kw5,000. Boys reported giving girls money, pants, lotion, shoes, school supplies, "love cards," and *chitenge* fabric.

Drug and Substance Abuse

Drug and substance abuse impairs judgement and may be associated with other risk-taking behaviours. Therefore, an understanding of drug and substance abuse is key to fully grasping the circumstances of high risk behaviour. This issue is an increasing concern for Zambian youth, especially in urban areas. Unfortunately, data are inadequate to illustrate the extent of the problem. The types of drugs and substances abused among young people both in- and out-of-school include marijuana (*dagga*), gasoline, wax, and fermented human waste -- which is mostly abused by street kids (Lubilo, 1997). Others are alcohol (usually a starting point for graduating to other forms), and tobacco (Zulu, 1998).

The reasons advanced for substance abuse include (Zulu, 1998 & Lubilo, 1997):

- Peer influence among adolescents
- To overcome frustration
- Low self esteem
- Curiosity
- Availability of these drugs
- For excitement
- Ignorance
- Lack of information about effects
- Poor family backgrounds/ family break-ups

Among affluent families, wide and unrestricted exposure to different styles of life may encourage young adults to abuse drugs and substances (Zulu, 1997).

Feldman et al. (1997) found that most (70%) of the 14-20 year old youth surveyed, especially females, knew someone who takes drugs (aged 14-20; N=276). Fifteen percent (mostly boys) had ever used non-injectable drugs. While 47% said they had never drunk alcohol, 16% (mostly boys) drank alcohol at least once/week.

Of the 39 cases handled by the Drug Enforcement Commission (DEC) in 1997, 32 were for young adults aged 15-24 (of which 29 were males).[1] The breakdown by substance was as follows: poly abuse[2]-18,

[1] Note: UN conversion factor estimates that for every one reported case, there are seven others that go unreported.
[2] *Poly abuse* is a term used to describe a combination of different drugs.

Valium-13, marijuana-6, heroin-1, inhalants-1. All of the Valium cases were recorded among in-school youths, and in most cases students sold drugs to fellow students. In another study investigating drug trafficking, abuse, and dependence, Malambo (1994) looked at 735 DEC case records. This number includes those that were recorded under the Lusaka-based rehabilitation and counselling programme that was established in 1991 under the National Education Division of the Drug Enforcement Commission. The following numbers were compiled in the report:

- The 16-23 age group topped all others in drug abuse (39%) [other age groups were: 24-31 (35%) and 32-39 (14%)].
- Of in-school youth, those in secondary schools were the greatest drug abusers (56%), followed by those in college (18%), primary school (14%) and university (12%).
- Young people still attending school were the greatest drug abusers, followed by unemployed youths.
- Peer pressure was a leading influence in drug abuse/dependence.

Some policy and legal efforts have been made to control drug and substance abuse in the country. The DEC was formed through an act of Parliament in 1989. This led to the formation of the National Education Campaign of the DEC in 1991, which is the unit that implements the rehabilitation and counselling programme. As Lubilo (1997) observed:

> Zambia has pieces of legislation responding to substance and drug abuse/addiction. Currently anyone below the age of 21 is not to be allowed entry into a liquor store or pub. However, enforcement is difficult since young people are seen as good buyers.

It is not uncommon to find young people either selling a variety of alcoholic beverages (as street vendors) or in a drunken capacity along most roads, bus stops, and streets of Lusaka's town centre.

Violence, Coercion, and Sexual Abuse

A study undertaken by the YWCA (1997) shows that violence touches the lives of all Zambian women and their families. Women and some men experience violence in many different forms, such as physical, psychological, sexual, economic, social or cultural abuse. Femicide (the murder of females) represents the most severe form of violence against women and is the most glaring example of inequality between the sexes. Although it occurs in Zambia, the information collected on femicide is often incomplete and little data is included on victims (e.g. age). Because most case records lack this information it is difficult to know the extent of femicide in the younger age groups. The YWCA femicide register has 134 cases recorded between 1990 and 1995, of which 108 are missing information on victim age. Between 1990 and 1995, five cases were recorded in the 10-24 age group. One 13 year old female was raped and killed by unknown persons in Lusaka, while the four older females were killed by their husbands, all of whom were over 24 years old. It is notable that four females under 10 were also killed in this time period (YWCA, 1995).

Young adults (usually males) have been known to commit this crime. Data on perpetrators show that a 22 year old male committed femicide in 1993, and, in 1994, a nine year old and 20 year old each committed femicide. Overall, the data on criminals, crimes, and victims are too small to generalise to a wider population. Nevertheless, a common and perhaps significant factor emerging from the mentioned cases is that the people committing these crimes are usually close acquaintances such as spouses, friends, or relatives. Also, these crimes usually occur within the home (YWCA, 1995).

A more common form of violence against women is that of sexual abuse. The daily papers, especially *Times of Zambia* and *Daily Mail*, frequently print stories of young girls being raped by a stranger, father, or other relatives. This increases the risk of unwanted pregnancy and contracting sexually transmitted infections.

A YWCA study investigating incest found that:

> Young women live in fear because of forced sexual intercourse with their fathers. In one community the young women said, "*we are told that when the time comes we must oblige to sleep with our fathers. It is disgraceful and really dehumanising.*" In another community an example was given in which a 16 year old girl attempted suicide twice because of continual sexual assault from her father (YMCA, 1997).

However, girls are not the only young victims. A recent study found that the sexual abuse of young boys by older women is an increasing, though largely unreported, problem. This study of tertiary level students (n=341 females, n= 628 males) examined the nature and extent of childhood sexual experiences between adults and children through a self-administered questionnaire and focus group discussions. Twenty percent of the participants (25.6% of males and 17.2% of females) were invited or forced to "play" sex as a child. About 18% said they had a same-age partner. Eight percent of the respondents reported adult-child sexual activity that involved force, abuse, or rape, while almost 26% reported willing participation in adult-child sex. Boys reported being induced into sexual behaviour by much older cousins, aunts, neighbours and house servants (Haworth et al., 1996).

A Lusaka study investigated the circumstances under which respondents between the ages of 18 and 21 had first experienced sex, and found that 19% (including boys) felt that they had been forced to initiate sex while 81% felt that they had initiated sex willingly (n=869 sexually active). More girls (28%) reported having been forced than boys (12%) (Kambou, 1998).

Young people in PLA research have reported several categories of close relatives that girls may have sex with (cousin, brother-in-law, father, uncle, brother and grandfather), and that, with the exception of cousins and brothers-in-law, sex is usually forced by the male relative (Shah et al., 1996). PLA has also revealed the perception that sex among close relatives is common, especially among cousins (though sex with cousins was viewed as typically consensual). It is also more common between brothers- and sisters-in-law and stepbrothers and stepsisters. The rarer father-daughter and uncle-niece sex occurs when *juju* (black magic) is involved, and is typically forced, as is brother-sister sex (though, in contradiction, boys in PLA who admitted to having sex with their sisters said it was not forced) (Mupela & Fetters et al., 1997).

Sex among cousins was perceived to be frequent, as well as intercourse between stepbrothers and stepsisters. Household circumstances where many different relatives live together may encourage this practice (shared residences are common in compounds) (Chambeshi et al., 1997).

Lusaka youth that participated in a PLA study perceived sexual relations between cousins and in-laws as common and consensual, while they thought that sex between fathers-daughters or uncles-nieces would occur only under forced circumstances (Fetters et al., 1997b).

In another study, PLA participants estimated that 20% of girls are forced to have sex. Force was perceived as more likely to occur with the following partner types: *Sene Sene* (Senegalese traders), grandfathers, uncles, and fathers. Reported types of force are threats and beatings, and that occasionally boys use knives to threaten or hurt girls when they refuse to have sex (Shah et al., 1996).

Women have little hope that the legal system will help. As Sifuniso (1997) observed:

> Rape cases, even among minors, are heard in open court. Sordid details are wrenched out of the victims to entertain idlers and a crime against a woman continues to be treated as a misdemeanour ... The issue of property grabbing from the widows by relatives of their deceased husbands is not taken seriously because recently this crime is being committed against widowers by the relatives of their deceased wives.

Health-Seeking Behaviour and Access to Services

Clinics are usually not the first choice of youth that are seeking advice or treatment (particularly related to reproductive health needs), and generally they delay using services and use services infrequently.

Chambeshi (1997) reported that both girls and boys mentioned that they would only go to the clinic after failing to get traditional medicine from *ng'anga* (traditional healers) and *vamizimu* (spiritual healers), or help from private practitioners. Similarly, Webb (1997) found that traditional healers were considered the first option for STD treatment and abortions, and formal health services were sought as a last resort. The study also noted some contradictory evidence on preferences for advice/treatment-seeking behaviour, as FGD participants cited friends, traditional healers, and private clinics, while narrative research respondents cited nurses and clinics. Another study found that adolescents use clinics mainly for treatment of sicknesses not related to sex, instead preferring to see traditional healers for STDs, pregnancy, and abortion for faster, more private service (Mupela & Fetters, 1997).

Several other studies have noted low use of clinics by adolescents. Young people that participated in several PLA studies reported low clinic use (Zambezi et al., 1996; Shah et al., 1996; Chibbamulilo, 1997). Webb (1997) found that antenatal clinic records showed that most pregnant girls delayed going to the ANC until the second trimester and a sizeable proportion delayed until the third trimester (many did not attend due to stigmatisation).

A review of records at six out-patient department (OPD) clinics showed that 25% of all attendees were adolescents (aged 11-25), with slightly more females than males. This percentage ranged from a low of 17% in Chipata to a high of 34% in Ndola. Importantly, the study also noted that the level of dialogue between staff and adolescent patients was highest at antenatal clinics and lowest in the OPD. Only one-third of OPD patients were able to ask all the questions they wanted. At selected health centres in three districts, less than one-third of young patients were attended to within 30 minutes. At selected health centres in six districts, around half of young adult STD cases went untreated due to unavailability of drugs --as a likely barrier to improving client attitudes towards clinic use, patients consider receiving medication as the main reason for seeking clinic services (Webb, 1997).

Why Do Youth Avoid Clinics?

It appears that youth use clinics rarely, and when they do use them it is primarily for illnesses that are not sexually related --largely because they feel they will receive the same treatment as adults for such illnesses (Shah et al., 1996; Zambezi et al., 1996). Formal health services are typically not user-friendly for young people.

Studies by Webb (1997) and Fetters et al. (1997b) identified as the following principal deterrents to clinic attendance:

- Fees that are too high (e.g. no money for national health medical scheme received by clinics)
- Shortages of drugs (and can't afford prescription at pharmacy)
- Poor staff attitudes/treatment
- Lack of privacy/confidentiality (may see friends/neighbours who will tell parents)
- Being embarrassed or reprimanded by nurses that know them
- Fear of being asked to bring sex partners
- Fear of injections
- Want to transmit disease to others as revenge

Most of these themes have been repeated in a number of other qualitative studies (Chibbamulilo, 1997; Mupela & Fetters, 1997; Zambezi et al., 1997; Shah et al., 1996; Chambeshi et al., 1997). In addition to further emphasis of the above reasons, these studies revealed several other perceived barriers among young adults, such as that they will be turned away because they are too young, that only married girls can get services/contraceptive pills, and that they feel shy. Interestingly, Chibbamulilo (1997) learned from FGDs with health centre staff that they were uncomfortable providing family planning services to youth below 15 years old.[1]

Ahmed (et al., 1997) reported results of focus groups with college students held during the first phase of an operations research study on emergency contraception. Students at Ridgeway campus revealed that students wanted privacy and confidentiality when seeking family planning services, and thus were discouraged from seeking care through campus or university teaching hospital (UTH) services. Students at the main campus said clinics were under-utilised because of the fear of being labelled promiscuous and the poor attitudes of clinic staff, who were often critical and unfriendly.

Youth and Provider Suggestions for Improving Use of Clinics

Shah (et al., 1996) noted the following suggestions for improving clinic use from boys during PLA research in a Lusaka compound:

- Abolish medical scheme
- Nurses should not insult boys getting STI treatment
- Clinic staff should stop eating when with a patient
- Increase the number of doctors to reduce congestion
- Correct treatment should be prescribed by clinic staff
- Staff should not hide the medicine

Chibbamulilo (1997) reported that health centre staff made some suggestions on how to increase youths' use of the clinic, such as having awareness campaigns about clinic-based youth-friendly clubs (using drama and posters); adding videos and games to youth-friendly clubs at the clinic; and adding skills training activities to youth-friendly clubs. Chikotola's study (1996) of service providers reported that eight of the nineteen nurses felt that adolescents need special attention. The participants identified key features necessary for serving youth, including staff training, health education, separate services for youth, school health services, counselling, youth-friendly services, and treating adolescents like adults. Ganges' (1997) evaluation of the CARE/MotherCare PALS Project Clinical Training Component assessed clinical and interpersonal skills of service providers working with adolescents and found that a

[1] The policy was changed in 1995 to allow minors to come to clinics without consent (Fetters, 1998).

large number reported changes in their attitudes towards young people after they received training on the special needs of youth. The participants identified future needs for youth-friendly services, and noted that simply increasing the number of participants in training for youth-friendly services would be useful, as well as making sure that a staff member who had received such training was at the clinic at all times.

Private Sector and other Sources for Care, Treatment, and Contraceptive Products

Webb (1997) found that chemists, community-based distributors (CBDs), and *kantembas* are preferred by youth as condom sources. Chibbamulilo (1997) reported that youth like private sector providers (such as street vendors and drug stores) because there is no congestion, faster service, no questions asked, and no counselling sessions (where nurses "scold" youth). However, private sector providers may not be appropriate, as they usually do not explain use of methods to clients, and storage tends to be poor, for example, condoms exposed to the sun (Webb, 1997).

Ahmed (et al., 1997) reported that college students who participated in FGDs did not view CBDs and health educators as viable outlets for contraceptives, due to a perceived lack of competence and the associated lack of privacy. This, along with the earlier described reluctance to seek campus clinical services, resulted in the following youth-specific recommendations: (1) new channels for distribution of emergency contraception must be sought if it is to be made accessible to youth (and other special groups); and (2) based on youth comments during FGDs, new outlets of both information and PC-4[1] could include chemists, on-campus peer counsellors, circles of friends, and the mini-mart at University of Zambia (UNZA) main campus.

[1] PC-4 is a packet of four oral contraceptive tablets packaged for use as emergency contraception.

Opportunities: What Do Data Suggest for Prioritising YARH Needs?

Young people between the ages of 10-24 comprise more than one-third of the population in Zambia, and that proportion is growing. Taking steps now to ensure their reproductive health, with particular attention to the younger ages, can translate into a healthier generation for today and the future. Available data provide evidence of the many risks, barriers, and challenges faced by today's youth. But there are also opportunities for action revealed by the data. Suggested priority areas for YARH efforts to consider are organised as follows:

1. Providing Information and Education
2. Influencing Behaviours, Relationships, and Community Norms
3. Increasing Service Access and Utilisation
4. Stimulating Advocacy and Policy
5. Improving Research and Data Collection

The suggested priority needs and actions that follow provide a starting point for discussing, prioritising, and action planning among those working in YARH. Current or future programme locations, resources, and operating constraints should be considered during this process.

Providing Information and Education

♦ Young people are not waiting until they are married to engage in sexual activity and, even when married, males, in particular, are practising unsafe behaviours such as multiple partners and low condom use. While clear information on safer practices is appropriate for all ages, increased emphasis on benefits of abstinence and delaying onset of sexual activity for the younger ages, introduction of preventive methods for the middle age groups, and the benefits of monogamous, protected sex for older youth is important.

♦ Youth are initiating sex at very young ages. Appropriate sexual and reproductive health education in schools should be provided before they become sexually active and start practising riskier behaviours. Teachers need to be trained accordingly. To help further understanding of the transition, more information is needed on decisions and conditions under which sex is initiated.

♦ The belief that there is no risk of STDs and pregnancy when sexual intercourse is with or between younger boys or girls should be addressed in family life education (FLE), peer outreach, condom promotion efforts, and IEC campaigns.

♦ Unsafe abortions pose a great risk to girls' health and there are a wide array of dangerous methods known by girls. School FLE programmes should focus on providing girls with accurate information to dispel misconceptions that self-induced abortion methods are effective and safe to use.

♦ Limited data show that secondary school students use drugs and substances. With an integrated approach to risk prevention, school programmes should also address substance abuse, as it impairs judgement that may lead to risky sexual behaviours.

♦ Address the common misperceptions regarding condoms and pills, such as that they cause sterility.

♦ Radio generally reaches more males than females (particularly older males), and is an important channel for programmes to consider in targeting strategies.

Influencing Behaviours, Relationships, and Community Norms

♦ Younger women are more at risk than younger men of STDs and HIV/AIDS, and because they exert less control over decision-making in a relationship --particularly in situations with older partners—they are less likely to insist on using a condom. Programmes that improve negotiating skills and risk-benefit analysis of young women may help, as would strategies to help them avoid dangerous situations.

♦ Perceived rates of sexual activity are generally higher than reported rates, and there are many inconsistencies in the data. IEC efforts should address the normative perception among young people that their agemates are sexually active. Changing the perception that peers are sexually active may help youth to delay their own sexual initiation or reduce sexual activity.

♦ The normative practice of exchange sex creates an incentive for young women that encourages increased sexual activity with multiple partners and with older adult men. Efforts should be made to identify alternative, acceptable incentives or benefits that enable girls to acquire resources and support from sources other than sexual relationships.

♦ Orphans are an increasingly larger proportion of the 10-24 age group. Their circumstances (ranging from living in a household without one or more of their biological parents, to dropping out of school, to living on the street) make them more vulnerable to sexual and reproductive health risks --such as prostitution-- and health problems for which they do not seek services. Programmes should consider ways to provide youth orphans with a supportive environment, such as by targeting them in IEC, counselling, and clinic outreach efforts. Additionally, education often provides a protective factor (resulting in lower levels of risk), but many orphans discontinue school. Efforts should be made to look at how to retain orphans longer in the educational system.

♦ Grandmothers and friends are primary sources of information on sexual and reproductive health matters. More programmes may want to include grandmothers, who are also the primary source of information on abortions, as a secondary target group to enhance this communication channel. Programmes can add or strengthen peer education components to capitalise on the reliance on friends and seek to ensure correct information is imparted.

♦ Parents and other adults can be secondary target audiences, though it is unlikely the barriers to parent-child communication on sexual health can be easily impacted. However, mother-daughter communication may be easiest to address. Despite parents' reluctance to talk to their own children, they are likely to also be someone's aunt or uncle, and in that capacity can reach young relatives with appropriate information and advice.

♦ Traditional healers are a popular source of information, advice, and treatment for many youth. Some youth will not readily change the behaviour of seeking help from traditional healers, so this channel should be targeted for improving quality of services (and possibly referrals to modern medical care) and information, particularly for STDs.

♦ Video shop owners, minibus drivers, vendors, and teachers are also sources of information and/or sexual partners. They can be provided with training, IEC materials, or contraceptives and serve as important distribution points.

♦ Because poverty and unemployment appear to be associated with risky sexual practices, particularly engaging in sex to receive gifts or money and choosing higher-risk partners, more income-generating projects that are specifically for girls should be considered.

♦ There are many differences between boys and girls' behaviour and distinct issues (for example, younger girls being approached by sugar daddies, the effect of peer pressure to have sex on boys). Programmes should develop profiles of the youth they are trying to reach segmented by age, behaviours, and other characteristics, and identify additional research needs. Channelling resources toward narrower, better-defined target groups may improve programme impact.

♦ The relationship between early sexual activity and other "risk-taking" behaviours such as drug or alcohol use should be better understood and addressed.

Increasing Service Access and Utilisation

♦ Contraceptive method use is very low considering levels of sexual activity, and traditional methods are the choice of contraception for many. To increase demand for and access to modern methods, providing a choice of methods to young people in a youth-friendly manner at alternative delivery points is essential.

♦ It appears that cost is a major deterrent to youth seeking clinical services, even with the current health scheme. A scaled payment system should be considered for youth.

♦ Because of access barriers, alternative sources of contraceptive supplies for youth need to be tested and successful distribution efforts should be increased. One example of an alternative strategy could be condom vending machines placed in bathrooms at bars or other areas where young people congregate. Other distribution sites, such as youth clubs, could also be tried.

♦ Services should be promoted to youth as having a "new" image of youth-friendliness, and promotion efforts should be directed toward youths' perceptions of barriers to service use. However, promoting a new image should not be done until the services are modified to match increased expectations of youth for a better experience. Issues such as negative provider attitudes, shortages of drugs, waiting time, and private space are critical to youth accepting services and should all be addressed adequately <u>before</u> demand is stimulated (or else risk losing repeat visits of those that come for the first time).

♦ Training should be encouraged for all providers to address youth issues. For example, the perception among health workers that youth are initiating sex at later ages (e.g. 18 or older) should be changed by using training opportunities to inform them of the high rates of sexual activity among younger unmarried youth. Additionally, providers should be aware of the prevalence of STDs and pregnancy rates for those under 20, understand how provider attitudes impact service delivery and utilisation, and respond to the special needs of youth.

♦ Establishing strong linkages between nurses/doctors, peer counsellors, and schools should be explored. Because schools are an ideal place to reach large numbers of youth at younger ages before they become sexually active, building a positive image of health providers and the institutions they represent may help encourage health-seeking behaviours.

♦ Most pregnant adolescents tend to make their first antenatal visit in the second trimester. IEC messages should be developed that encourage young women to visit the clinic earlier to ensure their own health as well as that of the child.

Stimulating Advocacy and Policy

♦ Girls should be informed that if they are pregnant they can still continue school. School officials should support their continuation and attitudinal changes are necessary to reverse community and family pressure against continuation. This can help reduce the number of dropouts, delay second births, and reduce unsafe abortions.

♦ Policies related to access to information and services, including abortion, should be made clear to providers.

♦ Educate opinion leaders and providers about demand and need for strong postabortion care services and follow-on family planning counselling.

♦ Incest and coercion appear to be fairly common, yet the legal system does not provide sufficient support for young women. Advocacy efforts are needed to improve the gender-biased legal environment and provide protection for victims.

♦ Access to safer abortion services is hindered by the legal requirements and provider/administrator reluctance to conduct/allow abortions in their hospitals, as well as lack of knowledge of the legal rights to abortion by women and providers --thus impacting the rate of illegal abortions and number of post-abortion care complications. Policies of individual hospitals should reflect the legality of abortion. Consideration could be given to amending the 1972 Termination of Pregnancy Act to reduce the number of physicians required for consent.

♦ Access to information and education should be supported by policy.

Improving Research and Data Collection

♦ Data were often contradictory and inconclusive. Studies should be designed adequately and have larger sample sizes to increase reliability and provide more evidence on prevalence of YARH indicators.

♦ Evaluation of youth friendly services and peer education/counselling is needed to demonstrate impact.

♦ Additional research on the effect of sexual abuse and coercion on young people is needed to better understand the link between sexual abuse/coercion and risk behaviours later on.

♦ One of the barriers cited by youth related to visiting health facilities is cost. Research is needed to better understand what urban and rural youth are willing to pay (if anything) for services.

♦ Improved data collection on violence against women and drug/substance abuse is needed.

♦ Cost studies are needed to improve understanding of the cost of different YARH interventions relative to the number of youth reached, and the additional cost of adding youth friendly services to existing services.

- It would be useful to learn more about differences between those youth practising safer behaviours (e.g. consistent condom use) and those youth that are not. Programmes can use this information to help further segment their target audiences and determine the best approaches to changing their behaviour.

- It is important to collect additional data to look at variations in sexual activity across geographic areas (e.g. compounds), to help services reflect needs more accurately and to improve selection of target group/message priorities by area.

- More reliable data on first sexual experience are needed (e.g. use of contraception, age and type of partner).

- Data should be collected to understand the extent of the relationship between early onset of sexual activity, unprotected sexual activity, and other "risk-taking" behaviours.

Programmes for Young People

To assess the general level of programme activities and extent to which activities address youth needs related to sexual and reproductive health, the FOCUS team interviewed key informants representing various organisations. Key informants were identified with the assistance of Project Concern International (PCI), USAID, and the members of the USAID Adolescent Task Force. The majority of the key informants and programmes identified are based in Lusaka, though many of the Lusaka-based organisations have national or multi-province interventions. To collect programme information, four youth interviewers were trained and hired to assist the lead researcher with the interviews. A semi-structured questionnaire[1] was used for each interview (see Appendix B). In a few cases, key informants self-administered questionnaires or portions of questionnaires.

Programmes with varying degrees of youth emphasis are reflected in this programme inventory: some key informants reported that their organisation has an entire programme dedicated to young people, while others reported on strong components that are part of programmes related to a broader range of age groups. For purposes here, "programmes" will be used to refer to both specific youth programmes and programme components, although sometimes distinctions will be drawn using the separate terms. Programme will also refer to the youth focus of an association or membership group.

Appendix M contains "programme profiles" of the 48 programmes surveyed. Information is presented in individual tables to supplement the synthesis presented here. Programme profiles aim to provide a concise, comprehensive description for easy reference, and do not contain all of the individual programme data collected. Additional appendices provide information on individual programmes within a comprehensive table, and are referenced as appropriate in the synthesis that follows.

It should be noted that, while key informants were asked to respond only about their activities and services to young people between 10-24, many programmes cover a broader or smaller age group. Programme descriptions may include services provided through a collaborating entity, e.g. clinics or schools. Though some information on coverage and reach was elicited, it was beyond the capacity of this inventory to assess the relative strength and coverage of each programme.

Types of Organisations Represented

Most organisations are non-profit NGOs (none self-identified as for-profit). Thirty-seven organisations are non-profit NGOs, six are government entities, and seven are affiliated with a church or religious group. Some of these organisations are also affiliates of international or Zambian organisations or membership associations. There are several government institutions that co-ordinate or implement national efforts related to young adult reproductive health (e.g. the Curriculum Development Centre of the Ministry of Education, the Ministry of Youth, Sport, and Child Development, and the Ministry of Health's Health Education Unit).

Main Programme Goals

Main goals of individual programmes are shown in the programme profile tables (Appendix M). Because the majority of programmes appear to have goals that reflect the full spectrum of pre-coded

[1] An international programme survey questionnaire developed by Advocates For Youth (Washington, D.C.) was extremely useful for design of the inventory questionnaire, as was the input of USAID partners and youth interviewers.

items on the questionnaire, it is possible that key informants may have overstated programme goals due to interviewer prompting (interviewer error in coding may have also contributed). However, it is also likely that a broader focus is inherent in most programmes, as they are inspired to attempt to meet the diverse needs of their youth beneficiaries and other target groups in a holistic manner.

Over 80% of programmes specified HIV/AIDS and STD prevention as primary goals. Lists of the most frequently mentioned goals and the additional ones specified follow.

Most frequently mentioned goals by percentage of programmes:

1. HIV/AIDS prevention (85%)
2. STD prevention (83%)
3. Family life education (71%)
4. Pregnancy prevention (69%)
5. Youth development/leadership (65%)
6. Gender awareness/education (58%)

Additional goals specified:

- Prevent child abuse
- Promote behavioural change
- Establish community counselling centres/strategies
- Encourage abstinence
- Encourage HIV Testing
- Provide counselling
- Provide marriage counselling
- Build self-esteem/confidence
- Promote human development
- Improve quality of life of people with AIDS (PWAs)
- Involve males in sexual RH
- Improve primary health
- Respond to unmet YARH needs in project sites
- Enhance collaboration and co-ordination of AIDS organisations
- Increase awareness of reproductive health
- Conduct research related to young people
- Promote natural family planning
- Improve/promote access and utilisation of quality YARH services
- Reduce adolescent morbidity and mortality
- Encourage safer sex behaviours
- Increase adolescent use of clinics
- Improve hygiene and nutrition
- Promote responsible parenting
- Establish good boy-girl relationships
- Alleviate abuse of street children
- Support females to complete education
- Mobilise youth and defend their interests
- Provide youth information so they can make informed choices

Geographic Coverage

Though the extent of coverage (i.e. numbers of youth reached) is difficult to gauge, programme activities for youth are occurring in all nine Zambian provinces, and some programmes operate nationally.[1] Lusaka Province (particularly Lusaka Urban District and Kafue District) and the Southern and Copperbelt Provinces appear to have the most concentrated YARH efforts.

The table in Appendix C shows geographic locales (provinces and districts); additionally, the programme profiles in Appendix M show individual programme locations by province and district where available, and sometimes to the level of compound and site name.

[1] Some key informants described their programmes as national. While this may mean something is occurring in each of the nine provinces, it does not necessarily mean that all 72 districts are exposed to the intervention.

Ages of Youth Targeted

Programmes are targeting a wide variety of age segments, as can be seen in the programme profiles. Most programmes reported ages above and below, or within, the 10-24 "young adult" age group (six programmes specified the 10-24 age range).[1] Twenty-four programmes address at least ages 10-14 or broader. For those programmes reporting low and high age range numbers, the average low range target across programmes is 11.8 years old, and the average high range target is 24.7 years old. With the exception of one programme that targets only youth 14 years of age and under, all other programmes include the 14-18 age group within their target. Thirty-four programmes include the 20-24 age group. Thus, it appears that 14-18 year olds are the most frequently included in programmes' target age ranges, and that older youth between 20-24 are also targeted by a majority of programmes.

Characteristics of Targeted Youth

With the exception of one programme that is essentially a research association (and thus depends on individual study research parameters to segment youth), all programme key informants reported one or more main characteristics of their target youth groups.[2]

Only one programme exclusively targets female youth.[3] Almost all target urban youth, and about two-thirds target rural youth. The majority of targeted youth are from low-income families, and slightly more programmes are targeting out-of-school youth than in-school youth (41 and 39 programmes respectively). Similarly, unmarried youth are targeted more than married (43 and 35 programmes respectively). Twenty-five programmes target street youth, and 20 reported reaching youth in a workplace.[4]

Other distinct characteristics of targeted youth by number of programmes are:

- Refugees (12)
- Handicapped/disabled (7)
- Sub-standard living conditions/destitute (2)
- HIV-positive youth (2)
- Sexually active (2)
- Youth considering being sexually active (1)
- Females with multiple partners (1)
- Muslim (1)
- Catholic (1)
- Christian (2)
- Orphans (1)
- Youth at fish camps (1)
- Truck and taxi drivers (1)
- Abused (1)

It is notable that three programmes specified segmentation by higher-risk behaviour groups (sexually active youth and females with multiple partners) and nine specified a health condition (handicapped, HIV-positive), as this may be conducive to more effective targeting of activities and primary messages.

Reasons for Targeting Youth

Why are these types of youth being targeted? Key informants (17) most frequently mentioned vulnerability and risk. Almost as many key informants mentioned dimensions of being in-need, (e.g.

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[1] Several programmes did not provide ages.

[2] Though intended to elicit information on how programmes have segmented their target audience, key informants may have responded more broadly to include all types of youth they feel their programme reaches in some way (even if a characteristic may be representative of only a small portion of those reached). Informants were first prompted by the interviewer with a selection of characteristics, then asked to provide any other characteristics of their target audience (see questionnaire in Appendix B).

[3] FAWEZA/Promotion of girls' and women's education

[4] This may have been misinterpreted to be employed youth, instead of youth targeted in the workplace setting itself.

need for awareness, education, information, and youth-friendly health programmes). Several programmes looked to research findings and available data as grounds for a youth-focus. One key informant eloquently stated *"We want to help them grow into responsible citizens and parents of this nation because they are the future leaders."*

Family Planning Services Provided to Young People

Seventeen programmes include contraceptive provision, either directly through peer educators or other distributors, or through collaborating health centres/clinics. Most of those that do provide contraceptives supply male condoms (16), and eight programmes supply female condoms. Six provide pills and five provide foaming tablets/spermicide. Because 34 programmes provide referrals to health service providers, youth may get appropriate advice regarding access to specific contraception by those that do not provide any methods or who do not provide the most appropriate methods for that adolescent. Methods and corresponding number of programmes are reported below:

Family Planning Methods

Method	No. Programmes (n=16)*
Male condoms	16
Female condoms	8
Pills	6
Foaming tablets/Spermicide	5
IUD^	2
Injectable^	2
Norplant^	2
Emergency contraception^	2
Diaphragm^	1
Cervical cap^	1
Menstrual regulation^	1
Sterilisation^	1
Natural family planning	5

**Missing method types from one programme.*
^Solely via participating health centres/clinics.

Thirteen programmes reported providing family planning methods for free. Three programmes reported some fees, as follows:

Contraceptive Fees^		
Type	Fee	Organisation/ Programme
Male condoms (4-pack)	Kw200 (13 cents)*	• Society for Family Health/ Peer Education & Promotion • CARE/ Testing Community Based Approaches to Adolescent and Sexual Health
Foaming tablets (4-pack)	Kw200 (13 cents)	• Society for Family Health/ Peer Education & Promotion
Pills (2 cycles)	Kw500 (33 cents)	• Society for Family Health/ Peer Education & Promotion
Female condom (2-pack)	Kw250 (16 cents)	• Society for Family Health/ Peer Education & Promotion
Registration Fee**	Kw1000 (66 cents)	• Planned Parenthood Association of Zambia/ FLE & Youth Development

^Based on February 1998 exchange rate of Kw1,500/$1
**SFH often provides free condom samples.*
***PPAZ provides contraceptive for free with paid registration (PPAZ provides male & female condoms, pills, foaming tablets/spermicide).*

Specific Services and Activities

Key informants were asked whether their programme included certain services and activities (responses were elicited by prompting). HIV/AIDS and STD prevention education seems to be the most emphasised. Interestingly, a large number of programmes address assertiveness and decision-making skills. A high proportion also provides some type of education about harmful traditional practices.

Results are shown in the following table. While this information provides a idea of what is being included in programmes, it does not present a measurement of these items as a proportion of programme effort, so their relative intensity cannot be shown.

Type of Service^	No. Programmes* (n=47)
HIV/AIDS Prevention Education	44
STD Prevention Education	42
Referrals to health service providers	37
Education about Harmful Traditional Practices	37
Assertiveness Skills	37
Decision-making Skills	37
Sexuality Education that includes information on *both* abstinence and contraception	+35
Reproductive Health Physiology/Anatomy Education	34
Education about Gender Issues	33
Club Activities (e.g. drama, journalism)	32
HIV/AIDS Counselling	30
Recreational Activities (e.g. games, sports)	30
Contraceptive Education	29
Pregnancy Counselling	27
Couple Communication Skills	26
Contraceptive Counselling	21
Vocational Training	19
Contraceptive Distribution	16
HIV/AIDS Care	15
STD Diagnosis and Treatment	10
Pregnancy Services	7
HIV/AIDS Testing	7
Sexuality Education that includes information on abstinence *only*	+5
HIV/AIDS Treatment	4

^ Note that no minimum level of service/activity was specified, so may range from very minor component to programme emphasis.
** One programme missing.*
+ One programme indicated that married youths receive sexuality education that included abstinence and contraception, while unmarried youths receive abstinence-only education.

Programme Duration and Resources

The majority of programmes began after 1995. This may be indicative of a recent upward trend in organisational interest in youth, or funding cycles that resulted in new programmes replacing earlier ones.

Programme representatives are largely hopeful that their programme will be ongoing, but acknowledge great dependency on donor support and donor funding cycles. This results in a high level of uncertainty in programme funding. Sixteen programmes reported funding would last one or more years. Ten expected current funding to last less than 6 months. Others were not certain of duration of available funds, or of how much would be available in the next donor funding cycle. Some programmes supplement their resources with fundraising or sales activities and membership fees and support. Many programmes rely on a large number of volunteers, including peer educators, to help stretch scarce personnel resources.

Twenty-three programmes reported their amount of annual funding. Among these, annual funding ranged from $1,600 to almost $700,000, with more than half of programmes operating on less than $22,000/year.

Donors have supported programmes in part or in full, for varying time periods. Donors reported as supporting programmes in some way are as follows (see Appendix D for a list of organisations' programmes being funded by each donor):

- Adventist Development Relief Agency (ADRA)
- Alliance for Children
- CAFOD (Canada)
- Christian Aid (UK)
- Department for International Development (DfID)
- Family Federation for World Peace
- Forum for African Women Educationalists, Kenya
- Government of the Republic of Zambia
- Institute for Cooperation with Developing Countries (HIVOS)
- International Planned Parenthood Federation (IPPF)
- Joint United Nations Programme on AIDS (UNAIDS)
- Marie Stopes-Zambia
- Margaret Sanger Centre International (MSCI)
- MISREOR (Germany)
- Netherlands Development Organisation (SNV)
- Norwegian Agency for Development (NORAD)
- Population Council
- Society for Family Health (SFH)
- Southern African Training Programme (SAAT)
- Street Kids International (Canada)
- Swedish International Development Authority (SIDA)
- United Nations Development Programme (UNDP)
- United Nations Education for Scientific & Cultural Organisation (UNESCO)
- United Nations Fund for Population Activities (UNFPA)
- United Nations International Children's Fund (UNICEF)
- USAID (via JSI/SEATS, CEDPA, JHU, MotherCare, PCI, FHI)
- World Association of Girl Guides (WAGGS)
- World Food Programme (WFP)
- World Health Organisation (WHO)

Programme Approaches

Programmes are using a variety of strategies to reach targeted young people (including the services discussed earlier). Appendix M contains more detailed information on activities that each programme implements, with estimates of numbers of youth reached, inasmuch as that information was provided. Those programmes with outreach activities, typically conducted by peer educators, reported reaching the highest numbers of youth. Several programmes work in partnership with health centres to provide youth-friendly services, such as training providers to be youth-friendly and clinic space devoted to "youth corners" staffed by peer educators and with IEC materials. The following sections describe sites used, youth involvement, secondary target audiences, training, communication methods, materials developed, and research.

Sites Utilised

Typically, more than one venue is used for programme purposes. The programme profiles in Appendix M show site types reported for each programme.[1] As shown in the following summary table, schools are popular venues, though primary schools are not as commonly utilised as secondary schools. Health centres have some role in a number of programmes' strategies through collaborative relationships and referral systems. Programmes are also using community centres and, notably, religious institutions (such as churches) are utilised to advance reproductive health among young people.

[1] Key informants were not asked to describe how each site was used, so the degree and type of use is not known.

Site Types	No. Programmes
Senior Secondary School	27
Junior Secondary School	26
Community Centre	24
Health Centre/Clinic	23
Primary School	19
Community-based Org./NGO	19
Religious Institution (e.g. church)	18
College	15
Street	14
Recreational Facility	13
University	12
Youth Centre	11
Hospital	9

Several other types of sites were mentioned, such as marketplace, home, disco, bar, skills training centre, and refugee camp.

Youth Involvement

Youth appear to be involved in many programme aspects, and the most common and longer-term role they have is as peer educators. About three-fourths of the programmes have some type of peer educator. Typically there are fewer than 25 peer educators --ranging from a low of two peer educators to a high of 300 or more, depending on the number remaining active beyond training. The following sections describe aspects related to peer educators, followed by other areas of youth involvement that key informants described.

Peer Educators: Main Goals

What are peer educators' primary goals? HIV/AIDS prevention is the leading goal across programmes, followed closely by STD prevention and unwanted pregnancy prevention. Peer educators have other ultimate and intermediate goals, such as:

- Safer sex/behaviour change
- Life skills/decision-making
- Abstinence promotion
- Reproductive health education
- Assertiveness and negotiation skills
- Responsible parenthood/family planning
- Gender issues awareness
- Improving physical, social, mental health
- Anatomy education
- Communication skills
- Recruitment to services
- Parent-child dialogue
- Product promotion
- Prevention of child abuse
- Health education
- Improving primary health care
- Prevention of drug abuse
- Moral education

Of key informants that described programmes with peer educators, less than half reported distribution of condoms by peer educators. Five reported that other contraceptives are also distributed (contraceptive type reported by only two programmes: *femidom* and foaming tablets, respectively).

In almost three-fourths of programmes with peer educators, peer educators provide referrals to service providers.

Selection
Peer educators were selected using a variety of techniques. Some informants noted a multi-step process, other selected peer educators using few criteria. See the programme profiles for information by programme.

Types of selection criteria/processes:

- Former training/workshop participants
- Volunteers
- Recommended/nominated
- Clubs/other organisations
- Advisory/selection committee
- Recruiting activities
- Former clients
- Programme members
- At school
- Application/interview process
- Elections

Incentives
Only about half of programmes with peer educators reported that specific incentives are provided to the peer educators. A few programmes provide wages or allowances--the only specified amount by a programme[1] was Kw45,000 ($30)/month. Most commonly, transport and meal expenses are covered. Other types of incentives offered are badges, training/workshops, and materials like stationery.

Supervision
A majority of programmes with peer educators have some type of supervision, and this information is included in the programme profiles. Several programmes provide supervision on a regular basis, for example daily, weekly, biweekly, or monthly. Some programmes designate specific persons (e.g. youth co-ordinator) in supervisory relationships with peer educators. Other methods of supervision mentioned are reports and tracking sheets. The intensity of supervision is difficult to gauge without additional inquiry.

Training
According to informants, most programmes trained their peer educators when the peer educators began their work. Almost as many are providing in-service training opportunities. Type of training and content is described below.

Training at Start

- Peer education training
- Workshops/lectures
- Field training
- Family Life Education
- Sexual and reproductive health
- HIV/STD education
- Gender issues
- Street education
- Peer education training
- Counselling skills
- Marketing skills
- Leadership skills
- Workshops/lectures

Ongoing Training

- Refresher courses (varied content)
- Workshops/lectures/briefings (varied content)
- Family Life Education
- Networking and exchanges with other organisations/programmes
- Counselling skills
- Capacity building

[1] YWCA/Monica Makulu Drop-in Centre

Youth Involvement in Programme Stages

Key informants were asked whether youth had been involved, and how, in the following stages of programme development: planning/design, research, materials development, implementation, monitoring, and evaluation. Almost all programmes have involved or are currently involving youth at one or more programme stages. The implementation stage was reported as the most common stage of involvement, followed by planning/design, research, materials development, monitoring, and evaluation.

How have youth contributed at these different programme stages? During planning/project design (37 programmes), youth have been consulted prior to project initiation, worked on annual action plans, participated in planning workshops, drawn proposals, sat on committees, and been included explicitly in decisionmaking.

Involvement in research (32 programmes) is also related to youths' role in project design, as many programmes reported that youth did original baseline data collection and PLA exercises at the planning stage. Youths have participated as research assistants and data collectors on specific research efforts during the course of programmes.

Materials development (27 programmes) has ranged from working on brochures to curriculum design. Youth have produced or been part of the process of producing posters, newsletters, manuals, flyers, stickers, drama tapes, teaching aids, flip charts, and articles for publication. Two informants noted that youth have pretested materials for their programme.

Youth appear to be very involved in implementation (41 programmes), primarily through peer education activities -- which are often the heart of a programme. As one informant described it, "*youth are the programme.*" In addition to varying degrees of involvement as peer educators or counsellors, youth have conducted outreach to communities and specific activities such as condom provision, drama shows, and workshops.

Some degree of involvement in monitoring and evaluation (27 and 23 programmes, respectively) was reported. The line between monitoring and evaluation is blurred -- often the monitoring activities feed into the "evaluation" of the programme. Evaluation was typically described as process evaluation of a qualitative nature (e.g. observation, reports, supervisory/site visits), but is sometimes based on data collected over time or data collected from specific activities (e.g. workshop questionnaires). Where youth are involved in monitoring, it may be that they are responsible for filling out data collection or record-keeping forms during their work (reported by six programmes), or that they supervise each other (e.g. a senior peer educator monitors a more junior one). Examples of youth involvement in evaluation were similar to those for monitoring.

Training

Programmes have trained youth in the following areas (some of the below represent training provided to peer educators): .

- Peer education
- Leadership skills
- Life skills
- Communication skills
- Family life education
- Counselling
- Sex education
- Condom negotiation
- Family planning
- HIV/AIDS prevention and positive living
- Behavioural change workshops
- Parent aid education
- First aid
- Public relations
- Business skills
- Self-help projects

Secondary Programme Targets

Most programmes have secondary target groups (see programme profiles in Appendix M). Parents and community members have been included in more than half of programmes, often in sensitisation workshops, but also in focused training and research activities. Several programmes noted teachers and elders as target groups.

Additional groups:

- Traditional birth attendants
- Community-based distributors
- Clinic staff
- Nurses
- Traditional healers
- Policymakers
- Traditional initiators
- PWAs
- Social workers
- Students at teachers colleges
- Mothers
- Guardians
- Radio personalities
- Community groups/committees
- Association members
- Volunteers/patrons
- Church fellowships
- National, provincial, and district-level information officers
- Compound section chairmen

Training Content Areas

Many of the secondary target groups have been trained in one or more of the content areas below.

- Adolescent sexual and reproductive health
- Youth friendliness
- FLE
- Counselling
- Family planning
- Capacity building
- Reproductive health
- Orphan care
- AIDS awareness
- Community caregiving
- Communication skills
- Life skills
- Population education
- HIV/AIDS management
- Income generating activities
- Basic monitoring and evaluation skills
- Leadership training
- Anti-AIDS club management
- Team work
- Programme management
- Proposal writing
- Training-of-trainers
- Pastoral counselling
- Police-victim support
- Paralegal training

Communication Methods

Programmes use a variety of communication methods. Key informants were asked if their programme used certain methods. About 88% responded that their programmes use small group forums, 77% use large group forums, and more than 80% use print materials. Drama is another commonly used method (75%), followed closely by video/film, counselling, and formal lectures. Songs are used by the majority of programmes, as are games. Less than half are using radio or television, and ten reported use of a telephone "hotline," though this number may be slightly inflated by programmes that are not necessarily running a promoted "hotline" but that do take calls from and/or provide advice over the phone to youth. Communication methods are listed below in order of the number of programmes using the methods (note: this does not indicate frequency of use *within* programmes).

1. Small group discussions or training (42)
2. Print materials (e.g. pamphlet, brochure, newsletter, newspaper) (39)
3. Large group presentations (37)
4. Drama sketches or plays (36)
5. Counselling (35)
6. Formal lecturer or guest speaker (34)
7. Songs (34)
8. Films or videos (32)
9. Games (29)
10. Radio (20)
11. Television (19)
12. Telephone hotline (10)

Notably, several programmes reported other communication methods such as debates, e-mail, picture codes, church announcements, performing arts festivals, and variety shows.

IEC/Training Materials and Activities

Programmes have developed some new IEC and training materials. Most programmes indicated that materials are available for use by others, though for materials in limited supply photocopying costs may be charged. A table of programme materials produced by the different programmes is in Appendix G.

