

Perception of Adolescents on Sexual and Reproductive Health Services (SRHS) in Chipata Township, Lusaka-Zambia.

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Abstract- This study was purposed to establish the perception of adolescents on sexual and reproductive health services (SRH) in Chipata Township of Lusaka district in Zambia. The study focused on three main thematic areas, including; identification of factors leading to adolescents’ taking up of sexual and reproductive health services; determination of barriers to accessing and utilizing SRH services among adolescents, and identification of the role of guardians/parents and health care providers in the access of SRH services by adolescents. As a case study analysis, the study used a qualitative research approach with purposive and convenient sampling as techniques in which 32 participants who were adolescents’ boys and girls, health service providers and parents/guardians featured. Research instruments used included in-depth structured interviews. The data were analysed through thematic and content coding of emerging pertinent commonalities in views of participants. The study revealed that among the several factors which lead adolescents to access the sexual and reproductive health services were: fear of getting pregnant; postponement of early marriages, and finding someone to talk and to know more about sexuality. Contrariwise, among the key barriers to service accessibility were negative attitude by health service providers; lack of information on the services and their availability; long waiting hours and long distances to the health centers; lack of confidentiality among health service providers which lead to lack of trust; non-availability of most essential contraceptives in health centers (method mix); cultural norms which prevent adolescents from accessing contraceptives e.g. no sex before marriage and providers being adults only. The study further established that parents and health care service providers play critical roles such as providing and promoting SRH information and offer curative services respectively. The study recommends that government through the Ministry of Health should strengthen training programs in adolescent health for service providers; adolescents and young people should be involved in program planning, service delivery, and information dissemination; strengthening community structures for supportive environment and use of innovative approaches such as social media in delivering social and behavioral change communication (SBCC) rather than the traditional information, education and communication (IEC) materials.

Index Terms- Adolescents, Perception, Reproductive Health Services, Sexual.

I. INTRODUCTION

Zambia is a landlocked country with a youthful population in which the youth comprises 68% of the population according to the National Youth Policy (2015). This population is faced with a lot of sexual and reproductive health (SRH) challenges such as teenage pregnancies, early and child marriages, Sexually Transmitted Infections (STI) and Human Immunodeficiency Virus (HIV), unsafe abortions, and Drugs and Substance abuse among others. Despite Zambia being a signatory to many global, international and regional commitments that seek to advance the sexual and reproductive health of the general population i.e. women, men and young people, these challenges still pose a huge burden on the majority Zambians compounded with poverty. Among the many commitments / conventions signed and domesticated by Zambia include; the East and Southern Africa (ESA) Commitment of 2013 which seeks to advance youth friendly health services; the Africa Union Continental Policy on Sexual and Reproductive Health 2010 that seeks to address maternal mortality; and the sexual and reproductive health of the general population including adolescents; The Campaign to Accelerate Reduction of Maternal Mortality in Africa (CARMMA) 2010, and the International Conference on Population and Development (ICPD) which seek to ensure universal Access to reproductive Health Care for the general populous. Additionally, the United Nations Millennium Development Goals (MDGs 2000 – 2015) sought to address maternal mortality, gender equality and access to education. There are several interventions by the government of the Republic of Zambia complimented by cooperating partners and other civil society organizations, yet the sexual and reproductive health trends among adolescents are not changing significantly. For example, in 2014 according to the ZDHS, the teenage pregnancy rate was at 28% while in 2018 it went up to 29%. This research, therefore, sought to explore perceptions among adolescents on sexual and reproductive health information and services poised to explore major reasons as to why young people do not take up sexual and reproductive health services despite so many multimillion interventions sponsored by the government and the

donor community. The findings should help shape the programming perspective for better responses to the ADH needs.

1.1. Problem Statement

Sexual and reproductive health service utilization by the adolescents is pathetic. This is reflected in the ill health of young people among many other issues. Adolescent pregnancies are on the increase as the number of schools' dropouts are very high year in year out among adolescent girls. For example, the Ministry of Education through its Statistical Bulletin indicated that 13,640 girls dropped out of school in 2017 due to unplanned adolescent pregnancies. In 2018 according to the ZDHS, child marriages increased from 28% to 29%. Utilization of contraceptives or modern family planning methods is also low among young people in Zambia. Low condom use contributes to transmission of sexually transmitted infections including HIV/AIDS and unplanned pregnancies. In order to address the various barriers responsible for these indicators, there is need to effectively understand and further engage the different actors especially at the community level on social and gender norms.

1.2. Study Objectives

1.2.1. Main Objective

To establish the perception of adolescents on sexual and reproductive health services (SRH).

1.2.2 Specific Objectives

- i. To identify factors which lead adolescents to take up SRH services, particularly contraception services.
- ii. To determine barriers to accessing and utilizing SRH services among adolescents
- iii. To ascertain the role of guardians/parents and health care providers in addressing adolescents' access to SRH services.

II. LITERATURE REVIEW

1.2. Background

Globally, adolescents face different sexual and reproductive health challenges such as lack of access to quality SRH information and services, teenage pregnancy, drugs and substance abuse, sexual abuse, rape, defilement, unsafe abortions, STIs and HIV among other. This is because most adolescents are sexually active. Similar trends are happening in Zambia as well. About 32% of adolescents aged 15 to 17 years and 60% of those aged 18-19 years are sexually active in Zambia; but only 40% of adolescents report regular condom use (ZDHS 2018). The adolescent girls who are not using condoms or contraceptives are at greater risk of contracting HIV and other STIs and having unplanned pregnancies with some of them ending in maternal mortality caused by unsafe abortions or because their bodies are not fully developed to go through delivery. According to the ZDHS (2018), about 6 Girls who give birth during adolescent years have a greater risk of death than women who have children in their early 20s, and their babies are at a higher risk of negative health outcomes or complications such as low birth weight and greater risk of neonatal death. Almost 1 in 5 adolescent girls aged 15 to 19 is already married (compared to only 1 in 100 adolescent boys). One (1) out of every 4 girls aged 17 is either pregnant or already has a child; by age 19, this figure

is 6 out of every 10 girls. Many of these pregnancies are unplanned; 25% of married adolescents have an unmet need for contraceptives, and this figure is likely higher among unmarried adolescent girls. Between a period of 5 years i.e. 2013 and 2018, Zambia recorded an increase in the number of teenage who have begun child bearing. According to ZDHS 2013/14, 28% of teenage girls had started bearing children while in 2018 it was at 29%. Adolescents are also affected by HIV and AIDS. According to the ZDHS (2018), HIV prevalence among youth aged 15-24 who have had sexual intercourse in the past year, 3.8% are HIV positive. The trend is that HIV prevalence among youth is higher in urban areas (5.3%) than in rural areas (2.6%). HIV prevalence is higher among young women than young men (5.6% versus 1.8%). This is the reason why it was important to investigate factors that prevents adolescent girls from accessing SRH services. The perception also affects the service uptake. Understanding the adolescents' perception is key in determining the nature of interventions needed in order to help rescue the situation.

1.1. Contraceptives