Research

Approximately half of programmes are currently doing or planning to do some type of research on youth. This research may be useful to other programmes. Not all informants were specific about the research, but the information provided is included in Appendix H.

Programme Management and Monitoring

Programme management and monitoring is summarised in the following sections on staffing, collaboration, monitoring, and evaluation.

Staffing

Thirty-four programmes have full-time, paid staff. However, the number of staff is low (17 programmes have one to two full-time staff). Twelve programmes have part-time, paid staff (number ranges from 2 to 32).

Volunteers help ameliorate the low staffing, and generally do not receive financial or other incentives. Twenty-six programmes have volunteers (excluding peer educators) ranging in number from 1 to 3,000.[1] Most of these programmes have fewer than 20 volunteers; half have less than 10. With the exception of programmes with peer educators, only two programmes reported a regular monthly stipend for their volunteers (Kw50,000 ($33)/month[2] and Kw10,000 ($7)/month[3]) Several programmes provide some small allowances for meals or transportation. (Peer educator incentives were discussed in a previous section.)

Training[4]

Thirty-eight organisations are providing regular and/or volunteer staff with opportunities for some type of in-service or ongoing training. Sometimes staff are sent to external training programmes (e.g. a 4-week adolescent health course in Sweden). Training content includes topics such as management, supervision, reproductive health, HIV/AIDS, and counselling skills.

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[1] There are two programmes with an estimated 3,000 volunteers: Society for Women Against AIDS (SWAAZ)/Youth and School Activities, and MOH/Health Education Unit/Adolescent and youth Education in Reproductive Health. SWAAZ estimates may include volunteers that do not work on the youth activities. The number of MOH/HEU programme volunteers likely reflects those volunteers working with collaborating NGOs.

[2] Zambia Student Christian Movement/AIDS and Health Project (13 volunteers).

[3] ADRA/Child Alive (27 volunteers).

[4] Does not include peer educators' training, which is described in later section.

International Conferences and External Workshops
Staff from more than half of programmes have attended an international conference or external workshop. This includes various AIDS conferences, regional conferences, and adolescent reproductive health workshops. Appendix F contains a table of conferences and workshops by programme (unfortunately, many key informants were unable to recall the exact titles, so often the titles are incomplete or missing).

Collaboration

Informants were asked if they or another programme representative participates on a co-ordinating body. More than 40 diverse groups were mentioned, most commonly the Lusaka youth friendly services committees and the IEC Subcommittee of the Interagency Technical Committee for Population, the National Adolescent Co-ordinating Committee, and Zambia National AIDS Network (see Appendix E for a table showing the groups listed by organisation/programme).

Monitoring[1]

Reports are the most frequently used monitoring tool, as reported by the majority of key informants. Informants specified monthly, quarterly, and --more rarely-- annual, and weekly report systems. In addition, more than one-fourth of programmes are using forms (e.g. peer educator forms, client forms, clinic registry) to collect different types of information for monitoring purposes. Meetings and on-the-spot oversight are other methods used. Specific staff members may be designated to provide oversight, and reporting may be done to external donors. One informant described pre- and post-test activity evaluation, and another informant mentioned use of job descriptions as a basis for measuring individual performance. Programme profiles contain this information for individual programme reference.

Most informants indicated that monitoring was used to improve or modify the programme. Strategic planning, identifying gaps and weaknesses, and problem solving were frequently mentioned uses of monitoring results. Some noted specific benefits of their monitoring system, such as tracking the number of youth reached.

Evaluation

Slightly more than half of programmes (26) have been evaluated in some way. Details on evaluation methods were not successfully obtained from most informants (see programme profiles). It appears that external evaluators often conduct the evaluation, and that external evaluators are frequently affiliated with a donor. Some informants mentioned specific methods, as noted below.

- Discussions with programme beneficiaries
- Field visits
- Focus group discussions
- Sales numbers and visits
- Individual questionnaires
- Workshop/training evaluation
- Interviews with project staff
- Interviews with stakeholders
- Participatory methodology
- Reports

[1] Specific information was also provided on supervision of peer educators, as discussed earlier and shown in programme profiles.

Some informants mentioned findings from their programme evaluations, as noted in programme profiles. Most (19) said that they have modified the programme in some way as a result (e.g. more emphasis on training or changes in training content, developing supervisors' guide, expansion to new areas, equipment procurement). Forty-two programmes are expected to be evaluated in the future, most in late 1998 and in 1999.

Experiences and Perspectives

Information was elicited from key informants on a variety of areas in order to achieve a sense of programme challenges, responses, and lessons learned; to gather opinion on contextual areas like policy and training needs of YARH programmes; and to solicit views on expanding their programmes.

Major Obstacles and Programme Responses

The most common obstacle mentioned was the lack of funding for the programme. There were also related issues like lack of equipment (particularly transport vehicles) and materials. To deal with this, most programmes are actively seeking donor funds and/or support from collaborating organisations. A few are trying to be more self-sustaining, and others noted that they have been networking with other organisations that have income-generating activities and selling advertising space (e.g. *Trendsetters Newspaper*) to raise revenue.

Attrition and low motivation of peer educators have also been a challenge. Programmes are trying to provide incentives with the scarce resources they have. Although peer educators typically appear to be minimally compensated, one key informant noted "*we are competing against other NGOs who offer attractive allowances to their peer educators, so our [unmotivated] peer educators want to run away.*" One programme's response to the challenge of retaining and motivating peer educators is to involve them more in training workshops and in the planning process. Another programme provides their peer educators with bicycles and small funds for drama activities.

Lack of staff is another issue, along with the need for improving technical expertise. Increasing volunteer cadres and networking with other organisations are approaches to ameliorating this challenge, and some programmes have supported training and study-tour opportunities in response to technical deficiencies. Community and parental resistance has prompted programme leaders to talk to parents and involve church leaders.

Examples of these and other obstacles and programme responses are shown in the table in Appendix I.

Lessons Learned

As more services and activities become focused on adolescents, programmes are learning much from their experiences. Key informants related a variety of observations, including positive experiences and challenging lessons, many of which reflect the earlier discussion of obstacles and responses.

There have been many positive lessons related to involving youth in programmes --particularly that peer education works and should be expanded. Programmes have learned that there are specific challenges to reaching young people, and that youth need a supportive environment that includes enhancement of parent-child communication, service access, confidentiality, and community support. Some informants related learning more about the severity of certain problems, such as child abuse and the impact of AIDS,

and the need to concentrate efforts more. Inter-organisational collaboration can be a positive experience, but also presents challenges. Because of funding and resource issues, some organisations are striving to become more self-sufficient and less reliant on donors. Volunteerism is difficult to sustain in the current economic situation. Examples of these and other lessons learned are shown in Appendix J.

Programme Expansion

Almost all key informants indicated interest in expanding, improving, or replicating the programme -- some by incorporating specific programme strategies, others by increasing geographic/target audience coverage or enhancing collaborative efforts. The table in Appendix K shows the type of programme expansion envisioned by organisation/programme.

Policies Affecting Young Adult Reproductive Health

When asked for their views related to policies that impact young adult reproductive health, informants spoke not only about policies and laws, but also of formal and informal practices, as well as different problems related to the issue. Below are examples of views on the various issues, grouped thematically (similar comments were merged to reduce duplication).

Youth Friendly Services/Reaching Youth

- There are more youth-friendly services now
- Youth-friendly services are an achievement for young people
- Now it is no longer necessary for females to seek consent before accessing family planning services
- There is still a lack of youth-friendly services
- User fees discourage young people from using services
- Encouraging distribution of condoms to youth is encouraging them to be promiscuous

Need for Youth Reproductive Health Policy

- Need to have YARH policies in place to provide a base for advocating for youth issues in the country
- No policy on adolescent reproductive health; so follows general reproductive health framework
- There are no specific youth policies and as such their reproductive health needs are not specifically addressed, e.g. family planning and abortion policies were not so specific to youth
- The National Youth Policy was a good first attempt, though excluded reproductive health
- NGOs must recommend youth policies and participate in implementing them

School

- Pregnant girls should be allowed to go back to school
- Teen mothers can now come back to school after having children

Specific Policies and Laws

- The conditions set on the abortion act are not user-friendly
- Abortion is not allowed within the church or country; we refer to others
- Abortion and early marriage should not be legal because this affects moral standards
- The laws are discriminatory against people with HIV/AIDS
- Policy about not giving contraceptives to youth below 18 needs to be revisited
- Youth being allowed to go in a bar and drink is a bad policy
- Social-economic policies should be emphasised; these in turn will enable youth to live disease free lives

Problems with Policies

- Youth under 18 are not emphasised; we need to lobby for younger (10 and up)
- Youth are not involved in the formulation of the policies as they should be
- Youth are used by politicians to get in power
- All policies are paper policies, lip service, no implementation
- Policies are not getting messages across
- Policies are too weak
- Policies are unrealistic
- Need to simplify policies
- Wrong priorities
- Policies need to be supported by funding

Positive Developments

- Policies are very promising, taking into account what they have learned
- There is a general awareness of youth needs
- Family planning policy issues are clear and practical
- Good that efforts are being made to come up with adolescent reproductive health policies
- New family planning policy is favourable towards youth
- MOH/CBOH/ITCP contributes to reproductive health direction
- Support the national policy on strengthening the reproductive health programme

Issues and Problems

- Should be more attention to needs of girl child
- More economic empowerment for women
- Stigma of adolescent reproductive health
- Child abuse needs attention
- Mothers should breast feed babies for one year
- Lack of education on health issues
- Lack of skilled counsellors
- Lack of training materials
- Lack of access to information
- Poor health services are prevalent
- Essential to have sex education and information, but will not necessarily change behaviours

Training Needs

> "Programme implementers need thorough training to understand and appreciate the reproductive health needs of the young. People working with youth need to understand their physical and psychological development to appreciate young people's problems and needs. Communicators need to be trained in ways to reach youth with clear messages they will understand and appreciate." - Key Informant

Key informants spoke of needing more training for both programme staff and youth in specific content areas and skills, and they also mentioned resource concerns, as shown in the following list.

Topics, content, and skills areas:

- Increase awareness of YARH needs
- How to prepare youth for marriage/sex in marriage
- Awareness of physiology/anatomy/sexuality
- Information on abstinence and contraceptives
- Reproductive health information
- Abortion issues (e.g. safe abortion, crisis management)
- Pregnancy prevention
- Sensitisation regarding HIV/AIDS stigma
- Use of parent-elder component
- Intensified sex education from primary school level
- Behaviour change lessons in schools
- Assertiveness skills
- Life skills training
- Communication skills
- Vocational skills development
- Materials development skills
- Peer education
- Counselling
- Monitoring and evaluation
- Youth-friendly health services
- Adolescent programme management
- Qualified trainers
- Training trainers and supervisors
- Training peer educators and community health workers
- More practical training (e.g. in condom distribution)
- Training in communicating messages for youth
- Training in physical and psychological development of young people

Other needs:

- More clear and available information
- Materials (e.g. flipcharts, handouts)
- Resource people
- Incentives for peer educators
- Allowances/funds for motivation
- More funds for training
- More time for workshops
- Finances
- Transportation

Improving YARH Programmes

Many informants had ideas and views on how to improve young adult reproductive health programmes. They are presented by thematic group below and include the following overall ideas:

- Better and earlier reproductive health education in schools
- Out of school youth, rural youth, younger adolescents and parents and elders as targets
- Involvement of youth and expansion of youth-friendly services
- Training for specific groups *and* training in certain areas
- Strengthening the government's role and co-ordination between entities
- Stronger policies and advocacy efforts
- Expansion of communication efforts
- Greater financial support and sustainability of programmes

School-based Education

- Emphasis on reproductive health in school curricula
- Compulsory sex education
- Reproductive health programmes in school starting in first grade
- Broaden sex education to include child care, planning for children's future, managing a home

Target Groups and Strategies

- Target out-of-school youth, especially girls
- Target groups should include much younger children, e.g. ages 6-8, so equipped as they grow
- Pre-adolescent sexuality programmes
- More education for males on sexual and reproductive health
- Reproductive health education emphasised to parents
- Increase communication between adolescents and parents
- Form alliances among youth and parents
- Include other groups, e.g. elders older than 50
- Expand to rural areas

Youth Involvement

- Involve youth
- Youths themselves need to run programmes, not just be receivers of information
- Youth should be allowed to set up youth centres
- Country should listen to voice of youth and decisions should not be made for youth without their knowledge

Youth-Friendly Services

- More youth-friendly services
- Free provision of family planning and HIV prevention methods and information to youth

Training

- Train health personnel/educators in adolescent reproductive health
- Training in STD/HIV/AIDS counselling
- Capacity building
- Training teachers to teach sex education
- Train puberty rite attendants

Government Role

- More commitment, support, and participation of government
- Lead ministry with a structure to support youth
- Government body to co-ordinate and assess NGO activities
- Government-established body to help NGOs solicit donor funds
- Need a youth reproductive health department within MOH

Co-ordination

- More inter-organisation co-ordination of efforts
- Develop training manual and directory of work done by different organisations
- Co-ordinated IEC development, distribution, and documentation

Policy and Advocacy

- Improve advocacy by developing specific advocacy campaign methodologies
- Develop youth-specific policies regarding their reproductive health concerns
- Develop realistic policy networks from referrals
- Policies should be implemented

Communication Methods

- Design more spots on radio and television
- Produce more materials
- More outreach programmes/awareness campaigns
- More education/information provision
- Revitalise social welfare centres run by district councils with sports or games for life

Programme Funding and Sustainability

- Increase funding and support for programmes
- Financial and material support to implementing agencies like NGOs
- Encourage NGO self-reliance

Special Topics

- Need to be able to talk about safe and legal abortion, e.g. manual vacuum aspiration
- Address harmful traditional practices
- Address gender issues
- Emphasise value of nutrition
- More income generating activities to keep youth from mischief
- Address more issues like preparing youths for parenthood, antenatal care, nutrition,

Discussion of Findings and Possible Responses

There are many exciting and innovative programmes addressing YARH needs underway in Zambia, particularly in Lusaka District. Those who are working in YARH can consider a variety of ways to strengthen or expand the reach of existing efforts at the project, community, district, and national level. Additionally, trying new directions and testing different strategies is an ongoing process toward striving to identify "what works" in the ever-changing environment of YARH. The following suggestions for improving YARH have been grouped according to broad themes discussed throughout the paper.

Targeting

- Few programmes exclusively target younger adolescents (10-14 years old or younger), which are crucial ages to emphasise in programme strategies. As the research data presented earlier in the report show, the majority of youth become sexually active between the ages of 15-19. Thus, the younger age group may provide the best "window of opportunity" for delaying onset of sex and to impart knowledge and skills (e.g. negotiation skills) supporting safe practices --before unsafe practices start. Programmes should try to more narrowly target efforts with clear and appropriate messages toward this age group.

- As research reveals, there are many differences between boys' and girls' behaviour and distinct issues (such as girls seeking payment/gifts for sex and that boys are more likely to have more than one recent sexual partner). However, most programmes are targeting both and may not be segmenting effectively enough with targeted strategies and appropriate messages. No programmes specifically concentrate resources on targeting boys only, and only one specifically targets girls only. Channelling resources toward narrower, better-defined target groups with clear, relevant messages may improve programme impact.

- More programmes should be implemented in rural settings and other parts of the country where youth are not being reached in order to better meet the needs of the underserved. Programmes should look at available prevalence and clinical data to set geographic priorities. For example, there are provincial differences in the percentage of 15-19 year olds who have given birth (ranging from about 23% in Luapula to 38% in North-Western province), and clinic records may show that antenatal care is less utilised by women in one area than another. HIV prevalence also varies by province and district.

- While more than half of programmes have parents and the community as secondary target audiences, few programmes are targeting video shop owners, truck/minibus drivers, vendors, or teachers. These types of people have been identified by youth as sources of information (boys see pornographic videos; teachers provide FLE), a source of contraceptives (vendors), or as types of sexual partners (girls have sexual relations with drivers).

- Few programmes are targeting traditional healers, and more should consider them for targeting with youth-specific messages or including in training efforts. They are often the first source that youth access for treatment (particularly for reproductive health and abortion concerns) and they are also cited as a common source of information on sexual and reproductive health.

- Some key informants noted that parental and community resistance is an important barrier to address. Parents and others in the community may be important secondary targets, and a number of programmes already include them. Involving parents and community leaders early in a project is important to ensure support. Increasing the number of youth-parent alliance groups and focusing more on skills training in parent-child communication may be helpful strategies. Programmes with experience in these areas should document their approach so that others may replicate.

Information, Education and Communication

♦ Health centres, particularly those with "youth corners," should ensure they have copies of the *Trendsetters* youth newspaper available for youth to look at while they are waiting. This may stimulate sales of *Trendsetters* to new readers. *Trendsetters* may also benefit from more formal linkages to health centres and could aid in promoting health centres' new, more youth-friendly image by adding a regular "ask the nurse (or doctor)" column. Peer educators could also be encouraged to promote *Trendsetters* to their contacts.

♦ Health centres can strengthen efforts to form linkages with schools and develop special events for reproductive health promotion, such as a "reproductive health day" or "youth health day." School FLE club patrons could try teaming with providers at health centres to discuss issues and strategies (the MOE/CDC is planning to expand the POPED programme by starting FLE clubs in primary schools; this would provide a good opportunity to reach youth under age 14).

♦ Use of media (especially radio stations) as a strategy could be increased as a means of providing information and initiating dialogue regarding YARH. Boys are reached more regularly by radio than girls, but girls have also cited radio as a leading source of information. Some programmes have experience with using radio that may benefit others (e.g. the *New Teen Generation* show managed by the Society for Family Health).

Access

♦ Access to contraceptives is a key issue for young people. While condom provision is popular among programmes, pills are provided by only a few. Though programmes refer youth to health centres, data show that they are less likely to want to obtain contraceptives in this way. To improve girls' access in particular, more programmes should consider having a broader selection of methods available (ideally a barrier method would be used either alone or in conjunction with another method for dual protection benefits, but many girls may be more motivated to prevent pregnancy through a method they control rather than relying on their partners to use condoms, particularly because pregnancy prevention is often more of a concern to girls than HIV prevention). It may be possible to have special hours at a programme facility when a visiting nurse from one of the clinics who has been trained in youth-friendly services is available for confidential contraceptive counselling/provision.

♦ Informants had positive views and experiences related to health centre youth-friendly services (which are most common in Lusaka and Kafue). The programmes with youth-friendly services should critically review the successful elements of their services to achieve consensus and propose a model to replicate in health centres throughout the provinces. Forms should be standardised for consistent record keeping (a co-ordinating body could determine standards) and, ideally, youth-friendly training provided to providers at health centres.

Policy and Advocacy

♦ There appears to be some confusion related to current policies affecting youth. Providers, educators, project managers, etc. should understand and correctly communicate the legal aspects, such as that pregnant girls may return to school and that medical abortion is legal with certain requirements. These groups may also be effective in advocating for change to policies and common practices, such as abortion restrictions and medical barriers to youth reproductive health (e.g. inconvenient clinic hours).

♦ Informants identified a broad range of policy issues and concerns. Consideration should be given to increasing advocacy efforts that reduce barriers and increase access of youth to information and services.

A priority-setting exercise could be conducted by those organization involved (or interested in getting involved) in youth advocacy to determine those issues to concentrate on. The list of issues mentioned by key informants could serve as a starting point for discussion.

♦ Community youth advocacy groups could be formed by peer educator leaders, school anti-Aids club leaders, etc. Groups could select adult patrons as advisors. These groups could advocate their priority concerns to neighbourhood health committees and work on special events to promote adolescent health in their compounds.

Youth Involvement and Incentives

♦ Although almost all programmes have reportedly involved youth in some way, individual programmes should actively consider additional ways that they can increase youth involvement during different programme stages. While it may take some additional time and ongoing investment, programme experiences thus far support the practical benefits of involving youth. Involved youth (particularly peer educators) are likely to be successful examples of a programme's impact, as they are likely to adapt or maintain their behaviour to reflect the programme's objectives.

♦ Incentives appear minimal to non-existent for some peer educators, and this may affect retention and daily motivation. Programmes should investigate what youth consider to be motivating factors and incentives for varying levels of commitment (e.g. working one day a week versus five), and identify what incentives (not necessarily financial, e.g. bicycles, skills training courses) they are able to offer to help motivate and retain their peer educators. Resources for this should be considered early, when designing a programme and submitting proposals requesting funding.

♦ Because lack of funds is a commonly mentioned obstacle for programmes, more emphasis on income-generating projects that youth run could help overcome this and sustain programmes -- particularly those targeting older youth. It would also be a way of keeping youth (especially out-of-school unemployed youth) occupied and acquiring new skills.

♦ Income-generating projects that provide girls with skills-building and alternative sources of money may reduce reliance on sugar daddies and other higher-risk partners for exchange sex (a problem revealed by research data).

Collaboration

♦ Programmes with peer educator components could benefit by networking further and helping each other to strengthen the weaker components of their respective peer educator programmes. For example, a programme with a well-developed supervision/monitoring system could share their approach/tools with another programme, or a programme with training/refresher training modules could share their curricula or provide technical assistance. Peer educators could do short (e.g. one-day) "exchanges" with other programmes in order to see how a different programme operates by shadowing one of the programme's educators.

♦ There are a large number of collaborative groups, such as the Adolescent Reproductive Health Consortium and Male Involvement Committee, which may benefit different programmes. Programmes should be aware of the existence of the different co-ordinating bodies and committees, both as possible groups to join or to look to as an informational resource and networking opportunity.

♦ Key informants had much to share about strategies, challenges, lessons learned, policies, and other areas. A conference-style event that brings them together to present and discuss experiences, priorities, and strategies would benefit all. A regular forum should be provided for sharing information and ideas.

♦ Many organisations/key informants have e-mail access. A list-serve could be set-up to link programmes and provide a forum for sharing current successes, research findings, news of relevant training courses, meetings and conferences, etc.

Training

♦ Informants emphasised staff training as an area needing improvement, as well as improved curricula for training or conducting workshops in different areas with young people. Before "reinventing the wheel," programmes should look for opportunities to share curricula or technical assistance for training. Training needs should also be realistically considered when developing a programme proposal for funding, as should staff development opportunities (such as external workshop participation).

♦ Provider attitudes and facility issues were revealed as barriers to service use in research with youth. Programmes should consider training that focuses on components of youth-friendly services where appropriate.[1]

Research, Monitoring, and Evaluation

♦ Several programmes have used PLA to shape and improve their strategies while actively engaging the community. Formative research, including use of PLA, should be consistently applied to better define and segment target audiences and their needs. Organisations with more advanced experience, e.g. CARE, should be tapped for advice and assistance in replicating PLA.

♦ No programmes indicated that they had done any cost studies. Cost studies are needed to improve understanding of the additional expense of providing youth-friendly services and to help policymakers and others with decisions related to replication.

♦ Research conducted on youth should be made available and publicised/shared by organisations to increase access to qualitative and quantitative data. Programmes that are not already doing so can systematically send reports to a central resource location, such as the UNICEF Resource Centre. Announcements can be made in the *Reproductive Health Newsletter*.

♦ Though most programmes are making efforts to monitor and evaluate, there appears to be a reliance on reports and less use of forms for tracking than there could be. Quantitative monitoring and evaluation techniques should be improved to compile evidence of programme effectiveness. This can be done through standardised record keeping to track new and repeat users of specific services, and periodic surveys in the areas where the programme is working. Exit interviews with youth at clinics or other facilities can be a cost-effective way of gathering information on the how satisfactory the experience was for the young person.

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[1] In 1999, FOCUS on Young Adults will publish a tool to assist clinic and programme managers in assessing and developing youth-friendly services. It will be available on the FOCUS Web site: www.pathfind.org/focus.htm.

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Appendices

Media Perspectives of the Youth in Urban Zambia

Nzima, M., 1995

Citation: Nzima, M.M. *Media Preferences of the Youth in Urban Zambia*. Lusaka, Zambia: Morehouse School of Medicine Zambia HIV/AIDS Prevention Project. 1995.

Brief Description: Study aimed at assessing listenership, viewership, and readership levels among out-of-school youths; Includes assessment of appropriateness of information delivered via various media (e.g. timing, language, cultural aspects); Study by Morehouse School of Medicine Zambia HIV/AIDS Prevention Project in August 1995.

Study Design:
- N=578 urban youth 12-18, mostly out-of-school
- Lusaka and Ndola

Key Findings/Highlights

- Note: no breakdown by sex, location, or age provided
- Sources of information among those having heard or read about on HIV/AIDS in last 6 months: radio (62%), TV (47%), newspaper (29%), magazine (32%), friends (3%).
- 15% of youth owned their own radio; 27% said their parents owned one. Less than 3% of parents reported to own TV.
- Though television was seen as conveying information better than any other source, radio was the most preferred medium by youth.
- Of those youths that most favoured print media, most preferred messages illustrated in pictorial form (especially cartoons).
- Youth expressed opinion that frequency and timing of information from the different sources were often inadequate; 51% preferred listening to information in presence of family and/or friends, and 55% said they discussed the subject after the programme ended.
- Content not very comprehensible if in formal English. Preference found for use of colloquial English, *Nyanja* (Lusaka), and *Bemba* (Ndola) languages.
- Those with 7 or fewer years in school were less likely to have read information in magazine/newspaper.

Introduction to Appendix A

Appendix A is a collection of summaries of research and evaluation studies related to young adult reproductive health in Zambia that may be useful for program staff and researchers. Each summary includes the full citation, brief description, design, and the key findings and highlights of the study.

Study summaries are organised by section chronologically, starting with the most recent.

Sections are noted at the base of each page, as follows:

- National Demographic and Health Surveys
- General Youth Reproductive Health
- Participatory Learning and Action Appraisals
- In-School Youth
- HIV/AIDS
- Abuse, Coercion, and Violence
- Drugs and Delinquency
- Media

These are broad categories. It should be noted that for many studies, the topics of other sections are also relevant.

Zambia Demographic and Health Survey, 1996 (ZDHS 1996)

Central Statistical Office, 1997

Citation: Central Statistical Office [Zambia] and Ministry of Health and Macro International Inc. *Zambia Demographic Health Survey, 1996.* Calverton, Maryland: Central Statistical Office and Macro International Inc. 1997.

Brief Description: National sample survey of women of reproductive age (15-49) with data on demographic, health, and other indicators.

Study Design:

- Included sample of men aged 15-49 surveyed from every fourth household
  Females:
  N=8,021
  n=2,003 weighted (1,982 actual) aged 15-19
  n=1,830 weighted (1,823 actual) aged 20-24
  Males:
  N=1,849
  n=460 weighted (458 actual) aged 15-19
  n=404 weighted (395 actual) aged 20-24
- 3-stage probability proportional to size/systematic sampling
- Household questionnaire, women' s questionnaire, and men's questionnaire

Key Findings/Highlights

[See attached ZDHS table of relevant indicators]

Zambia Demographic and Health Survey, 1992 (ZDHS 1992)

Gaisie, K., et al., 1993

Citation: Gaisie, K., Cross, A.R., Nsemulila, G. *Zambia Demographic Health Survey, 1992.* Calverton, Maryland: University of Zambia, Central Statistical Office and Macro International Inc. 1993.

Brief Description: National sample survey of women of reproductive age with data on demographic, health, and other indicators

Study Design:

N=7,060 females 15-49
n=1,964 aged 15-19
n=1,435 aged 20-24

- 3-stage probability proportional to size/systematic sampling

Household questionnaire and women' s questionnaire

Key Findings/Highlights

[See attached ZDHS table of relevant indicators]

Indicator	ZDHS 1992 Females	ZDHS 1996 Females	ZDHS 1996 Males
Never had sex	• 15-19: 39.5% • 20-24:4.3%	• 15-19: 41.7% • 20-24: 5.2%	• 15-19: 33.8% • 20-24: 10.6%
Age of first Sex	• 15-19: 19.2% by age 15 • 20-24: 20.2% by age 15	• 15-19: 21.7% by age 15. The same percentage was found for those 20-24	• 15-19: 39.3% by age 15 • 20-24: 31.9% by age 15
Median age at first intercourse	• 20-24: 16.6 • 20-24: Urban - 17.0, Rural - 16.2 • 20-49: Urban - 16.6, Rural - 16.0	• 20-24: not available • 20-24: Urban - 17.0, Rural – 16.2 • 20-49: 16.4 • 20-49: Urban - 16.9, Rural – 16.1	• 15-19: not available • 20-24: not available • 25-59: 16.7 • 25-59: Urban – 17.4, Rural – 16.0
First intercourse by exact age, according to current age group	• 15-19: By age 15 (19.2%) • 20-24: By age 15 (20.2%), by age 18 (68.9%), by age 20 (86.9%)	• 15-19: By age 15 (21.7%) • 20-24: By age 15 (21.7%), by age 18 (69.1%), by age 20 (86.2%)	• 15-19: By age 15 (39.3%) • 20-24: By age 15 (31.9%), by age 18 (70.2%), by age 20 (82.6%)
Median age at first marriage	• 20-24: 18.6 • 20-24: Urban – 19.7, Rural – 17.9	• 20-24: 18.5 • 20-24: Urban – 19.7, Rural – 17.8	• 25-59: 23.5 • 25-59: Urban – 24.4, Rural – 22.8
Number of sexual partners in last 12 months among unmarried	Not measured	• 15-19: No partner (68.9%), 1 partner (25.0%), 2-3 partners (5.0%), 4+ partners (0.7% • 20-24: No partner (52.6%), 1 partner (36.3%), 2-3 partners (8.5%), 4+ partners (1.1%)	• 15-19: No partner (49.4%), 1 partner (21.5%), 2-3 partners (20.4%), 4+ partners (8.5%) • 20-24: No partner (30.6%), 1 partner (33.8%), 2-3 partners (21.7%), 4+ partners (13.7%)
Number of sexual partners in last 12 months among married	Not measured	• 15-19: No partner (2.0%), 1 partner (96.6%), 2-3 partners (1.3%), 4+ partners (0.2%) • 20-24: No partner (3.4%), 1 partner (94.6%), 2-3 partners (1.8%), 4+ partners (0.1%)	• 15-19: not available • 20-24: No partner (1.6%), 1 partner (66.5%), 2-3 partners (19.9%), 4+ partners (12.0%)
Whether sexually active in last 4 weeks.	• 55.7% of 15-19 year old women sexually active in last 4 weeks • 60.9% of 20-24 year old women sexually active in last 4 weeks	• 26.9% of 15-19 year olds sexually active in last 4 weeks • 53.5% of 15-19 year olds sexually active in last 4 weeks	• 27.9% of 15-19 year olds sexually active in last 4 weeks • 49.5% of 20-24 year olds sexually active in last 4 weeks
Whether had sex in last 12 months for money /gifts/favours	Not measured	• 38.4% of sexually active unmarried 15-19 and 28.4% of 20-24 had been involved in sex for money/gifts/favours in the last 12 months	• 39.3% of sexually active unmarried 15-19 and 36.1% of 20-24 had been involved in sex for money/gifts/favours in the last 12 months
Median age at first birth	• Urban - 18.8%, Rural - 18.6%	• Urban - 19.1% Rural - 18.5%	N/A
Whether begun childbearing	• 33.8% of teens aged 15-19 have begun childbearing (65.6% of 19 year-olds, 54.3% of 18 year olds, 29.9% of 17 year olds, 14.7% of 16 year olds, and 5.3% of 15 year olds are mothers or pregnant with first child)	30.7% of teens aged 15-19 have begun childbearing (59.4% of 19 year-olds, 46.1% of 18 year olds, 28.3% of 17 year olds, 15.3% of 16 year olds, and 4.5% of 15 year olds are mothers or pregnant with first child)	N/A

Indicator	ZDHS 1992	ZDHS 1996	
	Females	Females	Males
One child	• 1.7% of 15 year olds • 8.7% of 16 year olds • 21.1% of 17 year olds • 37.5% of 18 year olds • 44.5% of 19 year olds	• 1.9% of 15 year olds • 10.4% of 16 year olds • 19.4% of 17 year olds • 30.3% of 18 year olds • 36.9% of 19 year olds	N/A
Two or more children	• 0.2% of 15 year olds • 0.0% of 16 year olds • 1.0% of 17 year olds • 6.7% of 18 year olds • 15.4% of 19 year olds	• 0.0% of 15 year olds • 0.3% of 16 year olds • 0.9% of 17 year olds • 4.1% of 18 year olds • 15.1% of 19 year olds	N/A
Ever use of any modern method of contraception	• 15-19: 7.3% (Condoms: 5.6%; Pill: 1.9%; Diaphragm/foam/jelly: 0.4%; Injection: 0.1%; Male sterilisation: 0.1%) • 20-24: 24.1% (Condoms: 15.1%; Pill 12.8%: Diaphragm/foam/jelly: 1.6%; IUD: 0.6%; Injection: 0.5%; Female sterilisation: 0.1%)	• 15-19: 13.7% (Condoms: 11.7%; Pill: 2.6%; Diaphragm/foam/jelly: 0.2%; Injection: 0.1%) • 20-24: 36.3% (Condoms: 24.9%; Pill: 18.9%; Diaphragm/foam/jelly: 0.5%; IUD: 0.3%; Injection: 0.8%; Male sterilisation: 0.1%)	• 15-19: 23.9% (Condoms: 23.9%; Pill 1.2%; IUD: 0.4%) • 20-24: 54.8% (Condoms: 51.5%; Pill 8.5%; Diaphragm/foam/jelly: 1.4%; Injection: 0.2%; female sterilisation: 0.2%)
Ever use of any traditional method of contraception	• 15-19: 8.4% • 20-24: 28.7%	• 15-19: 8.3% • 20-24: 28.6%	• 15-19: 8.5% • 20-24: 28.4%
Number of children at first use of contraception	• 15-19: Never used contraception (73.6%), 0 children (6.9%), 1 child (17.8%), 2 children (0.9%), 3 children (0%) • 20-24: Never used contraception (55.8%), 0 children (6.6%), 1 child (27.6%), 2 children (6.6%), 3 children (2.4%)	• 15-19: Never used contraception (61.5%), 0 children (12.1%), 1 child (25.1%), 2 children (1.1%), 3 children (0%) • 20-24: Never used contraception (43.7%), 0 children (7.6%), 1 child (33.9%), 2 children (11.4%), 3 children (2.9%)	N/A
Current method use	• 15-19: Any modern method (1.5%), Pill (0.7%), diaphragm/foam/jelly (0.1%), condom (0.7%), traditional methods (2.0%) • 20-24: Any modern method (7.1%), Pill (4.2%), IUD (0.2%), injectable (0.1%), diaphragm,/foam/jelly (0.1%), condom (2.4%), female sterilisation (0.1%), traditional methods (4.1%)	• 15-19: Any modern method (4.7%), Pill (1.1%), IUD (0.0%), injectable (0.1%), condom (3.5%), traditional methods (2.7%) • 20-24: Any modern method (12.3%), Pill (6.4%), IUD (0.1%), injectable (0.7%), diaphragm/foam/jelly (0.0%), condom (5.1%), traditional methods (8.0%)	• 15-19: Any modern method (12.2%), condom (12.2%), and traditional methods (1.7%) • 20-24: Any modern method (23.6%), Pill (2.5%), diaphragm/foam/jelly (0.3), condom (20.8%), traditional methods (6.8%)

Indicator	ZDHS 1992	ZDHS 1996	
	Females	Females	Males
Current method use among married	• 15-19: Any modern method (3.4%), Pill (1.8%), diaphragm,/foam/jelly (0.0%), condom (1.7%), traditional methods (5.2%) • 20-24: Any modern method (7.7%), Pill (4.3%), IUD (0.1%), injectable (0.1), condom (3.0%), female sterilisation (0.1%); traditional methods (5.5%)	• 15-19: Any modern method (8.8%), Pill (2.8%), injectable (0.3), condom (5.7%), traditional methods (8.1%) • 20-24: Any modern method (14.7%), Pill (8.7%), IUD (0.1%), injectable (0.7%), condom (5.1%), traditional methods (10.0%)	• 15-19: not available • 20-24: Any modern method (13.5%), Pill (2.3%), condom (11.2%), traditional methods (16.2%)
Discussion of family planning by couples	• 15-19: Never (51.6%), once or twice (30.8%), three or more (17.1%) • 20-24: Never (38.9%), once or twice (35.3%), three or more (25.7%)	• 15-19: Never (44.0%), once or twice (35.9%), three or more (20.1%) • 20-24: Never (34.6%), once or twice (34.7%), three or more (30.5%)	N/A
Fertility preferences	• 15-19: Have another soon (32.2%), have another later, (59.8%), have another undecided when (1.9%), undecided (2.5%), wants no more (2.0%) • 20-24: Have another soon (31.6%), have another later, (60.3%), have another undecided when (1.2%), undecided (2.0%), wants no more (4.2%)	• 15-19: Have another soon (34.0%), have another later, (57.9%), have another undecided when (3.6%), undecided (1.9%), wants no more (2.6%) • 20-24: Have another soon (28.9%), have another later, (59.2%), have another undecided when (1.3%), undecided (2.3%), wants no more (7.9%)	N/A
Unmet need for family planning	• 15-19: 27.8% (23.9% for spacing, 3.9% for limiting) • 20-24: 28.9% (25.9% spacing 3.0% for limiting)	• 15-19: 25.2% (24.4% for spacing, 0.8% for limiting) • 20-24: 27.5% (26.2% spacing 1.3% for limiting)	N/A
Antenatal provider during pregnancy	• Antenatal provider during pregnancy for mothers under age 20 at birth: nurse/trained midwife (88.4%), doctor (3.6%), traditional birth attendant (1.1%), no one (6.8%)	• Antenatal provider during pregnancy for mothers under age 20 at birth: nurse/trained midwife (92.9%), doctor (2.1%), traditional birth attendant (0.6%), no one (4.1%)	N/A
Who assisted mothers under age 20 at birth	• Nurse/trained midwife (46.8%), relative/other (36.4%), traditional birth attendant (11.0%), doctor (3.6%), and no one (2.1%)	• Nurse/trained midwife (45.2%), relative/other (44.9%), traditional birth attendant (4.3%), doctor (3.7%), and no one (1.3%)	N/A
Place of delivery for mothers under age 20 at birth	• For mothers under age 20 at birth: health facility (50.6%) and at home (48.9%) • 9.4% of babies were smaller than average and 2.2% very small (0.4% don't know/missing)	• For mothers under age 20 at birth: health facility (48.9%) and at home (50.8%) • 13.9% of babies were smaller than average and 4.5% very small (0.4% don't know/missing)	N/A
Infant mortality rate for children of mothers <20	• 123.2 per 1,000 • Note: for all age groups, children born less than 2 years after previous birth are twice as likely to die in infancy than those born after an interval of 4 years or more	• 141.3 per 1,000 (70% higher than for children whose mothers were 30-39 at time of birth.) • Note: for all age groups, children born less than 2 years after previous birth are twice as likely to die in infancy than those born after an interval of 4 years or more	N/A

Indicator	ZDHS 1992 Females	ZDHS 1996 Females	ZDHS 1996 Males
Maternal mortality rates	Not measured	• 15-49, maternal mortality ratio is 649 per 100,000 live births • Maternal mortality rate (per 1,000 woman-years of exposure): • 15-19: 0.75% • 20-24:1.40%	N/A
Knowledge of specific STDs	Not measured	• 15-19: HIV/AIDS (85.8%), syphilis (56.4%), gonorrhoea (57.6%), genital warts (3.4%), other (1.2%), none (9.1%) • 20-24: HIV/AIDS (88.5%), syphilis (73.5%), gonorrhoea (76.1%), genital warts (6.1%), other (1.3%), none (5.5%)	• 15-19: HIV/AIDS (92.8%), syphilis (61.9%), gonorrhoea (63.3%), genital warts (5.1%), other (2.0%), none (4.1%) • 20-24: HIV/AIDS (94.8%), syphilis (85.6%), gonorrhoea (87.9%), genital warts (7.7%), other (0.8%), none (1.4%)
Self-reported STDs in last year	Not measured	• 15-19: any STD (1.3%), syphilis (0.6%), gonorrhoea (0.6%), HIV/AIDS (0%), genital warts (0.2%) • 20-24: any STD (2.8%), syphilis (1.2%), gonorrhoea (1.3%), HIV/AIDS (0.2%), genital warts (0.1%)	• 15-19: any STD (3.3%), syphilis (0.3)%, gonorrhoea (2.0%), HIV/AIDS (0%), genital warts (0%), discharge from penis (2.2%), sore/ulcer on penis (1.3%) • 20-24: any STD (7.6%), syphilis (1.8%), gonorrhoea (4.3%), HIV/AIDS (0.0%), genital warts (0.4%), discharge from penis (3.6%), sore/ulcer on penis (3.5%)
Action taken by respondents <30 who reported having had an STD in past year	Not measured	• (n=114): Sought treatment (97.8%), informed partners (93.4%), avoided sex (7.3%), used condoms (2.0%), took medicine (22.6%), partner infected/no measure taken (55.9%), no measures taken (15.7%)	• (n=70): Sought treatment (86.2%), informed partners (57.0%), avoided sex (44.3%), used condoms (6.9%), took medicine (33.2%), other (1.7%), partner infected/no measure taken (12.6%), no measures taken (21.0%)
Ever heard of AIDS	• 15-19: 98.0% • 20-24: 98.9%	• 15-19: 99.3% • 20-24: 99.8%	• 15-19: 98.5% • 20-24: 100%
Sources of information on AIDS among those who had heard of AIDS	Not measured	• 15-19: radio (46.8%), TV (22.0%), newspaper (9.0%), pamphlet (6.7%), health worker (33.1%), mosque/church (3.6%), school (31.0%), community meeting (4.0%), friend/relative (62.2%), workplace (0.1%), live drama (6.4%), other source (0.9%) • 20-24: radio (55.8%), TV (22.7%), newspaper (12.3%), pamphlet (8.4%), health worker (57.1%), mosque/church (5.1%), school (9.8%), community meeting (5.8%), friend/relative (60.2%), workplace (0.8%), live drama (5.1%), other source (0.8%)	• 15-19: radio (64.9%), TV (30.8%), newspaper (20.1%), pamphlet (17.8%), health worker (10.5%), mosque/church (5.9%), school (37.8%), community meeting (5.2%), friend/relative (58.2%), workplace (0.7%), live drama (3.1%), other source (1.2%) • 20-24: radio (76.9%), TV (29.7%), newspaper (26.4%), pamphlet (23.4%), health worker (26.0%), mosque/church (5.7%), school (22.7%), community meeting (5.6%), friend/relative (63.1%), workplace (3.3%), live drama (1.9%), other source (3.2%)

Indicator	ZDHS 1992 Females	ZDHS 1996 Females	ZDHS 1996 Males
Knowledge of ways to avoid AIDS among those who had heard of AIDS	Not measured	• 15-19: no way to avoid AIDS (9.9%), abstain from sex (35.4%), use condoms (35.0%), have only one sexual partner (34.0%), avoid sex with prostitutes (3.1%), avoid homosexuals (0.0%), avoid transfusions (2.1%), avoid injections (3.6%), avoid kissing (0.3%), avoid mosquito bites (0.0%), avoid traditional healers (0.1%), other ways (5.0%), don't know any way (22.6%), percentage with misinformation (5.5%) • 20-24: no way to avoid AIDS (8.6%), abstain from sex (26.6%), use condoms (42.8%), have only one sexual partner (49.3%), avoid sex with prostitutes (4.2%), avoid homosexuals (0.2%), avoid transfusions (3.8%), avoid injections (5.4%), avoid kissing (0.4%), avoid mosquito bites (0.1%), avoid traditional healers (0.3%), other ways (5.0%), don't know any way (14.3%), percentage with misinformation (5.7%)	• 15-19: no way to avoid AIDS (2.7%), abstain from sex (43.4%), use condoms (54.5%), have only one sexual partner (29.0%), avoid sex with prostitutes (6.4%), avoid homosexuals (0.0%), avoid transfusions (3.2%), avoid injections (4.1%), avoid kissing (1.2%), avoid mosquito bites (0.5%), avoid traditional healers (1.0%), other ways (6.5%), don't know any way (8.1%), percentage with misinformation (8.3%) • 20-24: no way to avoid AIDS (4.0%), abstain from sex (44.9%), use condoms (54.6%), have only one sexual partner (42.6%), avoid sex with prostitutes (10.5%), avoid homosexuals (0.2%), avoid transfusions (9.5%), avoid injections (6.5%), avoid kissing (1.0%), avoid mosquito bites (0.2%), avoid traditional healers (0.0%), other ways (7.0%), don't know any way (6.3%), percentage with misinformation (8.2%)
Perceived risk of getting AIDS among those who had heard of AIDS	Not measured	• 15-19: no risk at all (64.4%), small (22.0%), moderate (8.9%), great (4.6%), has AIDS (0.0%), don't know (0.1%) • 20-24: no risk at all (40.5%), small (26.1%), moderate (24.0%), great (9.4%), has AIDS (0.0%), don't know (0.0%)	• 15-19: no risk at all (69.7%), small (22.2%), moderate (5.4%), great (2.3%), don't know (0.4%) • 20-24: no risk at all (57.0%), small (29.5%), moderate (9.0%), great (4.6%), don't know (0.0%)
Changes in behaviour to avoid AIDS among those who had heard of AIDS	Not measured	• 15-19: no change in behaviour (19.2%), kept virginity (35.6%), stopped sex (9.5%), began using condoms (2.7%), restricted to one partner (34.8%), fewer partners (2.8%), asked spouse to be faithful (3.5%), other sexual behaviour (0.1%), non-sexual behaviour (20.9%) • 20-24: no change in behaviour (18.2%), kept virginity (4.9%), stopped sex (10.2%), began using condoms (3.2%), restricted to one partner (62.2%), fewer partners (2.7%), asked spouse to be faithful (11.8%), other sexual behaviour (0.3%), non-sexual behaviour (19.2%)	• 15-19: no change in behaviour (7.3%), kept virginity (29.9%), stopped sex (20.2%), began using condoms (17.6%), restricted to one partner (18.0%), fewer partners (16.3%), asked spouse to be faithful (1.0%), avoid sex with prostitutes (6.4%), other sexual behaviour (3.8%), non-sexual behaviour (17.9%) • 20-24: no change in behaviour (4.6%), kept virginity (10.0%), stopped sex (12.7%), began using condoms (28.6%), restricted to one partner (38.1%), fewer partners (25.3%), asked spouse to be faithful (5.7%), avoid sex with prostitutes (10.5%), other sexual behaviour (3.9%), non-sexual behaviour (19.3%)

Indicator	ZDHS 1992 Females	ZDHS 1996 Females	ZDHS 1996 Males
Knowledge of condoms and sources of condoms among those who had heard of AIDS	Not measured	• 15-19: know about condoms (94.2%), public sector (41.3%), private medical sector (6.9%), private pharmacy (1.8%), other source (17.0%), don't know a source/missing (33.0%) • 20-24: know about condoms (97.6%), public sector (55.9%), private medical sector (10.0%), private pharmacy (1.9%), other source (12.0%), don't know a source/missing (20.2%)	• 15-19: know about condoms (99.1%), public sector (32.4%), private medical sector (4.7%), private pharmacy (2.2%), other source (42.4%), don't know a source/missing (18.4%) • 20-24: know about condoms (100.0%), public sector (42.2%), private medical sector (6.9%), private pharmacy (4.9%), other source (35.1%), don't know a source/missing (10.8%)
Ever used condoms for family planning and/or to avoid STDs (among those who had intercourse in the last 12 months)	Not measured	• 15-19: family planning (21.9%), to avoid STDs (23.1%), either reason (30.5%) • 20-24: family planning (28.0%), to avoid STDs (21.1%), either reason (36.2%)	• 15-19: family planning (44.0%), to avoid STDs (50.1%), either reason (51.2%) • 20-24: family planning (61.0%), to avoid STDs (65.3%), either reason (69.9%)
Used condom with spouse or other partner during last sexual intercourse in the 4 weeks preceding survey (among those who had intercourse in last 12 months)	Not measured	• 15-19: spouse (7.6%), other partner (0.8%), any partner (4.1%) • 20-24: spouse (7.0%), other partner (2.4%), any partner (6.1%)	• 15-19: spouse (not available), regular partner (0.0%), someone else (0.0%), any partner (0.0%) • 20-24: spouse (17.5%), regular partner (0.8%), someone else (1.3%), any partner (6.4%)
Mass media access	• 15-19: read newspaper weekly (43%), watch TV weekly (27.4%), listen to radio weekly (56.4%) • 20-24: read newspaper weekly (44.3%), watch TV weekly (21.1%), listen to radio weekly (60.2%)	• 15-19: no mass media (47.9%), read newspaper weekly (26.5%), watch TV weekly (32.3%), listen to radio daily (34.7%), all three media (11.7%) • 20-24: no mass media (48.5%), read newspaper weekly (24.2%), watch TV weekly (29.5%), listen to radio daily (36.3%), all three media (11.2%)	• 15-19: no mass media (39.3%), read newspaper weekly (42.1%), watch TV weekly (38.7%), listen to radio daily (34.4%), all three media (18.2%) • 20-24: no mass media (36.6%), read newspaper weekly (42.1%), watch TV weekly (41.4%), listen to radio daily (46.8%), all three media (24.8%)

Adolescent Reproductive Health Evaluation Baseline Research

Mano Consultancy Services, Ltd., 1998

Citation: Mano Consultancy Services, Ltd. Adolescent Reproductive Health Evaluation Baseline Research: Report for Margaret Sanger Centre International Programme on Premature Parenting and STDs. Lusaka: Mano Consultancy Services, Ltd. 1998.

Brief Description: Research done to provide baseline data at the outset of a project aimed at urban school pupils (aged 14-19) and students of rural youths skills training centres (aged 15-25).

Study Design:

- Series of focus group discussions and a knowledge, attitudes, and practices (KAP) study
- First focus group discussion guide used with secondary school pupils (Livingstone and Lusaka), teachers (Livingstone), parents (Livingstone), health care providers (Livingstone, Chongwe), skills training centre trainees (Mongu and Chongwe) and skills training centre trainers (Chongwe)
- Second focus group discussion guide used with out-of-school youths in Choma (2 groups) and Lusaka (2 groups) and parents in Choma (2 groups)
- First KAP carried out in six secondary schools (Chongwe, Mumbwa, Kaoma, Choma, Petauke, Mongu) and six skills training centres (Lusaka (2), Livingstone, Kitwe, Kabwe(2)), N=336 (n=155 male, mean age 19.5: n=136 female, mean age 18.4)
- Second KAP with in- and out-of-school youth (Choma, Livingstone, Chipata, Lusaka, Kabwe, Kitwe); N=291 (n=189 male; n=143 female; mean age not provided, age range from 17 to over 30, most between 17-25)
- KAP questionnaires either self-administered or done by one-to-one interview

Key Findings/Highlights

First FGD Round

- Pupils mention that health advice was best obtained from health education materials, and from health personnel; however, they were not always satisfied, as health staff would tell them that they had nothing wrong with them or did not need to know. They also said they would be happy with advice from teachers.
- Pupils were aware of family planning, although the majority (75%) initially mentioned that FP was for married people only. After a heated discussion, a greater proportion agree that FP was necessary for their own peers, since many were in fact having sex.
- All pupils who were using FP mentioned condoms; they discussed the easy availability of condoms as the primary reason, together with the protection against STDs and pregnancy.
- Although HIV education had given pupils an accurate view of the transmission of HIV, there were strong views that this education had been overbearingly moralistic and did not provide sufficient information. All pupils emphasised the need for full explanation of scientific facts.
- All health workers said that health education was an integral component of their work. Most mentioned post-factum health education; indeed, some respondents said it was embarrassing to raise issues to patients who had not already presented with associated symptoms.
- Government workers discussed the tendency of youth people to seek treatment of STDs in private clinics, since most thought that private clinics would not ask for partners to be brought, nor try to educate patients on their conditions. They also mention that many go to traditional healers, for more effective cures.
- Health workers discussed how young people are more worried about HIV and ask for tests, however, they noted that behaviours did not seem affected by these worries, since STDs were increasing and sexual behaviour was unchanged.
- No teachers of secondary school pupils had received any training on adolescent sexual or reproductive health, HIV or family planning. They stated that the only mention of sexual health is in grades 11 and 12, when mentioned in biology, however, they did not provide details which would help pupils in making decisions about sexual behaviour and health care. Some said that they took the opportunity to discuss HIV and family planning, but that they wanted family life and sex education to be introduced into the curriculum.
- Teachers said that many pupils were having sex, and seemed unperturbed by the prospect of pregnancy or HIV. Teachers were reluctant to agree that family planning should be made available to young people, since they thought that it would sanction teenage sex.
- According to skills training centre trainers, the high rate of sex and pregnancy was attributed to economic temptation and to the boredom of rural areas.
- All skills training centre trainers were in full support of making family planning available for young people. They pointed out that rural areas were particularly lacking in both education and supplies.

Second FGD Round

- The parents interviewed thought that young people should get advice from within the family; they acknowledged the

difficulty that older people have talking about traditionally taboo subjects with youth, but appreciated the need to do so.

- The youths tended to get information about sex at an early age-as young as 8-however this information was not necessarily correct as evidenced in the discussions.
- Most participants believe many girls and fewer boys have sex against their will, as a result of social or peer pressure, to preserve a relationship, or by force.
- Parents were unhappy about youth and family planning; they were more focused on contraception as a means of spacing subsequent children, and opposed anything that promotes 'premarital' sex.

KAP Surveys

- The overwhelming condemnation of extra-marital sex is accompanied by a strong (75%) perception that "there is a lot of it about," particularly amongst young people. Schoolgirls who get pregnant are at fault and should generally be expelled as punishment and a warning to others. An alarming 40% of respondents feel that people with AIDS deserve to suffer "as they have probably lived immoral lives."
- Although almost all respondents recognise unwanted pregnancy, STDs and HIV as major dangers from unprotected sexual intercourse, and 70% acknowledge the condom as an effective protection against transmission, only one third of respondents claim to always use condoms.
- A major threat-perhaps the major threat-to adolescent reproductive health is trans-generational intercourse; apart from the anecdotal evidence, the relatively high rate of HIV seroprevalence in adolescent females (7 times higher than in adolescent boys) suggests a high frequency of young women having relations with, and being infected by, older men. When answering "have you ever received gifts or money from a sexual partner," 74% of all female respondents said yes; this figure rises to 89% when those women whose oldest partners were 21 and over are selected.
- In response to "to whom would you go for advice or help," the majority of respondents mentioned friend in the case of emotional/relationship problems and an institutional option (hospital, PPAZ, counsellor, etc.) in the case of sexual health problems.
- When questioned about their age at sexual debut, the median age for boys was 14+/- 1 year, and the median age for girls was 13+/- 1 year.

Emergency Contraception in Zambia: Setting a New Agenda for Research and Action

Ahmed et al., 1998

Citation: Ahmed, Y., Ketata, M., Skibiak, J.P. *Emergency Contraception in Zambia: Setting a New Agenda for Research and Action.* The Population Council, Africa OR/TA Project II. 1998.

Brief Description: Describes activities and findings of the first phase of the operations research study "Enhancing Access to Family Planning Services through the Introduction of Emergency Contraceptives;" study launched September 1997.

Study Design:

- Study involved University Teaching Hospital, 15 health centres within the MOH/CBOH, 4 clinics operated by PPAZ, and main campus clinic of UNZA
- MCH/FP client survey: 1,600 women attending 8 Lusaka clinics
- FGDs: with 46 male and female university students at main and Ridgeway (medical school) UNZA campuses
- Client history forms: 316 reviewed (from all service delivery points)
- Provider interviews: 52 providers from each Lusaka-based facility involved

Key Findings/Highlights

- Emergency contraception services (pills under brand name PC-4) were available in over 21 health care facilities across Lusaka and rural areas in Copperbelt Province.
- Mean age of emergency contraception users was about 29, with a range of 19-43.
- Youth aged 19 and below make up only 14.2% of MCH/FP clients at the 4 MOH clinics (Chawama, Chipata, Kanyama, Mtendere), and less than 3% at the PPAZ clinics(Lusaka, Kabanana, BB Camp, Ng'ombe).
- FGDs with students at Ridgeway campus revealed that students wanted privacy and confidentiality when seeking family planning services, and thus were discouraged from seeking care through campus or UTH services. Students at the main campus said clinics were under-utilised because of the fear of being labelled promiscuous and the poor attitudes (often critical and unfriendly) of clinic staff.
- Community-based distributors and health educators are not seen as viable outlets, due to a perceived lack of competence and the associated lack of privacy.
- Two youth-specific recommendations were made related to accessibility: (1) new channels for distribution of emergency contraception must be sought if it is to be made accessible to youth (and other special groups); (2) based on youth comments during FGDs, new outlets of both information and PC-4 could include chemists, on-campus peer counsellors, circles of friends, and the mini-mart at UNZA main campus.

Sexual Activity and Condom Use in Lusaka, Zambia

Agha, S., 1998 and 1997

Citation: Agha, S. *Sexual Activity and Condom Use in Lusaka, Zambia.* Washington, DC: Population Services International. 1997. And: Agha, S. "Sexual Activity and Condom Use in Lusaka, Zambia." *International Family Planning Perspectives*, 24(1): 32-37. 1998.

Brief Description: Examines sexual activity and condom use in Lusaka; data from the 1996 Lusaka Sexual Behaviour and Condom Use Survey conducted by PSI as part of a midterm assessment of 7 social marketing projects.

Study Design:

- N= 806 men (n=415) and women (n=391, aged 15-49); (n=394, aged 15-24)
- Weighted distribution of females 15-19=29%; 20-24=23%
- Weighted distribution of males 15-19=27%; 20-24=18%
- 2-stage probability sample

Key Findings/Highlights

- 24% of women and 25% of men aged 15-24 had never had sex.
- Of 15-24 year olds, 40% of women were married, compared to 9% of men.
- Among unmarried and sexually active 15-24 year olds, 9% of women had no regular partner, compared to 34% of men.
- Among unmarried and sexually active 15-24 year olds, 27% women had a regular partner, compared to 33% of men.
- 27% of women 15-19 used a condom at last sex.
- 21% of women 20-24 used a condom at last sex.
- 35% of men 15-19 used a condom at last sex.
- 36% of men 20-24 used a condom at last sex.
- Condom use was significantly associated with non-marital sexual activity for both men and women.
- Women 15-19 more likely to report condom use at last sex than those over 20 (due to higher number of regular and casual partners for younger women).
- Among condom users aged 15-24 (n=102), 79% reported using condoms for pregnancy prevention (more females (93%) than males (76%) reported this), and 99% for HIV//AIDS/STD prevention.
- Reasons for non-use of condoms reported by non-users 15-24 were: do not like condoms (64%), trust partner (55%), partner objected (37%), not available (35%), and cost (5%). [Note: it is unclear whether use of other contraceptives (e.g. for pregnancy prevention) was investigated as reason for condom non-users not to use condoms.]
- Condom use at last sex was significantly higher among younger than older adults (females 15-24 compared to 25-49; males 15-29 compared to 30-49).
- Among those aged 20-24, condom use was significantly higher for men than women (may be explained by older men having sex with younger women or men's levels of commercial sex partnerships).
- No significant association found between schooling and condom use, although men with secondary level or higher education levels were 2 times more likely than those with primary or other schooling to report condom use at last sex.
- Suggests that condom use has been positively influenced in Lusaka as a result of condom marketing, promotion and distribution activities (i.e. Maximum brand condom advertising campaign).
- Level of casual sexual partnership is higher among unmarried and married men than for unmarried and married women.
- Findings suggest that AIDS prevention approaches that target men directly should receive the greatest attention in Zambia, as women may be less able to negotiate safer sex due to prevailing gender differences in decision making.
- Clear need for a better understanding of male sexuality; for example, men's fears about compromising their masculinity may be very important in determining whether they take precautions such as condom use.
- Programmes to relay gender-specific information to men in a manner acceptable to them are urgently needed and societal changes in to increase women's status and reduce gender inequalities are desirable.

Adolescence, Sex and Fear: Reproductive Health Services and Young People in Urban Zambia

Webb, D., 1997

Citation: Webb, D. *Adolescence, Sex and Fear: Reproductive Health Services and Young People in Urban Zambia*. Lusaka, Zambia: Central Board of Health/UNICEF. November 1997.

Brief Description: Findings of UNICEF research study intended to design a training package for health workers in 5 districts (Lusaka, Livingstone, Chipata, Ndola, and Kitwe) to improve service delivery for adolescents with regard to sexual and reproductive health.

Study Design:

- Narrative research questionnaire: N=1100 students aged 10-19 (n=498 male, n=602 female)
- Semi-structured clinic exit interviews: N=152 adolescents aged 10-24 (n=52 male, n=100 female; total of 12 clinics)
- FGDs: about 20/district (separately with in-school and out-of-school youth)
- Semi-structured health worker interviews: N=175, average of 35/district (most clinic-based, some hospital-based; majority nurses)
- Key informant interviews: 5/district
- Medical record review: 12 clinics

Key Findings/Highlights

- 71% of boys and 38% of girls reported ever having had sex.
- Sex is primary motivation for boys to engage in relationships, whereas for girls material and non-material (e.g. desire for marriage) are lead motivations. Other reasons are proving manhood and fertility, copying elders' behaviour, watching pornographic films, and pleasure.
- Boys are primary initiators of relationships.
- School children perceive average age of initiation to be 15-16, while health workers tend to see either marriage or age of 18 as appropriate for sexual debut.
- Among in-school youth, first sex usually with age-mates.
- For boys, the main worry concerning sex is the risk of acquiring STDs and AIDS; for girls it is pregnancy.
- While girls suggest use of a condom, boys are responsible for obtaining one.
- Sources of condoms are chemists, CBDs, *kantembas*, and clinics (however, FGDs revealed clinics are not popular sources).
- Among those who reported ever having had sex (n=550), ever use of condoms was highest among schoolgirls 15-19 (59%) and lowest among schoolboys 10-14 (12%). For girls 10-14, 25% reported ever using condoms, as did 36% of boys 15-19 (note: reliability questioned).
- The largest single reason for non-use of condoms is 'getting excited and forgetting' (especially for boys).
- The main reason for abortion is the desire to continue schooling.
- Traditional healers are considered the first option for abortion; chloroquine overdose appears most popular method.
- 64% of health care workers considered abortions very common or common in community.
- 12% of male students and 9% of female students (10-19) claimed to have made someone pregnant or been pregnant, respectively.
- Girls usually tell boyfriend first about pregnancy; it is perceived that boys accept fatherhood 50% of the time.
- Antenatal clinics were most popular option for monitoring pregnancy, however many girls don't attend due to stigmatisation. Antenatal clinic records have shown that most girls delay going to the ANC until the second trimester, and a sizeable proportion until the third. For example, in Lusaka 16% attended the ANC during the first trimester, 63% during the second, and 21% during the third.
- Review of records at OPD (outpatients department) clinics showed that 25% of all attendees were adolescents, with slightly more females than males, and of all STD cases at OPD about 40% are adolescents.
- Large variation in antenatal syphilis prevalence between sites - average 9%, highest level 14.5% for 10-25 year olds.
- When asked whether they had ever had an STD, a large sample of students aged 10-19 reported as follows: 6.4% boys 10-14, 7.4% girls 10-14, 9.5% boys 10-14, and 13.7% girls 15-19 (N=1100). The study's author notes that 8.2% of respondents that claimed never to have had sex also claimed they had an STD.
- High stigmatisation of STDs among young people. Upon discovery, boys are mostly ashamed and girls hurt by unfaithfulness of boyfriend.
- Contradictory evidence of advice/treatment-seeking behaviour: FGD participants cited friends, traditional healers, and private clinics, and narrative research respondents cited nurses and clinics.

- FGD participants cited lack of money, drug shortage, poor staff attitudes, and lack of privacy as the main deterrents to clinic attendance. Narrative research respondents emphasised lack of confidentiality and poor staff attitudes. Health care workers considered embarrassment, stigma, and nurse attitudes as primary deterrents.
- Around 25% of clinic attendees are adolescents, and of the STD cases presented at OPD, around 40% are in adolescents.
- Higher level of staff-adolescent patient dialogue in antenatal clinics than OPD.
- Only one-third of clinic patients were able to ask all the questions they wanted to; less than one-third were attended to in under 30 minutes; and about 25% experienced a lack of privacy in the clinic. However, the majority considered clinic staff friendly (except in Lusaka).
- Around half of STD cases at clinics go untreated due to unavailability of drugs, while patients consider receiving drugs as the most important aspect of service provision.
- Traditional healers considered the first option for STD treatment; formal health services visited as a last resort. Concluded that outreach education, both in schools and in the community, is vital.

What's Up Kafue? An Assessment of the Livelihood, Sexual Health and Needs of Young People in Kafue District

Clara, M. et al., 1997

Citation: Clara, M. et al. *What's Up Kafue? An Assessment of the Livelihood, Sexual Health and Needs of Young People in Kafue District*. 1997.

Brief Description: A needs assessment done three weeks pre-project in rural and peri-urban communities of Kafue district (Nangongwe, Shikoswe, Zambia compound, Kafue estates, and Kabuchende compound, Chanyanya and fishing camps); study undertaken through local (FLMZ, PPAZ) and international (Swedish Association for Sex Education and Division of International Health Care Research) institutional collaboration. The purpose of the assessment was to identify how personal qualities, social environments and availability of services and support influences young people's behaviour in Kafue district. The researchers used the focus group discussions to document the concerns of youth in the communities targeted by the study.

Study Design:

- Targeted in- and out-of-school youth, as well as community leaders, health clinic staff, and teachers
- Focus group discussions, key informant interviews and participatory observations
- N=not specified

Key Findings/Highlights

- Kafue district serves as an example of a former industrial area experiencing high levels of unemployment; both young and old depend on the informal sector for a living.
- The study is divided into sections on lifestyles and general concerns, relationships, sexual and reproductive health, and health-seeking behaviour of youth. Within each section, the authors have reported on young people's perception and description of the issues, their knowledge, attitudes and behaviours, and proposed solutions to the problems of each subject area.
- Poverty is common and rampant in all communities and is seen as a cause of many social problems. It is the number one concern of many youth participating in the study. Other major concerns are lack of clean water, substance abuse, prostitution, and diseases.
- To combat the above problems, young people felt that they should seek employment, use abstinence (or condoms, if already sexually active) to avoid STDs and unwanted pregnancy, and engage in faithful, monogamous relationships.
- Young people felt that the government's role in dealing with their most pressing problems should be to reduce fees at health centres, build new centres that are more conveniently located, and provide recreation and entertainment for youth.
- Health centre staff noted the most common health problems encountered by young people include incomplete abortion, assault and STDs (especially gonorrhoea and syphilis.)
- Early sex is common among young people, especially girls who report engaging in sex for gifts and money.
- Unwanted pregnancies and HIV/AIDS/STIs are common.

Evaluation of the CARE/MotherCare PALS Project Clinical Training Component

Ganges, F., 1997

Citation: Ganges, F. *Evaluation of the CARE/MotherCare PALS Project Clinical Training Component.* Washington DC: MotherCare and John Snow International. 1997.

Brief Description: Evaluation of clinical training component of Partnership for Adolescent and Reproductive Health (PALS) Project in Lusaka. Clinical and interpersonal skills were assessed, as well as knowledge of information covered in training. Adolescent clients and peer counsellors also interviewed. Copies of evaluation instruments included in appendices.

Study Design:

- N=23 trained providers
- N=17 non-trained providers
- N=65 adolescent clients
- N=8 peer counsellors

- The evaluation consisted of interviews with trained providers, non-trained providers and adolescent clients, observation of trained providers, written assessment using a skills checklist, interviews with peer counsellors and a review of antenatal and family planning clinic registers.

Key Findings/Highlights

- The majority of trained respondents indicated that there was at least some change in their attitudes toward adolescents (87%) and/or personal communication (43%). Many acknowledged that pre-training they treated teens with disdain and were rude and unprofessional, however, post-training they felt more confident in talking with adolescents, no longer turned them away when they sought care, and some even encouraged colleagues to treat youth differently. A few (22%) mentioned a change in the quality of care (other than interpersonal counselling), such as doing a genital inspection.
- When asked what additional skills/topics they felt would be useful if a refresher course were offered, several trained providers mentioned that simply training more clinicians in youth-friendly services would be useful, to be sure that someone for the youth would be on duty at all times. Being trained in community outreach for the purpose of reaching more youth in the community was also expressed as a need (instead of waiting for adolescents to show up at the clinic).
- When trained providers were asked how they shared what they learned during the training with their fellow providers, encouraging fellow staff members to change their attitude when providing care to youth was by far the most frequent way (n=15); a few also encouraged staff to refer adolescents to them (n=5).
- When non-trained providers were asked what changes in the clinic were evident as a result of having providers trained in youth-friendly services, 7 stated that more youth are coming to the clinics, 7 stated that youth feel more open, and 6 said interpersonal communication with youth had improved.
- When non-trained providers were asked for their recommendations, the most frequent responses were to train more staff in youth-friendly service provision and provide more rooms for youth.

Unmet Need for Family Planning in Lusaka and Mansa, Zambia

Mushingeh, C. and Kurz, K., 1997

Citation: Mushingeh, C., Kurz, K. *Unmet Need for Family Planning in Lusaka and Mansa, Zambia.* Washington, DC: International Center for Research on Women. 1997.

Brief Description: Study of the unmet need for family planning in Lusaka and Mansa; qualitative and quantitative methods used; study done by University of Zambia and International Center for Research on Women.

Study Design:

- N= 309 women aged 14-49 years randomly selected from compounds in Lusaka and Mansa for a survey, mean age 26; adolescents 14-20 comprised 24% (n=75) of sample, mean age 18
- In-depth interviews with women aged 14-49 years purposively chosen from the sample (n= 70) ; 24 of the interviews with adolescents
- In-depth interviews with 50 partners

Key Findings/Highlights

- 63% of adolescents were sexually active; 40% married; and had an average of 1.8 live births.
- Adolescents' unmet need was 43%, met need 30%, and no need 28%. [unmet need=unmet need for spacing+unmet need for limiting, per standard DHS definition; met need=family planning users; no need=do not want to wait at least 2 years before having next child]
- Among those adolescents using a contraceptive method (30%), 41% were pill users, 30% condom users.
- Significantly more adolescents than adult women reported using condoms (30% vs. 14%).
- Although adolescents had slightly higher levels of unmet need than adult women, the difference was not statistically significant.
- Reasons for not using a method among never married adolescent women were infrequent sex and fear of side effects.
- Many unmarried adolescents do not seek a method because they believe the attitude of most service providers is that they should not be having sex and therefore should not need a family planning method.
- Recommendation to improve counselling skills of service providers for adolescent clients.

Project for Integrating Health and Family Life Education and Income Generation for Out-of-School Youth

Mukuka, L. and Tembo, R., 1996

Citation: Mukuka, L., Tembo, R. *Project for Integrating Health and Family Life Education and Income Generation for Out-of-School Youth.* Lusaka, Zambia: Ministry of Sports, Youth and Child Development. August, 1996.

Brief Description: Examines knowledge, attitudes, values, and beliefs regarding human sexuality and adolescent development.

Study Design:

- n=208 aged 15-17 (sampled from 650 trainees at 7 youth skills training centres located in 7 different provinces)
- n=34 parents
- n=14 instructors
- Data collected primarily through FGDs

Key Findings/Highlights

- Regardless of cultural background/regional origin, both unmarried/married males and females:
(1) had sufficient knowledge about human sexuality;
(2) were highly sexually active; and
(3) were engaging in multiple sexual relations.
- Girls were having sex for material benefits.
- Despite contraceptive method knowledge, each site had a high incidence of teen pregnancy and increasing STD levels.
- For males and females, poverty and unemployment emerged as the strongest factors in influencing sexual behaviour.

Partnership for Adolescent Sexual and Reproductive Health (PALS/MotherCare): Needs Assessment Draft Report

Chikotola, B., 1996

Citation: Chikotola, B. *Partnership for Adolescent Sexual and Reproductive Health (PALS/MotherCare): Needs Assessment Draft Report.* CARE International, Zambia. 1996.

Brief Description: Describes the results of a needs assessment done in the 7 clinics where the PALS project would be implemented.

Study Design:

- N= 19 nurses
- N= 50 adolescents
- Interviews by use of a questionnaire

Key Findings/Highlights

- Out of 14, at least one nurse said she would turn away a pregnant adolescent and another stated reprimanding before providing care. None admitted discussion of pregnancy termination.
- At least 3 nurses said that sex education promotes sexual activity; another 3 said adolescents should not have access to contraceptives; 10 said it was okay if married; and another 7 said adolescents should not be sexually active.
- The majority of the nurses indicated that sex before marriage was bad because it promotes prostitution among the adolescents.
- 16 nurses stated that all should be involved in the education of adolescents on issues of sexuality and reproduction (i.e. medical personnel, the community and parents).
- When asked whether anything should be done differently for adolescents, 8 of 19 nurses stated that adolescents need special attention. Other things mentioned were staff training, health education, separate services, school health services, counselling, youth-friendly services and treating the adolescents like adults.
- At least 18 nurses said they were prepared to care for adolescents in their various clinics; one said she was not prepared because she did not have adequate knowledge about adolescents.

The Evolution and Application of Participatory Learning and Action in the Partnership for Adolescent and Reproductive Health Project (PALS)

Kambou, S., 1998

Citation: Kambou, S.D. *The Evolution and Application of Participatory Learning and Action (PLA) in the Partnership for Adolescent Health Project (PALS).* CARE/Zambia, CARE/USA and FOCUS on Young Adults Programme. [May draft]1998.

Brief Description: Primarily a discussion of CARE's PLA experience under the PALS Project, but also includes data from 6 compounds where surveys were conducted (in addition to PLA).

Study Design:

- N=1,294 (n=638 males; n=656 females)
- Mean age 14.4, range 8-21
- Stratified convenience household sampling method
- 53-item questionnaire (modified slightly in 4 versions used)
- 7 sites in 6 Lusaka Compounds: Kanyama, Chelstone, Chilenje, George, and Chipata (Maripodi and Mandevu)

Key Findings/Highlights

- Initiated sexual activity: girls-362 (55%); boys-519 (81%); total-881 (68%).
- Mean age of the sexually initiated was 14.4 years (mean age of sexually active boys was one year younger than the mean age of sexually active girls, 14.79 years and 15.72 years respectively). Mean age of respondents who had not yet initiated sex: 13.2 years.
- Among those that had initiated, 75% of boys and 64% of girls had had sex in the last 3 months (mean age: 15.1 years).
- Compound of residence was strongly associated with sexual status of adolescents: girls residing in Maropodi and George compounds are more likely to have initiated sex or to be sexually active than girls residing in other study sites (p<0.002). Sexual activity among male adolescents was less in Chelstone and Kanyama than in the other study sites (p<0.000).
- It appears that there is a considerable time lag between age at first sex and age at second sexual experience. Of the respondents who had initiated sex (n=881), median age at first sex for females was 13.0 years (range 4-19 years); median age at first sex for males was 11.0 years (range 4 to 19; mode of 10).
- Of the n=547 respondents reporting age at second sexual experience, median age was 15.0 years for girls (range 8-21) and 12.0 years for boys (range 4-19).
- When asked about the circumstances under which they first experienced sex, 163 (19%) felt that they had been forced to initiate sex while 706 (81%) felt that they had initiated sex willingly (n=869). More girls (28%) than boys (12%) reported forced sex.
- Of the sexually active adolescents, 325 (37%) reported ever use of condom.
- Of the sexually active adolescents, 14 girls (3.8%) and 26 boys (5%) reported ever having had a sexually transmitted disease.
- Compared to survey results, during PLA in the same sites boys tended to overestimate age at first sex and girls to underestimate (author notes that the incongruity may be related to team composition, ability of team members to collect this kind of data, and ability of team to analyse and aggregate this kind of data).

Understanding Their Perspective: An Analysis of Adolescent Sexual and Reproductive Health: Ng'ombe Compound, Lusaka, Zambia

Chambeshi, M., et al., 1997

Citation: Chambeshi M, et al.. *Understanding Their Perspective: An Analysis of Adolescent Sexual and Reproductive Health: Ng'ombe Compound.* Lusaka, Zambia: PPAZ. April 1997.

Brief Description: The appraisal used a mix of verbal and visual tools to enable adolescents to carry out their own analyses in Ng'ombe Compound; collaborative study by CARE/Zambia, Planned Parenthood Association of Zambia, and Makeni Ecumenical Center, in April 1997.

Study Design:

- Participatory learning and action methods used with boys and girls 8-20 in Ng'ombe Compound, Lusaka
- N=430 boys and girls 10-19 interviewed to supplement the participatory appraisal in order to compile a baseline data set (results not included in report)

Key Findings/Highlights

- Girls get most information from female relatives and initiation ceremonies led by *banachimbusas* (elder women that teach girls how to: prepare for marriage, care for husbands, *donsa* (pull labia to certain length), and observe certain rules set by elders).
- Boys' main sources of information are pornographic videos, shows, radios, friends, books, and elders.
- Boys and girls engage in sex at a very young age (5 and 7 respectively).
- Usually the boy initiates sex, though sometimes an older girl may propose to younger boy. Decisions to have sex more commonly made by those girls sent out for money for household, or orphans and girls working as sex workers.
- Perception that in-school youth (especially girls) are less sexually active than out-of-school.
- Reasons for why boys have sex include *nyele* (sensational sexual feeling), peer pressure, and to test functioning of sexual organs.
- Girls have sex to prove to their boyfriend that they love them, because friends influence them, because they want money for self or for household, to feel nice, and to prepare for marriage.
- Reasons given as to why they do not have sex included fear of diseases, pregnancy and parents; school expulsion; and it is a sin before marriage. Knowledge of undesirable consequences of sexual activity such as pregnancy, abortion, STIs, and HIV.
- Boys preferred to have girls younger than them as sex partners (believed to have lower chance of pregnancy), and they prefer are schoolgirls because they are smart, clean, not too expensive, and don't have STIs.
- Boys' most common partners are neighbour girls, sister-in-laws, and cousins.
- In-school girls preferred schoolmates and boys from well-off families as partners, as well as teachers.
- Out-of-schools girls preferred minibus conductors and vendors (because they always have money to give them).
- Boys and girls aged 10-14 had minimal knowledge of contraceptive methods, while girls aged 14-19 had greater knowledge of a variety of methods.
- Some believe condoms to be harmful because using them might lead to impotence.
- Girls felt family planning pills are only for girls that have children.
- Although condom is the most well known contraceptive method, majority of boys and girls do not use condoms regularly, if at all. Reasons: too big, prefer skin-to-skin sex, lack of money, can't enjoy sex, can move from vagina to womb (girls only), fear being called a prostitute (girls only), and not necessary because boys' sperm too weak to make girl pregnant).
- Those using condoms said they did so to protect themselves from disease.
- Limited knowledge of STIs and symptoms.
- Perception that young people are too young to get infected or transmit STIs.
- Knowledge of how to prevent STIs, including abstinence and condom use.
- Both girls and boys mentioned that they would only go to the clinic after failing to get traditional medicine (from *Ng'anga* (traditional healers) and *Vamizimu* (spiritual healers) or help from private practitioners. They avoid the clinic primarily because of the poor attitude of service providers toward young people with STIs, and also because of the fees for the medical scheme.
- Perception that abortions common in the compound.
- Grandmother would be preferred contact for information and support for an abortion.
- Many abortion methods mentioned --most common were taking capsules bought at market and drinking *muleza* tea; least common was going to hospital doctor.
- Girls have abortions so they can continue school; so they do not disappoint parents; because boy refuses responsibility; because boys tell girls to abort so they can avoid marrying them; and because girls want to continue having fun and don't want baby. Some girls believe younger girls (e.g. under 14) would be more likely to choose to have abortion.

- Reported payments for sex in the form of money (from boys to girls) and gifts like jewellery, clothes, and lotion.
- Amounts paid for sex vary from Kw100 to Kw15,000. Boys reported different payments for sex with a condom (Kw5,000) and for that without a condom (Kw10,000).
- Sexual enhancements used by boys to prolong erections include *vumbwe* (roots soaked in water then drunk), dried herbs that are chewed and *mutoto* (roots dried then chewed). Boys and girls both may use *mandrax* "kill-me-quick pills" (aphrodisiacs) bought from chemists.
- Perception that likelihood of pregnancy is higher if girl lives with grandparent, on own, or with older sister. Living with a male relative makes it less likely to be sexually active because more strict than females.
- Sex among cousins perceived to be frequent, as well as between stepbrothers and stepsisters. Household circumstances where many different relatives live together may encourage this (shared residences common in compound).

A Report on the Mini-Participatory Learning and Action (PLA) Exercise for the JSI/SEATS Programme in Zambia

Chibbamulilo, P., 1997

Citation: Chibbamulilo, P. *A Report on the Mini-Participatory Learning and Action (PLA) Exercise for the JSI/SEATS Programme in Zambia.* Lusaka, Zambia: JSI/SEATS. [Draft] 1997.

Brief Description: Participatory learning and action methods used to gather baseline data and mobilise community stakeholders in 2 clinic catchment areas (Bauleni and Matero Reference) for the SEATS Young Adult Programme in Zambia.

Study Design:

- FGDs used in conjunction with PLA tools such as ranking and scoring, mapping, and transect walks [neighbourhood health committee responsible for organising and mobilising community into the mini-PLA groups]
- FGDs with youth in separate male and female groups: Matero-Chunga (1 male/1 female); Matero-East(2 male/2 female); Matero-Chingwele (1 male/1 female); Bauleni (2 male/1 female)
- FGDs with members of 'Youth-Friendly Clubs' in the 2 catchment areas
- 4 FGDs with parents aged 35 and older (more men than women)
- FGDs with providers at Bauleni and Matero Reference Centre clinics
- FGDs with neighbourhood health committees
- Interviews with private sector service providers

Key Findings/Highlights

- Primary sources of information on sexual/reproductive health for youth were friends, media (radio and TV), school science/other materials, and print media. Less common sources were parents, churches, pornographic films, and drama performances. Parents cited their own sources when young as primarily initiation ceremonies (women), parents, and other elders like cousins --indicating how times have changed for youth sources.
- Girls are initiating sex earlier than boys. Girls begin between 10-14, and boys 12-15. Parents perceived youth to be initiating at between 10-15.
- Parents viewed condom promotion as encouraging youth to believe there is nothing wrong with sex and thus increasing their sexual activity.
- Girls are offered money (Kw50-Kw10,000) or other things for sex, so there is an incentive to have sex; sometimes parents 'indirectly' send daughters out for sex money due to poverty.
- Boys said ideal age for sexual initiation was 20 or as high as 30; girls ranged from 15 to 29. Parents either said when married or 18 for girls and 25 for boys.
- STIs, AIDS, and unwanted pregnancy were identified as consequences of sex, as was disruption of school for pregnant girls. Abortion was also mentioned, with opinion that in-school girls are more likely than out-of-school girls to have an abortion (exception was *mahule* [sex workers] who abort so business isn't disrupted).
- Perception that more than half of girls under 19 that get pregnant abort. Illegal abortions done with herbs, chloroquine tablets, and other chemicals. Those with money can have private surgeries.
- Awareness of several contraceptive methods (pills and condoms) was high, although there were misconceptions such as that the painkiller Cafenol can be used to terminate pregnancies. Parents, especially older ones, were less aware of methods.
- Though use perceived to be low, the most popular contraceptive method is the condom. It was reported that couples stop using condoms after the first several encounters. "Not knowing" the girl makes it more likely to use a condom.
- Youth may not use condoms because they reduce pleasure of skin-to-skin sex, girls fear boys will prick the tip anyway, boys may see girls as promiscuous (one male mentioned boys may be seen as promiscuous by girls), and church teachings that condoms do not protect against AIDS because they have microscopic holes.
- Pills are well known but believed to cause infertility or birth defects.
- Ideal family sized ranged from 2-4 for boys and 3-5 for girls (2-5 for parents), with economic hardship being reason to have smaller family.
- Clinic use by youth is low. Youth avoid clinic because they feel shy; they will lose privacy (may see other friends/neighbours); because of poor quality of service (e.g. delays, rudeness); for STI treatment you must bring your partner (a popular misconception among both youth and parents --according to providers, patients are encouraged to refer partners); and poor gender balance of providers (e.g. no male for boys to talk with). Medical schemes were also reported to deter youth because of the Kw500/month fee.
- Neighbourhood health committee (NHC) members had less favourable attitudes toward family planning provision to youth. They felt contraceptive use by youth was immoral and should only be for married people (despite their awareness of youths' reproductive health problems). Matero NHC better organised and with more link to community than Bauleni NHC.

- Youth like private sector providers (street vendors and drug stores) because no congestion, faster service, no questions asked, and no counselling sessions (like when nurses "scold" youth).
- Private sector providers do not explain use of methods to clients. Storage tends to be poor (e.g. condoms exposed to sun).
- Health centre staff were uncomfortable providing family planning services to youth under 15 years old.
- Health centre staff made some suggestions on how to increase youths' use of the clinic, such as awareness campaigns about youth-friendly clubs (using drama and posters); add videos and games to youth-friendly clubs at clinic; and add skills training activities to youth-friendly clubs.
- Members of youth-friendly clubs at the 2 clinics (formed April 1997) assessed their activities and identified areas needing improvement (e.g. counselling and skills training). Lack of financial and material resources identified as major constraints to launching proposed activities.

A Participatory Assessment of Adolescent Sexual and Reproductive Health: New Kanyama Compound, Lusaka, Zambia

Mupela, E. and Fetters, T., 1997

Citation: Mupela E., Fetters T. *A Participatory Assessment Of Adolescent Sexual And Reproductive Health In New Kanyama Compound, Lusaka.* Lusaka, Zambia: CARE International in Zambia. March, 1997.

Brief Description: One-week participatory appraisal to investigate sexual and reproductive health perspectives of youth in New Kanyama Compound; Study done by CARE/Zambia in March 1997.

Study Design:

- Boys and girls 13-19
- Participatory learning and action methodology used (included ranking and scoring, diagrams, sex census, FGDs, body mapping, and other PLA tools)
- New Kanyama Compound, Lusaka

Key Findings/Highlights

- Adolescents use the clinic mainly for treatment of sicknesses not related to sex. They prefer to see *ng'angas* (traditional healers) for STIs, pregnancy, and abortion for faster, more private service.
- Reasons for avoiding clinic: nurses scold/shout at them; fear that parents/neighbours will find out; shortage of medicine; no guarantee they will receive treatment because preference given to those already known.
- Girls have sex to get money for small items, clothes and food; for pleasure; because boy might leave otherwise; because they are curious to try after seeing careless elders do it in open; and to become pregnant to prove not fertility.
- Boys have sex to prove manhood; because it is difficult to refuse when girls request; because of love for girls/love growing stronger with sex; and for pleasure.
- Reasons not to have sex: fear of STIs and AIDS; religion forbids sex unless married; no money to pay for sexual favours; desire to concentrate on studies; and afraid of making the girl pregnant.
- Age of sexual initiation for boys was between 5-16; for girls between 4-19 (from interview and secret sex census results).
- Girls may have abortions so they can continue school; because they are not ready for the responsibilities and want to continue having fun; because their fear parents' anger; and there is no support for the child, either from boy's or girl's family.
- Abortion methods include legal abortion, herbs from the traditional healer, drugs (capsules, Panadol), and washing powder mixed with Coca-Cola.
- Low awareness/knowledge of STIs and inaccurate knowledge of treatment; wider knowledge of modern and traditional contraceptives and family planning methods.
- Contraceptives are not used because available only at clinics/hospitals/pharmacists; nurses at clinics ask too many questions and often don't approve of young people using contraception; use of contraceptives at young age may cause infertility; and pharmacies are too expensive.
- Boys provided reasons for not using condoms specifically, such as girlfriends don't like them, girls won't trust you/thinks you're sick, and condom is too big.
- Places for sex are shops after closing, unfinished houses, toilets at night, in flowers/bushes, and in boys' "cabins" (small room behind main house).
- Boys get information on sex from *X-Bass* (sexually explicit) movies they watch at markets; magazines, cousins/grandmothers/ friends, storybooks, and a little from school science class.
- Perception that sex among close relatives is common, especially among cousins (usually consensual). It is also more common between brothers- and sisters-in-law and stepbrother and stepsister. Father-daughter and uncle-niece sex occurs when *juju* (black magic) involved and is rare/would happen by force, as would brother-sister sex (though boys who admitted to sex with sisters said it wasn't forced).
- Partners favoured by girls are related to girls' motivation for money, social status, and material gifts, like *ntemba* owners (vendors) and bus/minibus drivers. Some mentioned *fibanda* (ghosts), "unreal" people that pose as wealthy and entice one to sleep with them.
- Boys favour girls for physical appearance (e.g. light-skin, well-built buttocks, small breasts, coloured (mixed blood). Some favour educated girls/girls from rich families.

"Don't Trust Your Girlfriend or You're Gonna Die Like a Chicken:" A Participatory Assessment of Adolescent Sexual and Reproductive Health in a High Risk Environment

Fetters, T. et al., 1997a

Citation: Fetters T., et al. *"Don't Trust Your Girlfriend or You're Gonna Die Like A Chicken": A Participatory Assessment of Adolescent Sexual Reproductive Health in A High Risk Environment.* Lusaka, Zambia: CARE International. April 1997a.

Brief Description: Survey results that supplement PLA findings; Mtendere, New Kanyama, Misisi, and Ng'ombe compounds; collaborative operations research study by CARE/Zambia, Planned Parenthood Association of Zambia, and Makeni Ecumenical Centre, April 1997.

Study Design:

- N=1,634 youth 10-19 (n=855 male; n=779 female)
- Mtendere: n=399 (208 male/191 female)
- New Kanyama: n=415 (214 male/201 female)
- Misisi: n=417 (225 male/192 female)
- Ng'ombe: n=403 (208 male/195 female)
- Average age males 15.8, females 15.3
- Convenience sampling at households
- Interviews with one-page questionnaire

Key Findings/Highlights

- Socio-economic situations and compound infrastructure more alike for New Kanyama and Mtendere, and for Misisi and Ng'ombe.
- 55% of males and 47% of females were students; the average number of years of school was 6.5.
- Ever had intercourse: Average across compounds - 78% of males/56% of females; Mtendere - 68% of males/41% of females; New Kanyama - 79% of males/56% of females; Misisi - 84% of males/72% of females; Ng'ombe - 76% of males/56% of females.
- About 17% initiated sex before age 10. Most reported initiating sex between 11-14 (slightly higher than PLA perceived estimates of 9-12). Younger average age for boys than girls also differs from PLA perceptions that girls initiate sex at younger ages than boys do.
- Average age of first sex: Average across compounds - 11.8 for males/13.3 for females; Mtendere - 11.8 for males/13.4 for females: New Kanyama - 12.1 for males/13.2 for females; Misisi - 12.1 for males/13.2 for females; Ng'ombe - 12.2 for males/12.7 for females.
- Main sources of information on sex: friends, grandparents, media (radio, movies, TV), and practical experience (see adults with each other and animals having sex).
- Relationship with first sex partner (n=675 male, n=447 female): Males – 45% friend, 38% neighbour, 5% cousin, 5% stranger, 1% prostitute, 6% other; Females – 60% friend, 22% neighbour, 5% cousin, 5% stranger, 8% other.
- Had sex at least once in last 3 months (n=676 male, n=440 female): Males –55%; Females- 50%.
- Had more than one sex partner in last 3 months (n=376 male, n=229 female): Males-55%, Females-40%.
- Received money/gift for sex at last sex (n=656 male, n=440 female): Males-2%, Females-65%.
- Gave money/gift for sex at last sex (n=656 male, n=440 female): Males-35%, Females-0%.
- Ever used a condom (n=656 male, n=440 female): Males-34%, Females-25%. Data show majority of protected sexual acts may have been in late adolescence (e.g. after age 15).
- Ever used a contraceptive method (n=656 male, n=440 female): Males-19%, Females-22% (likely condom not identified by respondents as contraceptive method).
- Ever made someone/been pregnant at least once (n=656 male, n=440 female): Males-9%, Females-21%.
- Ever had an STI (n=656 male, n=440 female): Males-8%, Females-4%.

"Young Love": A Participatory Assessment of Adolescent Sexual and Reproductive Health, Misisi Compound Control Site, Lusaka, Zambia

Fetters, T., et al., 1997b

Citation: Fetters T. et al., *"Young Love": A Participatory Assessment of Adolescent Sexual and Reproductive Health, Misisi Compound Control Site, Lusaka.* Lusaka, Zambia: CARE International. February 1997b.

Brief Description: Participatory learning and action methodology used in Misisi Compound to enable community to analyse issues and concerns; Study done by CARE/Zambia in February 1997.

Study Design:
- Participatory learning and action tools used by boys and girls 8-20 in Misisi Compound, Lusaka
- Supplemented by questionnaire survey with boys and girls 10-19 (N=417)
- (results not included in report)

Key Findings/Highlights

- Boys make most decisions regarding sex.
- Boys have sex because they feel it's natural or they 'love' girls, they get aroused by X-bass videos, and they feel penis is supposed to be used when need arises.
- Girls have sex mainly to get money for food and cosmetics. They also may fear losing the boyfriend, feel peer pressure, or think refusing will result in the boy threatening to beat the girl.
- Some youth refrain from sex because they fear parents, desire to complete school, fear pregnancy/diseases (girls more worried about pregnancy than disease), or have no interest. Additionally, some girls are religious and believe it's a sin not to wait until married.
- Places for sex are *Selenje Bar and Rest House* (most popular), maize fields, homes/boys' cabins, certain bars and brothels, old quarry pits, toilets, friends homes, dark corridors, video shows, fields along Kafue road, in bushes, and near communal taps.
- Information comes from friends, grandparents, media (radio, movies at video clubs, and TV), and practical experience. Adolescents can speak with grandparents more freely (not at all with parents). They may get information from aunts, friends, older siblings, local health centres, and churches. They also see animals and older people having sex. School is not important source because most stop school early in the compound.
- *Ngangas* (traditional healers) are important source of information on and treatment of STIs.
- Some accurate, but incomplete knowledge of reproductive systems/contraception/STIs, and with a variety of misconceptions.
- Methods for abortions were described as taking red and black capsules, mixing Panadol with Coca Cola, taking herbs, and drinking boiled tea leaves, and being pricked by elders (who use cassava stick) or clinic nurses. No knowledge of legal abortion exhibited.
- Living arrangements may relate to sexual behaviour. As described by boys, those girls who live on their own or with single fathers have most likelihood of becoming pregnant; those in parent-headed households have least chance.
- Sexual relations between cousins and in-laws are common and consensual. If sex between fathers-daughters or uncles-nieces occurs it's usually by force.
- Appears peer pressure is major factor in initiating sex; girls without a boyfriend may be called names like *gonga* (condemned).
- Perception that boys and girls start sex between 9-12 years old (however, this is earlier than self-reported initiation).
- Consequences of sexual activity are seen as unwanted pregnancy that can result in illegal abortions and possibly death, girls forced to stop school, and to a lesser extent the spread of STIs and HIV/AIDS among young people.
- Perception that out-of-school boys and girls more sexually active than those in school.
- Some held belief that boys under 14 cannot impregnate a girl ("sperms not strong enough").
- Condoms viewed as method for disease prevention, not pregnancy prevention.
- Condoms disliked for sex because skin-to-skin sex feels better, condoms are too big for young boys, and condoms can burst so abstinence only way to prevent pregnancy. Boys were sceptical of anyone having the ability to use a condom every time.
- Perception that condom use is rare among those under 15.
- Girls rarely initiate condom use for fear that boy will think they're sick or don't trust/love them.
- Belief that beautiful and healthy appearance eliminates need for protection.
- Girls receive more money for sex without condoms (Kw30,000-45,000 with condom and Kw50,000-60,000 without).
- Girls prefer boys that have money (e.g. working boys), and dress well. *Yos* are popular, as may be 'gangsters' or *galagata* (boys that wear certain types of shoes). *Kamwalas* (thieves) are also preferred because they dress well and give girlfriends money. Schoolboys were least preferred.
- Boys perceived that girls prefer sex partners like sugar daddies, younger boys, *Kamwalas*, minibus conductors, and *Ntemba* boys (small vendors).
- Some boys preferred younger girls for their small body size and *cadets* (vaginas). Others preferred good looking, medium-build girls.

- Sometimes girls initiate sex and give boys something, but if they pay boys for sex boys don't trust them because they may be sick or be a *hule* (prostitute).
- Payment is usually made for sex. In-school girls were estimated to get Kw500-1,500; out-of-school girls charge according to status of man (e.g. up to Kw10,000 per hour). One group of girls reported the following partner types and payments: *Kamwala*-Kw10,000; *Kantemba* (vendors)-lotion/soap/biscuits/sweets; unemployed-Kw2,000; teacher-past papers; schoolboys-homework/test answers; footballers-Kw5,000. Boys reported giving girls money, pants, lotion, shoes, school supplies, "love cards," and *chitenge* fabric.
- When asked what amenities/services they'd like to see in the compound, the need for schools and clinics was stressed. One group of boys specified the following: library, good houses, children's park, regular garbage collection, vocational courses, starter capital for projects, clinics, and schools and recreational facilities. It was felt that many problems stem from lack of activities for young people, which encourage them to steal or gamble.

Participatory Assessment of Adolescent Sexual and Reproductive Health in Mtendere Compound, Lusaka

Shah et al., 1996

Citation: Shah M. et al.. *Participatory Assessment Of Adolescent Sexual And Reproductive Health In Mt'endere Compound, Lusaka*. Lusaka, Zambia: CARE International In Zambia. November 1996.

Brief Description: Participatory appraisal in Mtendere Compound to investigate sexual and reproductive health issues from adolescent's perspective; Study done by CARE/Zambia October/November 1996.

Study Design:

- Participatory learning and action methodology used with boys and girls 8-20 in Mtendere Compound
- Supplemented by questionnaire survey with boys and girls aged 10-19 (N= 405) (results not included in report)

Key Findings/Highlights

- Most girls received information on sex and reproductive health from female relatives (grandmothers and aunts first source, then aunts and sisters), friends, and *Ng'anga* (traditional healers). Girls in school got information from teachers and books.
- Boys get information from friends, pornographic magazines and films, and elders.
- Friends preferred for discussing concerns and questions.
- Large gaps in information in issues related to reproduction and reproductive health.
- Boys appeared more knowledgeable of STIs than girls.
- Most adolescents above age 15 had heard of more than one contraceptive method.
- They learn about contraceptive methods from friends, radio, TV, and at anti-AIDS clubs.
- Decisions regarding relationships, sex, and contraceptives usually made by boys, whereas abortion decisions made by female partners. Girls may sometimes propose sex to boys. Girls may refuse to have sex with a boy.
- Boys usually make the decision to buy and use a condom, though girls may sometimes suggest it. Boys may agree to use a condom but cut holes in it -- thus girls often feel condom is no safer.
- Girls may seek help from grandmothers, friends, aunts, or female neighbours, and, more rarely, traditional healers to get an abortion.
- Most abortions attempted using unsafe methods (drugs, traditional medicines, sticks pushed up vagina, etc.). Hospital abortions are rare. Girls may have abortions because of fear of parents, possibility of school expulsion, male partner refuses responsibility, male partner has no ability to support girl/her parents don't want to support another member of household, and girl still wants to have fun.
- Peer pressure among boys influences sexual activity, (e.g. competition for number of partners). Pleasure, fun, feels good, and aroused by girls are other reasons.
- Girls have sex to get money and food; poorer girls feel desire to have same things as better off girls. In-school girls may have sex for curiosity, to get help with schoolwork, to earn pocket money/snacks, etc, and to get copies of exams from teachers. Out-of-school girls have sex more for material gain (which increases number of partners).
- There are various reasons to not have sex. Those who are virgins do not have sex because they are 'good Christians' so are abstaining until marriage, because they are scared of STIs, and scared of pregnancy (particularly girls because fear parents will disown them and having a child makes it harder to marry). Schoolgirls fear expulsion. One group of school girls mentioned strict parents, self-discipline, caring/giving mothers, no friends/not influenced by peers, and religious convictions. Boys may not have sex because they lack the money to pay.
- Places to have sex include bushes, toilets, at home, unused cars, school classrooms, boys' cabins, buildings under construction, and hotels/motels (for those with money).
- Most stated that they preferred to have age-mates as sex partners, however, girls out-of-school preferred older boys or men (they can pay well in return for sexual favours), and some boys mentioned that they go for younger girls (they ask for less money and are more likely to be free of any infectious diseases).
- Most preferred sex partners are friends, "gangsters" (well dressed, have money), drivers, minibus conductors, *wenges* (wear high-waisted trousers), and *yos* (wear low-waisted baggy trousers).
- Perception of girls that teachers have sex with female students.
- Belief that it's safe to have unprotected sex at young ages because no danger of pregnancy or STIs.
- Although high level of awareness about condoms, use is rather limited. Boys do not like to use condoms because they are too big and slip off, reduce pleasure, and it's a religious sin.
- Some girls believe contraceptive pills have too many side effects and cause sterility if used for a long time.
- Girls (especially older ones) may use Panadol tablets (believed to reduce power of men's blood) and *Muleza* root for contraception.
- Though abstinence was the lowest reported type of contraceptive method used, one group of girls analysed it to be the most preferred method because it's the safest way to prevent pregnancy and STIs.
- Boys' knowledge of HIV transmission and prevention did not appear to decrease sexual risk-taking.

- Appears that about 25% initiate sex before age 10, and by age 15 more than half have initiated.
- Perceived age of initiation as early as 5, but average is 12 for girls and 14 for boys. Comparison to sex census results showed this may be underestimate of boys' age of initiation.
- Perception that girls initiate sex earlier than boys because they mature faster.
- Perception that in-school boys and out-of-school girls most sexually active.
- Boys and girls have gaps in periods of sexual activity. Girls more likely to be sexually active before puberty, with a decrease afterward until 15-16 years old.
- There are several categories of close relatives that girls may have sex with (cousin, brother-in-law, father, uncle, brother and grandfather); with the exception of cousins and brothers-in-law, sex is usually forced by the male relative.
- Levels of sexual activity may be influenced by who the adolescent lives with: perceived that living with parents makes it much less likely to become pregnant than if living with grandmother because parents more strict (most adolescents reported living with their mother, followed by both parents, and grandmother).
- Perceived that girls from better off households may be less likely to have sex.
- Low use of clinics, and when used it's primarily for illness that are not sexually related. Boys' reluctance is related to fear of being insulted by the nurses, lack of money for the health scheme and treatment, and being asked to return with their partners. It is also embarrassing to queue-up and be seen by others they know, because others will think they have an STI. Girls have similar concerns, but also said nurses turn them away because they are too young and that only married girls can get contraceptive pills.
- Boys' suggestions for improving clinic use: (1) abolish medical scheme, (2) nurses not insult boys getting STI treatment, (3) clinic staff stop eating when with patient, (4) increase number of doctors to reduce congestion, (5) correct treatment prescribed by clinic staff, and (6) staff should not hide the medicine.

Adolescent Sexual Reproductive Health in Peri-Urban Lusaka

Zambezi, R., et al., 1996

Citation: Zambezi, R., et al. *Adolescent Sexual Reproductive Health in Peri-Urban Lusaka.* Lusaka, Zambia: CARE International. 1996. [See also Shah, M. and Nkhama, G. *Listening to Young Voices: Participatory Appraisal in Adolescent Sexual and Reproductive Health in Peri-Urban Lusaka.* Lusaka, Zambia: CARE International. 1996.]

Brief Description: Participatory appraisal carried out in Chawama Compound to get adolescents perceptions on sexual and reproductive health; paper presented at a conference; study by CARE/Zambia.

Study Design:

- Used participatory learning and action methodology (a mix of visual and verbal tools facilitating participants own analysis)
- Targeted in-and out-of-school boys and girls 13-17 years old, but ended up with 8-17 age range
- Chawama Compound, Lusaka

Key Findings/Highlights

- Adolescents hardly ever use the clinic, particularly if it concerns their sexual and reproductive health. They feel they are not treated well by the clinic staff and staff say they are too young to ask questions. Also, older people may see them enter and suspect they have an STI.
- School youth reported they see some diagrams in their textbook and get a hurried session from the teacher.
- There is a general lack of information and no one to answer their questions regarding sexual and reproductive health.
- Boys had more accurate information and were more concerned about STIs as compared to the girls.
- Boys' sources of information were grandfathers, friends, and videos (in-school boys also reported textbooks/teacher).
- Girls' main source of information is grandmothers, followed by aunts, female neighbours, and friends (plus textbooks/teachers for in-school girls).
- Both boys and girls have initiated sex very early with little or no contraception.
- Youth believed that most girls have sex by age 12 and boys by 14, but some start as early as 8.
- Boys usually initiate sex, and girls will sometimes refuse if they don't receive cash or gifts. Boys also usually decide whether to use a condom (girls feel it suggests unfaithfulness or STI if they ask).
- Both boys and girls talked about being able to have 'skin-to-skin' sex with age-mates because when they are under 15 there is no danger of pregnancy or STIs, as it is only the older girls and boys who carry infections.
- Peer pressure, particularly among boys, is motivator to have sex. Boys discuss sexual experiences with each other, while girls share with a few close friends. Peer pressure for girls manifests itself more in need to have certain clothes and items and 'look smart' to keep up with other girls.
- Boys have sex for pleasure, fun, or to keep up with peers.
- Sugar daddies have sex with girls because they think the girls do not have HIV/AIDS; girls choose sugar daddies as sex partners because of peer competition to dress well, lack of food, cosmetics, and need for money.
- Boys believed that girls are the main carriers of STIs and that it is normal for a boy to be infected as part of growing up; girls felt that boys are main carriers.
- 'Dry sex' is preferred to 'wet sex'.
- Poorer girls are far more sexually active than the other groups and tend to have multiple sex partners, since their main aim is to have sex for monetary benefits.
- Household living arrangements related to sexual behaviour: those living with grandmothers more informed and less sexually active; girls living with grandfathers more likely to have sex with close relatives, especially their grandfather; and those living with uncles less sexually active than those living with aunts.

Opinion Poll Survey on the Readmission of the Pregnant Girl Child into School

ZARD Youth Committee, 1997

Citation: Zambian Association of Researchers in Development Youth Committee. *Opinion Poll Survey on the Readmission of the Pregnant Girl Child into School.* Lusaka, Zambia: ZARD. 1997.

Brief Description: Survey undertaken in rural and urban areas of 6 districts (Lusaka, Mazabuka, Kabwe, Kafue, Chongwe, and Mumbwa); Change in readmission policy occurred when Minister of Education announced (September 1997) that school girls who become pregnant will no longer be expelled, and that those who have been expelled were free to return to school.

Study Design:

- Questionnaire, structured interview schedules
- N = Approximately 500 males and females from low and medium high density areas (in each of the selected areas; included approximately 20 pupils, 10 teachers, 30 parents, 15 pregnant girls under age 15, 10 politicians, 23 traditionalists, & persons representing 5 churches, 1 donor organisation, & 5 NGOs)

Key Findings/Highlights

- NOTE: Report did not include results for all subgroups for each question.
- Most of the respondents support the declaration. Participants supporting the declaration included 31% teachers, 54% pupils, 58% church respondents, 73% politicians, and 52% parents.
- Participants that felt the declaration would encourage immorality included 85% teachers, 79% pupils, 78% church respondents, 45% NGO respondents, 65% traditionalists, 10% pregnant girls, and 76% parents.
- Some of the reasons against the declaration include an increase in the transmission of STDs among school pupils, discipline will be difficult to administer, will encourage immorality, and girls will not be at ease as they will be looked down upon and stigmatised.
- Some of the reasons for the declaration included: girls who became pregnant would have learned a lesson from their mistake and would serve as an example for other pupils, since parents discipline their daughters, readmission won't change the situation, and it would prepare the girl for the future.
- Respondents were for readmission of pregnant girls because: this would reduce illiteracy levels in women, everyone has the right to education, the education would empower the girl to be in a position to look after the child and herself, a girl-child will be given the chance to complete her education, it will help increase the number of educated women and thus bridge the gap between men and women in education, and to give women a chance to contribute meaningfully to national development.
- Generally, the respondents suggested special circumstances that would make the declaration acceptable: girls who are raped, those who become pregnant for the first time, and those with a good academic record.
- Most NGOs felt they can carry out sensitisation/awareness campaigns and civic education for pupils and the general public. 99% of NGOs felt that sex education still has a role to play following the declaration.
- Given a chance to go back to school, 84% pregnant girls declared that they would not make the same mistake of becoming pregnant. 91% would like to be treated like other pupils if readmitted.
- It was highly recommended that the readmission should be on special cases such as pregnant girls having their own schools, and that sex education be introduced in school so that the declaration is not misunderstood as a green light to immorality.

Sexual Activity Among Junior Secondary School Girls in Zambia

Pillai, K., et al., 1997

Citation: Pillai, V.K., et al.. "Sexual Activity Among Junior Secondary School Girls in Zambia." *Journal of Biosocial Sciences.* 29, 297-301. 1997.

Brief Description: Survey of females attending junior secondary school in urban Zambia; Lusaka-Central and Copperbelt Provinces.

Study Design:

- N=305 in first three forms (selected from original sample of 537 aged 13-21)
- Original sample was randomly selected from urban junior secondary school girls
- Self-administered questionnaire

Key Findings/Highlights

- Degree of involvement with a boyfriend has significant positive effect on intensity of sexual activity.
- Liberal sexual attitudes are associated with increased romantic involvement with boys (though not significant).
- Academic ability factor has no significant direct influences on involvement with a boyfriend or intensity of sexual activity.
- Traditional courtship forms are slowly being replaced by modern (more western) patterns of courtship behaviour.
- Educators need to accept students' new liberal attitudes toward sex. Provision of accurate information about sex and family life to students may help to shape their sexual attitudes as a social and biological phenomenon.
- The likelihood of sexual activity within a close relationship is high; appropriate programmes needed to assist teenagers with skills and information to negotiate and engage in sexual activity.

Attitudes Toward Sexual Behaviour Among Unmarried Zambian Secondary School Females

Pillai, V. and Roy, L., 1996

Citation: Pillai, V.K., Roy, L.C. "Attitudes Toward Sexual Behaviour Among Unmarried Zambian Secondary School Females." *The Journal of Social Psychology,* 136(l), 111-112. 1996.

Brief Description: Summary of survey of unmarried females enrolled in secondary schools in two large, urban Zambian provinces in December 1991.

Study Design:

- N= 527 unmarried secondary school females 13-21
- Self-administered questionnaire

Key Findings/Highlights

- Those with high academic self-esteem, who felt that the number of teacher-imposed restrictions was high, believed that they belonged to the upper social class, and desired more male children were more likely to hold liberal sexual attitudes.
- Those who felt that their parents imposed a large number of restrictions on their social activities were more likely to hold non-liberal attitudes toward sex.
- Results suggest that traditional parental restrictions imposed on teenagers engender conservative attitudes toward sex.

Study of Sex Education (including related Social Education) Programmes for Young Adults

Harland C., et al., 1995

Citation: Harland, C., Shenton, L., McMillan, M. *Study of Sex Education (including related Social Education) Programmes for Young Adults.* Lusaka, Zambia: Study Fund Committee of the World Bank Social Recovery Project. June 1995.

Brief Description: Study to examine the impact of available social and sex education programmes on young adults in Zambia; Study conducted October-March 1995.

Study Design:

- Visits to 4 primary and 4 secondary schools (in Lusaka), training institutions, NGOs, Government Ministries, churches, and facilities for street children
- Semi-structured interviews
- Analysis of 767 letters submitted to Post newspaper's 'Loving and Living' (agony-style) column

Key Findings/Highlights

- There is a gap between the problems that young people face and those that advisory services aim to tackle.
- Many programmes estimate youth development to be slower than it is, and in particular underestimate age when youth tend to become sexually active. Thus services are often too late/inappropriate for target groups (e.g. most girls do not receive sex education until they are over 16, after many have already begun childbearing).
- Results of review of individual schools indicated that schools were trying to give pupils basic knowledge on AIDS and sex mainly through a system of clubs and guest speakers. Programme thrusts tended to be moralistic, and did not address needs of sexually active.
- Churches were offering some services on sex education and AIDS prevention through various youth groups/activities, with emphasis on abstinence until marriage.
- Analysis of letters to agony column showed most were from young people Lusaka and Copperbelt Provinces (and likely urban dwellers); men and women almost equally corresponded; the median age was 19.5; almost all were single; and the more than half were in school.
- Lists of problems in letters by frequency and gender are presented in report.
- Letter analysis showed that, among those under 16, girls' main problems were with parents, partners losing interest, married men, and desire for marriage and/or children. Boys' main problems were desire for sex, worries about masturbation, technical questions on sex, and religious doubts.
- Among those aged 17-19, unfaithfulness emerged as most common problem, followed by parental strictness/problems.
- Among those aged 20-22 the main problems were similar to the 17-19 year olds. Some concerns increase, such as tribal issues related to marriage and illegitimate pregnancy.
- Among those aged 23-25, unfaithfulness is primary concern, parent problems were also common, and issues related to marriage choices were frequent

Teenagers in Zambia: Sexual Activity among School Going Females

Pillai, V., and Benefo, K., 1995

Citation: Pillai, V.K., Benefo, K. "Teenagers in Zambia: Sexual Activity Among School Going Females." *International Journal of Contemporary Sociology,* 32(1): 125-132. 1995.

Brief Description: National sample survey of secondary school going females in urban Zambia; examines a few selected social and demographic aspects of adolescent sexuality.

Study Design:
- N=516 secondary school going females aged 13-20 in urban Zambia
- Self-administered questionnaire

Key Findings/Highlights

- Large proportion of the teenagers in sample were dating, thus increasing the likelihood of teenage sexual activity.
- Two additional factors increase the likelihood of teenage fertility: (1) the knowledge of the safe period (when conception is less likely to occur) is low and (2) a large proportion (27%) of the teenagers had engaged in intercourse in the 2 months preceding the survey.
- A very small proportion of the sexually active teenagers used contraceptives.

Teenage Sexual Activity in Zambia: The Need for a Sex Education Policy

Pillai, V., and Yates, D., 1993

Citation: Pillai, V.K., Yates D.L. "Teenage Sexual Activity in Zambia: The Need for a Sex Education Policy." *Journal of Biosocial Science*, 25:411-414. 1993.

Brief Description: Data presented on the initiation and extent of sexual activity among Zambian teenagers; Lusaka-Central and Copperbelt Provinces; Need for sex education assessed by examining the role of parents as a source of sex information and the extent of family planning knowledge among teenagers.

Study Design:
- N=516 secondary school going females aged 13-20 in urban Zambia
- 7 schools randomly selected and 20% of female students randomly drawn from forms 3-7
- Self-administered questionnaire

Key Findings/Highlights

- 71% had boyfriends, among whom 67% reported steady or close relationship with their boyfriend (thus higher risk of intercourse for almost half of the respondents).
- Almost 26% of 14 year olds had close boyfriends.
- About 30% had had intercourse in the preceding 2-month period.
- 31% of 17 year olds had had intercourse in the last 2 months.
- In the preceding 2-month period, about 27% indicated that they had intercourse rarely or more often (from scale of very rarely, rarely, somewhat often, often, very often).
- In the preceding 2 month period, 33% of 13-16 year olds and 24% of 17-20 year olds had had intercourse rarely or more often.
- 65% had heard of modern family planning methods (proportion higher for 17-20 group than younger ages).
- Of those who had heard of modern family planning methods, 94% had never used modern methods.
- 30% felt it was easy or very easy to discuss sexual matters with their mothers. 77% felt it was not easy to discuss sexual matters with their fathers.
- 46% of those 17 years and older indicated that they had undergone traditional female initiation ceremony.
- Provides compelling evidence of the need for sex education programmes.

The Needs and Aspirations of Secondary School Girls and their Attitudes and Advisors on Selected Issues of Sexuality

Mudenda, S., 1992

Citation: Mudenda, S. *The Needs and Aspirations of Secondary School Pupils and the Attitudes and Advice on Selected Issues of Sexuality.* Lusaka, Zambia: IAS/UNZA. 1992.

Brief Description: Research to examine needs and aspirations of secondary school students, their sources of counselling on sexuality issues, attitudes about various sexual behaviours, and knowledge about HIV/AIDS.

Study Design:

- N=792 (392 females; 400 males)
- Grades 9 and 11 at 6 co-educational, 5 male only, and 4 female-only schools in Central, Lusaka, and Southern Provinces
- Mean ages: males 16.3, females 16.5

Key Findings/Highlights

- *Full document not obtained; information extracted from abstracts compiled by Bangwe, L. and Muti, G., 1994.*
- Generated extensive data on situation of secondary school students.

Study into the Attitudes, Knowledge and Behaviour of Students at Higher Institutions of Learning: A Case Study of Natural Resources Development College

Mkumba, S. and Edwards, J., 1992

Citation: Mkumba, S., Edwards, J. *Study into the Attitudes, Knowledge and Behaviour of Students at Higher Institutions of Learning – N.R.D.C.* Paper presented at the third Zambian AIDS NGO Conference. Lusaka, Zambia. December 1992.

Brief Description: Study undertaken among students at Natural Resources Development College; baseline data for evaluating Kara Outreach Programme; examines HIV/AIDS knowledge, attitudes, and behaviour; study by Kara Counselling and Training Trust, Ltd. and National Resources Development College.

Study Design:

- N=195 (149 male; 38 female) in 1st-3rd years of college. [Sample based on those that returned questionnaire sent to all students.]

Key Findings/Highlights

- Study demonstrates there is still a need for educational interventions and appropriate material targeting older age groups.
- Students at high institutions of learning are at risk because of 'gold rushing' (game among 3rd-year male students at beginning of year to compete for 1st-year females) and 'importing' (bringing sex workers into college throughout the year) activities.
- 75% had received some HIV/AIDS education in the past (most at school, then media, health enters, and workplaces).
- Some confusion regarding transmission of HIV/AIDS (e.g. non-transmissible sources), as well as misconceptions about HIV/AIDS. Majority had some positive attitudes toward people with HIV/AIDS.
- 81% indicated interest in being involved in college anti-AIDS campaign.
- 34% currently had regular partner; 29% more than one partner in last year.
- 44% had never used a condom. Those that had never used a condom more likely to think it reduces sexual pleasure than those that had used them.
- Condom use with regular partners; never (27%), sometimes (57%) and always (16%). Use with 'other' partners; never (12%), sometimes (28%) and always (60%).
- 27% reported condom breakage during use.
- 43% would use condoms if they were more easily available.
- 33% reported not knowing anyone with HIV. 9% had a relative with HIV/AIDS, 30% had a friend/relative who died from AIDS, and 43% knew an HIV positive co-worker/friend or knew one who has died.

HIV Prevention Among Zambian Adolescents: Developing a Value Utilisation/Norm Model

Feldman D., et al., 1997

Citation: Feldman, D.A., et al. "HIV Prevention Among Zambian Adolescents: Developing a Value Utilisation/Norm Change Model." *Social Science and Medicine*, 44:455-468. 1997.

Brief Description: Pre-intervention study conducted to help determine how to successfully implement an intervention to reduce HIV risk among adolescents in urban Zambia.

Study Design:

- N=276 (n=154 males; n=138 females) aged 14-20 (average age 17) attending (n=138) and not attending (n=138) secondary school in Lusaka during 14-month period over 1992-1993
- Collected ethnographic and sexual data
- 12 FGDs with students, out-of-school youth, and ritual initiators

Key Findings/Highlights

- Most male and female adolescents had had sexual intercourse (77%; 210).
- 74% had boy/girlfriend at time of interview (n=208).
- Almost all (79%) of male and female adolescents 14-20 with a current boyfriend/girlfriend had had sex in the last four weeks (n=189). Differences in percentage sexually active in last four weeks among youth in the study: 89% of out-of-school males, 86% of out-of-school females, 79% of in-school males, and 47% of in-school females.
- Almost all aged 14-20 with a current boyfriend/girlfriend had had sex in the last four weeks (79%; n=189).
- 17% (mostly boys) had 2 or more partners simultaneously.
- More than half (53%) of schoolgirls claimed to be virgins, compared to 21% for total sample.
- Nearly all (90%) of the sexually active females surveyed had received money or gifts for sex on at least some occasions. 71% of sexually active compound boys reported having given money or gifts for sex, while only 6% (3 of 51) of girls had given money or gifts to boy for sex. Thirteen boys reported they sometimes received money or gifts for sex from girls. Focus groups also revealed that sometimes a boy that is considered handsome or very poor will be given money or gifts from the female sex partner.
- 55% agreed they need to change their behaviours to prevent AIDS.
- Of those who had not modified their behaviour to prevent AIDS (59%), 40% intended to do so in the future (includes sexually inactive so not best measure).
- 86% felt they are capable of changing their behaviour (lowest self-efficacy among compound boys).
- More than half (53%) of sexually active youth had never used a condom (compound boys least likely to have used, compound girls most likely).
- 7% of those sexually active in last 4 weeks (n=149) used condom every time, 33% sometimes, 60% never.
- Of those having sex with one or more partners other than boy/girlfriend in last 4 weeks (n=109), 4% used a condom every time, 39% sometimes, 58% never.
- 76% agreed they would use a condom if partner asked
- Most (70%), especially females, knew someone who takes drugs. 15% (mostly boys) had ever used non-injectable drugs.
- 47% had never drunk alcohol. 16% (mostly boys) drank alcohol at least once/week.
- 25% of those sexually active had engaged in fellatio; 12% (mostly compound girls) had engaged in cunnilingus; and 10% (mostly compound girls) reported insertive or receptive anal intercourse, only a few of whom reported using condoms.
- FGDs found that compound girls had sex with older ("middle aged") men more for increased security (e.g. in case became pregnant) than financial reasons.
- 28% of girls (n=114) had undergone ritual initiation (chisunga), which includes instruction on how to dry out the vagina and stretch the labia majora.
- 12% of girls had engaged in dry sex (additional probing found girls and boys prefer wet sex, and adults dry sex.)
- 76% know someone with AIDS or who has died of AIDS.
- 57% very worried about getting AIDS (more so the out-of-school youth). However, 55% think they had little or no chance of getting AIDS (especially in-school youth). 25% (mostly out-of-school females) think their chance is high/very high.
- Adolescents confused about cause and transmission of HIV/AIDS (most cited intercourse as both cause and primary mode of transmission.)

Early Intervention: HIV/AIDS Programmes for School-aged Youth

Seifert, K., 1997

Citation: Seifert, K. *Early Intervention: HIV/AIDS Programmes for School-aged Youth.* Washington, DC: Office of Sustainable Development, Bureau for Africa. US Agency for International Development. 1997.

Brief Description: Study sponsored by the United States Agency for International Development to identify low-cost HIV/AIDS awareness programmes in in-school as well as community-based settings that target school-age children and particularly adolescent and pre-adolescent youth.

Study Design:

- Included in-depth review of a community-based outreach programme for out-of-school youths in Zambia (Zambia Morehouse/YWCA Programme: Out-of school Youth Component of the Morehouse HIV/AIDS Prevention Project)

Key Findings/Highlights

- Review of out-of-school component of the Zambia Morehouse/YWCA Programme that began September 1994, with activities first in Lusaka and then in Copperbelt and Central Provinces. Programme emphasis on peer outreach workers (POWs) and supportive IEC activities.
- 3 evaluations since programme start: mid-term quantitative, internal evaluation, and USAID operations research study. The mid-term evaluation occurred 18 months after programme start and examined behavioural component using post-test only coincident cross-sectional design (n=105 youth clients in experimental group and n=101 youths at community meeting places in comparison group). Intervention group reported significantly greater knowledge about STDs, AIDS, and condoms; more discussion about AIDS; more appropriate attitudes toward sexual choice in relations; fewer sexual partners, and higher levels of condom use in sexual intercourse.

Primary conclusions:

- Involving youth in programme planning and monitoring helps to ensure that interventions are appropriate and respond to audience's needs.
- A varied, holistic approach increases likelihood of behaviour change.
- Young teens, including high-risk youth, can be effective advocates for HIV/AIDS prevention.
- Same-sex sessions allow teens to discuss sensitive issues related to HIV/AIDS, while mixed-group sessions are good for practising simulated real-life negotiating skills.
- Positive and close community relations enhance programme support and sustainability.
- Regular and effective monitoring and evaluation are needed to measure progress and attribute actions to observed results.

The HIV Epidemic in Zambia: Socio-demographic Prevalence Patterns and Indicators of Trends among Childbearing Women

Fylkesnes, K., et. al, 1994

Citation: Fylkesnes, K., et al. "The HIV epidemic in Zambia: socio-demographic prevalence patterns and indications among childbearing women." *AIDS 1997,* 11:339-354. 1997.

Brief Description: Sentinel site survey data from repeated cross-sectional surveys consisting of personal interviews with and unlinked blood sample testing of women attending antenatal care in 1994.

Study Design:

- N=11,517 females 15-44 in 27 urban and rural areas throughout the nine provinces (no sample sizes provided for age groups; noted 208 did not provide information on age)

Key Findings/Highlights

- Urban females: 20% of 15-19 and 32% of 20-24 were HIV positive.
- Rural females: 8% of 15-19 and 15% of 20-24 were HIV positive.
- Age distribution of infection for urban 15-19 year olds was steeper than that for those in rural areas, going from 11% for 15 year olds to 28% for 19 year olds, with rural 15-19 year olds at 4% for age 15 and to 11% for age 19.
- For all age groups the urban-rural ratio was 2:1.
- Found no significant relationship between educational attainment and infection for the 15-19 age group, although across all urban and rural residents infection was significantly associated with educational attainment (infection rates rose with higher levels of educational attainment).
- Overall, unmarried women were more likely to be infected than married, though separate analysis of the 15-24 age group showed no differences between unmarrieds and marrieds.
- There may be encouraging signs of a decrease in prevalence. Surveillance data in Lusaka for 1993 and 1994 showed a downward trend in HIV prevalence among 15-19 year olds, changing from 28% in 1992, to 23% in 1994.

A Situational Analysis of Young People with HIV/AIDS in Lusaka, Zambia

Macwan'gi, M., 1993

Citation: Macwan'gi, M. *A Situational Analysis of Young People with HIV/AIDS in Lusaka.* Lusaka, Zambia: IAS/UNZA. 1992.

Brief Description: Assesses sociocultural and behavioural factors that facilitate the transmission of HIV infection among young people, to determine their needs and expectations that could be served by a network of people with AIDS, and to make specific recommendations for implementing a network of people with HIV/AIDS; Study commissioned by Commonwealth Youth Programme Africa Centre and Kara Counselling and Training Trust.

Study Design:

- FGDs with 82 youth 15-30
- FGDs were as follows: gone public with HIV status; not gone public with HIV status; unemployed; employed; in school; not sexually active; college students; parents; and health providers.

Key Findings/Highlights

- High level of knowledge of HIV/AIDS.
- Perceived HIV/AIDS to be common health problem among youth.
- Majority knew/had seen someone suffering from HIV/AIDS.
- Main worries about HIV/AIDS: AIDS affects young people most (those sexually active and most productive), fear of death, marital problems, lack of cure, and contamination through medical equipment.
- Going public for HIV positive youth resulted in stigmatisation and isolation.
- Majority of non-sexually active youth not in favour of condom use because felt promotes casual sex/sex before marriage, viewed HIV/AIDS sufferers as sinners, and felt there should be a law against polygamy.
- Most youth had heard of condoms, but about 25% had never seen one.
- Major condom information sources were friends and siblings.
- Few reported ever having used condoms, but did say friends had.
- Problems with using condoms: causes mistrust, men prefer skin-to-skin contact, men complain condoms messy, girls want to get pregnant, fear being assaulted by husband, not knowing how to use correctly, reduces sexual pleasure, may cause allergic rash, can get stuck in vagina, against religion, do not protect 100% against pregnancy/STDs, may be defective (e.g. may break, have holes).
- Multiple sex partners reported very common among both married and unmarried people.
- Youth supportive of networking among PWAs.
- Respondents felt government and parents should have lead role in sex education.

An Investigation of the Behavioural Aspects of "Dry Sex" Practice in Urban Lusaka

Nyirenda, J., August 1991

Citation: Nyirenda, J.M. *An Investigation of the Behavioural Aspects of "Dry Sex" Practice in Lusaka Urban.* The University of Zambia. August, 1991.

Brief Description: Study conducted in University Teaching Hospital to explore and document new information related to the behavioural aspects of dry sex practice as a risk factor in the transmission of HIV infection and to determine whether women in urban Lusaka would be willing to abandon dry sex behaviour after they have been counselled about the risk of HIV associated with dry sex practice.

Study Design:

- N= 50 female Lusaka residents in the child bearing age (17-41 years; all but 5 married)
  - n=8 females <20 years old
  - n=23 females 21-30 years old
- Random interval or systematic sampling method
- Focus group discussion for women, questionnaire focused interviews, and in-depth interview with an herbalist

Key Findings/Highlights

- Dry sex is widely practised among respondents (86%), cutting across all social, economic and ethnic backgrounds.
- Most respondents not aware that dry sex practice might increase their risk of contracting HIV infection.
- After a brief counselling session on HIV/AIDS, more than half of the women spontaneously decided to stop dry sex behaviour.

Report of Knowledge, Attitudes, Behaviour, and Practices Survey and Evaluation of the Anti-AIDS Project

Chiboola, H., 1990

Citation: Chiboola, H. *Review of Knowledge, Behaviour and Attitudes Practical Survey and Evaluation of the Anti-AIDS Project.* Lusaka, Zambia: UNICEF. 1990.

Brief Description: Evaluation study carried out to analyse the activities, performances and progress of anti-AIDS projects and to assess young people's knowledge, attitudes, beliefs and practices on AIDS; Conducted September-October 1990; Study commissioned by Anti-Aids project, Lusaka.

Study Design:

- N=160 youth 11-25 (102 female; 58 male) n=94 primary and secondary school; n=8 tertiary; n=58 out-of-school
- Randomly selected from 3 primary schools, 3 secondary schools, UTH School of Nursing, 3 non-school areas in Lusaka; 1 primary school, 2 secondary schools, 2 non-school areas in 2 districts (Nyimba and Petauke Districts) in Eastern Provinces

Key Findings/Highlights

- Knowledge of AIDS: 73% knew AIDS caused by virus called HIV; 94% knew spread by sexual intercourse; 32% incorrectly thought caused by intercourse.
- Misconceptions about AIDS: can get it from having sex with a woman who's had abortion/miscarriage (23%); caused by witchcraft/evil spirits (3%). A few also thought AIDS spread by donating blood, kissing, and mosquito bites.
- 89% feared contracting AIDS, 8% had no fear of contracting AIDS.
- 47% believed condoms could protect them from getting AIDS.
- 66% had had sex in last 6 months (n=106), 60% females and 78% of males.
- Only 22% of those who had sex in last 6 months said sometimes or always used condoms (18% females, 26% males). 2% females and 2% males said always used condoms.
- 89% said they were afraid of getting AIDS.
- 65% reported AIDS had prompted them to change sexual behaviour very much, 11% moderately, 10% slightly, and 12% not at all.
- 87% said they avoided AIDS by sticking to one sexual partner or avoiding sex with too many partners before/after marriage: 3% said used condoms; and 3% said were too young to have any partners.
- 68% believed condoms could help prevent pregnancy, AIDS, and STDs, but only 48% thought condoms could protect them from AIDS.
- Media sources for information on AIDS: booklets/pamphlets (74%); newspapers/magazines (69%); radio/TV (68%); posters/leaflets (67%).
- Talked about AIDS with: friends/classmates (78%), brothers/sisters (70%); boyfriends/girlfriends (68%).
- Identified a need to consolidate ongoing programmes on AIDS prevention, appraise and improve on evident shortcomings in these programmes, concluding information and education on AIDS remains fundamental to prevention.
- IEC materials should be complemented by interpersonal communication activities.

Adult-Child Sexual Experiences Reported by Tertiary Students in Zambia

Haworth A., et al., 1997

Citation: Haworth, A., et al. *Adult-Child Sexual Experiences Reported by Tertiary Level Students in Zambia.* Paper presented at International Conference on AIDS, July 7-12. Lusaka, Zambia. 1996.

Brief Description: Workshop paper presented at 1997 Lusaka International Conference on AIDS; examined the nature and extent of childhood sexual experiences between adults and children.

Study Design:

- N=969 students (628 male; 341 female). Female participants were considerably younger than male participants (50% of females were age 18-21; 18% of males were age 18-21.) The students were from predominantly urban backgrounds.
- Questionnaires and FGDs; intent of researcher was to measure what students *say* they do, not *what* they do.

Key Findings/Highlights

- 20% (25.6% of males and 17.2% of females) were invited or forced to "play" sex as a child.
- About 18% said they had a same-age partner.
- 8% reported adult-child sexual activity that involved force, abuse, or rape, while almost 26% reported willing participation in adult-child sex.
- Rising problem (typically unreported) of young boys being sexually abused by older women. When asked who forced them, the answers included older girls, adult women, cousins, and aunts and servants.
- Older men tend to seek schoolgirls as "safe" sexual partners.
- 49% of those who thought AIDS is a threat to them used condoms at last sex, while only 29% of those who don't feel they are vulnerable to HIV used a condom during their most recent sexual encounter.

Confronting the Hidden Crime: Incest in Zambia

Zambia YWCA, 1997

Citation: Young Women's Christian Association [Zambia]. *Confronting the Hidden Crime: Incest in Zambia.* Lusaka, Zambia. 1997.

Brief Description: Study to generate information about incest that can be used to formulate a policy framework that will safeguard the well-being of children within the family unit.

Study Design:

- Interviews with key informants, FGDs (with a total of 309 females and 173 males), sample surveys, review of secondary data, panel discussions, and women's rights tribunal and sample survey
- Research sites: Eastern, Lapel, Copperbelt, and Lusaka provinces

Key Findings/Highlights

- Majority of study participants said incest is "taboo," but identified permissible sexual partners from among family members.
- Data suggest that incest cuts across all socio-economic categories, occurs in rural as well as urban communities, and involves various family members (e.g. father-daughter, mother-son, brother-sister, uncle-niece, grandfather-granddaughter, in-laws, and cousins).
- *Vzimba* (charms) to amass wealth seen as a cause of incest. Among some groups there is a strong belief that father-daughter sex combined with use of herbs will increase animal stock. There is also a view that daughters are to blame for what happens with their fathers.

Femicide Register

YWCA, 1995

Citation: Young Women's Christian Association [Zambia]. *Femicide Register.* Lusaka, Zambia. 1995.

Brief Description: A catalogue of violent incidents against women to determine extent of femicide; Register was established in September 1993.

Study Design:

- Data gathered from accounts from *Times of Zambia, Zambia Daily Mail, Crime News, Weekly Express*, central police files, and personal stories

Key Findings/Highlights

- Victims range in age from a few months to 73 years and come from all parts of Zambia.
- In one-third of cases, perpetrators are intimate partners of the women.
- Men who kill women are normally sentenced to short jail terms.
- The media reflects society's attitude and indifference at blaming women.

Femicide Case Records

Year	Under 10	10–14	15–19	20–24	Above 24	Missing age	Total
1995*	1	0	0	0	0	8	9
1994	2	0	2	0	6	30	40
1993	1	0	0	2	7	23	33
1992	0	0	0	0	2	13	15
1991	0	1	0	0	1	15	17
1990	0	0	0	0	1	19	20
Total	4	1	2	2	17	108	134

*Total number recorded up to July, 1995
Source: YWCA 1995

Violence Against Women: Zambian Perspectives

YWCA, 1994

Citation: Young Women's Christian Association [Zambia]. *Violence Against Women: Zambian Perspectives*. Lusaka, Zambia. 1994.

Brief Description: Presents perspectives on violence against women from a cross-section of society and information about the extent and implications of different forms of abuse, as well as findings on the effectiveness of the YWCA anti-violence programme.

Study Design:

- N=646 (women, men, boys, girls)
- Rural, urban, and peri-urban residents; police, media, traditional rulers, students, donors, health workers, women with disabilities, CSWs
- Participatory research methods that included 32 focus group discussions, 13 interviews, and a questionnaire

Key Findings/Highlights

- Violence touches the lives of all Zambian women and their families.
- Abuse appears in many forms: physical, psychological, sexual, economic, social, and cultural.
- There is high awareness of violence, but little known of what to do to address the problem.

Drug Trafficking Abuse and Dependence in Zambia: A Pilot Investigation into the Categories of People involved and Consequential Behavioural Activities

Malambo, T., 1994

Citation: Malambo, T. *Drug Trafficking Abuse and Dependence in Zambia: A Pilot Investigation into the Categories of People Involved and Consequential Behavioural Activities*. 1994.

Brief Description: Review of Drug Enforcement Commission case records for the period 1991-1994 (including DEC branches at Society House and Chinama Hills Hospital); Research report submitted to the UNZA Department of Psychology.

Study Design:

- N=735 case records of controlled/illicit drug traffickers, abusers, and dependants
- N=74 drug abusers
- N=39 questionnaire respondents who received counselling at Society House and Chinama Hills Hospital

Key Findings/Highlights

- General: Drug problem in Zambia is increasing, particularly in cannabis trafficking. Foreigners predominate in "hard drug" trafficking.
- The 16-23 age group topped all others in drug abuse (39%) (other age groups were: 24-31 (35%) and 32-39 (14%)).
- Young people in secondary schools were the greatest drug abusers (56%), followed by those in college (18%), primary school (14%) and in university (12%).
- Young people still going to school were the greatest drug abusers, followed by unemployed youths.
- Peer pressure was a leading influence in drug abuse/dependence.
- There was a relationship between area of residence and types of drugs.
- The types of offence/crimes committed due to drug abuse (as indicated by 31 respondents) were as follows: theft (38%), illegal possession of drugs (28%), assault (16%), prostitution (13%), assault and theft (3%).

Juvenile Delinquency in Zambia: Causes, Effects and Solutions

A. Suuya Management Consultants Ltd., 1993

Citation: A. Suuya Management Consultants, Ltd. *Juvenile Delinquency in Zambia: Causes, Effects and Solutions.* Lusaka, Zambia. June 1993.

Brief Description: Study to outline the causes, effects and solutions of juvenile delinquency in Zambia.

Study Design:

- N= 62 juveniles from Katombora Reformatory School, Nakambala Approved School and Children's Town
- Random sampling
- Interviews with structured and unstructured questions

Key Findings/Highlights

- Causes of juvenile delinquency are poverty, urbanisation, lack of proper care, large families, lack of recreation facilities, broken homes, drug and substance abuse
- Effects of juvenile delinquency include loss of property and life, parents forsaking their own children, financial drain on the nation, loss of potential foreign investors, and an ever increasing number of drop outs joining an army of illiterates
- Recommendations include intensifying education of Zambians on the need to have small and manageable families and strengthening family planning activities countrywide.

Evaluating the Programme Effects of a Radio Drama about AIDS in Zambia

Yoder, P., et al., 1996

Citation: Yoder, S.P., et al.. "Evaluating the Programme Effects of a Radio Drama about AIDS in Zambia." *Studies in Family Planning,* 27(4): 188-203. 1996.

Brief Description: Evidence is considered that a radio drama broadcast weekly for nine months (39 thirty-minute episodes) had an impact on knowledge and behaviour related to AIDS among *Bemba* speakers in northern Zambia, based on large sample surveys conducted before and after the drama was broadcast.

Study Design:

- Baseline
    - N=1,613 males/females 15-49
    - Mean age 25.9
- Follow-up
    - N=1682 males/females 15-49
    - Mean age 26.9
- 3-stage cluster sampling procedure
- Questionnaire with additional questions on radio drama for follow-up survey
- Copperbelt and Northern Provinces

Key Findings/Highlights

- Study of effects of the *Nshilakamona* ("I have not yet seen it") *Bemba*-language radio drama about AIDS that included as lead characters 2 couples with teen daughters in school.
- 40.1% of those under 26 had high access to radio (e.g. owned a radio); 24.9% had high exposure to the drama (listened very often or all the time).
- Among the entire sample, 45% reported ever listening.
- Fewer than one-third were regular or recent listeners of the drama; 12% listened very often/all the time.
- Residence and gender affected radio listening -- more urban than rural residents and more males than females reported listening to radio.
- While study found improvements in the accuracy of knowledge of AIDS and in awareness of risk reduction measures, these changes could not be attributed to listening to the radio drama alone (those not exposed experienced similar positive changes).

Media Perspectives of the Youth in Urban Zambia

Nzima, M., 1995

Citation: Nzima, M.M. *Media Preferences of the Youth in Urban Zambia*. Lusaka, Zambia: Morehouse School of Medicine Zambia HIV/AIDS Prevention Project. 1995.

Brief Description: Study aimed at assessing listenership, viewership, and readership levels among out-of-school youths; Includes assessment of appropriateness of information delivered via various media (e.g. timing, language, cultural aspects); Study by Morehouse School of Medicine Zambia HIV/AIDS Prevention Project in August 1995.

Study Design:

- N=578 urban youth 12-18, mostly out-of-school
- Lusaka and Ndola

Key Findings/Highlights

- Note: no breakdown by sex, location, or age provided
- Sources of information among those having heard or read about on HIV/AIDS in last 6 months: radio (62%), TV (47%), newspaper (29%), magazine (32%), friends (3%).
- 15% of youth owned their own radio; 27% said their parents owned one. Less than 3% of parents reported to own TV.
- Though television was seen as conveying information better than any other source, radio was the most preferred medium by youth.
- Of those youths that most favoured print media, most preferred messages illustrated in pictorial form (especially cartoons).
- Youth expressed opinion that frequency and timing of information from the different sources were often inadequate; 51% preferred listening to information in presence of family and/or friends, and 55% said they discussed the subject after the programme ended.
- Content not very comprehensible if in formal English. Preference found for use of colloquial English, *Nyanja* (Lusaka), and *Bemba* (Ndola) languages.
- Those with 7 or fewer years in school were less likely to have read information in magazine/newspaper.

ID#:______

ZAMBIA YARH INVENTORY
QUESTIONS FOR PROGRAM / PROJECT MANAGERS

Date:____________________ **Interviewer (s):**____________________

Time Start:____________

SECTION ONE: Contact Information

101. Name of Organization:____________________
102. Name of Contact person:____________________
103. Contact's Position/Title:____________________
104. Contact Address:____________________
105. Contact Phone:__________ 106. Fax:__________ 107. E-Mail:__________

108. Type of Organisation
1. ❑ Government/Public Sector
2. ❑ Private Non-Profit Organisation (NGO)
3. ❑ Private For-Profit Organisation (NGO)
4. ❑ Affiliate of Church or Religious Group
5. ❑ Other:____________________

This survey is intended for programs serving young people between the ages of 10-24. If your program serves this age range ***in addition*** *to older and/or younger people, please answer the questions based* ***only*** *on services provided to those aged 10-24.*

SECTION TWO: General Description

201. What is the name of your program providing services to youth?____________________
(if unable to provide name ask for brief description)

202. When did the program begin? Month:________ Year:________

203. How long do you expect the program to continue?____________________

204. Where is the program operating geographically? *(probe: can you tell me the names of the provinces, districts, or towns?)*

1. ❑ Province(s) Name(s)	2. ❑ District(s) Name(s)	3. ❑ Town/Village/Compound Name(s)

205. Thank you for telling me about where the program is operating geographically. What types of sites is the program being implemented in? *(multiple responses allowed)*

Type of Site Location	*Probe: Name(s)?*
1. ❑ Primary School	
2. ❑ Junior Secondary School	
3. ❑ Senior Secondary School	
4. ❑ College	
5. ❑ University	
6. ❑ Recreational Facility	
7. ❑ Community Centre	
8. ❑ Youth Centre	
9. ❑ Religious Institution	
10. ❑ Community-based Org./NGO	
12. ❑ Health Centre/Clinic	
13. ❑ Hospital	
14. ❑ Street	
15. ❑ Other:	

206. What, approximately, is the program's annual budget?
1. ❑ Amount:______________ 2. ❑ Don't Know 3. ❑ Do Not Want to Reveal

207. Who provides funding or other resources? Name(s):____________________________

208. How long will current funding keep the program going?
1. ❑ Less than 3 months 4. ❑ 1 Year
2. ❑ 3-6 Months 5. ❑ 2 Years
3. ❑ 7-11 Months 6. ❑ 3 Years 7. ❑ Other:____________________

SECTION THREE: Staffing and Collaboration

301. Does this program have any full-time, paid staff ?
1. ❑ Yes →How many full-time, paid staff work on this program? ________
2. ❑ No

302. Does this program have any part-time, paid staff ?
1. ❑ Yes →How many part-time, paid staff work on this program? ________
2. ❑ No

303. Does this program have any volunteer staff?
1. ❑ Yes →
2. ❑ No↓

A. How many volunteers work on this program? ________
B. Are any of these volunteers peer educators?
1. ❑ Yes→How many?_______ 2. ❑ No
C. Do volunteer staff that are ***not*** peer educators receive any allowances or incentives? 1. ❑ Yes→What?___________________ How often?__________
2. ❑ No

304. Is there any in-service or ongoing training for current staff to improve or gain new skills?
1. ☐ Yes→Please describe:____________________
2. ☐ No

305. Does the program use peer educators or counsellors?
1. ☐ Yes →
2. ☐ No↓

A. Do the peer educators receive any payment or stipend or incentives?
   1. ☐ Yes →What is it?__________ How often?________ 2. ☐ No
B. How many peer educators are there?______
C. How were they selected?____________________
D. How are they supervised?____________________
E. Did they receive training before beginning their work?
   1. ☐ Yes →Please describe:____________________
   2. ☐ No
F. Is there any ongoing training to help them improve or gain new skills?
   1. ☐ Yes→Please describe:____________________
   2. ☐ No
G. What are the primary goals of the peer educators? *(multiple responses allowed)*
   1. ☐ Pregnancy prevention 2. ☐ HIV/AIDS prevention 3. ☐ STD prevention
   4. ☐ Other:____________________
H. Do they distribute condoms? 1. ☐ Yes 2. ☐ No
I. Do they distribute other contraceptives? 1. ☐ Yes→Types:__________ 2. ☐ No
J. Do they provide referrals? 1. ☐ Yes 2. ☐ No

306. Have youths been involved in the program in any of the following ways? *(Read out-loud)*

1. Planning or project design
   ☐ Yes→Please describe briefly:____________________
   ☐ No

2. Research
   ☐ Yes→Please describe briefly:____________________
   ☐ No

3. Materials Development
   ☐ Yes→Please describe briefly:____________________
   ☐ No

4. Implementation
   ☐ Yes→Please describe briefly:____________________
   ☐ No

5. Monitoring
   ☐ Yes→Please describe briefly:____________________
   ☐ No

6. Evaluation
❑ Yes→Please describe briefly:______________________
❑ No ______________________

307. Do you or any other representative of your program participate on any co-ordinating bodies?
1. ❑ Yes→Which one(s)?:______________________
2. ❑ No ______________________
____

308. Has any staff attended an international conference or external workshop?
1. ❑ Yes→Which conferences/workshops?:______________________
2. ❑ No ______________________
____

SECTION FOUR: Program Targets and Strategies

401. What is the main goal of the program? *(multiple responses allowed)*
1. ❑ Pregnancy prevention
2. ❑ STD prevention
3. ❑ HIV/AIDS prevention
4. ❑ Family Life Education
5. ❑ Youth Development/Leadership
6. ❑ Gender Awareness/Education
7. ❑ Other:______________________
____
____
____

402. What are the ages of young people targeted by this program?______________________

403. I would like to know the main characteristics of the targeted youth. Please answer **yes *or* no** as I read a selection of characteristics out-loud.
Are they...
1. Males? ❑ Yes ❑ No
2. Females? ❑ Yes ❑ No
3. Urban Youth? ❑ Yes ❑ No
4. Rural Youth? ❑ Yes ❑ No
5. In-School Youth? ❑ Yes ❑ No
6. Out-of-School Youth? ❑ Yes ❑ No
7. Married Youth? ❑ Yes ❑ No
8. Unmarried Youth? ❑ Yes ❑ No
9. Street Youth? ❑ Yes ❑ No
10. Youth in a workplace (e.g. factory)? ❑ Yes ❑ No
11. Refugees? ❑ Yes ❑ No
12. Youth from Low-Income Families? ❑ Yes ❑ No
13. From a specific racial or ethnic group? ❑ Yes→Which groups?______________ ❑ No
14. If there is a characteristic that I did not mention please describe it:______________________
____

404. Why are these types of youth being targeted?______________________
____
____

405. In addition to young people, does the youth program also target or include parents or other types of people?
1. ❑ Yes→Please describe non-youth target audience(s) and activities:____________________
2. ❑ No ____

*(probe: has the community been involved in any way?)*______________________________

406. Has the program trained or do you plan to train any specific types of people?
1. ❑ Yes→Who?____
2. ❑ No What type of training?____

407. For my next question, please answer **yes *or* no** as I read choices to you out-loud. I would like to know what communication methods the program is using.
Are you using…
1. Radio? ❑ Yes ❑ No
2. Television? ❑ Yes ❑ No
3. Print Materials? (pamphlet, brochure, newsletter, newspaper) ❑ Yes ❑ No
4. Telephone Hotline? ❑ Yes ❑ No
5. Films or Videos? ❑ Yes ❑ No
6. Drama Sketches or Plays? ❑ Yes ❑ No
7. Songs? ❑ Yes ❑ No
8. Games? ❑ Yes ❑ No
9. Formal Lecturer or Guest Speaker? ❑ Yes ❑ No
10. Small Group Discussions or Trainings? ❑ Yes ❑ No
11. Large Group Presentations? ❑ Yes ❑ No
12. Counselling? ❑ Yes ❑ No
13. If you are using a method that I did not mention please describe it:____________________

408. Please describe any new training or IEC *(information, education, and communication)* materials and activities developed by the program. You can tell me the titles if you wish.
____

*(probe: Can you provide copies of any of these?*__________ *Are they available for use by other organizations?*____*)*

409-412. Does the program provide contraceptives or family planning services to young people?
(If Yes tick the types mentioned. For each type ticked ask if it is provided free or sold. If sold ask the price.)

409.	410. What Types?	411. Are they free?	412. Sold at what price?
1. ❑ Yes→ 2. ❑ No↓	1. ❑ Condoms	❑ Yes ❑No→	
	2. ❑ Pills (oral contraceptives)	❑ Yes ❑No→	
	3. ❑ Foaming tablets (spermicide)	❑ Yes ❑No→	
	4. ❑ Spermicide	❑ Yes ❑No→	
	5. ❑ Female Condoms	❑ Yes ❑No→	
	6. ❑ Diaphragms	❑ Yes ❑No→	
	7. ❑ Cervical Caps	❑ Yes ❑No→	
	8. ❑ IUD	❑ Yes ❑No→	
	9. ❑ Injectable (Depo-Provera)	❑ Yes ❑No→	
	10. ❑ Norplant	❑ Yes ❑No→	
	11. ❑ Emergency contraception ("morning after pill")	❑ Yes ❑No→	
	12. ❑ Menstrual regulation	❑ Yes ❑No→	
	13. ❑ Natural family planning instruction (Rhythm Method)	❑ Yes ❑No→	
	14. ❑ Other:	❑ Yes ❑No→	

413. Does the program provide referrals to health service providers? 1. ❑ Yes 2. ❑ No

414. Thank you for telling me about these services. Now I will ask you if the program offers certain specific services, and I may repeat some of what you have already told me. As I read out-loud, please tell me **yes *or* no**:

Program Services/ Activities	***Yes***	***No***
1. Repr.Health Physiology/Anatomy Education	❑	❑
2. Sexuality Education that includes information on ***both*** abstinence and contraception	❑ (if Yes skip to #4)	❑
3. Sexuality Education that includes information on abstinence ***only***	❑	❑
4. Contraceptive Education	❑	❑
5. Contraceptive Counselling	❑	❑
6. Contraceptive Distribution	❑	❑
7. Pregnancy Counselling	❑	❑
8. Pregnancy Services	❑	❑
9. STD Prevention Education	❑	❑
10. STD Diagnosis and Treatment	❑	❑
11. HIV/AIDS Prevention Education	❑	❑
12. HIV/AIDS Counselling	❑	❑
13. HIV/AIDS Testing	❑	❑

14. HIV/AIDS Treatment	❑	❑
15. HIV/AIDS Care	❑	❑
16. Education about Harmful Traditional Practices	❑	❑
17. Assertiveness Skills	❑	❑
18. Couple Communication Skills	❑	❑
19. Decision-making Skills	❑	❑
20. Education about Gender Issues	❑	❑
21. Vocational Training	❑	❑
22. Recreational Activities (e.g. games, sports)	❑	❑
23. Club Activities (e.g. drama, journalism)	❑	❑

415. Now I would like to learn more about the program activities or services offered to youth. What are the main activities or services you would like to describe in more detail?

Please…	***Activity #1***	***Activity #2***
Describe the type of activity:		
The purpose or objective(s):		
The location and sites:		
How many times a week does this activity occur?		
How many youth are reached by this activity weekly? …Monthly?		

SECTION FIVE: Monitoring and Evaluation

501. How are program staff and activities monitored? *(probe: Are there any forms or reports you can share?)*__________

502. How do you use this information?__________

503. Has the program ever been evaluated?
1. ❑ Yes → A. How was it evaluated?__________
2. ❑ No↓ B. What were the major findings? __________

C. Was the program modified due to the evaluation?
1. ❑ Yes →What was modified?__________
2. ❑ No

*(probe: Are there any forms or reports you could share?)*__________

504. Are there plans for the program to be evaluated in the future?
1. ❑ Yes → When?__________
2. ❑ No

505. Are there future plans for any type of youth research or is there now a research study in progress?
1. ❑ Yes → Please tell me about these research plans:__________
2. ❑ No

SECTION SIX: Experiences

601. What major obstacles have been encountered?__________

602. How has the program tried to address these obstacles?__________

603. What are some of the lessons learned from the experience of the program? *(probe: what has or has not worked?)*____

604. Would you like the program to be expanded?
1. ❑ Yes →How so?________________________________
2. ❑ No

605. Is there anything else you would like to tell me about the program?

SECTION SEVEN: Perspectives

Please tell me your views on the following issues:

701. Policies affecting youth reproductive health in Zambia (health, legal, etc.): __________

702. Most important training needs of youth reproductive health programs:__________

703. What needs to be done to improve youth reproductive health programs in this country:____

Thank you for giving us this useful interview! We would greatly appreciate any documents or materials you can share. We thank you very much for your time and contribution to this program survey.

→Time End:________________

→After leaving the interview the Interviewer should list the documents and materials collected:

→Interviewer comments:

Geographic Locations of Programme Activities as Specified[1]		
National	√	(some Programmes did not specify further)
Provinces		*Districts*
Central	√	
		Chibombo
		Kapiri Mposhi
	√	Kabwe*
		Mkushi
	√	Mumbwa
	√	Serenje
Copperbelt	√	
	√	Chililabombwe
	√	Chingola
	√	Kalulushi
	√	Kitwe
	√	Luanshya
	√	Lufwanyama
	√	Mpongwe
	√	Mufulira
	√	Masaiti
	√	Ndola*
Eastern	√	
	√	Chadiza
		Chama
	√	Chipata*
		Katete
	√	Lundazi
		Mambwe
		Nyima
		Petauke
Luapula	√	
		Chienge
		Kawambwa
		Mansa*
		Milenge
		Mense
		Nchelenge
	√	Samfya
Lusaka	√	
	√	Chongwe
	√	Kafue
		Luangwa
	√	Lusaka*
Northern	√	
		Chilubi
	√	Chinsali
		Isoka
		Kaputa
	√	Kasama*
		Luwingu
		Mbala
		Mpulungu
	√	Mpika
		Mporokoso
		Mungwi
	√	Nakonde
North-Western	√	
	√	Kabompo
	√	Kasempa
		Mufumbwe
		Mwinilunga
	√	Solwezi*
	√	Zambezi
		Chavuma
Southern	√	
	√	Choma
		Gwembe
	√	Kalomo
		Kazungala
	√	Livingstone*
	√	Mazabuka
	√	Monze
		Namwala
		Itezhi-tezhii
		Siavonga
		Sinazongwe
Western	√	
		Kalabo
	√	Kaoma
	√	Lukulu
	√	Mongu*
	√	Senanga
		Shangombo
		Sesheke

**Provincial headquarters*

[1] See programme profiles in Appendix M for individual programme locations.

APPENDIX C: Programme Activity Locations

Places in Lusaka Specified by Programmes
Balastorn Park
Bauleni
Chainda
Chaisa
Chawama
Central Lusaka
Chelston
Chibulya
Chilenje
Chipata
Chongwe
Chuunga
Civic Centre
Garden
George
Kabanana
Kalingalinga
Kamanga
Kamwata
Kanyama
Kaunda Square
Libala
Lilanda
Lilayi
Lusaka West
Mandevu
Matero
Mississi
Mtendere
Munali
New Kanyama
Ng'ombe
Northmead (shopping area)

APPENDIX D: Donors and Funding Sources

Donor/Source of Funding[2]	Organisation/ Programme
Adventist Development Relief Agency (ADRA)	• Adventist Development Relief Agency/ Child Alive
Alliance for Children	• Fountain of Hope Association/ Street children services
Canadian International Development Fund (CIDA)	• Forum for African Women Educationalists of Zambia/ Promotion of girls and women's education • Salvation Army/ HIV/AIDS Programme
CAFOD (Canada)	• Youth Alive Zambia/ Behaviour Change & Education for Life Process
Christian Aid (UK)	• Copperbelt Health Education Project/ Peer Education & Life Skills Project
[British] Department for International Development (DfID)	• Society for Family Health/ Peer Education & Promotion
Family Federation for World Peace	• Youth Federation for World Peace/ Sex Education to Youth
FAWE (Nairobi)	• Forum for African Women Educationalists of Zambia/ Promotion of girls and women's education
Government of the Republic of Zambia	• Zambia Information Service/ Population Communication Project • Network of Zambian People Living with AIDS • MOH/HEU/ Adolescent & Youth Education in Reproductive Health • MOE/CDC/ POPED • MOE/CDC/ HIV/AIDS Education & Life Skills Programme • MYSCD/DYD/ Project for Integrating Health, FLE & Income Generation for OSY • MCDSS/ Street Children Programme • Sepo Centre/ Behavioural Change for Youth • Commonwealth Youth Programme Africa Centre (from MYSCD)
Institute for Cupertino with Developing Countries (HIVOS)	• Zambezi Youth Organisation/ Youth Enterpreneurship Promotion Programme
International Planned Parenthood Federation (IPPF)	• Planned Parenthood Association of Zambia/ FLE & Youth Development
Joint United Nations Programme on AIDS (UNAIDS)	• Zambia National AIDS Network
Misereor (Germany)	• Youth Alive Zambia/ Behaviour Change & Education for Life Process
Marie Stopes-Zambia	• Kara Counselling & Training/ Residential Training for Female Orphans & Vulnerable Children
Netherlands Development Organisation (SNV)	• Forum for African Women Educationalists of Zambia/ Promotion of girls and women's education • Zambezi Youth Organisation / Youth Enterpreneurship Promotion Programme
Norwegian Agency for Development (NORAD)	• Kara Counselling & Training/ Residential Training for Female Orphans & Vulnerable Children • Zambia National AIDS Network • Society for Women & AIDS in Zambia/ Youth & School Activities • Copperbelt Health Education Project/ Peer Education & Life Skills Project • Forum for African Women Educationalists of Zambia/ Promotion of girls and women's education • Sepo Centre/ Behavioural Change for Youth

[2] Donors have funded the organisations/programme for varying periods of time and with various levels of support; support may not be current for the above programmes.

APPENDIX D: Donors and Funding Sources

Donor/Source of Funding[2]	Organisation/ Programme
Project Concern International (PCI)	• Network of Zambian People Living with AIDS • Community Youth Concern/ Integration Into Literacy Programme for Less Advantaged & Orphaned Youth • Zambia Student Christian Movement/ AIDS & Health Project • Zambia National AIDS Network • Society for Women & AIDS in Zambia/ Youth & School Activities
Population Council	• CARE/ Testing Community Based Approaches to Adolescent Sexual and Reproductive Health
Society for Family Health	• Alangizi National Association of Zambia/ Traditional Counselling
Southern African AIDS Training Programme (SAAT)	• Network of Zambian People Living with AIDS • Family Life Movement of Zambia / Sexual & Reproductive Health Programme • Zambia National AIDS Network • Copperbelt Health Education Project/ Peer Education & Life Skills Project • Sepo Centre/ Behavioural Change for Youth
Street Kids International (Toronto, Canada)	• YWCA/ Youth Skills Enterprise Initiative
Swedish International Development Agency (SIDA)	• MOE/CDC/ HIV/AIDS Education and Life Skills Programme • FLMZ, PPAZ/Kafue Adolescent Reproductive Health Project
United Nations Development Programme (UNDP)	• MOH/HEU/ Adolescent & Youth Education in Reproductive Health • Youth Outreach Association • Family Life Movement of Zambia/ Sexual & Reproductive Health Programme • MOE/CDC/ HIV/AIDS Education & Life Skills Programme • Copperbelt Health Education Project/ Peer Education & Life Skills Project
United Nations Educational, Scientific, & Cultural Organisation (UNESCO)	• Forum for African Women Educationalists of Zambia/ Promotion of girls and women's education
United Nations Fund for Population Activities (UNFPA)	• Commonwealth Youth Programme • Zambia Information Services/ Population Communication Project • YWCA/ Adolescent Youth Reproductive Health • Catholic Women's League/ Girl Child Adolescent Reproductive Health Project • MOE/CDC/ POPED • PPAZ, YWCA, FLMZ/ Strengthening NGO Activities in Adolescent Reproductive Health • Girl Guides Association of Zambia/ Health for Adolescent Refugees Project • MYSCD/DYD/ Project for Integrating Health, FLE, & Income Generation for OSY • Forum for African Women Educationalists of Zambia/ Promotion of girls and women's education
USAID (& via JSI/SEATS, CEDPA, JHU, MotherCare, FHI)	• Adventist Development Relief Agency/ Child Alive • MOH/HEU/ Adolescent & Youth Education in Reproductive Health • Society for Family Health/ Peer Education & Promotion • Youth Media/ Trendsetters Newsletter • JSI/SEATS/ Lusaka Urban Youth Friendly Health Services • CARE/ Partnership for Adolescent Sexual & Reproductive Health • CARE/ Testing Community Based Approaches to Adolescent

APPENDIX D: Donors and Funding Sources

Donor/Source of Funding[2]	Organisation/ Programme
	Sexual & Reproductive Health • Youth Activists Organisation/ Sexual Reproductive Health Project • Girl Guides Association of Zambia/ Health of Adolescent Refugees Project
World Association of Girl Guides (WAGGS)	• Girl Guides Association of Zambia/ Health of Adolescent Refugees Project
World Food Programme (WFP)	• Fountain of Hope Association/ Street children services
World Health Organisation (WHO)	• MOH/HEU/ Adolescent & Youth Education in Reproductive Health • Society for Women & AIDS in Zambia/ Youth & School Activities • Chawama UNESCO Trust Organisation/ Youth Development Education Programme (Preventive Health Education for Youth component)
Commonwealth Secretariat	• Commonwealth Youth Programme Africa Centre
Commonwealth Youth Programme	• Commonwealth Youth Programme Africa Centre
Cooperative alliance	• Commonwealth Youth Programme Africa Centre
Local & international donor community	• Family Health Trust/ Anti-AIDS Project
Depends on donor funding research proposals	• Zambia Association for Researchers in Development/ ZARD Youth Committee
Donors & sympathisers	• Zambia Red Cross Society
Fundraising	• Zambia Scouts Association/ Educational Programme • Youth Federation for World Peace/ Sex Education to Youth • Youth Outreach Association • Youth Media/ Trendsetters Newsletter • Young World Association/ National Youth Economic Reform Programme
Members	• Zambia Scouts Association/ Educational Programme • UNZA Medical Students Association/ HIV/AIDS/STDs Committee • Young World Association/ National Youth Economic Reform Programme
Sales	• Youth Media/ Trendsetters Newsletter
Advertising	• Youth Media/ Trendsetters Newsletter
Self-funding	• Society for Women & AIDS in Zambia/ Youth & School Activities
Raised from own Programmes, through pre-school/facilities for hire	• YMCA/ Recreational activities for youth & refugees
Individual efforts	• Youth Vision Training Organisation/ Youth Reproductive Health Project
Communities (in-kind)	• Copperbelt Health Education Project/ Peer Education & Life Skills Project

APPENDIX E: Co-ordinating Body/Group Participation

Co-ordinating Body or Group	Organisation/Programme
Youth Friendly Health Services	• Family Life Movement of Zambia/ Sexual & Reproductive Health Programme • Zambia Student Christian Movement/ AIDS & Health • CARE/ Testing Community Based Approaches to Adolescent Sexual & Reproductive Health • JSI/ SEATS/ Lusaka Urban Friendly Youth Services Planned Parenthood Association of Zambia/ FLE & Youth Development • Fountain of Hope Association/ Street children services • MYSCD/DYD/ Project for Integrating Health, FLE & Income Generation for Out-of-School Youth • Zambia Red Cross Society/ Street Kids Programme • Zambia Scouts Association/ Educational Programme • Community Youth Concern/ Integration into Literacy Programme for Less Advantaged & Orphan Youth
Adolescent Reproductive Health Consortium	• PPAZ, YWCA, FLMZ/ Strengthening NGO activities in Adolescent Reproductive Health • Family Life Movement of Zambia/ Sexual & Reproductive Health Programme • YWCA/ Monica Makulu Youth Drop-in-Centre • PPAZ /FLE & Youth Development.
Africa Network of People Living with AIDS	• Network of Zambian People Living with AIDS
AIDS Secretariat (to be set-up)	• Zambia National AIDS Network
Alliance for Community Action on Female Education	• Forum for African Women Educationalists of Zambia/ Promotion of Girls & Women's Education
CARE (Collaboration)	• Sepo Centre/ Behavioural Change for Youth
Central Board of Health	• YMCA/ Recreational activities for youth & refugees
Children in Need Network (CHIN)	• Fountain of Hope Association/ Street children services • Copperbelt Health Education Project/ Peer Education & Life Skills Project • Salvation Army/ HIV/AIDS
Christian Council of Zambia	• Zambia Student Christian Movement/ AIDS & Health • YMCA/ Recreational activities for youth & refugees
Commonwealth Youth Programme Africa Centre Credit Initiative	• YWCA/ Youth Skills Enterprise Initiative
Family Health Trust (FHT/ for Anti-AIDS Clubs)	• Commonwealth Youth Programme • Salvation Army/ HIV/AIDS • YMCA/ Recreational activities for youth and refugees
Federation of African Medical Students Association (FAMSA)	• UNZA Medical Students Association/ HIV/AIDS/STDs Committee
Gender in Development Division (GIDD)	• Catholic Women's League/ Girl Child Adolescent Reproductive Health • Forum for African Women Educationalists of Zambia/ Promotion of Girls & Women's Education • Alangizi National Association of Zambia/ Traditional Counselling
HIV/AIDS task force for LDHMT	• Kara Counselling & Training/ Residential Training Programme for Orphans & Vulnerable Children: Voluntary Counselling & Testing Programme • Youth Activists Organisation/ Sexual Reproductive Health Project
Inter-agency Technical Committee for Population (Subcommittees: IEC, Reproductive Health, Research, Children and Youth)	• Youth Media/ Trendsetters Newspaper • YWCA/ Adolescent Youth Reproductive Health • Society for Family Health/ Peer Education & Promotion • Planned Parenthood Association of Zambia/ Strengthening NGO

APPENDIX E: Co-ordinating Body/Group Participation

Co-ordinating Body or Group	Organisation/Programme
	Activities in Adolescent Reproductive Health • Family Health Trust/ Anti-AIDS Project • MOE/CDC/ POPED • MYSCD/DYD/ Project for Integrating Health, FLE & Income Generation for Out-of-School Youth • Zambia Information Services/ Population Communication Project • MOH/HEU/ Adolescent & Youth Reproductive Health • Youth Outreach Association • Alangizi National Association of Zambia/ Traditional Counselling
Interfaith Network	• Youth Alive Zambia/ Behaviour Change & Education for Life Process • CARE/ Testing Community Based Approaches to Adolescent Sexual & Reproductive Health • YMCA/ Recreational activities for youth & refugees
Kafue Adolescent Reproductive Health Project Core Group (FLMZ & PPAZ)	• Planned Parenthood Association of Zambia/ FLE & Youth Development • Family Life Movement of Zambia/ Sexual & Reproductive Health Programme
LDHMT AIDS Programme Planning Committee	• Youth Vision Training Organisation/ Youth Reproductive Health Project
Life Skills Working Team (MOE/CDC)	• Family Health Trust/ Anti-AIDS Project
Male Involvement Committee	• Youth Activists Organisation/ Sexual Reproductive Health Project
MOH Reproductive Health Committee	• YWCA/ Adolescent Youth Reproductive Health • MOE/CDC/ POPED • MOH/HEU/ Adolescent & Youth Reproductive Health
National Adolescent Co-ordinating Committee (MOH but to be handed over to CBOH)	• Family Life Movement of Zambia/ Sexual & Reproductive Health Programme • Kafue FLE/ Kafue Adolescent Reproductive Health Project • JSI/SEATS/ Lusaka Urban Youth Friendly Health Services • CARE/ Partnership for Adolescent Sexual & Reproductive Health
National HIV/STD/TB & Leprosy Programme	• Youth Activists Organisation/ Sexual & Reproductive Health Project • Society of Women Against Aids in Zambia / Youth & School Activities (for World AIDS Day prayers)
National Youth Development Council	• Youth Federation for World Peace/ Sex Education for Youth
National Youth Liaison Agency	• Young World Association/ National Youth Economic Reform Programme
Network of Zambian People Living With AIDS	• Commonwealth Youth Programme
NGOCC	• Society for Women & AIDS in Zambia/ Youth & school activities • Copperbelt Health Education Project/ Peer Education & Life Skills Project
Parents Committee	• JSI/SEATS/ Lusaka Urban Youth Friendly Health Services
Parents-Partners-Peers Committee	• Youth Activists Organisation/ Sexual Reproductive Health Project
PPAZ (Collaboration)	• Sepo Centre/ Behavioural Change for Youth
Programme for Advancement of Girls Education (PAGE)	• MOE/CDC/ HIV/AIDS Education & Life Skills Programme • Forum for African Women Educationalists of Zambia/ Promotion of Girls & Women's Education • YWCA/ Monica Makulu Youth Drop-in Centre
Project support groups (University of Zambia & Zimbabwe)	• Copperbelt Health Education Project/ Peer Education & Life Skills Project

APPENDIX E: Co-ordinating Body/Group Participation

Co-ordinating Body or Group	Organisation/Programme
Sara Communication Initiative Committee (UNICEF)	• Family Health Trust/ Anti AIDS Project
Society for Family Health (SFH)	• Alangizi National Association of Zambia/ Traditional Counselling
Thematic Group on Child Abuse	• Community Youth Concern/ Integration into Literacy Programme for Less Advantaged & Orphaned Youth
UNAIDS	• Commonwealth Youth Programme
UNFPA	• Commonwealth Youth Programme
UNFPA RH Sub-Programme	• YWCA/ Adolescent Youth Reproductive Health
USAID Adolescent Task Force	• JSI/Seats/ Lusaka Urban Youth Friendly Health Services • CARE/ Partnership for Adolescent Sexual & Reproductive Health • CARE/ Testing Community-Based Approaches to Adolescent Sexual & Reproductive Health • Society for Family Health/ Peer Education & Promotion
WHO	• Commonwealth Youth Programme
Youth Alive Zambia	• Society for Women & AIDS in Zambia/ Youth & School Activities
Youth Development & Training Committee	• Girl Guides Association of Zambia/ Health of Adolescent Refugees Project
Zambia Association for Researchers in Development (ZARD)	• Youth Committee of the Zambia Association for Researchers in Development • Youth Outreach Association
Zambia Council for Social Development	• Fountain of Hope Association/ Street children services
Zambia National AIDS Network (ZNAN)	• Family Health Trust/ Anti-AIDS project • Fountain of Hope Association/ Street children services • Copperbelt Health Education Project/ Peer Education/ Life Skills project • Network of Zambian People Living with AIDS • Youth Alive Zambia/ Behaviour Change & Education for Life Process
Zambia National Commission for UNESCO	• Chawama UNESCO Trust Organisation/ Youth Development Education Programme (Preventive Health Education for Youth component)
Zambia Red Cross Society	• Zambia Scouts Association/ Educational Programme
ZamCam	• Society for Family Health/ Peer Education & Promotion • JSI/SEATS/ Lusaka Urban Youth Friendly Services • CARE/ Partnership for Adolescent Sexual & Reproductive Health • CARE/ Testing Community-Based Approaches to Adolescent Sexual & Reproductive Health

APPENDIX F: Conferences and External Meeting Participation

Conference/External Meeting[3]	Organisation/ Programme
Reproductive health integration workshop	• Adventist Development Relief Agency/ Child Alive
AIDS Programme & the national conference on the revised population policy at Mulungushi C.C.	• Alangizi National Association of Zambia/ Traditional Counselling
Mulungushi international conference organised by ZNAN	• Chawama UNESCO Trust Organisation/ Youth Development Education Programme (Preventive Health Education for Youth component)
Drug and substance abuse – Harare	• Commonwealth Youth Programme
Sexual Reproductive Health – South Africa; HIV/AIDS/STD in Africa – Uganda; SANASO	• Community Youth Concern/ Integration Into Literacy Programme for Less Advantaged & Orphaned Youth
World AIDS conference; Africa AIDS conference; World Youth Forum 1996	• Copperbelt Health Education Project/ Peer Education & Life Skills Project
Adolescent Reproductive Health - Baltimore – Aug. 96; Adolescent Reproductive Health in Ethiopia	• Family Life Movement of Zambia/ Sexual & Reproductive Health Programme
In Nairobi, and the coming one in Kampala	• Girl Guides Association of Zambia/ Health of Adolescent Refugees Project
CASA Conference - Abidjan; SANASO – Swaziland	• Kara Counselling & Training/ Residential Training for Female Orphans & Vulnerable Children: VCT Programme
ARH Conference & Life Skills Curricula Development	• MOE/CDC/ HIV/AIDS Education & Life Skills Programme
Reproductive Health for Youth (international); Kenya Centre for Reproductive Health	• MOH/HEU/ Adolescent & Youth Education in Reproductive Health
Adolescent Reproductive Health Workshop; Health communications – U.S.; Programme planning; study tours	• MYSCD/DYD/ Project for Integrating Health, FLE, & Income Generation for OSY
STD/AIDS in Africa – Abidjan	• Network of Zambian People Living With AIDS
ARH Management (annual conference)	• PPAZ, YWCA, FLMZ/ Strengthening NGO Activities in Adolescent Reproductive Health
African Youth Forum - Addis January/97; Programme Development for HIV/AIDS & Sexuality U.S. May/ June,1997	• PPAZ/ FLE & Youth Development
Regional Evaluation - Zimbabwe 96; Regional sensitisation – Zimbabwe 97; Regional follow-ups of community counselling 97 – Malawi	• Salvation Army/ HIV/AIDS Programme
NASO; SANASO; Abidjan Women's AIDS conference; Belgian conference; Women & AIDS-CNDA	• Society for Women & AIDS in Zambia/ Youth & school activities
3 annual medical workshops for AIDS (Reg./Int'l); Annual STOP AIDS conference of IAMSA	• UNZA Medical Students Association/ HIV/AIDS/STDs Committee
Youth Reproductive Health - Bangkok; YMCA Zonal Meeting – South Africa	• YMCA/ Recreational activities for youth & refugees
Global democratic Kabwe, Zambia; Poverty alleviation; Youth leadership entrepreneurship	• Young World Association/ National Youth Economic Reform Programme

[3] Unfortunately, many key informants were unable to recall the exact titles, so often the titles are incomplete or missing.

APPENDIX F: Conferences and External Meeting Participation

Conference/External Meeting[3]	Organisation/ Programme
Strategic Communications on Planning Health & Reproductive Health, USAID	• Youth Activists Organisation/ Sexual Reproductive Health Project
National AIDS conference; substance abuse workshop	• Youth Alive Zambia/ Behaviour Change & Education for Life Process
2nd & 3rd World Congress for YFWP & WFWP (95, 97) in Washington; local conferences; World's Youth in Transition (1996)	• Youth Federation for World Peace/ Sex Education to Youth
Youth Leadership & Reproductive Health – Washington; Gender Lens– Zambia	• Youth Media/ Trendsetters Newsletter
2 RH workshops – JHU/Baltimore, USA & Addis Ababa, Ethiopia; MSI-RH management course	• YWCA/ Adolescent Youth Reproductive Health
Street Youth Kids Study Tour – Tanzania 1997	• YWCA/ Youth Skills Enterprise Initiative
1st African Youth Conference - Ghana; Positive Living Ambassadors; youth in Zambia	• Zambia Information Service/ Population Communication Project
AIDS conferences in the region & world	• Zambia National AIDS Network
Networking in the HIV/AIDS prevalence	• Zambia Scouts Association/ Educational Programme
AIDS conferences - Holland and Capetown	• Zambia Student Christian Movement/ AIDS & Health Project

APPENDIX G: IEC and Training Materials Produced by Programmes

IEC/Training Materials Produced	*Organisation/ Programme (material description if provided)*	*Available for others' use*
Brochure	▪ Community Youth Concern/ Integration Into Literacy Programme for Less Advantaged & Orphaned Youth *(UNFPA)*	No
	▪ Youth Federation for World Peace/ Sex Education to Youth	√
	▪ Zambia Student Christian Movement/ AIDS & Health Project	√
	▪ Kara Counselling & Training/ Residential Training for Female Orphans & Vulnerable Children: VCT Programme *(HIV counselling & testing)*	√
	▪ YWCA/ Adolescent Youth Reproductive Health *(Family planning; STDs, antenatal care for teens)*	√*(copies not provided)*
	▪ Society for Family Health/ Peer Education & Promotion *(HIV/AIDS/STDs, Maximum, Safe Plan, Care Female Condom brochures, SFH activities in Zambia)*	√
	▪ Young World Association/ National Youth Economic Reform Programme	√
	▪ PPAZ, YWCA, FLMZ/ Strengthening NGO Activities in Adolescent Reproductive Health *(STIs, family planning)*	√
	▪ Family Life Movement of Zambia/ Sexual and Reproductive Health Programme *(STIs, mother and daughter dialogue, father and son dialogue, fertility awareness)*	√
	▪ Kafue FLE/ Kafue Adolescent Reproductive Health Project	√
	▪ MYSCD/DYD/ Project for Integrating Health, FLE & Income Generation for OSY	√
	▪ Planned Parenthood Association of Zambia (PPAZ)/ FLE & Youth Development *(Teens & family planning, STDs, FLE)*	√
Curriculum	▪ YWCA/ Adolescent Youth Reproductive Health *(FLE)*	√*(copies not provided)*
	▪ PPAZ, YWCA, FLMZ/ Strengthening NGO Activities in Adolescent Reproductive Health	√
	▪ MOE/CDC/ HIV/AIDS Education and Life Skills Programme *(Planning to write HIV/AIDS book for pupils & a teachers resource book)*	?
	▪ CARE/ Partnership for Adolescent Sexual & Reproductive Health	√
	▪ MYSCD/DYD/ Project for Integrating Health, FLE & Income Generation for OSY *(FLE)*	√
	▪ CARE/ Testing Community Based Approaches to Adolescent Sexual and Reproductive Health *(peer counselling/training developed by adolescents)*	√
	▪ MOE/CDC/ POPED *(Plan to write HIV/AIDS books for pupils and teachers resource book)*	?

APPENDIX G: IEC and Training Materials Produced by Programmes

IEC/Training Materials Produced	Organisation/ Programme (material description if provided)	Available for others' use
Manual	▪ Youth Activists Organisation/ Sexual Reproductive Health Project (developed by participatory methods to provide more simplified method for information about STDs/HIV/AIDS)	√
	▪ YWCA/ Adolescent Youth Reproductive Health *(FLE for parent educators)*	√*(copies not provided)*
	▪ MOE/CDC/ POPED	?
	▪ PPAZ, YWCA, FLMZ/ Strengthening NGO Activities in Adolescent Reproductive Health	√
	▪ Family Life Movement of Zambia/ Sexual and Reproductive Health Programme (Parent Aid Manual)	√
	▪ Planned Parenthood Association of Zambia (PPAZ)/ FLE & Youth Development *(FLE manual, Parent-elder manual)*	√ *(PPAZ must train users first)*
	▪ Fountain of Hope Association/ Street children services *(Training manual to be completed)*	?
	▪ Family Health Trust/Anti-AIDS Project(Happy Healthy & Safe)	√ *(at a nominal fee yet to be determined)*
Booklet	▪ PPAZ, YWCA, FLMZ/ Strengthening NGO Activities in Adolescent Reproductive Health	√
	▪ MYSCD/DYD/ Project for Integrating Health, FLE & Income Generation for OSY *(Importance of early antenatal care)*	√
	▪ Fountain of Hope Association/ Street children services *(Street children)*	?
	▪ Network of Zambian People Living with AIDS *(Book on nutrition for people with AIDS)*	√
	▪ MOH/HEU/ Adolescent & Youth Education in Reproductive Health *(Participatory methodology book)*	√
Newsletter	▪ Zambia Information Service/ Population Communication Project *("Pop News" quarterly)*	√
	▪ Zambia National AIDS Network *(ZNAN Newsletter)*	√
	▪ PPAZ, YWCA, FLMZ/ Strengthening NGO Activities in Adolescent Reproductive Health	√
Magazine	▪ Community Youth Concern/ Integration Into Literacy Programme for Less Advantaged & Orphaned Youth *("Let's Talk About It" magazine)*	√
	▪ Family Health Trust/ Anti-AIDS Project *(Happy Health & Pregnancy -to be published)*	√
Flipchart	▪ YWCA/ Adolescent Youth Reproductive Health *(FLE)*	√*(copies not provided)*
	▪ Family Life Movement of Zambia/ Sexual and Reproductive Health Programme *(FLE)*	√
	▪ Alangizi National Association of Zambia/ Traditional Counselling *(shows reproductive organs)*	√*(if published)*
Video	▪ Society for Family Health/ Peer Education & Promotion *("It's My Choice," "The Real Men," "Live the Dream" – in Bemba, Nyanga, Lunda & English)*	√ *(after discussions on use)*
	▪ Zambia Information Service/ Population Communication Project *(Video documentaries, e.g:"Toward the Year 2000")*	√
	▪ PPAZ, YWCA, FLMZ/ Strengthening NGO Activities in Adolescent Reproductive Health	√
Pamphlet	▪ Zambia Scouts Association/ Educational Programme *("The Scout" pamphlet)*	√
Poster	▪ Kafue FLE/ Kafue Adolescent Reproductive Health Project	√

APPENDIX G: IEC and Training Materials Produced by Programmes

IEC/Training Materials Produced	Organisation/ Programme (material description if provided)	Available for others' use
Newspaper	▪ Youth Media/ Trendsetters Newspaper	√
Song	▪ Society for Family Health/ Peer Education & Promotion *(Maximum Audio album)*	√
Aprons	▪ Society for Family Health/ Peer Education & Promotion (*Safe Plan &Maximum*)	*(staff use)*
T-shirts	▪ Society For Family Health/ Peer Education & Promotion ▪ Youth Friendly Health Services (for Peer Educators)	*(staff use)*
Drama	▪ PPAZ, YWCA, FLMZ/ Strengthening NGO Activities in Adolescent Reproductive Health	√
Specific Responses Not Categorised[4]		
STIs, teen pregnancy	▪ Community Youth Concern/ Integration Into Literacy Programme for Less Advantaged & Orphaned Youth	*No*
Misc. publications/ papers presented at conferences	▪ Youth Federation for World Peace/ Sex Education to Youth	√
Fliers on AIDS	▪ Zambia Student Christian Movement/ AIDS & Health Project	√
Charts on behavioural change	▪ Youth Alive Zambia/ Behaviour Change & Education for Life Process	√
Three reports	▪ Network of Zambian People Living with AIDS	√
Educational kits for schools	▪ UNZA Medical Students Association/ HIV/AIDS/STDs Committee	?
National AIDS conference reports	▪ Zambia National AIDS Network	√
Information/statistics sheet describing organisation work	▪ Chawama UNESCO Trust Organisation/ Youth Development Education Programme (Preventive Health Education for Youth component)	√
Survey report on readmission of pregnant girl-child	▪ Zambia Association for Researchers in Development/ ZARD Youth Committee	√
Contribution to FHI "Network" edition on ARH	▪ Girl Guides Association of Zambia/ Health of Adolescent Refugees Project	√ *(through FHI)*
Four compound baseline research document	▪ CARE/ Testing Community Based Approaches to Adolescent Sexual and Reproductive Health	√
Life skills/RH, peer education, pastoral counselling	▪ Copperbelt Health Education Project/ Peer Education & Life Skills Project	√ *(copies at cost)*

[4] Some of the responses describe research reports. Also see Appendix H for study reports that may be possible to obtain through various organisations.

APPENDIX H: Current and Future Research on Youth

Description of Research	Organisation/ Programme Name
Study research from outside of country to learn more ways to enhance programme	• Alangizi National Association of Zambia/ Traditional Counselling
Operations research on different types of interventions	• CARE/ Testing Community Based Approaches to Adolescent Sexual and Reproductive Health
Percentage of dropouts in educational institutions; Impact of FLE once started	• Catholic Women's League/ Girl Child Adolescent Reproductive Health Project
Evaluate impact of seminars after participants return to community	• Chawama UNESCO Trust Organisation/ Youth Development Education Program (Preventive Health Education for Youth component)
Research on early marriages in Matero planned	• Community Youth Concern/ Integration Into Literacy Programme for Less Advantaged & Orphaned Youth
Establishment of youth-friendly centres, parent-child "peer" relationship	• Copperbelt Health Education Project/ Peer Education & Life Skills Project
Attitudes & perceptions specific to thematic areas; Documentation of specific challenges encountered	• Family Life Movement of Zambia/ Sexual & Reproductive Health Programme
Strategic resource planning for girls education in Africa	• Forum for African Women Educationalists of Zambia/ Promotion of girls and women's education
Investigate reasons for rural to urban influx	• Fountain of Hope Association/ Street children services
Research on income generating activities	• Kafue FLE/ Kafue Adolescent Reproductive Health Project
Including youth in distribution of female condom	• Kara Counselling & Training/ Residential Training for Female Orphans & Vulnerable Children: VCT Programme
Needs assessments on the life skills needed by Zambian youth	• MOE/CDC/ HIV/AIDS Education and Life Skills Programme
Youth & adolescent reproductive health	• MOH/HEU/ Adolescent & Youth Education in Reproductive Health
Prevalence of HIV/AIDS	• Network of Zambian People Living with AIDS
Provide baseline data on youth being served in project sites as a basis for future comparison, assessment, & evaluation	• Planned Parenthood Association of Zambia/ FLE & Youth Development
Baseline on a number of ARH indicators, e.g. sexual practices, to judge programme impact	• PPAZ, YWCA, FLMZ/ Strengthening NGO Activities in Adolescent Reproductive Health
Ongoing PLA done through CARE, PCI in collaboration with Livingstone DHMT; Blood tests of pregnant women in health centre	• Sepo Centre/ Behavioural Change for Youth
Research on characteristics of most disadvantaged youth, e.g. social factors	• Young World Association/ National Youth Economic Reform Programme
Carry out research on the existing programme	• Youth Activists Organisation/ Sexual Reproductive Health Project
Now doing research on behaviour change	• Youth Alive Zambia
IEC study on youth	• Youth Media/ Trendsetters Newsletter
Research on how youth access RH information, how they use it, & whether it's adequate	• Youth Vision Training Organisation/ Youth Reproductive Health Project
Baseline study is in progress	• YWCA/ Adolescent Youth Reproductive Health
Research on teenage mothers, abortions	• YWCA/ Monica Makulu Youth Drop-in Centre
To find out if people are benefiting from our programmes	• YWCA/ Recreational Activities for youth & refugees
Situation analysis of girl child in newly-established coeducational schools; Opinion poll survey on the readmission of the pregnant girl child into school	• Zambia Association for Researchers in Development/ ZARD Youth Committee
Identification of statutory & customary laws & practices that discriminate against girls	• Zambia Information Service/ Population Communication Project

APPENDIX I: Obstacles and Programme Responses

Type of Obstacle[1]	Selected Responses (how addressed obstacle)[2]
Funding & Resources Issues	
Funding not sufficient	♦ Soliciting for funds/resources from collaborating organisations and donors ♦ Trying to be self-reliant ♦ Trying to be self-sustainable - to talk to donor community and the government about policy on HIV/AIDS, priorities, targets for programme ♦ Funding diversity: Approaching as many different donors as possible ♦ Approached Ministry of Education for financial and resource support ♦ Writing proposals ♦ Advertising revenue ♦ Networking with organisations in income-generating activities ♦ Embarked on voluntary programme in community ♦ Peer educators and home-based psycho social counsellors work on voluntary basis
Lack of equipment/resources (e.g., transportation, materials, computer, office space)	♦ Acquiring funds for a vehicle/transportation ♦ Further procurement of the equipment by funders ♦ Searching for accommodation ♦ Formed partnership in return for office space
Peer Educator Issues	
Attrition and lack of motivation of peer educators (particularly due to unpaid work/lack of incentives) *"Sustainability is difficult to ensure, we rely so much on peer educators who do so much yet receive no allowances."*	♦ Involved peer educators in courses, training workshops, & planning process to keep them motivated ♦ Trying to work with another project in small-scale enterprise ♦ Providing peer educators with bicycles, funds to carry out activities like drama & debates, performing arts festivals, FLE lessons & peer counselling sessions. ♦ Group meeting to address needs
Staffing Issues	
Lack of staff	♦ Hiring conference facilitators
Lack of resource persons for important activities	♦ Networking with other organisations
Technical deficiencies (e.g. lack of qualified staff/little experience in YARH)	♦ Family planning guidelines developed ♦ Employing qualified staff ♦ Use of technical agency (Margaret Sanger) ♦ Study-tours in Africa sub-region (Uganda, Tanzania)
Government wants to cut staff	♦ Lobbying government to reverse their decision to cut staff in MOH because they were already understaffed even before restructuring
Labour intensive supervision	♦ Transport for supervisors
Low morale/motivation in staff	♦ Trying to work out a way of paying/providing incentives for non-paid staff
Difficulty in report writing	♦ ZARD organises training workshops for members from time to time
Problems with youth leaders	
Lack of time	
Logistics	
Planning	

APPENDIX I: Obstacles and Programme Responses

Type of Obstacle[1]	Selected Responses (how addressed obstacle)[2]
Resistance & Support Issues	
Parents not willing to allow kids to attend meetings	♦ Talking to parents
Initial resistance because accused of showing obscene pictures (e.g. reproductive organs)	♦ Involving parents & church leaders ♦ Sensitising workshops for community (health centres, schools, parents) ♦ Doing advocacy work, (e.g. variety show, father-son football initiative)
If child is abused by father, mother fears to reveal such case	♦ Sensitising parents on consequences of child abuse
Media, especially poor newspaper reporting	♦ Writing back to newspapers to right situations
Poor response from authorities in some institutions	♦ Approached Ministry of Education ♦ Strategic plans to target workshops for authorities
Government	♦ Signed MOU with Ministry of Communications Development &Social Services & Ministry of Youth, Sport & Child Development
Lack of commitment especially of youth organisations	♦ Involving youth
Youth with poor attitudes before workshops	
Materials/Information	
Showing same videos over and over is boring	♦ Trying to obtain & show a variety of videos
Poor training materials/exercises	♦ Efforts to improve training skills
Lack of promotional materials for the youth	♦ Youth put in charge of promotional materials
Limited access to information	♦ Finding different information sources
Lack capacity to develop IEC materials	
Misc. Programmatic Concerns	
Duplication of efforts	♦ Networking with other youth organisations
Difficult to influence people to adopt positive behaviours	♦ Give factual information
Difficult to reach certain types of youth (i.e., hard-to-reach, those with special needs)	♦ Continue to have workshops to help change people's attitudes ♦ Major publicity campaign on sexual priorities ♦ Learning sign language to communicate with deaf, dumb, & blind
Increased outreach needs	♦ Use of community centre clinics ♦ Zoning of catchment areas ♦ Training of trainers ♦ Recruitment of more volunteers
Message segmentation for different age groups	♦ Collaboration with organisations specifically dealing with youth
Plans delayed/altered due to MOH delinkage	♦ Dealing with what does not directly involve health staff, but incorporating them in the clinic programme (to get around delinkage)
Monitoring and evaluation	

Lessons Learned	Organisation/ Programme Name
Youth Involvement & Peer Education	
More peer education needs to be done	• Kara Counselling & Training/ Residential Training for Female Orphans & Vulnerable Children: VCT Programme • PPAZ, YWCA, FLMZ/ Strengthening NGO Activities in Adolescent Reproductive Health
Peer education works & increases sustainability of programmes	• Family Health Trust/ Anti-AIDS Project • Family Life Movement of Zambia/ Sexual & Reproductive Health Programme • Kafue FLE/ Kafue Adolescent Reproductive Health Project
Most of the youth organisations run by youth are not formalised & not running as well as they could be	• Zambia National AIDS Network
Involving youth at all stages of a programme ensures success	• Family Life Movement of Zambia/ Sexual & Reproductive Health Programme • MYSCD/DYD/ Project for Integrating Health, FLE & Income Generation for OSY
Youths can work hard if taken seriously	• Youth Activists Organisation/ Sexual Reproductive Health Project
Kids have a lot of talent in drama, poetry & other areas	• Community Youth Concern/ Integration Into Literacy Programme for Less Advantaged & Orphaned Youth
Youth Challenges & Needs	
Youth need support from community members around them	• Community Youth Concern/ Integration Into Literacy Programme for Less Advantaged & Orphaned Youth • Youth Alive Zambia/ Behaviour Change & Education for Life Process
Introducing competition among (youth) condom sales agents encourages them to sell more. (e.g. the one with highest sales gets a bicycle.)	• CARE/ Testing Community Based Approaches to Adolescent Sexual & Reproductive Health
Youth lack information & access to services	• Youth Media/ Trendsetters Newsletter
Adolescents need to talk to parents	• CARE/ Testing Community Based Approaches to Adolescent Sexual & Reproductive Health
Youth need someone to talk to about their problems	• Youth Alive Zambia/ Behaviour Change & Education for Life Process
Youth are ready to testify if you give them confidentiality	• Salvation Army/ HIV/AIDS Programme
Youth are willing to change if encouraged by public at large	• Youth Alive Zambia/ Behaviour Change & Education for Life Process
Key Issues Need Greater Attention	
There is a lot of child abuse & nothing is done about it	• Community Youth Concern/ Integration Into Literacy Programme for Less Advantaged & Orphaned Youth • Youth Alive Zambia/ Behaviour Change & Education for Life Process
Educate people on the importance of educating females, especially in rural areas	• Forum for African Women Educationalists of Zambia/ Promotion of girls & women's education
The AIDS problem is very serious/data is alarming	• Youth Federation for World Peace/ Sex Education to Youth
Negative social impact is increasing	• MOH/HEU/ Adolescent & Youth Education in Reproductive Health
People are still reluctant to know HIV status	• Kara Counselling & Training/ Residential Training for Female Orphans & Vulnerable Children: VCT Programme

APPENDIX J: Lessons Learned

Lessons Learned	Organisation/ Programme Name
Different approaches to orphan care need to be pursued	• Kara Counselling & Training/ Residential Training for Female Orphans & Vulnerable Children: VCT Programme
Need to bring in traditional education to reach all	• Family Life Movement of Zambia/ Sexual & Reproductive Health Programme
Need to expand programme to other clinics & towns	• Zambia Red Cross Society
Most youth projects would succeed if all expectations are met	• Youth Media/ Trendsetters Newsletter
Collaboration	
Cheaper & better variety of expertise if networking with other NGO's as a consortium	• YWCA/ Adolescent Youth Reproductive Health
It is difficult to work in isolation as an NGO because you can't know who is doing what	• Youth Outreach Association
Institutional collaboration has no clear cut supervisory role, & sometimes conflict with each other	• Kafue FLE/ Kafue Adolescent Reproductive Health Project
Sharing expertise helps to achieve more	• Family Life Movement of Zambia/ Sexual & Reproductive Health Programme
Overcoming Stigmas/ Barriers	
Stigmatisation is slowly being broken	• Network of Zambian People Living with AIDS
People within Catholic Church can now freely discuss issues pertaining to sex	• Catholic Women's League/ Girl Child Adolescent Reproductive Health Project
Many people are willing to come out into the open	• Network of Zambian People Living with AIDS
Though difficult, need to involve/deal with the community; you need patience & understanding	• Society for Women & AIDS in Zambia/ Youth & school activities • Fountain of Hope Association/ Street children services
Need to involve parents in programmes	• Planned Parenthood Association of Zambia/ FLE & Youth Development
Funding/ Resources	
Self-reliance is better than going around begging money from donors	• Zambia Scouts Association/ Educational Programme
Become capable of building resources on your own to achieve our goals & objectives	• Young World Association/ National Youth Economic Reform Programme
Much of the programme activities are donor driven; we want to be independent	• Zambia Student Christian Movement/ AIDS & Health Project
Plans are not fulfilled due to limited funds (not able to print posters & brochures)	• YMCA/ Recreational activities for youth & refugees
Socio-economic situation in Zambia makes it difficult to work voluntarily	• CARE/ Partnership for Adolescent Sexual & Reproductive Health
It has been difficult & taken much effort to get help from NGOs & the government	• Alangizi National Association of Zambia/ Traditional Counselling
Management	
Importance of monitoring tools	• PPAZ, YWCA, FLMZ/ Strengthening NGO Activities in Adolescent Reproductive Health
Planning is important above all for a programme to succeed	• UNZA Medical Students Association/ HIV/AIDS/STDs Committee

Lessons Learned	Organisation/ Programme Name
Trained personnel are a great resource & prerequisite for achieving programme goals	• Zambia Information Service/ Population Communication Project • MOE/CDC/ POPED • PPAZ, YWCA, FLMZ/ Strengthening NGO Activities in Adolescent Reproductive Health
Report writing requires a lot of patience; we have had to redo the same work over & over again	• Zambia Association for Researchers in Development/ ZARD Youth Committee
Communication Strategy	
Segmented messages are more effective than those cutting across all age groups	• Zambia Information Service/ Population Communication Project
A mix of media channels is more effective than using a select few	• Zambia Information Service/ Population Communication Project
The implementation of the communication problem can be done by all the media personnel	• Zambia Information Service/ Population Communication Project
Openly discussing issues with parents & youths helps bring out & behaviour in youths	• Chawama UNESCO Trust Organisation/ Youth Development Education Programme (Preventive Health Education for Youth component)
Miscellaneous	
There is still a long way to go	• Kara Counselling & Training/ Residential Training for Female Orphans & Vulnerable Children: VCT Programme
Too soon to tell what key lessons are	• JSI/SEATS/ Lusaka Urban Youth Friendly Health Services • Girl Guides Association of Zambia/ Health of Adolescent Refugees Project • MCDSS/ Street Children Programme

Expansion Idea	*Organisation/Programme*
Expand coverage to more areas in the country/nationally	▪ Youth Federation for World Peace/ Sex Education to Youth ▪ Youth Alive Zambia/ Behaviour Change & Education for Life Process ▪ Youth Media/ Trendsetters Newsletter ▪ YWCA/ Adolescent Youth Reproductive Health ▪ Society for Family Health/ Peer Education & Promotion ▪ Catholic Women's League/ Girl Child Adolescent Reproductive Health Project ▪ MOE/CDC/ POPED ▪ Family Life Movement of Zambia/ Sexual & Reproductive Health Programme ▪ Girl Guides Association of Zambia/ Health of Adolescent Refugees Project ▪ Planned Parenthood Association of Zambia/ FLE & Youth Development ▪ Fountain of Hope Association/ Street children services ▪ Forum for African Women Educationalists of Zambia/ Promotion of girls and women's education ▪ MCDSS/ Street Children Programme
Expand into other youth programmes	▪ Youth Media/ Trendsetters Newsletter
Replicate programme	▪ Kafue FLE/ Kafue Adolescent Reproductive Health Project
Move to rural areas as well	▪ Community Youth Concern/ Integration Into Literacy Programme for Less Advantaged & Orphaned Youth ▪ Sepo Centre/ Behavioural Change for Youth
Include more communities outside Lusaka	▪ UNZA Medical Students Association/ HIV/AIDS/STDs Committee
Increase outreach to other compounds	▪ Copperbelt Health Education Project/ Peer Education & Life Skills Project
Expand in areas with more street kids & efforts to reach them	▪ YWCA/ Youth Skills Enterprise Initiative ▪ MCDSS/ Street Children Programme
Expand association globally	▪ Young World Association/ National Youth Economic Reform Programme
Decentralisation of programme	▪ Zambia Information Service/ Population Communication Project ▪ Family Health Trust/ Anti-AIDS Project
Train more youth to be included/include more youth in programme	▪ Youth Activists Organisation/ Sexual Reproductive Health Project ▪ Copperbelt Health Education Project/ Peer Education & Life Skills Project
Set-up intensified peer education activities in whole district	▪ JSI/SEATS/ Lusaka Urban Youth Friendly Health Services
Reinforce peer education programme	▪ MYSCD/DYD/ Project for Integrating Health, FLE & Income Generation for OSY
Implement FLE	▪ MYSCD/DYD/ Project for Integrating Health, FLE & Income Generation for OSY
Reach every young person in school	▪ Zambia Scouts Association/ Educational Programme ▪ Zambia Student Christian Movement/ AIDS & Health Project
Start-up small groups in communities	▪ YMCA/ Recreational activities for youth & refugees
Increase human resources (e.g. employ more staff/volunteers)	▪ Network of Zambian People Living with AIDS ▪ YWCA/ Monica Makulu Youth Drop-in Centre

APPENDIX K: Expansion Ideas

Expansion Idea	*Organisation/Programme*
Increase number of trained volunteers	▪ Adventist Development Relief Agency/ Child Alive
Incorporate with other churches	▪ Salvation Army/ HIV/AIDS Programme
Involve other partners to have project development responsibilities	▪ MOH/HEU/ Adolescent & Youth Education in Reproductive Health
Work with as many organisations as possible	▪ Youth Outreach Association ▪ Zambia Red Cross Society
Involve government	▪ Zambia Red Cross Society
Involve more community people	▪ Chawama UNESCO Trust Organisation/ Youth Development Education Programme (Preventive Health Education for Youth component)
Include more learning institutions	▪ UNZA Medical Students Association/ HIV/AIDS/STDs Committee
Have media programmes	▪ Youth Federation for World Peace/ Sex Education to Youth ▪ Youth Alive Zambia/ Behaviour Change & Education for Life Process
Introduce environmental & drug abuse programmes	▪ Commonwealth Youth Programme
Project to enroll more orphan girls	▪ Kara Counselling & Training/ Residential Training for Female Orphans & Vulnerable Children: VCT Programme
Target more people with counselling & testing	▪ Kara Counselling & Training/ Residential Training for Female Orphans & Vulnerable Children: VCT Programme
Provide employment opportunities to more youth	▪ Youth Media/ Trendsetters Newsletter
Include another income generating activity for youth (e.g. vocational training)	▪ CARE/ Partnership for Adolescent Sexual & Reproductive Health ▪ MYSCD/DYD/ Project for Integrating Health, FLE & Income Generation for OSY
Use micro-credit programmes for youth	▪ CARE/ Testing Community Based Approaches to Adolescent Sexual and Reproductive Health
Support people in other provinces financially	▪ Network of Zambian People Living with AIDS
Provide free condoms	▪ CARE/ Testing Community Based Approaches to Adolescent Sexual and Reproductive Health
More research to identify what works	▪ CARE/ Testing Community Based Approaches to Adolescent Sexual and Reproductive Health
Include regional experiences	▪ Zambia National AIDS Network
More workshops, seminars	▪ Adventist Development Relief Agency/ Child Alive ▪ Chawama UNESCO Trust Organisation/ Youth Development Education Programme (Preventive Health Education for Youth component)
Organise workshops, dinner dances, & exhibitions	• Alangizi National Association of Zambia/ Traditional Counselling
Have own premises	▪ Chawama UNESCO Trust Organisation/ Youth Development Education Programme (Preventive Health Education for Youth component)

Contact List[5]

Adventist Development Relief Agency (ADRA)
Child Alive
Dr. J. Cook, Project Director
Private Bag 5, Mwami, Chipata
Phone: 062-21080
Fax: 062-21080

Alangizi National Association of Zambia
Traditional Counselling
Mrs Iress Phiri , President
Mr. Gilead Lemba Mwenya, contact person for youth efforts
Private Bag E763, Lusaka

CARE
Partnership for Adolescent Sexual and Reproductive Health
Mary Simasiku, Community Counsellor/Co-ordinator
P.O. Box 36238, Lusaka
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Fax: 265060
E-mail: carefp@zamnet.zm

CARE
Testing Community Based Approaches to Adolescent Sexual and Reproductive Health
Tamara Fetters, Operations Research Co-ordinator
P.O. Box 36238, Lusaka
Phone: 265901/7
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E-mail: fetters@zm.care.org (or) care@zamnet.zm

Catholic Women's League (CWL)
Girl Child Adolescent Reproductive Health Project (GARHP)
Chisekwa Maulu, Administrative Assistant
Margaret Sendwe, Chairperson & Co-ordinator
P.O. Box CH310089, Lusaka
Phone: 281283

Chawama UNESCO Trust Organisation
Youth Development Education Programme (Preventive Health Education for Youth component)
Mr. Peter Steven Mumba, Executive Director.
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c/o Zambia National Commission for UNESCO
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Fax/Phone: 254954
E-mail: ncunesco@zamnet.zm

[5] The contact information presented here was verified and updated as much as possible prior to finalising this report for printing in 1999.

Commonwealth Youth Programme Africa Centre (CYPAC)
Commonwealth Youth Programme (CYP)
Dr. Richard Mkandawire, Regional Director
P.O. Box 30190, Lusaka
Phone: 252733/153
Fax: 253698
E-mail: cypac@zamnet.zm

Community Youth Concern (CYC)
Integration Into Literacy Programme for Less Advantaged and Orphaned Youth
Mrs. M.G. Shinkanga, Executive Director
P.O. Box 35806, Lusaka
Phone: 235305/8
Fax: 235307

Copperbelt Health Education Project (CHEP)
Peer Education/Life Skills Project
Sr. Lynn Walker, Project Director
P.O. Box 23567, Kitwe
Phone: 229512/222723
Fax: 222723
E-mail: chep@zamnet.zm

Family Health Trust (FHT)
Anti-AIDS Project
Mr. Mwape Chalowandya, Project Manager
P/BAG RW 75X, Lusaka
Phone: 223589
Fax: 222834

Family Life Movement of Zambia (FLMZ)
Sexual & Reproductive Health Programme
Mwape Lubilo, National Youth Co-ordinator
P.O. Box 37644, Lusaka
Phone: 221898
Fax: 221898
E-mail: flmz@zamnet.zm

Fountain of Hope Association
Street children services
Rodgers Mwewa, Executive Director
P.O. Box 30269, Lusaka
Phone: 233236
E-mail: pip@zamnet.zm

Forum for African Women Educationalists of Zambia (FAWEZA)
Promotion of Girls and Women's Education
Mrs. Barbra Y. Chilanga, National Chairperson
P.O. Box 50093, Lusaka-Ministry of Education
Phone: 251293
Fax: 254139

Girl Guides Association of Zambia
Health of Adolescent Refugees Project (HARP)
Brenda Hanampota, Project Co-ordinator
P.O. Box 31396, Lusaka
Phone: 255198
E-mail: zamme@unhcr.ch

JSI/SEATS-Lusaka Urban Youth Friendly Health Services
Anna Chirwa, Project Manager
Plot 11296, Nchoncho Road, Lusaka
Phone: 2391904
Fax: 239195
E-mail: achirwa@zamnet.zm

Kara Counselling and Training
Residential Training for Female Orphans and Vulnerable Children: VCT Programme
Dr. Sonja Weinreich, Voluntary Counselling and Testing Programme Manager
P.O. Box 37559, Lusaka
Phone: 227086/7
Fax: 229848
E-mail: kara@zamnet.zm

Ministry of Community Development and Social Services (MCDSS)
Street Children Programme
Miss Grace Kasaro, Social Welfare Officer
Mrs. Monica Masisani, Senior Social Welfare Officer
Community House, Sadzu Rd., Lusaka
Phone: 223472
Fax: 225885, 235342

Ministry of Education/Curriculum Development Centre (MOE/CDC)
HIV/AIDS Education and Life Skills Programme
Irene Malambo, Sr. Curriculum Specialist
P.O. Box 50092, Lusaka
Phone: 254071/087 or 250900
Fax: 254071

Ministry of Education/Curriculum Development Centre (MOE/CDC)
Population Education in Formal Education (POPED)
Absolom B.K. Nzala, Curriculum Development Specialist
P.O. Box 50092, Lusaka
Phone: 254071/087 or 250900
Fax: 254071

Ministry of Youth, Sport, and Child Development/ Department of Youth Development (MYSCD/DYD)
Project for Integrating Health, FLE and Income Generation for Out-of-School Youth;
Mrs. Fanny Banda, Assistant Director of Youth
Mrs. H. Matanda, Permanent Secretary
Ministry of Sport, Youth and Child Development
MEMACO House, PO Box 50195, Lusaka
Phone: 253871 and 254693/5
Fax: 223996

Ministry of Youth, Sport, and Child Development/ Department of Youth Development (MYSCD/DYD)
Strengthening NGO Activities in Adolescent Reproductive Health (now known as Strengthening MSYCD/NGOs in Adolescent Reproductive Health Activities)
Mr. L.J. Kamwambi, Director of Youth Development
MSYCD/DYD, Lusaka, Zambia
Phone: 253871
Fax: 254693
Note: The project secretariat has moved from PPAZ to DYD, where the new project co-ordinator is Patrick Nkandu. The seven consortium members consist of: PPAZ, YWCA, FLMZ, MYSCD, CYC, YAWA, and GARHP.

Ministry of Health/Health Education Unit (MOH/HEU)
Adolescent and Youth Education in Reproductive Health
Mr. Sikwanda Makono, Health Education Specialist
P.O. Box 30205, Lusaka
Phone: 222402
Fax: 223228

Network of Zambian People Living with AIDS
David Chipanta, Co-ordinator
P.O. Box 32717, Lusaka
Phone: 223191
Fax: 223152
E-mail: napnzp@zamnet.zm

Planned Parenthood Association of Zambia (PPAZ)
FLE and Youth Development
Mr. S.C. Musonda, Executive Director
P.O. Box 32221, Lusaka
Phone: 228198/78
Fax: 228165
E-mail: ppaz@zamnet.zm

Planned Parenthood Association of Zambia and Family Life Movement of Zambia
Kafue Adolescent Reproductive Health Project
Mr. F. J. Phiri, Project Co-ordinator
P.O. Box 360254, Kafue
Phone: 311665
Fax: 311665
E-mail: kafyth@zamnet.zm

Salvation Army
HIV/AIDS Programme
Colonel T. Shipe, Territorial Commander
P.O. Box 34352, Lusaka
Phone: 238291 or 228327
Fax: 226784
E-mail: sathq@zamnet.zm

Sepo Centre
Behavioural Change for Youths
Ms. Miniva Mwelwa, Administrator
P.O. Box 60545, Livingstone
Phone: 321836
Fax: 321836

Society for Family Health (SFH)
Peer Education and Promotion Project
Moses Chanda, Youth Programme Co-ordinator
P.O. Box 50770, Lusaka
Phone: 292443
Fax: 292463
E-mail: sfh@zamnet.zm

Society for Women and AIDS in Zambia (SWAAZ)
Youth and school activities
Grace Tembo, Co-ordinator Outreach
Bernadett Sikanyika, Co-ordinator Lusaka Base
P.O. Box 50270, Lusaka
Phone: 221738 or 252904
Fax: 222643 or 254809

UNZA Medical Students Association
HIV/AIDS/STDs Committee
Izukanji Sikazwe, Vice President
P.O. Box 50110 RW, Lusaka
E-mail: isikawe@hotmail.com

Young Men's Christian Association (YMCA)
Recreational activities for youth and refugees
Mr. Simukoko, Senior General Secretary
P.O. Box 37549, Lusaka
Phone: 260777
Fax: 260777

Young Women's Christian Association (YWCA)
Adolescent Youth Reproductive Health
Ann Banda, Co-ordinator
P.O. Box 56115, Lusaka
Phone: 255204 or 254751
Fax: 254751
E-mail: YWCA@zamnet.zm

Young Women's Christian Association (YWCA)
Monica Makulu Youth Drop-in Centre
Ms. Cecilia Chomba, Youth Co-ordinator
Along Nationalist Rd., Opposite VTH Mortuary
Phone: 252726
Fax: 254751

Young Women's Christian Association (YWCA)
Youth Skills Enterprise Initiative
Mrs. Mwaka Mulenga, Youth Skills Enterprise Initiative Co-ordinator
P.O. Box 50115, Lusaka
Phone: 255204
Fax: 254751
E-mail: ywca@zamnet.zm

Young World Association
National Youth Economic Reform Programme
Barbara Mhlanga, Acting President
P.O. Box 34430, Lusaka
Phone: 222390

Youth Activists Organisation
Sexual Reproductive Health Project
Holo M. Hachonda, Project Co-ordinator
Clement Bwalya, Financial Controller
Moffat Ng'ombe, Programmes Officer
Hilda Dhliwayo, Administrative Assistant
P.O. Box, 32730, Lusaka
Phone: 239190/4
Fax: 2391295
E-mail: trends@zamnet.zm

Youth Alive Zambia
Behaviour Change and Education for Life Process
George Mwila, Assistant National Co-ordinator
Sister Luzia, Youth Co-ordinator
National AIDS BCP Catholic Secretariat Box 31965, Lusaka
Phone: 227844/55
Fax: 225289 or 220996

Youth Federation for World Peace
Sex Education to Youth
Elias Shawa, Public Relations Officer
P.O. Box 33578, Lusaka
Phone: 223378
Fax: 223138

Youth Media
Trendsetters Newspaper
Ms. Mary Phiri, Editor-in-Chief
Mr. Evans Banda, Managing Editor
P.O. Box 37230, Lusaka
Phone: 239192-94
Fax: 239195
E-mail: trends@zamnet.zm

Youth Outreach Association
Frank Chitalima, Secretary
P.O. Box 35587, Lusaka
Phone: 290224

Youth Vision Training Organisation
Youth Reproductive Health Project
Mr. Douglas Chipoya, Research /Information Officer
P/B Rw 96, UTH, Lusaka
Phone: 251200, ext. 4017
E-mail: dmchipoya@hotmail.com

Zambezi Youth Organisation (ZAYO)
Youth Enterpreneurship Promotion Programme (YEPP) [proposed health & family planning component]
Clement Chinyundu, Secretary
YEPP C/O Zambezi Youth Organisation
P.O. Box 150098, Zambezi, North-Western Province
Phone: 08 371123; Fax: 08 371078

Zambia Association for Researchers in Development (ZARD)
ZARD Youth Committee
Clara Mumba, Chairperson
P.O. Box 37836, Lusaka
Phone: 222883
Fax: 222883
E-mail: zard@zamnet.zm

Zambia Information Services
Population Communication Project
Mr. Patrick Jabani, Director
P.O. Box 50020, Lusaka
Phone: 251975
Fax: 251975
E-mail: informza@zamnet.zm
IEC Working Group contact (activities targeting rural in-and out-of-school youth)::
Mr. Daka Innocent, Secretary
Samfya Population IEC Working Group
PO Box 68, Samfya
Phone: 02-830186

Zambia National AIDS Network (ZNAN)
Network activities; AIDS Youth organisations are members
Patrick M. Salamu, Network Co-ordinator
P.O. Box 32401, Lusaka
Phone: 231153
Fax: 231154
E-mail: znan@zamnet.zm

Zambia Red Cross Society (ZRCS)
Street Kids Programme
Joseph S. Kalaluka, Street Educator
P.O. Box 50001, Los Angeles Blvd., Lusaka
Phone: 250607, 254798
Fax: 252219
E-mail: zrcs@zamnet.zm

Zambia Scouts Association
Educational Programme
Mr. Paul Kafula, Field Scout Commissioner
P.O. Box 31278, Lusaka
Phone: 254823
Fax: 254823
E-mail: zamscout@zamnet.zm

Zambia Student Christian Movement
AIDS & Health Project
Mr. Gilbert Banda, Executive Director
P.O. Box 32834, Lusaka
Phone: 702344
Fax: 233372
E-mail: MDF@zamnet.zm

Programme Profiles[1]

Programme Name (description if no title)	Child Alive
Organisation	**Adventist Development Relief Agency (ADRA)**
Contact	Dr. Joy Cook, Project Director Private Bag 5, Mwami, Chipata Phone: 062-21080; Fax: 062-21080
Timeframe	September 1995 - September 1999
Funding/Resources	USAID & ADRA
Staff	1full-time, 1part-time, 27 volunteers (paid Kw10,000/month)
Geographic Area	Eastern Province (Chipata District: Chipata South, Chadiza District)
Site Types	Mwami Hospital offices, private schools (14 in Chadiza, 23 in Chipata), Jr. secondary schools (4 Chadiza, 3 Chipata), Sr. secondary schools (2 Chadiza, 1 Chipata), health centre/clinic (10 Chadiza, 4 Chipata), Mwami General Hospital
Characteristics of Targeted Youth	Age (unspecified, child bearing); male, female, rural, married unmarried
Other Targeted or Included Groups	Couples, church groups, child bearing age groups, headmen, chiefs, influential leaders
Main Goals	Pregnancy prevention, HIV/AIDS/STD prevention, family life education
Implementation Strategy Examples	▪ Outreach activities, drama, poems, songs to teach on control of HIV/AIDS/STDs. In schools and villages, unspecified number of youths are reached.
Communication Methods	Drama, songs, games, guest speaker, small group, large group, counselling
Monitoring & Evaluation	*Monitoring:* monthly visits, data entered on forms by Community Based Distributors *Evaluation*: external evaluators, another planned future evaluation
Examples of Findings	N/A

[1] Profile information was obtained from key informant interviews (see Appendix B for key informant questionnaire). For a separate list of only programme contact information, see Appendix L. The contact information presented here was verified and updated as much as possible prior to finalising this report for printing in 1999. Additionally, some organisations sent programme updates and, as noted in footnotes of relevant profiles, this information is included in an addendum to this appendix.

Programme Name (description if no title)	Traditional Counsellors - Community-based Organisation
Organisation	Alangizi National Association of Zambia[2]
Contact	Mr. Gilead Lamba Mwenya (Mrs. Iress Phiri, President, previous contact) C/o Alangizi National Association of Zambia Private Bag E763, Lusaka
Timeframe	October 14 1997–Ongoing.
Funding/Resources	Society for Family Health recently for outreach activities, membership cards & Chairperson's efforts (e.g. got a loan)
Staff	2 full-time unpaid; Executive of 15 (7 male & 8 female) volunteers
Geographic Area	Nation-wide (have co-ordinators in each province/ district) In Lusaka District: all urban compounds (George, Ng'ombe, Kaunda Square, Mandevu, Chuunga, Matero East, Chawama, Chipata, John Laing, Kanyama, Chaisa, Garden)
Site Types	Community centres, school halls (e.g. rented at Evelyn Hone), private homes, social functions (e.g. kitchen parties), weddings, initiation ceremonies
Characteristics of Targeted Youth	Age 12–18; Males, females, youths staying with guardians/parents, in-school, out-of-school, low income
Other Targeted or Included Groups	Brides- & bride grooms-to-be, married couples, parents, other Co-ordinators, section chairpersons, any interested individuals/organisations Plan to target youth from well to residential areas ("bamu ma Yard")
Main Goals	Marriage Counselling, HIV/AIDS/STD counselling, family life education with emphasis on how husband and wife should treat each other, traditionally
Implementation Strategy Examples	▪ Outreach activities, drama, songs to teach about HIV/AIDS/STD prevention in communities, beat drums to call community members to a day's workshop, perform a sketch called "Nsongwe" depicting how families are supposed to live in their homes according to the African Tradition. Information is disseminated about the importance of school, marriage and HIV/AIDS/STD prevention. ▪ Counsellors then separate youths, choose 2 boys & 2 girls to facilitate in-depth discussions for 2-3 hours (morning sessions) reaching about 30 youths/week on Mondays, Wednesdays, and Fridays in 3 compounds. Co-ordinators organise married couples for the afternoon session, reaching about 20 couples/week. Co-ordinators follow up after the workshops. In one month (July 17-August 12) trained 362 youths & adults in 6 compounds of Lusaka. ▪ Private counselling as needed (when expressed by married couples, grooms/brides to be, etc.). This includes social relationships, traditional sex rites, expectations of a married woman/man, etc. A token of appreciation is given before & after consultation, initiation ceremonies (" Chinamwali/chisungu") for young girls who just attained puberty. Topics include sexuality, hygiene and STIs. ▪ Adult-to-youth & adult-to-adult educators were selected after being identified by community members & approved by Executive; as incentive they receive transport money to compound sites (SFH supports); they are supervised by the Executive; SFH trained the Executive in use of condoms & other family planing methods they market (April 27-29, 1998); sell male & female condoms at Kw200/packet, hand out pamphlets, & provide referrals (especially for pill).
Communication Methods	Drama, songs, drums, newspapers, television discussion shows (e.g. *Lets Talk About It* on Sunday Evening, ZNBC channel), flip charts, camera (take photos at each site visit), large group, small group
Monitoring & Evaluation	Monitoring: about 30 co-ordinators/counsellors meet at the chairpersons' residence every week on Sundays for 2-3 hours. Evaluation: not yet evaluated
Examples of Findings	Some marriage counsellors charge exorbitant fees & offer poor quality of service, & some drink beer at the expense of their community service; youths engage in very risky behaviour at night in bars, streets

[2] Please see addendum to this appendix for updated information.

Programme Name (description if no title)	Partnership in Adolescent Sexual & Reproductive Health
Organisation	CARE
Contact	Mary Simasiku, Community Counsellor/Co-ordinator P.O. Box 36238, Lusaka Phone: 265901/7; E-mail: carefp@zamnet.zm
Timeframe	October 1996-February 1998
Funding/Resources	MotherCare (USAID)
Staff	4 full-time, 125 peer educators
Geographic Area	Lusaka Province (Lusaka Urban District: Chilenje, Chipata, Chawama, George, Kanyama, Chelstone, Mandevu); Copperbelt Province (Ndola Urban District: 3 compounds); & Southern Province (Livingstone District: 3 compounds)
Site Types	Primary/Jr./Sr. secondary schools, community centre, community-based organisation/NGO, health centre/clinic
Characteristics of Targeted Youth	Age 10-18; male, female, urban, in-school, out-of-school, married, unmarried, street, workplace, low income
Other Targeted or Included Groups	Parents, neighbourhood health committees, clinic staff (have trained clinic staff; hope to train teachers and parents in adolescent sexual and reproductive health)
Main Goals	To reduce adolescent reproductive morbidity & mortality; safe sex; use of clinics; strengthening reproductive health services; unwanted pregnancy prevention; HIV/AIDS/STD prevention; youth development/leadership, gender awareness/education
Implementation Strategy Examples	▪ Use of "participatory learning & action" (PLA) methodology in planning & research activities. ▪ Developed training curriculum for adolescents & clinic staff. ▪ Peer training in reproductive health to help ensure provision of accurate & adequate information to about 125 Lusaka youth/month. ▪ Daily peer education & counselling to provide correct information & support to peers in all 7 Lusaka compounds, reaching about 2000 youth in 3 month period.
Peer Educators	*Incentives:* none *Selection:* between 14-18 years old; neighbourhood health committee; peer recruitment *Supervision:* community counsellor/supervisor; clinic staff *Training:* 7 day training on sexual & reproductive health; refresher courses *Contraceptives/Referrals:* provide condoms and referrals
Communication Methods	TV, print materials, films/videos, drama, songs, games, lecturer, small group, large group, counselling
Monitoring & Evaluation	Monitoring: clinic registry, forms (tally sheets), monthly clinic reports Evaluation: planned (no sooner than March 1998)
Examples of Findings	N/A

Programme Name (description if no title)	Testing Community-Based Approaches to Improving Adolescent Sexual & Reproductive Health
Organisation	CARE
Contact	Tamara Fetters, Operations Research Co-ordinator P.O. Box 36238, Lusaka Phone: 265901/7; E-mail: fetters@zm.care.org (or) care@zamnet.zm
Timeframe	January 1996 - September 1998
Funding/Resources	USAID, Population Council
Staff	6 full-time; 100 peer educators
Geographic Area	Lusaka Urban District (Mtendere, Ng'ombe, New Kanyama)
Site Types	Jr./Sr. secondary schools, religious institution, community-based organisation/NGO, health centre/clinic, street
Characteristics of Targeted Youth	Age 13-19; male, female, urban, in-school, out-of-school, married, unmarried, low income
Other Targeted or Included Groups	Clinicians, neighbourhood health committee, community (sensitisation), parents (to gain approval)
Main Goals	▪ Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, building self-esteem and self-confidence in intervention recipients
Implementation Strategy Examples	▪ Youth developed the peer counselling training curriculum ▪ Training in life skills (reproductive health and condom distribution) for peer educators in New Kanyama & Mtendere once/year (reach about 100 youth in 6 month period) ▪ "Open days" refresher course that include games & quiz for peer educators who are condom sales agents held twice a year at Rhodes Park and Ng'ombe (about 400 peer educators have been trained in the 3 compounds, and 200 attended "open days") ▪ Microcredit/business skills training in M'tendere & Ng'ombe to build self-esteem & confidence in youth (300/year trained)
Peer Educators	*Incentives:* none *Selection:* self-selected through PLA research activities *Supervision:* 2 field- and 3 office-based supervisors *Training:* 10 day training in peer counselling and community-based condom distribution; informal field training *Contraceptives/Referrals:* provide condoms and referrals
Communication Methods	Print materials, lecturer, small group, large group, counselling
Monitoring & Evaluation	Monitoring: peer counsellors have a take-home form & a clinic-based form Evaluation: plans for internal evaluation June/July 1998
Examples of Findings	N/A

Programme Name (description if no title)	Girl Child Adolescent Reproductive Health Project (GARHP)
Organisation	Catholic Women's League (CWL)
Contact	Chisekwa Maulu, Administrative Assistant Margaret Sendwe, Chairperson / Co-ordinator P.O. Box CH 310089, Lusaka Phone: 281283
Timeframe	1997 - 2002 (5 year programme pending UNFPA approval)
Funding/Resources	UNFPA
Staff	2 full-time; 4 volunteer committee members (plan to have 50 peer educators)
Geographic Area	Lusaka Urban District: (Catholic zones/centres in Kamanga, Chainda, Chelston, Zambia Air Force (Catholic parishes) (Future plans to go national)
Site Types	Church halls
Characteristics of Targeted Youth	Age 9-21; current emphasis on females [future plan both adolescent boys & girls], urban, rural, out-of-school, married, unmarried, street, Catholic
Other Targeted or Included Groups	Parents (sensitisation workshop)
Main Goals	Abstinence until marriage, unwanted pregnancy prevention, HIV/AIDS/STD prevention, youth development/leadership, FLE
Implementation Strategy Examples	▪ Pilot project (at Chelston parish) ▪ youth and parent sensitisation workshops in the zones/centres ▪ Future plans to train 1000 CWL members throughout country and to train 50 youth peer educators ▪ Future plans to train staff and committee in ARH, children's rights, child abuse and incest, intestate succession, and gender issues
Peer Educators	*Incentives:* will receive training allowance *Selection:* will be chosen from communities and different centres; will show potential with reference to church doctrine *Supervision:* will report to project co-ordinator *Training:* will consult youth consortium for training guidance/curriculum *Contraceptives/Referrals:* will not distribute contraceptives; will provide referrals
Communication Methods	Announcements in church, notices through CWL Centres (future plan to use multiple methods)
Monitoring & Evaluation	Monitoring: (future will be quarterly per UNFPA requirements) Evaluation: pilot project workshops were evaluated
Examples of Findings	Found need to expand to other centres at national level & to focus on ARH (issues like these are not freely discussed within the church circles) instead of other economic empowerment club activities (e.g. knitting) that CWL and other clubs are already doing

Programme Name (description if no title)	**Youth Development Education Programme (Component: Preventive Health Education For Youth)**
Organisation	**Chawama UNESCO Trust Organisation**
Contact	Mr. Peter Steven Mumba, Executive Director. P.O. Box 139, Chawama, Lusaka c/o Zambia National Commission for UNESCO Phone: 254340; Phone/Fax:254954; E-mail: ncunesco@zamnet.zm
Timeframe	Organisation formed 1984 before International Year for Youth 1985 Component: June, 1997 – Ongoing
Funding/Resources	WHO in past; no money completely for some time now
Staff	No full-time; 12 volunteers; 10 peer educators (3 male & 1 female are youths)
Geographic Area	Lusaka Urban District (Chawama – 7Km from Lusaka city)
Site Types	Catholic community hall centre, Catholic rented house, partner schools through UNESCO associated schools project
Characteristics of Targeted Youth	Age 15-26; male, female, urban, in-school, out-of-school, married, unmarried, street, refugee, low income, Christian youth groups, employed youths who approach us (e.g. from Yolk farms)
Other Targeted or Included Groups	Teachers from UNESCO Associated partner schools, model adults/families with community, section leaders, mothers (cook for youths during workshops)
Main Goals	Pregnancy prevention, HIV/AIDS/STD prevention, FLE, building self-esteem and self-confidence in intervention recipients
Implementation Strategy Examples	▪ AIDS awareness that aims to encourage youths practice abstinence and share ideas on safe sex practices at UNESCO centre (rented from catholic church) every Wednesday, once a week for 2 hours from 14 – 16 hours, reach about 25 – 30 youths a week. ▪ Model adults and families from within the community are invited to share experiences with the youths. So do teachers and pupils from UNESCO Associated schools project. ▪ Plan to hold a 5 days reproductive health & HIV/AIDS/STD course (covering family planning, effects of early pregnancies, etc.) during school holidays, to reach 35 in & out-of-school youths after every term, thereby reaching 100 youths a year (plan is contingent on donor funding; proposal was written and distributed in December 1997).
Peer Educators	Note: 4 of the 10 educators are youths *Incentives:* none *Selection:* some of the executive members already had a skill & volunteered; community members applied for membership to the science sector of UNESCO's 5 fields of competence *Supervision:* Executive director through the Life Skills Officer *Training:* the 4 youths trained at Kara Counselling Centre before joining the organisation; all received youth leadership training, some attend professional related courses (e.g. one peer educator (nurse) attended a nurse–counselling training) *Contraceptives/Referrals:* provide referrals
Communication Methods	Brochures, newspaper, films & videos, drama sketches & plays (have formed own group called Mangoma cultural & drama group), songs, guest speaker, small group, large group, counselling (individuals in the executive make follow-up visits, do counselling in homes or at the clinic)
Monitoring & Evaluation	*Monitoring*: management meetings on Wednesday, meet with parents of youth clientele once a month; invite UNESCO programme officers, partner NGOs (e.g. JICA, ZNAN) & any interested community members e.g. section leaders. *Evaluation* : none so far
Examples of Findings	N/A

Programme Name (description if no title)	3 Programme titles: **(1) Involvement Of University Of Zambia Students In Reproductive Health and HIV/AIDS Awareness Campaign** **(2) Ambassadors of Positive Living Programme** **(3) Annual Lusaka Street Youth Festival**
Organisation	**Commonwealth Youth Programme Africa Centre (CYPAC)** [Facilitates international, regional, and national meetings & seminars; advocates on specific issues (government ministries, NGOs, and communities do implementation)]
Contact	Dr. Richard Mkandawire, Regional Director P.O. Box 30190, Lusaka Phone: 252733/153; Fax: 253698; E-mail: iypac@zamnet.zm
Timeframe	(1) 2 year pilot awareness campaign (1998 – 2000) (2) 1993 - ongoing (3) 1995 - ongoing
Funding/Resources	(1) CYP / UNFPA/MYSCD; (2) & (3) CYP/MYSCD; other sources: Co-operative Alliance, Commonwealth Secretariat
Staff	(1) 2 full-time; 23 for pilot campaign peer educators (some HIV positive); (2) & (3) Varies depending on number of volunteers
Geographic Area	(1) & (3) Lusaka District; (2) All 22 Commonwealth countries in Africa
Site Types	(1) Jr./Sr. secondary schools, clinics, compounds, churches, colleges, university, community centres, streets, workplace; (2) CYP works through the Network of Zambian People Living with HIV/AIDS; (3) Major roads, youth centres, streets
Characteristics of Targeted Youth	Age 15-29; male, female, urban, rural, in-school, out-of-school, married, unmarried, street, workplace, refugees, low income, disabled
Other Targeted or Included Groups	Parents (parents' credit-support project); community (involved in mobilising youth and identifying low income youth)
Main Goals	Empowerment of youth. Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, gender awareness/education
Implementation Strategy Examples	Note: Primarily facilitative/catalytic role (work through youth-related ministries). ▪ (1) Reproductive health & HIV/AIDS awareness campaign (implemented by UNFA Demography Division in partnership with MYSCD/DYD). 2- year pilot programme involving UNZA students; 23 peer educators trained in collaboration with FLMZ, MOH, & LDHMT to work in clinics/churches/schools/university/ colleges. ▪ (2) Ambassadors of Positive Living Programme: CYP works through ZNAN to raise awareness/reduce stigmatisation of those living with AIDS & to help them live positive lives. [Programme came out of regional workshop held in 1993 in Lusaka with participants from 13 countries in Africa (30 male and female HIV positive individuals attended). Coverage has expanded to the remaining commonwealth (African) countries that have formed similar national networks.] ▪ (3) Annual Lusaka street Youth Festival to raise awareness & generate dialogue about the plight of street kids/families (walk/march along Cairo & Great East Roads to CYPAC for games, speeches, food, etc.). ▪ Other activities: training youth in HIV/AIDS prevention & positive living
Peer Educators	*Incentives:* (1) Minimal unspecified amount; (2) regional workshops & study tours; (3) T-shirts, refreshments *Selection:* interest in volunteering; some are HIV positive *Supervision:* (1) requested to submit reports to programme co-ordinator after every site visit; (2) organisational visit *Training:*(1) 23 peer educators (10 male & 13 female) trained for 10 days through FLMZ; (2) trained youth in HIV/AIDS prevention & positive living *Contraceptives/Referrals:* (1) distribute condoms; do not provide referrals
Communication Methods	Radio, TV, print materials, film/video, drama, songs, games, lecture, small group, large group, counselling
Monitoring & Evaluation	Monthly and annual reports
Examples of Findings	Need to strengthen programmes for HIV+ youth (resulted in more emphasis on training and recruitment).

Programme Name (description if no title)	**Integration into Literacy Programme for Less Advantaged and Orphaned Youth**
Organisation	**Community Youth Concern (CYC)** [3]
Contact	Mrs. M.G. Shinkanga, Executive Director P.O. Box 35806, Lusaka Phone: 235305/8; Fax: 235307
Timeframe	December 1996 – ongoing (currently no funding)
Funding/Resources	[No long-term donors mentioned] For 3-month period: Project Concern International
Staff	10 full-time; 10 part-time; 14 peer educators
Geographic Area	Lusaka Urban District (Matero, Mtendere)
Site Types	Primary school (Mahatma Gandhi & Mtendere Basic), jr. secondary school, community-based organisation/NGO (Matero & Mtendere open schools), health centre/clinic (YFHS)
Characteristics of Targeted Youth	Age 17-25; male, female, urban, rural, in-school, out-of-school, married, unmarried, low income, HIV positive
Other Targeted or Included Groups	Parents (group discussions, one-to-one talks)
Main Goals	Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, youth development/leadership, mitigation & integration of child abuse into child survival
Implementation Strategy Examples	• Peer education. • Drama show in marketplace. • Kids' clubs twice/week at Mtendere & Mahatma Ghandi schools reaching about 50 youth weekly. Topics like HIV/AIDS/STD prevention, awareness of reproductive health, child rights and child abuse procedure. • Reproductive health sessions once/week at Matero Open School.
Peer Educators	*Incentives:* transport, meal, and motivation allowance monthly *Selection:* identified by community; former clients; selected by CYC *Supervision:* monthly visit/reports; weekly questionnaires on achievements/statistics *Training:* peer education training at beginning; refresher courses *Contraceptives/Referrals:* do not distribute contraceptives; do provide referrals
Communication Methods	Print material (brochures/magazines/flyers), film/video, drama, songs, small group, large group, counselling, one-to-one
Monitoring & Evaluation	Monitoring: questionnaires, reports Evaluation: none thus far
Examples of Findings	N/A

[3] Please see the addendum to this appendix for updated information.

Programme Name (description if no title)	Peer Education/Life Skills Project
Organisation	Copperbelt Health Education Project (CHEP)
Contact	Sr. Lynn Walker, Project Director P.O. Box 23567, Kitwe Phone: 229512/22723; Fax: 222723; E-mail: chep@zamnet.zm
Timeframe	June 1994 - ongoing (current funding for 3 years)
Funding/Resources	NORAD, UNICEF, SAT, Christian Aid (UK), communities' in-kind contributions
Staff	6 full-time; 8 part-time; 140 volunteer peer educators
Geographic Area	Copperbelt Province: Kitwe District (Ipusukilo, Chimwemwe, Kwacha, Luangwa), Ndola Urban District (Chipulukusu, Ndeke, Nkwazi), Chililabombwe District (Lubengele, Kakoso), Chingola District (Chabanyama, Kapisha). Lufwanyama District (Kafubu Depot, St. Mary's), Mufulira District (Kamuchanga)
Site Types	Primary/Jr./Sr. secondary schools, college, university, recreational facility, community-based organisation/NGO, health centre/clinic
Characteristics of Targeted Youth	Age 10-25; male, female, urban, rural, in-school, out-of-school, married, unmarried, street, low income, disabled/special needs
Other Targeted or Included Groups	Parents & clinic staff (trained in youth-friendliness, lifeskills, reproductive health, pastoral counselling): social welfare staff; community (provision of human resources, networking with neighbourhood committees)
Main Goals	Life skills, reproductive health, counselling, training for transformation, HIV/AIDS/STD prevention, FLE
Implementation Strategy Examples	▪ Peer educators work to generate behaviour change, enable informed choices, & generate positive peer pressure among out-of -school youth in the districts 3 times/week (14 groups) reaching about 100 youth per group/day. ▪ "Debates Drama Quiz" (DDQ) to reach school-based youth with youth-friendly anti-AIDS activities. Venues are colleges, secondary, basic & primary schools. One DDQ session/week between 2 schools, reaching about 500 youth/session.
Peer Educators	*Incentives:* T-shirts, training, transportation money *Selection:* "snowball approach", through crash courses, out-of-school anti-AIDS clubs, repeated records of STIs, PWAs *Supervision:* project co-ordinator, regional volunteer co-ordinators, supervisors *Training:* one week residential training, one month field-based training; life skills/stepping stones in-service training *Contraceptives/Referrals:* distribute condoms & provide referrals
Communication Methods	Radio, TV, print materials, film/video, drama, songs, games, small group, large group, counselling, picture codes, educational demonstration
Monitoring & Evaluation	Monitoring: team of 3 staff in the research, monitoring & evaluation (RME) department; all staff & peer educators trained in monitoring evaluation techniques; FGDs & specific forms designed/used Evaluation: daily/weekly process evaluation; yearly impact evaluation; last evaluation consisted of field visits & FGDs
Examples of Findings	Youth-focused innovative approaches can easily be cross-pollinated among like-minded groups to increase benefits & eliminate piecemeal efforts

Programme Name (description if no title)	**Anti-AIDS Project**
Organisation	**Family Health Trust (FHT)**
Contact	Mr. Mwape Chalowandya, Project Manager P/BAG RW 75X, Lusaka Phone: 223589; Fax: 222834
Timeframe	February 1987 - ongoing contingent on funding
Funding/Resources	Multiple international and local donors
Staff	36 full-time; 1 volunteer; peer educators in Anti-AIDS clubs; [number unspecified]
Geographic Area	All 9 provinces
Site Types	Primary school, jr. secondary school, sr. secondary school, college, community centre, religious institution, health centre/clinic, hospital, street
Characteristics of Targeted Youth	Age 10-24; male, female, urban, rural, in-school, out-of-school, married, unmarried, workplace, refugees, low income, Muslim
Other Targeted or Included Groups	Patrons (trained in communications skills, management of anti-AIDS clubs, & monitoring and evaluation skills); community (to centralise the programme)
Main Goals	Unwanted pregnancy prevention, HIV/AIDS/STD prevention, youth development/leadership, gender awareness/ education
Implementation Strategy Examples	▪ 1000 Anti-AIDS clubs nation-wide with an estimated 65,000 youth participants ▪ Material production club for developing and providing accurate information to youth reached through anti-AIDS project ▪ Training patrons in management of anti-AIDS clubs/communication skills/monitoring & evaluation skills
Peer Educators	*Incentives:* none *Selection:* anti-AIDS club members *Supervision:* club patrons, leaders *Training:* anti-AIDS club manual *Contraceptives/Referrals:* [not specified]
Communication Methods	Print materials, telephone hotline, film/video, drama, songs, games, lecture, small group, large group; letter answering service
Monitoring & Evaluation	Monitoring: individual programme managers monitor their programmes, patrons & leaders monitor anti-AIDS clubs Evaluation: had internal & external evaluation; next planned for March 1998
Examples of Findings	[not specified]

Programme Name (description if no title)	**Sexual & Reproductive Health Programme** [3 components: Family Life Education/Out-of-School Youth (FLE/OSY), Youth Friendly Health Services (YFHS), and Parent-Elder Education Programme]
Organisation	**Family Life Movement of Zambia (FLMZ)**
Contact	Mwape Lubilo, National Youth Co-ordinator P.O. Box 37644, Lusaka Phone: 221898, Fax: 221898; E-mail: flmz@zamnet.zm
Timeframe	YFHS: 1995-ongoing (FLE since inception of organisation)
Funding/Resources	SIDA; UNICEF (YFHS); SAAT (FLE/OSY); UNFPA (Parent-Elder)
Staff	2 full-time/province for FLE/OSY; YFHS uses established staff in PPAZ & FLMZ, 8 part-time supervisors; estimated 300 peer educator are active (have trained over 600), about 50 peer educators working on YFHI
Geographic Area	FLE/OSY: Southern Province, Eastern Province, Lusaka Province, Central Province, Copperbelt Province, Western Province YFHS: Lusaka Province (Lusaka Urban District: Chilenje, Chawama, Kalingalinga); Kafue District: Chanyanya
Site Types	Jr./Sr. secondary school, college, university, recreational facility, community centre, health centre/clinic
Characteristics of Targeted Youth	Age 10-24; male, female, urban, rural, in-school, out-of-school, unmarried, street
Other Targeted or Included Groups	Parents, elders, community leaders, *banachimbusas* (traditional sex educators. One of them targets parents)
Main Goals	Aim to promote happy & healthy family through natural family planning programme. Unwanted pregnancy prevention; HIV/AIDS/STD prevention, FLE
Implementation Strategy Examples	▪ YFHS: Actual service started in August 1996. 1995 was spent on sensitisation workshops with policymakers, community leaders (e.g. area MPs) teachers & health centre staff. Youth peer educators who are trained in basic counselling & FLE communication skills are posted at youth corners in 3 different clinics (Chilenje, Chawama, & Kalingalinga). They try to motivate young people to utilise clinic services. At Chawama & Chilenje, peer educators are in the corners 1 full day and 2 half days/week. ▪ FLE: Started in 1988, lobbied with MOE & schools, & established community groups like homecraft centres & church groups. Provides accurate information so that youth can make informed decisions. Operates in 8 provinces, approximately 2-3 times/week (frequency depends on community need). Plan to include North-Western Province soon. ▪ Parent-Elder Programme (formerly Parent-Aid): Trains other target groups mentioned above in communication skills for dealing with young people.
Peer Educators	*Incentives:* transportation allowance, lunch, stationery *Selection:* varies, e.g. through church leaders, from community sensitisation workshops, from FLE activities (choose those who are willing and have the time) *Supervision:* (at different levels) national co-ordinator, provincial co-ordinator, provincial supervisor, site supervisor, senior peer educator *Training:* basic counselling skills, FLE communication skills; refresher courses once a month *Contraceptives/Referrals:* do not distribute contraceptives; do provide referrals
Communication Methods	Radio, print materials, films/videos, songs, games, lecturer, small group, large group, counselling
Monitoring & Evaluation	Monitoring: monthly meetings; every 6 months compare progress with objectives Evaluation: planned for 1999: YFHI & Kafue ARH project; planned June 1998: youth consortium activities
Examples of Findings	N/A

Programme Name (description if no title)	**Street children services**
Organisation	**Fountain of Hope Association**
Contact	Rodgers Mwewa, Executive Director P.O. Box 30269, Lusaka Phone: 233236; E-mail: pip@zamnet.zm
Timeframe	May 1996 - ongoing (current funding for 3+ months)
Funding/Resources	Alliance for Children, UNDP, WFP
Staff	7 part-time; 115 volunteers; 20 peer educators
Geographic Area	2 Provinces: Lusaka (Lusaka Urban District: Mississi, Chawama, Kamwala, Kanyama, Garden, Northmead, Snack Attack, Tonto's, intercity bus terminal, Cairo Road, Freedom Way); Central (Kabwe & Bwacha compounds)
Site Types	Recreational facility, community centre, youth centre, community-based organisation/NGO, street, bus terminal
Characteristics of Targeted Youth	Age 9-26; male, female, urban, rural, out-of-school, married, unmarried, street, workplace, low income
Other Targeted or Included Groups	Community; mothers (trained in business entrepreneurship/literacy)
Main Goals	To alleviate the problems of street children abuse Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, youth development/leadership, gender awareness/education
Implementation Strategy Examples	▪ Peer educators do street outreach. ▪ Drug and Health (hygiene) education at Kamwala Community Centre and Bwacha Community Centre 3 times/week. ▪ Basic education daily at Kamwala Community Centre and Kamwacha Community Centre, reaching 350-400 youth/week.
Peer Educators	*Incentives:* daily meal *Selection:* rehabilitation of street children identified skilled people *Supervision:* through street educators *Training:* street education; daily experience discussions *Contraceptives/Referrals:* do not distribute condoms, do provide referrals
Communication Methods	Radio, TV, telephone hotline, film/video, drama, songs, games, small group, large group, counselling, door-to-door campaign
Monitoring & Evaluation	Monitoring: weekly by programme officers who each report back to the board of directors on achievements & solutions & challenges Evaluation: done by UNZA; planned again in 1999
Examples of Findings	Management needed restructuring

Programme Name (description if no title)	**Promotion of Girls & Women's Education**
Organisation	**Forum for African Women Educationalists of Zambia (FAWEZA)**
Contact	Mrs. Barbra Y. Chilangwa, National Chairperson [key informant Violet Yumbe has retired] P.O. Box 50093, Lusaka – Ministry of Education Phone: 251293; Fax: 254139
Timeframe	March 1996-ongoing (pending new funding)
Funding/Resources	NORAD, FAWE (Nairobi), UNFPA, Canada, UNESCO
Staff	4 full-time; 14 peer educators
Geographic Area	All 9 provinces
Site Types	Primary/Jr./Sr. secondary schools, college, university, recreational facility, community centre, community-based organisation/NGO
Characteristics of Targeted Youth	All ages; female, urban, rural, in-school, out-of-school, married, unmarried, street, workplace, low income
Other Targeted or Included Groups	Parents (sensitisation on importance of girls education), community (through FAWEZA Programme: Alliance for Community Action on Female Education")
Main Goals	Promote girls/women's education so females complete education & training. Unwanted pregnancy prevention, HIV/AIDS/STD prevention (emphasis on abstinence, sensitisation, & counselling)
Implementation Strategy Examples	▪ Life skills training clubs to help girls become self-reliant when they grow-up. Reaches 20-30 girls/week. ▪ Programme is implemented through MOE officials (e.g. DEOs) who are all members of the NGO. Efforts pass through the districts to grassroots (village) levels. Operates in schools as part of the curriculum; HIV/AIDS/STD issuess are covered in class.
Peer Educators	*Incentives:* none *Selection:* elections at national, provincial, & district levels *Supervision:* supervised by chairpersons at each level *Training:* sensitisation on gender issues at National Assembly (need more training and capacity building) *Contraceptives/Referrals:* do not provide contraceptives or referrals
Communication Methods	Radio, TV, print materials, telephone hotline, film/video, drama, songs, games, lecture, small group, large group, counselling
Monitoring & Evaluation	Monitoring: none yet Evaluation: in future if funds are available
Examples of Findings	N/A

Programme Name (description if no title)	Health of Adolescent Refugees Project (HARP)
Organisation	Girl Guides Association of Zambia
Contact	Brenda Hanampota, Project Co-ordinator P.O. Box 31396, Lusaka Phone: 255198; E-mail: zamme@unhcr.ch
Timeframe	October 1997-February 2000
Funding/Resources	World Association of Girl Guides & Girl Scouts, Family Health International, UNFPA
Staff	1 full-time, 7 volunteers, 23 peer educators
Geographic Area	North-Western Province (Solwezi District: Maheba refugee resettlement)
Site Types	Jr./Sr. secondary schools, community centre, health centre, community-based organisation/NGO, health centre/clinic, refugee camp
Characteristics of Targeted Youth	Age 14-24; male, female, rural, urban, in-school, out-of-school, married, unmarried, street, workplace, refugees, low income
Other Targeted or Included Groups	Parents & elders (involved as group leaders); health providers and LWF social workers (trained in ARH needs)
Main Goals	Unwanted pregnancy prevention, HIV/AIDS/STD prevention, youth development/leadership, gender awareness/education, hygiene, nutrition, and skills training
Implementation Strategy Examples	▪ Unwanted pregnancy prevention efforts: Inform girls how to prevent unwanted pregnancy (at Meheba refugee resettlement, schools, and community) once/week, reaching over 10/session. ▪ STI prevention efforts: Increase awareness of the dangers of STIs (at Meheba refugee resettlement, schools, and community) once/week, reaching over 10/session)
Peer Educators	*Incentives:* badge *Selection:* after being trained in FHI/UNFPA/WAGGS Badge curriculum *Supervision:* by group leaders *Training:* badge curriculum; country-level meetings *Contraceptives/Referrals:* do not distribute contraceptives; do provide referrals
Communication Methods	Print materials, drama, lecture, small group, large group, counselling, "Adolescent Clinic Day"
Monitoring & Evaluation	Monitoring: project co-ordinator/Youth Development & Training Committee submit reports to World Bureau director & donors; donor representatives do on-site observation Evaluation: planned for September 1998
Examples of Findings	N/A

Programme Name (description if no title)	**Lusaka Urban Youth Friendly Health Services**
Organisation	**JSI/SEATS** (in collaboration with Lusaka District Health Management Team (LDHMT))
Contact	Anna Chirwa, Project Manager Plot 11296, Nchoncho Road, Lusaka Phone: 239190/4; Fax: 239195; E-mail: achirwa@zamnet.zm
Timeframe	October 1997-April 1999
Funding/Resources	SEATS (USAID) in collaboration with LDHMT
Staff	2 full-time; 20 peer educators
Geographic Area	Lusaka Urban District: (Matero Reference, Chainda, Kaunda Square, Bauleni, Lilayi, Civic Centre, Kalingalinga)
Site Types	Health centre/clinic
Characteristics of Targeted Youth	Age 10-24; male, female, urban, in-school, out-of-school, married, unmarried, street, low income
Other Targeted or Included Groups	Nurses/health centre staff; neighbourhood health committee (involved in PLA exercise); parents (neighbourhood committee formed)
Main Goals	To improve & promote access to & utilisation of quality reproductive health services for Lusaka aged 10-24 youth Unwanted pregnancy prevention; HIV/AIDS/STD prevention, gender awareness/education
Implementation Strategy Examples	▪ Use of "participatory learning & action" (PLA) methodology in planning & research activities. ▪ 2 clinics (Matero Reference & Bauleni) with peer educators based in "youth corners" and performing community outreach (expected to work 3 days/week). ▪ Contraceptive education available daily at the 7 health centres to enable youth to avoid risk of pregnancy. ▪ Pregnancy services (pre- & antenatal) available daily at 7 health centres and through community outreach.
Peer Educators	*Incentives:* transportation and meal; Kw 26,000; work 3 days a week; tee shirt & bag with logo *Selection:* advertised through neighbourhood health committees; criteria: aged 16-25, live in vicinity, demonstrated community and school spirit, ability to read and write, interest in voluntary work, & respectable behaviour *Supervision:* form used to track days/hours worked & type of work done; day-to-day supervision done by health centre staff; regular supervision by project staff *Training:* 7 day training covering reproductive health issues and counselling skills; 2-day periodic refresher training *Contraceptives/Referrals:* provide free male & female condoms, foaming tablets, & referrals
Communication Methods	Films/videos, formal lecturer, small group, counselling
Monitoring & Evaluation	Monitoring: forms developed to monitor Evaluation: plans for quarterly and final evaluations
Examples of Findings	N/A

Programme Name (description if no title)	**Kafue Adolescent Reproductive Health Project**
Organisation	**Planned Parenthood Association of Zambia (PPAZ) and Family Life Movement of Zambia (FLMZ)**
Contact	Mr. F. J. Phiri, Project Co-ordinator P.O. Box 360254, Kafue Phone: 311665, Fax: 311665; E-mail: kafyth@zamnet.zm
Timeframe	1996-2000 *(per April 1999 correspondence, project extended through 2001)*
Funding/Resources	SIDA (through MOH)
Staff	1 full-time, estimated 150 trained peer educator volunteers & 50 other volunteers
Geographic Area	Lusaka Province (Kafue District: urban & rural areas)
Site Types	Primary/Jr./Sr. secondary school, recreational facility, community centre, community-based organisation/NGO (YFHS), health centre/clinic, street, homes (individual counselling), fish camps
Characteristics of Targeted Youth	Age 10-24; male, female, urban, rural, in-school, out-of-school, married, unmarried, street, workplace, low income, fish camps
Other Targeted or Included Groups	Parents, teachers, health providers
Main Goals	Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE youth development/leadership, gender awareness/education
Implementation Strategy Examples	▪ Peer education/drama to influence positive behaviour change (STD prevention in particular) at Kafue schools & in communities once/week for 2 hours+, reaching an average of 1000 youths/month. ▪ Youth friendly health services in 5 Kafue clinics available everyday, reaching about 100 youth/month. ▪ Training health providers, teachers, & parents in reproductive health/FLE. ▪ "Miss Adolescent" contest organised by youth (December 1997).
Peer Educators	*Incentives:* none *Selection:* first selected by communities then trainers interview *Supervision:* by trainers at each community site *Training:* training in FLE & sexual reproductive health; in-service course for 2-3 weeks each year *Contraceptives/Referrals:* do not distribute condoms; do provide referrals
Communication Methods	Radio, TV, print materials (including newspaper articles), films/videos (UNFPA), drama, songs, games, lecture, small group, large group, counselling, variety shows
Monitoring & Evaluation	Monitoring: youth friendly health services forms; peer education returns Evaluation: SIDA recently conducted one; next to be in December 1998
Examples of Findings	Need for more promotion of youth project & incentives for peer educators (full report not seen yet)

Programme Name (description if no title)	Residential Training Programme For Orphans & Vulnerable Children: Voluntary Counselling and Testing (VCT) Programme
Organisation	Kara Counselling and Training
Contact	Dr. Sonja Weinreich, Voluntary Counselling and Testing Programme Manager P.O. Box 37559, Lusaka Phone: 227086/7; Fax: 229848; E-mail: kara@zamnet.zm
Timeframe	January 1997 - ongoing (current funding through 1998)
Funding/Resources	NORAD, Marie Stopes/Zambia
Staff	20 full-time; 3 volunteers; 2 peer educators
Geographic Area	Lusaka Province (Lusaka District: Lusaka West); Southern province (Choma District)
Site Types	Recreational facility, community centre, health centre/clinic
Characteristics of Targeted Youth	Age 14-30; male, female, urban, rural, in-school, out-of-school, married, unmarried, street, workplace, refugees, low income, orphans
Other Targeted or Included Groups	Parents (counselling & testing); community members (provide input, evaluation workshops, training in foster care)
Main Goals	Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, gender awareness/education; promote human development
Implementation Strategy Examples	▪ About 80 youth/month reached by counselling & testing services offered Monday-Saturday (at Hope House, Chawama, Helen Kaunda, Thornpark). ▪ Orphan girls' practical skills training (predominantly agricultural) Programme through a one year period at Lusaka West farm. First intake last year was 15 girls, now second intake of 22 girls, aiming at a maximum number of 40 by next year when Programme becomes self-sustaining (through reliance on agricultural & other income generating activities).
Peer Educators	*Incentives:* none *Selection:* from within Programme *Supervision:* report to manager once a month *Training:* workshops and group discussions *Contraceptives/Referrals:* do not distribute contraceptives yet; do provide referrals
Communication Methods	Radio, TV, print materials, telephone hotline, film/video, drama, songs, games, lecture, small group, large group, counselling (one-to-one)
Monitoring & Evaluation	Monitoring: weekly & monthly reports on activities/statistics Evaluation: internal & external have been done; not sure of future evaluation plans
Examples of Findings	Programmes are achieving their main goals, but counselling & testing not as self-sustaining as could be (resulted in targeting more people by adding orphan project activities)

Programme Name (description if no title)	Street Children Programmes
Organisation	Ministry of Community Development and Social Services (MCDSS)
Contact	Miss Grace Kasaro, Social Welfare Officer Mrs. Monica Masisani, Senior Social Welfare Officer Community House, Sadyu Road, Lusaka Phone: 223472; Fax: 225885, 234342
Timeframe	November 1992- Ongoing (current funding for 1 year)
Funding/Resources	Government
Staff	District social welfare officers (at least one/district); district street kid committees
Geographic Area	Copperbelt Province (Kitwe District); Southern Province (Kalomo, Livingstone, & Monze Districts)
Site Types	Street, community centre, district social welfare offices, health centre/clinic (through referrals)
Characteristics of Targeted Youth	Up to age 18; male, female, urban, rural, in-school, out-of-school, unmarried, street, low income, destitute or vulnerable
Other Targeted or Included Groups	Destitute or vulnerable parents/guardians/siblings
Main Goals	HIV/AIDS/STD prevention, youth development/leadership
Implementation Strategy Examples	▪ Social welfare officers take counselling course with HIV/AIDS component. ▪ HIV/AIDS/STD information provision to street children through district social welfare officers' community outreach and referrals to health centres. Includes recreational activities (games, sports). Total of 361 reached in 1996, 716 in 1997. ▪ Street kids committees in districts (NGO & government collaboration) ▪ Health Care Cost Scheme is available to all vulnerable people (open to anyone vulnerable including youth) to access health services except for chronic illness that receive free medication.
Communication Methods	Print materials, film/video, games, lecture, counselling
Monitoring & Evaluation	Monitoring: quarterly & annual field reports; annual workshops Evaluation: planned in future
Examples of Findings	N/A

Programme Name (description if no title)	HIV/AIDS Education & Life Skills Programme for Zambia
Organisation	Ministry of Education/Curriculum Development Centre (MOE/CDC)
Contact	Irene Malambo, Sr. Curriculum Specialist P.O. Box 50092, Lusaka Phone: 254071; Fax: 254087
Timeframe	1985-ongoing (current funding 3+ more years)
Funding/Resources	Government, UNICEF, SIDA (WHO initiated the programme)
Staff	1 full-time; 2 part-time; 2 peer educator volunteers who sit on HIV/AIDS Advisory Board Committee
Geographic Area	All 9 Provinces
Site Types	Primary/Jr./Sr. secondary school, college (through the curriculum).
Characteristics of Targeted Youth	Age 7-20; male, female, urban, rural, in-school, out-of-school, unmarried, low income
Other Targeted or Included Groups	Teachers
Main Goals	Unwanted pregnancy prevention; HIV/AIDS/STD prevention, gender awareness/education
Implementation Strategy Examples	▪ Developing HIV/AIDS teachers' resource book (now in draft form) and student curriculum. ▪ In 1993 a national Syllabus Review held by a multi sectoral team of officials recommended that more topics be included in the school curriculum: gender, environment, drug & substance abuse, HIV/AIDS, & human rights. New syllabus introduced 1997. Every subject (e.g. mathematics) included all these topics, and pupils were awarded higher marks as an incentive for answering questions related to these new topics (e.g. HIV/AIDS). However, materials have not been developed at the same pace per subject area as introduction of the syllabus. ▪ A set of 18 books initially developed in South Africa was adapted for Zambia in 1995. Two types: blue for lower grades 1-4, green for upper grades 5-7 (though intended for every school countrywide, they have not reached all intended targets due to fund limitations.)
Communication Methods	Songs (plans to start using different communication channels in future)
Monitoring & Evaluation	[None mentioned]
Examples of Findings	Note: A UNICEF study with 45 FGDs in 3 provinces covering 3 districts (Lusaka, Mazabuka, Monze) found several misconceptions young people have concerning their RH. The study recommended that MOE/CDC produce materials to address them (though severely limited by lack of funds)

Programme Name (description if no title)	Population Education in Formal Education (POPED)
Organisation	**Ministry of Education Curriculum Development Centre (MOE/CDC)**
Contact	Absolom B.K. Nzala, Curriculum Development Specialist P.O. Box 50092, Lusaka Phone: 254071/087 or 250900; Fax: 254071
Timeframe	Pilot project started 1985; government approved 1989. Curriculum to be implemented through 2001
Funding/Resources	UNFPA, Government
Staff	3 part-time (CDC Project Co-ordinator & 2 staff from UNZA that provide frequent TA); 10-24 peer educators (through collaboration with PPAZ & FLMZ)
Geographic Area	All 9 provinces
Site Types	Primary school, teachers colleges
Characteristics of Targeted Youth	Age 7-14; male, female, urban, rural, in-school, unmarried, low income
Other Targeted or Included Groups	Teachers (training in population education); parents (parent-teacher association kept informed); new plan to sensitise traditional healers
Main Goals	Create awareness and understanding of population issues with emphasis on reproductive health
Implementation Strategy Examples	▪ Trained 1228 teachers at teachers' colleges in POPED curriculum. ▪ Integration of population studies into curriculum (e.g. social studies, biology, home economics, environmental sciences). ▪ Future plan for FLE clubs that will be co-ordinated by "matrons" and "patrons" (teachers trained in population education).
Peer Educators	*Incentives:* stipend for workshop *Selection:* based on interest *Supervision:* through collaboration with PPAZ and FLMZ; meet to review work and discuss achievements *Training:* 1 week *Contraceptives/Referrals:* no contraceptive distribution in schools; new objective to have referral system
Communication Methods	Print materials (textbooks), films/videos (UNFPA), games, lectures, small group
Monitoring & Evaluation	Monitoring: each zone reports to their district, district reports to provincial level, provincial level reports to CDC project co-ordinator Evaluation: 1997 (another planned for 1998 or 1999)
Examples of Findings	Achievements noted; 700 teachers not trained that needed to be; use of local language important; reproductive health needed more emphasis

Programme Name (description if no title)	Project for Integrating Health & Family Life Education & Income Generation for Out-of-School Youth
Organisation	Ministry of Youth, Sport, and Child Development/Department of Youth Development (MYSCD/DYD)
Contact	Mr. Kamwambi, Director of Youth Mrs. Fanny Banda, Assistant Director of Youth Mrs. H. Matanda, Permanent Secretary MEMACO House, PO Box 50195, Lusaka Phone: 253871 or 254693/4; Fax: 223996
Timeframe	March 1996-ongoing (current funding until June 1998; need about $400,000 for expansion)
Funding/Resources	UNFPA (logistics), government (staff, facility expenses)
Staff	2 at headquarters in Lusaka; too many to count at other skills centres
Geographic Area	Lusaka Province (Chongwe District); Southern Province (Choma District); Central Province (Mumbwa District); North-Western Province (Kapompo District); Eastern Province (Lundazi District); Northern Province (Mpika & Chinsali Districts); Luapula Province (Samfya District); Western Province (Kaoma District)
Site Types	16 Youth Skills Training Centres (up to 2/province-expansion to all districts proposed)
Characteristics of Targeted Youth	Age 14-25; male, female, rural, out-of-school, married, unmarried, low income, disabled
Other Targeted or Included Groups	Parents (planned), community (provides premises/support of programme)
Main Goals	To empower youth to become self-reliant & to promote FLE & health. Unwanted pregnancy prevention, HIV/AIDS/STD prevention; youth development/leadership, gender awareness/education
Implementation Strategy Examples	▪ FLE/health curriculum implemented in two weekly lessons as part of larger skills/empowerment programme (18-month programmes with average enrolment of 40). ▪ Planned peer education programme: The FLE Programme will include a 10 day intensive "crash" peer educators' course. Participants will be selected from the 40 already enrolled students. The peer educators will be promised loans in return for peer education in their communities upon completion of their skills training. ▪ Work with local authorities (village headmen, chiefs & advisory committees, councils, & rural health centre staff). ▪ Ideas for developing the curriculum, brochures, & flip charts were drawn from youth. ▪ Condoms & referrals provided. ▪ Non-reproductive health (integrated) core services include skills training in various small-business enterprises/handicrafts & credit schemes (loans).
Communication Methods	Print materials, film/video, drama, songs, games, lecture, small group, large group
Monitoring & Evaluation	Monitoring: centre reports; MSYCD staff does on-site observation Evaluation: mini-evaluation in 1997; next planned by June 1998
Examples of Findings	Need for a resource centre to supply staff with information; original targets set too high

Programme Name (description if no title)	**Strengthening NGO Activities in Adolescent Reproductive Health**[4]
Organisation	[In 1999 is **MYSCD/DYD**-based project with 7 consortium members] *At time of interview consortium was* **PPAZ** (project co-ordinator), **YWCA, FLMZ, and MYSCD**
Contact	Mr. L.J. Kamwambi, Director of Youth Development MSYCD/DYD, Lusaka, Zambia Phone: 253871; Fax: 254693 Note: the project secretariat has moved from PPAZ to DYD, where the new project co-ordinator is Patrick Nkandu. (previous contact: Kelvin Sikwibele, Project Co-ordinator; PPAZ, Box 32221 Lusaka; Phone: 228178; Fax: 228165; E-mail: ppaz@zamnet.zm)
Timeframe	February 1996-ongoing (current funding cycle ends approximately June 1998)
Funding/Resources	UNFPA
Staff	1 full-time, 2 part-time (driver & secretary), estimated 40-50 peer educator volunteers/site (about 300 total)
Geographic Area	5 provinces: Southern Province (Livingstone, Choma, & Monze Districts); Eastern Province (Chipata District); Lusaka Province (Lusaka Urban District), Central Province (Kabwe Urban District); Copperbelt (Ndola Urban & Kitwe Districts)
Site Types	Jr./Sr. secondary school, college, university, recreational facility, community centre, health centre/clinic
Characteristics of Targeted Youth	Ages 14-25; male, female, urban, in-school, out-of-school, married, unmarried
Other Targeted or Included Groups	Parents, elders, community leaders (parent-elder education emphasising reproductive health communication with youth)
Main Goals	Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE
Implementation Strategy Examples	▪ Use of PLA during planning and research phases. ▪ 20 peer educators/site trained quarterly for outreach to youth (3 sessions as of February 1998) ▪ Peer/parent education sessions to promote good reproductive health behaviours & communication. Sessions twice a week at the sites, reaching an estimated 30 youths/session.
Peer Educators	*Incentives:* transportation allowance, lunch, stationery (quarterly) *Selection:* at schools (through centre guidance unit); resident development committee; PLA *Supervision:* peer supervisors at each site & resident development committees *Training:* 10-day course held away from homes with parental consent; refresher course & annual peer education training *Contraceptives/Referrals:* distribute condoms & foaming tablets; provide referrals
Communication Methods	Print materials, films/videos, drama, games (competition, quiz), formal lectures, small group, large group, counselling,(future plans for telephone hotline)
Monitoring & Evaluation	Monitoring: peer educators fill in record-keeping forms that a supervisor monitors Evaluation: anticipated programme evaluation in April 1998
Examples of Findings	N/A

[4] Per April 1999 correspondence, this project has entered its second phase of funding and is now known as "Strengthening MSYCD/NGOs in Adolescent Reproductive Health Activities." Please see the addendum to this appendix for additional updated information.

Programme Name (description if no title)	**Adolescent and Youth Education Programme in Reproductive Health**
Organisation	[Co-ordinating role] **Ministry of Health/Health Education Unit (MOH/HEU)** [5]
Contact	Mr. Sikwanda Makono, Health Education Specialist P.O. Box 30205 Lusaka Phone: 222404/224086; Fax: 223228
Timeframe	1995 – ongoing
Funding/Resources	Government grants, UNICEF, WHO, UNAIDS
Staff	3000 volunteers including peer educators [# peer educators not specified]
Geographic Area	All 9 provinces
Site Types	Primary school, jr. secondary school, senior secondary school, college, university, youth centre, health centre/clinic, hospital, street
Characteristics of Targeted Youth	Age 7-25; male, female, urban, rural, in-school, out-of-school, married, unmarried, street, workplace, refugees, low income, girls with multiple partners
Other Targeted or Included Groups	Parents (parent education); neighbourhood committees; nurses (integrate ARH into their curriculum)
Main Goals	Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, youth development/leadership, gender awareness/education
Implementation Strategy Examples	▪ Plays a co-ordinating role ▪ District education officers ▪ Peer education ▪ Health promotion at schools by teachers ▪ Youth friendly services at health centres and mobile locations 3 times/week
Peer Educators	*Incentives:* [not specified] *Selection:* through participatory research; self-selected *Supervision:* monitored time-to-time *Training:* done by participatory programmes *Contraceptives/Referrals:* distribute condoms; other non-prescriptive contraceptives; provide referrals
Communication Methods	Radio, print materials, film/video, drama, songs, games, lecture, small group, counselling
Monitoring & Evaluation	Monitoring: National & community level Evaluation: DHS results (Central Statistics Office)
Examples of Findings	[None mentioned]

[5] Please see the addendum to this appendix for updated information.

Programme Name (description if no title)	**Network of Zambian People Living with AIDS**
Organisation	**Network of Zambian People Living with AIDS** (affiliated with National AIDS Network)
Contact	David Chipanta, Co-ordinator P.O. Box 32717 Lusaka Phone: 223191; Fax: 223152; E-mail: napnzp@zamnet.zm
Timeframe	June 1996 – ongoing (but current funding depleted)[6]
Funding/Resources	Government, UNDP, SAT, PCI
Staff	3 full-time; 5 part-time; 5 volunteers (receive transport and allowances for workshops)
Geographic Area	All 9 provinces
Site Types	NGOs in informal sites
Characteristics of Targeted Youth	Youth with HIV/AIDS, male, female, urban, rural, in-school, out-of-school, married, unmarried, low income
Other Targeted or Included Groups	Anyone (all ages) with HIV/AIDS
Main Goals	Improve quality of life of people with HIV/AIDS
Implementation Strategy Examples	▪ Youth initiated, designed, and are implementing the programme. ▪ Condom provision. ▪ Youth developed booklet on nutrition for people living with HIV/AIDS. ▪ Capacity building workshops to teach positive living and boost esteem of people living with HIV/AIDS (twice every 3 months). ▪ Candlelight memorials once a year.
Communication Methods	Radio, TV, print materials, film/video, drama, songs, lecture, small group, large group, e-mail
Monitoring & Evaluation	Monitoring: track against action plan; reports Evaluation: expected when UNFPA identifies evaluators
Examples of Findings	N/A

[6] Per May 1999 correspondence, the organisation expects continued funding support. A primary funder has been UNDP.

Programme Name (description if no title)	Family Life Education & Youth Development
Organisation	Planned Parenthood Association of Zambia (PPAZ)
Contact	Mr. S.C. Musonda, Executive Director P.O. Box 32221, Lusaka Phone: 228198/78; Fax: 228165; E-mail: ppaz@zamnet.zm
Timeframe	January 1985 - ongoing (current funding for 1 year); new funding expected December 1998 and running under MSYCD/DYD
Funding/Resources	International Planned Parenthood Federation
Staff	17 full-time; 25 volunteer peer educators
Geographic Area	5 provinces: Copperbelt Province (Kitwe District: Mindolo Secondary School, Buchi Compound,) Northern Province (Kasama District: Kasama Town), Southern Province (Livingstone District: Hillcrest Secondary School & Linda/Libuyu), Eastern Province (Chipata District: Chipata Town), Central Province (Kabwe Urban District: Mindolo Secondary School, Bwacha Compound)
Site Types	Jr./Sr. secondary schools, community-based organisation/NGO, health centre/clinic
Characteristics of Targeted Youth	Age 10-24; male, female, urban, in-school, out-of-school, low income
Other Targeted or Included Groups	Parents & elders (trained in FLE and communication with youth; allow use of community centres by out-of-school youth)
Main Goals	Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, youth development/leadership, gender awareness/education, responsible parenthood, establishing good boy-girl relationships
Implementation Strategy Examples	▪ Developed parent-elder PLE training manual. ▪ FLE & peer counselling services: peer educators provide FLE information to fellow youth individually/in groups & also refer youth to various health centres; reach about 10 youth/week (at each regional site). ▪ In- & out-of-school FLE Clubs: reach about 10 youth/week (at each regional site); club leaders are selected/trained as peer educators.
Peer Educators	*Incentives:* none *Selection:* through branch youth advisory committees *Supervision:* regional programme manager & branch executive committee, youth leader collects reports for supervisors *Training:* FLE; annual refresher course *Contraceptives/Referrals:* do not distribute contraceptives; do provide referrals
Communication Methods	Radio, TV, print materials, film/video, drama, songs, games, formal lecturer, small group, large group, counselling, performing arts festivals, debates
Monitoring & Evaluation	Monitoring: FLE reporting and supervisory guide; guidelines for organising & implementing FLE & youth development activities; monthly peer educator activity records Evaluation: individual questionnaires & focus group discussions
Examples of Findings	The project has great potential to reach youth, particularly in Eastern & Central Provinces; need to improve supervision to reduce attrition of peer educators & youth in the programme (evaluation prompted development of supervision guide)

Programme Name (description if no title)	HIV/AIDS
Organisation	Salvation Army
Contact	Colonel T. Shipe, Territorial Commander P.O. Box 34352 , Lusaka Phone: 238291 or 228327; Fax:226784 Email: sathq@zamnet.zm
Timeframe	September 1995 - ongoing (current funding through 2000)
Funding/Resources	Salvation Army-Canada
Staff	1 full-time; volunteers [ongoing recruitment; no # reported], 25 peer educators
Geographic Area	Lusaka Urban District
Site Types	Religious institutions (churches)
Characteristics of Targeted Youth	Age 10-35; male, female, urban, in-school, out-of-school, married, unmarried, street, low income
Other Targeted or Included Groups	Adults (to be involved in encouraging youth), Sunday fellowships (video film shows on AIDS)
Main Goals	Set-up counselling strategies in communities/open counselling centres in communities, HIV/AIDS/STD prevention, unwanted pregnancy prevention (abstinence emphasis)
Implementation Strategy Examples	▪ Drama group activities are major part of programme ▪ Training volunteers in community counselling & HIV/AIDS management; drama group activities ▪ Workshops & video shows at churches
Peer Educators	*Incentives:* none *Selection:* through corps; at churches after showing videos/holding workshops *Supervision:* supervised by parsons *Training:* HIV/AIDS/STD training; exchange programmes with drama troupes involved in HIV/AIDS prevention *Contraceptives/Referrals:* do not distribute contraceptives; do provide referrals to hospitals and clinics
Communication Methods	Radio, TV, film/video, drama, songs, games, lecture, small group, large group, counselling
Monitoring & Evaluation	Monitoring: reports, feedback Evaluation: by regional representatives
Examples of Findings	Though more is needed, awareness raising and counselling are being done right, better to emphasise community counselling more than awareness/sensitisation

Programme Name (description if no title)	Behavioural Change for Youths
Organisation	Sepo Centre
Contact	Mrs. Miniva Mwelwa, Administrator P.O. Box 60545, Livingstone Phone: 321836; Fax: 321836
Timeframe	June 1996 – ongoing (3 months funding secured & waiting for additional)
Funding/Resources	SAAT, NORAD, Government
Staff	2 full-time; 4 volunteers; 20 peer educators
Geographic Area	Southern Province (Livingstone)
Site Types	Primary school (Namatama, Chuungu, Zambezi, Holy Cross); Jr./Sr. Secondary school (Linda, St.Mary's, Hillcrest); College (Dr. Livingstone, Livingstone Institute); recreational facility (Boating club, community centre, Linda Council); youth centre; religious institution (Maramba & Our Lady's catholic parishes; UCZ (Maramba, Coillard), Anglican (St. Andrews)); health centre/clinic (all 12 in urban Livingstone); hospital (Wards 8,9,11); border areas, marketplaces, bars, prisons
Characteristics of Targeted Youth	Age 14-35; male, female, urban, rural, in-school, out-of-school, married, unmarried, workplace, low income, truck drivers, taxi drivers, sex workers; out-of-school youth not involved in income generation activities found in streets, hotels, and bars
Other Targeted or Included Groups	Church elders (invited to behavioural change workshop so they will help youth in their congregation)
Main Goals	Integrated prevention control & care in HIV/AIDS
Implementation Strategy Examples	• Peer educators to enlighten youths about HIV/AIDS/STDs, 3 two-hour sessions/week reaching about 100-200/month. • Sessions on behaviour change for "safer" or "smart" sex to encourage abstinence until marriage, once/week reaching about 150/200 month.
Peer Educators	*Incentives:* none *Selection:* ages 20-51, out-of-school youth found in streets and followed-up on in hotels and bars *Supervision:* report to IEC co-ordinator *Training:* basic facts on HIV/AIDS, basic counselling and communication skills, community-based approaches; 2 peer educators visited CHEP *Contraceptives/Referrals:* provide condoms and referrals
Communication Methods	Print materials, telephone hotline (to talk with psycho-social counsellor), film/videos, drama, songs, games, formal lectures, small group, large group, counselling (personal counselling, group counselling, marriage encounter)
Monitoring & Evaluation	Monitoring: fortnightly questionnaire, staff meetings, monthly meetings with partners PPAZ, CARE, YWCA, clinic & hospital registers Evaluation: planned to happen soon by donors
Examples of Findings	N/A

Programme Name (description if no title)	Peer Education & Promotion Project
Organisation	Society for Family Health (SFH)
Contact	Moses Chanda, Youth Programme Co-ordinator P.O. Box 50770, Lusaka Phone: 292463; Fax: 292443; E-mail: sfh@zamnet.zm
Timeframe	April 1996 - ongoing (contingent on funding)
Funding/Resources	USAID, DFID, JICA
Staff	1 full-time; 32 part-time paid peer educators; 17 CBDs selling products (receive portion of sales profits)
Geographic Area	National (most provinces)
Site Types	Primary school, jr. secondary school, sr. secondary school, college, university, recreation facility, CBD programmes, discos, workplaces
Characteristics of Targeted Youth	Age 14-25; male, female, urban, rural, in-school, out-of-school, married, unmarried, street, workplace, low income
Other Targeted or Included Groups	[unspecified]
Main Goals	Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, youth development/leadership, career guidance, & trainings
Implementation Strategy Examples	▪ Peer educators do HIV/AIDS/STD education in community, schools, colleges, and health centres (quiz and drama activities) 3-5 times/week, reaching about 98 youth/day ▪ "Club NTG" (New Teen Generation) activities and radio show, with emphasis on abstinence, faithful relationships, overcoming peer pressure (assertiveness skills), & HIV/AIDS/STD protection & testing. Educational activities that include quiz, question and answer session, and drama show are held in community, secondary school, college, and health centre venues. About 98 youth reached per clinic event, 500 at community shows. (Radio show reaches weekly about 3 million listeners of Radio Phoenix, 1.7 million Radio 2 & 1.7 million Radio 4.)
Peer Educators	*Incentives:* wages *Selection:* interviewed; previous training and educational experience with YWCA, and theatre background *Supervision:* daily tracking sheets, monitoring reports, biweekly evaluation *Training:* product information, marketing skills, reproductive health group and individual counselling; bimonthly workshops *Contraceptives/Referrals:* distribute condoms & provide referrals
Communication Methods	Radio, TV, print materials (brochures), telephone hotline, films/videos, drama, games, songs (album), lecture, small group, large group, counselling
Monitoring & Evaluation	Monitoring: reports, supervision, meetings Evaluation: review all province activities and sales; next planned around June 1998
Examples of Findings	Found only bus stops and markets visited, so modified programme to include schools, communal places, clubs, colleges, and other identified NGOs to reach more youth

Programme Name (description if no title)	Youth and school activities
Organisation	Society for Women and AIDS in Zambia (SWAAZ)[7]
Contact	Grace Tembo, Co-ordinator Outreach Bernadett Sikanyika, Co-ordinator Lusaka Base P.O. Box 50270, Lusaka Phone: 221738 or 252904; Fax: 222643 or 254809
Timeframe	December 1989 - ongoing
Funding/Resources	NORAD, PCI, WHO, self-funding
Staff	3 full-time; 28 part-time; 3000-5000 volunteers; 60-100 volunteer peer educators
Geographic Area	Copperbelt Province (all districts); Southern Province (Livingstone & Monze Districts); Central Province (Serenje & Kabwe Urban Districts); North-Western Province (Kasempa District); Western province (Seranga & Mongu Districts); Lusaka Province (Lusaka Urban District: Mtendere, Chawama, Kabanana, Matero, Mandevu, Baulani compounds)
Site Types	Primary school, sr. secondary school, community centre, youth centre, religious institution, health centre/clinic, hospital, villages
Characteristics of Targeted Youth	Age 10 & up (below 10 for nursery school); male, female, urban, rural, in-school, out-of-school, married, unmarried, workplace, low income, disabled, HIV positive
Other Targeted or Included Groups	Parents (to improve family communication); community ("community preventive teams")
Main Goals	Empowering youth using community/family units as base. Unwanted pregnancy prevention; HIV/AIDS/STD prevention, FLE youth development/leadership, gender awareness/education
Implementation Strategy Examples	▪ Life skills training and drama activities for economic empowerment ▪ HIV positive youth trained in counselling and do volunteer peer education ▪ Community Preventive Teams trained in counselling, skills training, income generation, leadership training ▪ Condom provision and referrals to health service providers
Communication Methods	TV, print materials, films/videos, drama, songs, games, small group, large group, counselling, police radio, moulds for traditional counselling
Monitoring & Evaluation	Monitoring: monthly reports done for funders and used to monitor progress Evaluation: NORAD funded but findings not yet available; another evaluation planned next year
Examples of Findings	N/A

[7] Please see the addendum to this appendix for updated information.

Programme Name (description if no title)	**HIV/AIDS & STDs Committee Programme**
Organisation	**UNZA Medical Students Association**
Contact	Izukanji Sikazwe, Vice President P.O. Box 50110 RW, Lusaka E-mail: isikawe@hotmail.com
Timeframe	? – ongoing [not specified]
Funding/Resources	UNZA School of Medicine
Staff	16 volunteers; 4 peer educators
Geographic Area	Lusaka Urban District (Lusaka & Chongwe)
Site Types	University, community based organisation/NGO
Characteristics of Targeted Youth	Young adults [no age range specified]; male, female, urban, rural, in-school, out-of-school, married, unmarried, refugees
Other Targeted or Included Groups	Those reached by primary health activities in Chongwe
Main Goals	HIV/AIDS/STD prevention, FLE, primary health
Implementation Strategy Examples	▪ HIV/AIDS/STD prevention programme (education and awareness) at Ridgeway campus and Chongwe community. ▪ Primary health care activities in Village Concept Project in Chongwe community once/week. ▪ Trying to develop educational kits for schools.
Peer Educators	*Incentives:* none *Selection:* volunteered *Supervision:* by executive members *Training:* workshops and academic instruction *Contraceptives/Referrals:* do distribute condoms; do not provide referrals
Communication Methods	Lecture, small group, large group
Monitoring & Evaluation	Evaluation: planned for 3rd quarter 1998
Examples of Findings	N/A

Programme Name (description if no title)	**Recreational activities for youth and refugees**
Organisation	**Young Men's Christian Association (YMCA)**
Contact	Mr. Simukoko, Senior General Secretary P.O. Box 37549 Phone: 260777; Fax: 260777
Timeframe	June 1993 – ongoing
Funding/Resources	YMCA (earned through pre-school and facilities rental)
Staff	17 full-time; 5 part-time; 560 volunteers; 15 peer educators
Geographic Area	Lusaka District (Chongwe, Libala, Kalingalinga)
Site Types	Primary school, jr. secondary school, senior secondary school; community-based organisation/NGO
Characteristics of Targeted Youth	Age 10-26; male, female, urban, rural, in-school, out-of-school, unmarried, refugees, low income
Other Targeted or Included Groups	Community-based distributors, traditional birth attendants (family planning training); community (participated in setting up structures like the pre-school teachers programme)
Main Goals	HIV/AIDS/STD prevention, FLE, encourage HIV testing, communication skills development, counselling provision, reproductive health, family planning, abstinence promotion
Implementation Strategy Examples	▪ Peer educators promote abstinence & behaviour change. ▪ Drama tapes ▪ Health talks ▪ Pre-schools for those who cannot afford high fees Monday–Friday at Kalingalinga and Libala, reaching about 25 & 32 (mostly orphans) respectively/month.
Peer Educators	*Incentives:* workshop transport and lunch *Selection:* selected from branches: persons in charge choose potential peer educators *Supervision:* submit reports for monthly review *Training:* yes [unspecified content] *Contraceptives/Referrals:* do not distribute contraceptives; do provide referrals
Communication Methods	Print materials, film/video, drama, small group, counselling
Monitoring & Evaluation	Monitoring: quarterly & monthly reports Evaluation: NORAD consultants did evaluation but report not ready
Examples of Findings	N/A

Programme Name (description if no title)	**Adolescent Youth Reproductive Health**
Organisation	**Young Women's Christian Association (YWCA)**
Contact	Ann Banda, Co-ordinator P.O. Box 56115, Lusaka Phone: 255204 or 254751; Fax: 254751; E-mail: YWCA@zamnet.zm
Timeframe	1995 – 2001 (current funding through June 1998)
Funding/Resources	UNFPA
Staff	1 full-time; 4 peer educators
Geographic Area	Copperbelt Province (Kitwe District: Twatasha, Chipata); Southern Province (Livingstone District: Mukuni, Malota); Eastern Province (Chipata District: Mucini, Kapata); & Lusaka Province (Lusaka Urban District: Bauleni, Ng'ombe)
Site Types	[unspecified – emphasis on reaching out-of-school youth]
Characteristics of Targeted Youth	Age 12-19; male, female, urban, rural, out-of-school, married, unmarried, low income
Other Targeted or Included Groups	Parents, Elders (parent-elder education programme); community (mapping and selection of peer educators)
Main Goals	To respond to the unmet reproductive health needs of adolescents in project sites. Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE
Implementation Strategy Examples	▪ Peer educators provide reproductive health through community outreach activities 3 times/week in the 4 provinces (in Lusaka about 100 youth reached monthly). ▪ Parent-elder education training programme to improve parent-child and couple communication. ▪ Recreation encouraged as alternative to premarital sex.
Peer Educators	*Incentives:* none *Selection:* were YWCA volunteers nominated because of previous health work experience *Supervision:* report to co-ordinator, supervisor in each site *Training:* training of trainers in reproductive health *Contraceptives/Referrals:* do not distribute contraceptives; do provide referrals
Communication Methods	Print materials, films/videos, drama, songs, games, small group, large group, counselling
Monitoring & Evaluation	Monitoring: forms & reports (quarterly/annually) Evaluation: planned March 1998
Examples of Findings	N/A

Programme Name (description if no title)	**Monika Makulu Youth Drop-in Centre** (named after a late dedicated & founding member devoted to youth issues)
Organisation	**Young Women's Christian Association (YWCA)**
Contact	Ms. Cecilia Chomba, Youth Co-ordinator Along Nationalist Rd., Opposite UTH Mortuary Phone: 252726; Fax: 254751
Timeframe	April 1996 – ongoing (about 3 month funding secured)
Funding/Resources	SIDA, SAAT, UNFPA (funding); UNICEF (books), WHO (posters), USAID (training)
Staff	1 full-time; 3 part-time; 5 volunteers; 20 peer educators
Geographic Area	Lusaka Province (Chongwe & Kafue Districts)
Site Types	Primary/Jr./Sr. secondary schools, recreational facility, community centre, religious institution, health centre/clinic, hospital (referrals for rape/STD cases)
Characteristics of Targeted Youth	Age 14 –24, but have taken on even younger (i.e. have records of ages 3-13); male, female, rural, in-school, out-of-school
Other Targeted or Included Groups	Parents, elders (parent-elder education so they become peer educators also)
Main Goals	To provide information so youth can make informed choices (prevention of pregnancy, HIV/AIDS/STDs, child abuse, drug abuse)
Implementation Strategy Examples	▪ About 20 peer educators trained in reproductive health do one-to one discussions, drama performances & group discussions in schools (have formed "Y-Teen Clubs") ▪ Eight counsellors available at drop-in centre. ▪ Parent-elder education so that they teach fellow peers (e.g., teachers, church elders, nurses, other parents). ▪ Plan to have a youth tribunal in 1998, with testimonies from former clients. ▪ Cases of sexual abuse (3/4 occur within the family) are referred to main (adult) drop in centre for specialised treatment. ▪ Centre offers counselling, career guidance, skills sharing opportunities (discussions on RH, gender issues) and is a resource centre for videos, books, & tapes.
Peer Educators	*Incentives:* Kw5,000/month *Selection:* completed grade 12, ages 18-25, can read & write, have attended workshop in reproductive health *Supervision:* youth co-ordinator supervises on weekly basis, reporting every Friday *Training:* in-service peer educators *Contraceptives/Referrals:* do not distribute contraceptives; do provide referrals
Communication Methods	Radio (2 appearances on Radio 2 for SFH), TV, print materials (YWCA newsletter), telephone hotline, film/video, drama, songs, games, formal lectures, small group, large group, counselling, variety show (1994), plan to have educational debate
Monitoring & Evaluation	Monitoring: [approach not specified]; used for planning Evaluation: has been done [approach not specified]; planned again in 2000
Examples of Findings	Evaluation resulted in modifications to counselling, now intend to use mobile drop-in centre because, though centre is advertised, there is a lack of accessible transport for youth to get there

Programme Name (description if no title)	Youth Skills Enterprise Initiative
Organisation	Young Women's Christian Association (YWCA)
Contact	Mrs. Mwaka Mulenga, Youth Skills Enterprise Initiative Co-ordinator P.O. Box 50115, Lusaka Phone: 255204; Fax: 254751; E-mail: ywca@zamnet.zm
Timeframe	March 1996-June 1998 (seeking new funding to continue programme)
Funding/Resources	Street Kids International (Canada)
Staff	2 full-time; peer educators in new proposal plan (Kw150,000/month stipend)
Geographic Area	Lusaka Urban District (Mtendere & Matero)
Site Types	Community centre (Desai YWCA women's centre), youth centre (Matero)
Characteristics of Targeted Youth	Age 14-20; male, female, urban, out-of-school, unmarried, street, low income, abused, substandard living conditions
Other Targeted or Included Groups	Parents (who have formed support groups); Community (identification of potential participants)
Main Goals	Life skills (HIV/AIDS/STD prevention, FLE gender awareness/education), youth development/leadership
Implementation Strategy Examples	▪ Life skills training clinics offered on a weekly basis at Mtendere & Matero compounds to youth entrepreneurs in training, to raise awareness of issues related to their survival on the streets. About 20 youths reached in 3-month period. ▪ Loans are given to the entrepreneurs after training, once every 3 months, to be paid back with interest. Weekly consultations are provided.
Communication Methods	Radio, print materials, films/videos, drama, songs, games, formal lectures, small group, large group, counselling, peer groups' teamwork
Monitoring & Evaluation	Monitoring: monthly reports to supervisors & donors Evaluation: was done via participatory methodology; next planned June 1998
Examples of Findings	Programme has had positive impact on the lives of participants; they are attaining financial independence

Programme Name (description if no title)	**National Youth Economic Reform Programme**
Organisation	**Young World Association (National Youth Development Council)**
Contact	Barbara Mhlanga, Acting President P.O. Box 34430, Lusaka Phone: 222390
Timeframe	July 1997 - ongoing (expected to continue 6 years, but at present insufficient funds to continue past 3 months)
Funding/Resources	Membership & fundraising activities
Staff	4 full-time; 3 volunteers; 2 peer educators
Geographic Area	Lusaka Province (Lusaka Urban District, Kafue District)
Site Types	Street, constituencies' venues
Characteristics of Targeted Youth	Ages 12 & up; male, female, urban, rural, out-of-school, married, unmarried, street, low income; disabled
Other Targeted or Included Groups	Disadvantaged women, community
Main Goals	Supplement & present government's economic policies; sexual abuse prevention, drug abuse prevention, unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, youth development/leadership, gender awareness/education
Implementation Strategy Examples	▪ Economic empowerment to alleviate poverty & other social problems reaching about 40 youth/constituency [frequency not specified] ▪ Gender awareness to balance & promote female participation/ development
Peer Educators	*Incentives:* none *Selection:* application and membership *Supervision:* none *Training:* peer education programmes *Contraceptives/Referrals:* do not distribute contraceptives; do provide referrals
Communication Methods	Print materials (brochure), lecture, small group
Monitoring & Evaluation	Monitoring: staff have job descriptions/assignments; individual office evaluation Evaluation: reviewed resource shortfalls and recommendations; review every 3 months
Examples of Findings	Education lacking so need for seminars and training workshops

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Programme Name (description if no title)	**Sexual Reproductive Health Project**
Organisation	**Youth Activists Organisation**[8]
Contact	Holo M. Hachonda, Project Co-ordinator Clement Bwalya, Financial Controller Moffat Ng'ombe, Programmes Officer Hilda Dhliwayo, Administrative Assistant PO Box 37230, Lusaka (Plot No. 11296, Nchoncho/Washama Road, Villa Elizabetha) Phone: 239190/4 or 238823/4; Fax: 239195; E-mail: trends@zamnet.zm
Timeframe	April 1997 - September 1998
Funding/Resources	JHU, CEDPA
Staff	6 peer educators
Geographic Area	Lusaka District (Mtendere, Chelston, Chibolya, Chilenje); Kafue District
Site Types	Senior secondary school, youth centre, religious institution, community-based organisation/NGO
Characteristics of Targeted Youth	Age 14-24; male, female, urban, in-school, out-of-school, married, unmarried, workplace, low income
Other Targeted or Included Groups	Community (has provided venues and assisted with logistics)
Main Goals	Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, youth development/leadership, gender awareness/education; male involvement in sexual reproductive health
Implementation Strategy Examples	▪ Awareness programme to provide accurate information on sexual reproductive health (at churches 2 days/week, reaching about 40 youths/week) ▪ Private counselling time at churches one day/week, reaching about 10 youth/week
Peer Educators	*Incentives:* transportation allowance *Selection:* recruited *Supervision:* by programme youth co-ordinator *Training:* basic counselling skills *Contraceptives/Referrals:* do not distribute contraceptives; do provide referrals
Communication Methods	Print materials, film/video, drama, songs, games, lecture, small group, large group, counselling
Monitoring & Evaluation	Monitoring: pre- and post-tests; forms Evaluation: qualitative & quantitative [methods not specified]
Examples of Findings	More sex education activities acceptable at churches; increase plays and games & decrease lectures

[8] Please see the addendum to this appendix for updated information.

Programme Name (description if no title)	Behaviour Change and Education for Life Process
Organisation	**Youth Alive Zambia**
Contact	George Mwila, Assistant National Co-ordinator Sister Luzia, Youth Co-ordinator National AIDS BCP Catholic Secretariat, P.O. Box 31965, Lusaka Phone: 227854/55; Fax: 225289 or 220996
Timeframe	December 1996 - ongoing (current funding through 1998)
Funding/Resources	Misereor Germany, CAFOD
Staff	1 full-time; 250 peer educators
Geographic Area	Eastern Province (Chipata District); North-Western Province (Solwezi District); Southern Province (Monze District); Lusaka Province (Lusaka Urban District: most major compounds); Copperbelt Province (no districts specified)
Site Types	Jr. secondary school (Munali, Libala, David Kaunda, St.Mary's); Sr. secondary school (Kabulonga Boys & Girls); college (Evelyne Hone, Mongu Teachers); recreational facility; Christian community centre; religious institution (catholic & UCZ); street (rallies)
Characteristics of Targeted Youth	Age 10-30; male, female, urban, rural, in-school, out-of-school, married, unmarried, street, workplace, low income
Other Targeted or Included Groups	Parents, home-based care couples, religious people (priests, nuns)
Main Goals	Promoting behaviour change in youth, unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, gender awareness/education
Implementation Strategy Examples	▪ Youth involved in all aspects of programme, e.g. research on youth sexual behaviour, publishing a book and album of songs ▪ Workshops, seminars, and rallies at schools, churches, and colleges to help youth make informed decisions about their lives (full workshop is 4 days long); reaching about 100 youth weekly ▪ National radio programme once/week to sensitise youth and to promote behaviour change
Peer Educators	*Incentives:* none provided *Selection:* [not specified] *Supervision:* [not specified] *Training:* leadership and communication skills *Contraceptives/Referrals:* neither provided
Communication Methods	Radio, TV, print materials, telephone hotline, film/video, drama, songs, games, lecture, small group, large group, counselling
Monitoring & Evaluation	Monitoring: evaluation forms, meetings, use charts and graphs Evaluation: questionnaires, workshop evaluations
Examples of Findings	Behaviour change among those that were sexually active

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Programme Name (description if no title)	**Sex Education to Youth**
Organisation	**Youth Federation for World Peace**
Contact	Elias Shawa, Public Relations Officer P.O. Box 33578, Lusaka Phone: 223378; Fax: 223138
Timeframe	January 1996 – 2000; ongoing (current funding for one year)
Funding/Resources	Family Federation for World Peace & fundraising activities
Staff	24 peer educators
Geographic Area	Lusaka Province (Lusaka Urban District: Lusaka West, Matero, Balastorn Park, Chaisa, Chawama); Northern province (Kasama District); Luapula province (all districts); Southern province (unspecified); Western province (unspecified)
Site Types	Jr. secondary school, senior secondary school, college, university, community centre, youth centre, community-based organisation/NGO, religious institution, health centre/clinic
Characteristics of Targeted Youth	Age 16-30; male, female, urban, rural, in-school, out-of-school, married, unmarried, workplace, refugees, low income, sexually active
Other Targeted or Included Groups	Parents, teachers (participate in seminars; invited to be club patrons), community
Main Goals	Establish a safer world with equal opportunities, access, and security with regard to youth; unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, gender awareness/education (abstinence emphasis)
Implementation Strategy Examples	▪ Peer education ▪ Sex education workshops at the programme sites, reaching about 600 youth/week ▪ Sports clubs to provide youth with alternative activity at secondary schools & colleges/universities about 3 times/week (4 schools in Lusaka) ▪ Sexual purity clubs ▪ Publicity campaign on sexual purity
Peer Educators	*Incentives:* transport and meal payment monthly *Selection:* completed leadership training programme *Supervision:* every team has team leader; everyone reports to headquarters *Training:* leadership training; additional workshops planned *Contraceptives/Referrals:* do not distribute contraceptives; do provide referrals
Communication Methods	Print materials, film/video, drama, songs, games, lecture, small group, large group, counselling
Monitoring & Evaluation	Monitoring: observational visits, membership figures
Examples of Findings	N/A

Programme Name (description if no title)	Trendsetters Newspaper
Organisation	Youth Media
Contact	Mary Phiri, Editor in Chief Mr. Evans Banda, Managing Editor P.O. Box 37230, Lusaka Phone: 239192-94; Fax: 239195; E-mail: trends@zamnet.zm
Timeframe	May 1997 – ongoing
Funding/Resources	JHU (USAID), fundraising, sales, advertisements
Staff	7 volunteers (4 full-time)
Geographic Area	Lusaka Urban District
Site Types	[Points of sale] Jr. secondary school, senior secondary school, college, university, recreational facility, community centre, youth centre, community-based organisation/NGO, health centre/clinic, hospital, street, supermarkets
Characteristics of Targeted Youth	Age 10-30; male, female, urban, in-school, out-of-school, married, unmarried, street, workplace, low income, sexually active, those considering becoming sexually active
Other Targeted or Included Groups	Parents (parent-child communication and reproductive health issues); community (in planning stage and project design)
Main Goals	Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, youth development/leadership, gender awareness/education
Implementation Strategy Examples	▪ Youth run the newspaper production process ▪ 5,000 issues/month of Trendsetters sold at multiple sites ▪ Television documentary on youths' role in national development aired once on national TV
Communication Methods	Radio (advertising newspaper), newspaper, games (contests in paper), small group, large group, counselling (advice column)
Monitoring & Evaluation	Monitoring: deadlines & feedback from public Evaluation: planned for March 1998
Examples of Findings	N/A

Programme Name (description if no title)	**Youth Outreach Association**
Organisation	**Youth Outreach Association**
Contact	Frank Chitalima, Secretary P.O. Box 35587, Lusaka Phone: 290224
Timeframe	June 1994 - ongoing (current funding will last through 1998)
Funding/Resources	UNICEF & fundraising
Staff	5 peer educators
Geographic Area	Lusaka Urban District
Site Types	Primary school, jr. secondary school, senior secondary school, community centre
Characteristics of Targeted Youth	Age 10-30; male, female, urban, in-school, unmarried, low income
Other Targeted or Included Groups	Community (provides venues & mobilise people for group discussions)
Main Goals	Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, youth development/leadership, gender awareness/education
Implementation Strategy Examples	▪ Peer education workshops & talks in schools to create awareness & influence positive behaviours (twice/week reaching about 50 youth monthly)
Peer Educators	*Incentives:* none *Selection:* volunteered *Supervision:* partly by executive members *Training:* leadership skills, self-awareness, skills development *Contraceptives/Referrals:* do not distribute contraceptives; do provide referrals
Communication Methods	Radio, film/video, drama, songs, small group, large group
Monitoring & Evaluation	Monitoring: forms and reports for each activity Evaluation: planned in September 1998
Examples of Findings	N/A

Programme Name (description if no title)	**Youth Enterpreneurship Promotion Programme (YEPP) -** planned health & family planning component
Organisation	**Zambezi Youth Organisation (ZAYO)** [implementing organisation: National Youth Development Council]
Contact	Clement Chinyundu, Secretary YEPP C/O Zambezi Youth Organisation P.O. Box 150098, Zambezi, North-Western Province Phone: 08 371123; Fax: 08 371078
Timeframe	January 1998 – ongoing
Funding/Resources	SNV (Netherlands Development Organisation), HIVOS (Institute for Cupertino with Developing Countries)
Staff	Chairperson, secretary, [unspecified others]
Geographic Area	North-Western Province (Zambezi District)
Site Types	To be determined
Characteristics of Targeted Youth	Age 15-30; male, female, low income; about 15,000 youth
Other Targeted or Included Groups	Government & non-governmental organizations (mobilise them to improve services for youth)
Objective	To improve the standard of living of youth through enterpreneurship development
Main Goals	Promote development of poor & disadvantaged youth (mobilise youth; defend youths' interests; influence & mobilise government & non-government institutions to improve youth services)
Implementation Strategy Examples	▪ Mobilise youth to become members of the Zambezi Youth Body (electorate body for ZAYO). ▪ Identified as priorities: Health & family planning component, Education activities on literacy. ▪ Intend to carry out full programme in microenterprise development implemented through working groups. ▪ Offering training and extension work. ▪ Operating a credit scheme (revolving fund).
Communication Methods	To be determined
Monitoring & Evaluation	Intend to use progress reports, sample surveys on site. Project impact will be measured in terms of increased income, increased livelihood, skills acquired
Examples of Findings	N/A

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Programme Name (description if no title)	**Youth Reproductive Health Project**
Organisation	**Youth Vision Training Organisation**[9]
Contact	Mr. Douglas Chipoya, Research/Information Officer P/B RW 96, University Teaching Hospital, Lusaka Phone: 251200 (extension 4017); E-mail: dmchipoya@hotmail.com
Timeframe	January 1997 for 52 weeks
Funding/Resources	Currently individual efforts sustaining programme
Staff	No full-time; 4 volunteers; 2 peer educators
Geographic Area	Lusaka Province (Lusaka Urban District: Matero & Lilanda)
Site Types	Religious institution (St. John's church), Tuntembas (street vendors)
Characteristics of Targeted Youth	Age 10-24; male, female, urban, rural, in-school, unmarried, street low income
Other Targeted or Included Groups	Intend to involve parents
Main Goals	Pregnancy prevention, HIV/AIDS/STD prevention, FLE, Youth Development/leadership training
Implementation Strategy Examples	▪ Anti-AIDS walk was done once in programme sites [unspecified number of youths were reached]. ▪ Car washes regularly [number of times not specified]. Information was shared and disseminated in the process [unspecified number of youths were reached]. ▪ Group discussions among youths, initially done twice/week but now only once/month due to limited resources [unspecified number of youths reached].
Peer Educators	*Incentives*: none *Selection*: expressed a commitment towards youth work. *Supervision*: by the executive committee *Training*: no formal training *Contraceptives/referrals*: no contraceptives provided, do provide referrals
Communication Methods	Print materials, songs, small group discussions/ training, counselling, walks
Monitoring & Evaluation	Monitoring: reports are prepared for use in planning after a field activity Evaluation: reports
Examples of Findings	Need to involve parents to increase effectiveness

[9] Please see the addendum to this appendix for updated information.

Programme Name (description if no title)	**Youth Committee of the Zambia Association for Researchers in Development (ZARD)**
Organisation	**ZARD Youth Committee** (research subcommittee of a membership organisation)
Contact	Clara Mumba, Chairperson P.O. Box 37836, Lusaka Phone: 222883; Fax: 222883; E-mail: zard@zamnet.zm
Timeframe	July 1995 - ongoing (newly started)
Funding/Resources	Donor depends on who research proposal submitted to
Staff	11 volunteer committee members (committee members are 18-25 years old)
Geographic Area	Determined by research study (studies can be countrywide)
Site Types	Determined by research study
Characteristics of Targeted Youth	Determined by research study
Other Targeted or Included Groups	Policymakers, relevant community members per research topic
Main Goals	Conducting any research related to young people, youth development/leadership
Implementation Strategy Examples	▪ First study was just completed (opinion poll survey of pregnant girls in schools). ▪ Submit proposals for research funding (e.g. for a situational analysis of girl child in newly established co-educational schools). ▪ Youth are research assistants. ▪ Staff training in proposal and report writing; gender training.
Communication Methods	Reports, members from other committees offer TA
Monitoring & Evaluation	Monitoring: member meetings to inform on progress of research activities/assignments
Examples of Findings	N/A

Programme Name (description if no title)	Population Communication Project (youth are target segment)
Organisation	Zambia Information Services
Contact	Mr. Patrick Jabani, Director P.O. Box 50020, Lusaka Phone: 251975; Fax: 251975; E-mail: informza@zamnet.zm IEC Working Group contact (activities targeting rural in-and out-of-school youth): Mr. Daka Innocent, Secretary, Samfya Population IEC Working Group PO Box 68, Samfya Phone: 02-830186
Timeframe	March 1986 - ongoing (programme is being institutionalised)
Funding/Resources	UNFPA & government
Staff	5 full-time
Geographic Area	National (in 54 districts that currently have information officers)
Site Types	Collaborate with partners who target youth: MSYCD, FLMZ, PPAZ,YWCA,MOE
Characteristics of Targeted Youth	All ages; male, female, urban, rural, out-of-school, married, unmarried, street, disabled
Other Targeted or Included Groups	Parents, traditional and opinion leaders (targeted for advocacy messages on issues affecting youths) Community (FGDs to investigate their views on ASRH)
Main Goals	Co-ordination of national IEC subcommittee activities (Thus covers unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, gender awareness/education)
Implementation Strategy Examples	• ZIS is both a chair & secretariat for national IEC sub committee and participates in all activities of Inter-Agency Technical Committee for Population. ▪ Co-ordinating National IEC subcommittee activities. ▪ 1000 copies/province of Pop News distributed quarterly for schools. ▪ Outdoor broadcasts at schools & markets twice/week. ▪ Training national, provincial & district-level information officers in population issues, including ASRH.
Communication Methods	Radio, TV, print materials, film/video, drama, small group, large group
Monitoring & Evaluation	Monitoring/Evaluation: process evaluation and monitoring & terminal evaluation missions by both internal and external evaluators; discussions with programme beneficiaries; next evaluation planned July 1998
Examples of Findings	Programme found to have positive impact, but need to improve & increase human and facility capacities

Programme Name (description if no title)	**Zambia National AIDS Network (youth AIDS organisations are members)**
Organisation	**Zambia National AIDS Network (ZNAN)**
Contact	Patrick M. Salamu, Network Co-ordinator P.O. Box 32401, Lusaka Phone: 231153; Fax: 231154; E-mail: znan@zamnet.zm
Timeframe	1989 - ongoing (currently 5-year funding)
Funding/Resources	SAAT Programme, NORAD, UNAIDS, PCI
Staff	2 full-time; event-specific volunteers (e.g. World AIDS Day)
Geographic Area	National
Site Types	[Not specified - work with youth AIDS organisations.]
Characteristics of Targeted Youth	All ages & types
Other Targeted or Included Groups	Zambian population; community groups & project members (income generating activities, proposal writing, community caregiving)
Main Goals	Liaison, collaboration, co-ordination & networking
Implementation Strategy Examples	▪ Annual ZNAN national conference for information sharing ▪ Quarterly newsletter
Communication Methods	Print materials (newsletter), telephone hotline, lecture, small group, large group
Monitoring & Evaluation	Monitoring: reports, project visits Evaluation: planned 1999
Examples of Findings	N/A

Programme Name (description if no title)	**Street Kids Programme**
Organisation	**Zambia Red Cross Society (ZRCS)** in collaboration with FLMZ
Contact	Joseph S. Kalaluka, Street Educator P.O. Box 50001, Lusaka Phone: 250607 or 254798; Fax: 252219; E-mail: zrcs@zamnet.zm
Timeframe	October 1996 - ongoing (current funding 1year+)
Funding/Resources	ZRCS, donors, contributors
Staff	6 full-time; 4 volunteers; 4 peer educators (in collaboration with FLMZ)
Geographic Area	Lusaka Urban District (Garden Compound)
Site Types	Street (Cairo, Chachacha, & Freedom roads), health centre/clinic, major market places, drop-in centre, university (outreach)
Characteristics of Targeted Youth	Age 18-25; male, female, urban, in-school, out-of-school, unmarried, street, low income
Other Targeted or Included Groups	[None specified]
Main Goals	Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, youth development/leadership
Implementation Strategy Examples	▪ Peer counselling services provided 3 times/week at Chilenge, Kalingalinga, & Chawama clinics; reaching about 64 clients. ▪ Drop-in centre in Lusaka Garden Compound open 5 days/week to help reintegrate street kids into society by providing them with life skills (income generation); food & bathing services (reaches about 300/month at centre); peer educators doing follow-up outreach 5 days/week (about 25 youth/day contacted); & recreation (Saturdays, e.g. T&T gymnasium).
Peer Educators	*Incentives:* lunch when working *Selection:* their interest; talent *Supervision:* FLMZ supervisors *Training:* FLMZ trained *Contraceptives/Referrals:* distribute condoms; do not provide referrals
Communication Methods	Print materials, drama, songs, formal lecturer, large group, counselling
Monitoring & Evaluation	Monitoring: individual client visit forms; monthly monitoring reports Evaluation: planned sometime in 1998
Examples of Findings	N/A

Programme Name (description if no title)	**Educational Programme that includes reproductive health**
Organisation	**Zambia Scouts Association**
Contact	Mr. Paul Kafula, Field Scout Commissioner P.O. Box 31278, Lusaka Phone: 254823; Fax: 254823, Email: zamscout@zamnet.zm
Timeframe	February 1930 – ongoing (duration of RH component not specified)
Funding/Resources	Membership & fundraising activities
Staff	2 full-time; 147 volunteers; 5 peer educators
Geographic Area	National
Site Types	Primary/jr./sr. secondary school, community centre, religious institution, street, Red Cross
Characteristics of Targeted Youth	Age 12-20; male, female, urban, rural, in-school, out-of-school, married, unmarried, street, low income, handicapped
Other Targeted or Included Groups	Volunteers who co-ordinate youth programmes
Main Goals	Develop young people physically, mentally and spiritually so they contribute positively to nation. Unwanted pregnancy prevention, HIV/AIDS/STD prevention, FLE, Gender awareness/education
Implementation Strategy Examples	▪ Peer education, trainings (skills/leadership). ▪ Troop meetings for skills-building at schools, community centres, and churches once/week reaching about 24 youth weekly. ▪ Jamboree camps on skills sharing & management for the 7,200 members (once/year for districts, twice/year national).
Peer Educators	*Incentives:* badges for each activity *Selection:* ability assessed through their performance in Scout activities *Supervision:* district commissioners supervise activities at district level and report to the National Executive *Training:* leadership, communications skills, HIV/AIDS prevention; refresher training *Contraceptives and referrals*: distribute condoms; provide referrals
Communication Methods	Print materials, songs, games, lecture, small group, large group, counselling
Monitoring & Evaluation	Monitoring: reports & forms reviewed Evaluation: once/year; plan for next evaluation when resource people identified
Examples of Findings	Activities needed strengthening

Programme Name (description if no title)	AIDS and Health
Organisation	Zambia Student Christian Movement
Contact	Mr. Gilbert Banda, Executive Director P.O. Box 32834, Lusaka Phone: 702344; Fax: 233372; E-mail: MDF@zamnet.zm
Timeframe	February 1996 – 2002 (current funding expected to last 4 years)
Funding/Resources	PCI & fundraising activities
Staff	13 volunteers who receive training & monthly stipend (Kw50,000)
Geographic Area	Eastern Province (Chipata, Chadiza, Lundazi Districts), Southern Province (Livingstone, Mazabuka, Monze Districts); Lusaka Province (Lusaka Urban District); Central Province (Serenje District)
Site Types	Jr./sr. secondary school (Matero Boys & Girls, Lilanda Basic), college (David Livingstone), community centre, community-based organisation/NGO
Characteristics of Targeted Youth	Age 10-30; male, female, urban, rural, in-school, out-of-school, married, unmarried, workplace, low income, Christian
Other Targeted or Included Groups	People that have left colleges that help in training youth
Main Goals	Unwanted pregnancy prevention (abstinence emphasis), HIV/AIDS/STD prevention, FLE, Gender awareness/education, leadership training
Implementation Strategy Examples	▪ Abstinence promotion activities at schools, such as workshops, plenaries, group discussions, drama (3/week, reaching about 40 youth weekly).
Communication Methods	Radio, TV, print materials, film/video, drama, songs, lecture, small group, large group, counselling
Monitoring & Evaluation	Monitoring: workshop evaluation questionnaires reviewed & reports prepared for use in planning Evaluation: planned in future pending available funds
Examples of Findings	N/A

Addendum

Several organisations provided updates in 1999 as follows.

Alangizi National Association of Zambia

Due to lack of funds and facilities, the Alangizi National Association of Zambia reported (in June 1999) that it has been unable to complete planned youth reproductive health activities in 1998 and 1999. However, in late November 1998, representatives of the organisation toured the rural Eastern part of the country in an effort to educate youths about reproductive health issues. Currently, the association is working to raise funds for office facilities and future projects for youth.

Community Youth Concern (CYC)

New activities of CYC, as reported in June 1999, include a group counselling programme for literacy school students who are orphans or children in especially difficult circumstances. These children are sometimes more easily distracted by stress, and many of them experience abuse, therefore, they need the extra attention to focus on their studies. Additionally, CYC is now part of a consortium of seven organisations supported by UNFPA as a co-ordinated adolescent reproductive health project (see MSYD/DYD update below). Through this initiative, CYC is targeting both in-and out-of-school youth, and aims to empower adults and young people in their communities as peer educators. Sites in Lusaka are as follows: Chawama, Kamanga, Chainda, and Mtendere. School locations include Chawama Basic, Chimwemwe Primary, Mtendere Basic, Mahatma Gandhi Basic, Chitukuko Primary, and the Catholic Open School (for children who cannot afford to attend government schools). Training activities include training of supervisors, parent/elder training of trainers, training parent/elder peer educators, and training youth peer educators. CYC is also conducting public awareness campaigns, one-to-one outreach, and group discussions.

Ministry of Health/Health Education Unit (MOH/HEU)

In June 1999, the MOH/HEU reported it had initiated several adolescent reproductive health programs, as described below.

- Youth Health Promotion Empowerment Project (YHPEP)
  This is a programme to provide health education and sexuality and reproductive health life skills among adolescents. While the volunteer project has adequate human resources for implementation, it lacks material and financial resources to effectively carry out activities.

- The Shelter Africa Health Promotion Project (SAHPP)
  SAHPP is a non-profit volunteer project that includes activities in sexual and reproductive health education, with extension programmes for home-based care of chronically ill individuals, teenage single parents and TB control programmes. It also lacks adequate financial and material resources at this time to implement all planned activities.

- The Programme Against Substance Abuse (PASA)
  This volunteer-led programme aims to teach youth about the links between substance abuse and sexuality and reproductive health.

- The Teenage Mother Health Promotion Project (TMHPP).
  Volunteers with TMHPP have the overall objective of improving the plight of young women's health. It strives to enhance education opportunities for in- and out-of-school youth, and to encourage young mothers to return to school after delivery. It also aims to provide vocational skills and income support activities.

The MOH/HEU also has plans to implement a programme through the Department of Continuing Education that seeks to expand health education skills of youth employed in the formal and informal sector. The graduates of this programme will be pioneers for skills-development training in future health education and health promotion programs. The programme will use a participatory methodology to teach young people how to organise reproductive health and health promotion activities.

Ministry of Youth, Sport, and Child Development/ Department of Youth Development (MYSCD/DYD)

Per April 1999 correspondence, the project formerly known as "Strengthening NGO Activities in Reproductive Health" has entered its second phase of funding and is now known as "Strengthening MSYCD/NGOs in Adolescent Reproductive Health Activities." The expanded consortium of seven members consists of: PPAZ, YWCA, FLMZ, MYSCD, CYC, Young Africans Welfare Association (YAWA), and the Girl Child Adolescent Reproductive Health Project (GARHP). Additionally, the project secretariat has moved from PPAZ to DYD.

Society for Women and AIDS in Zambia (SWAAZ)

Per April 1999 correspondence, youth and school activities have continued to support educating the community through drama. Notably, in addition to reproductive health efforts, SWAAZ youth have been engaged in gender awareness and human rights education for local court justices (with WILDAF). They have worked to reduce inequities by changing discriminatory attitudes among local justices, women, the media, and general public.

Youth Vision Training Organisation

Per April 1999 correspondence, the Youth Vision Training Organisation is seeking funds to implement at project aimed at improving youth's access to information on reproductive health concerns. This initiative focuses on how youth can use information, communication technologies and other print-based information services as a way of increasing their active participation in reproductive health matters. One of the key objectives is to establish a community-based youth health information resource centre.

Youth Activists Organisation (YAO)

YAO provided a descriptive update in April 1999. The organisation was formed in 1995 and most of its members are high school students. YAO is managed primarily by young people with the assistance of a project manager. It includes youth clubs in two secondary schools in Lusaka's rural districts and one community-based football and reproductive health club in Mukwakwa village in Northern Zambia. YAO targets both in- and out-of-school youth and emphasises the following issues through a variety of interventions:

- Adolescent sexuality
- Human and civic rights
- Environmental education
- Child abuse
- Substance abuse
- Communication skills
- HIV/AIDS education for young people

YAO provides leadership training in these programmatic areas and organises activities mainly through schools. YAO has also worked in partnership with local churches to promote sexual/reproductive health and family planning education efforts in five communities in Lusaka. The organisation also maintains close links with several local and international health organisations. YAO is receiving support for projects through Johns Hopkins University/Population Communication Services (JHU/PCS), Centre for Development and Population Activities (CEDPA), and USAID.

YAO is currently working with JHU/PCS to increase male involvement in sexual and reproductive health and family planning programs throughout Zambia through the father-son football (soccer) initiative. They have trained 50 peer educators in Kafue and have facilitated peer education sessions on sexual and reproductive health for more than 150 in Chongwe, Kafue, and a fishing camp in Nchelenge district.

YAO has also been instrumental in introducing "Africa Alive!" in Zambia. Youth football and sexual reproductive health training camps were held in Chongwe, Kafue, and Nchelenge in 1998, and targeted 14-25 year old in-and out-of-school males.

YAO conducted interfaith outreach sessions in December 1998, including a five-day training course for 20 youth on facilitation and basic communication skills. YAO selected the participants from churches where it had worked previously and from a group of young people nominated by an Interfaith Committee. All participants had received prior training as peer educators, thus they had knowledge of sexual and reproductive health issues. The training course focused on participatory methods, facilitation skills and activity planning and implementation. The workshop was intended to prepare church youth leaders to initiate health promotion activities within their communities and work with the Interfaith Committee to strengthen existing programs.

As of May 1999, YAO has been working on the Schools Outreach Session. The project involves working with schools in Lusaka, Copperbelt, and Southern provinces to enrich anti-AIDS clubs in five schools in each province. So far, the training sessions have reached 400 students in the two pilot demonstration sites. YAO, in co-operation with members of Ubwato Ne Nkafi Theatre Group and Club NTG, will conduct 15 five-hour participatory learning sessions in the fifteen schools chosen for the intervention. With the assistance of Family Health Trust, YAO will work through the existing Anti-AIDS clubs to build on their programs. The districts chosen for this intervention already offer youth-friendly health services. Eventually, YAO hopes to reach 750 students in the three districts with this program. In consultation with school leaders and the Anti-AIDS clubs, YAO chose two students to attend the Youth Leadership Workshop held in June 1999.

The Schools Outreach Session project includes three objectives:
1. Introduce youth to basic concepts of sexual and reproductive health
2. Encourage youth to actively seek youth-friendly health services
3. Motivate youth to initiate their own health promotion activities.

In June 1999, YAO plans to bring together the 30 leaders from intervention sites to participate in the Youth Leadership Workshop. YAO will introduce participants to the Participatory Learning Manual and help each team design an action plan for initiating health promotion activities in their school. Youth from the same districts will be encouraged to work together to promote area-wide programmes involving youth from other schools. YAO will lead the workshop in collaboration with Ubwato Ne Nkafi and Club NTG.

In addition to the training activities described above, YAO has developed several materials during 1998 and 1999. They produced the Training of Trainers curriculum, focused on improving peer educators' communication and facilitation skills. The curriculum includes information on project planning, management, implementation, monitoring, and evaluation. This curriculum was used at the Interfaith Outreach workshop. YAO has also produced a curriculum for the Schools Outreach Session that will help them conduct sexual and reproductive health sessions in 15 schools through the anti-AIDS clubs. Additionally, they have developed a participatory learning manual based on their experience with this methodology and the "enter-educate" approach. This manual is intended for use in future youth leadership workshops implemented by YAO, and it will also be made available to various local youth organisations interested in using this approach.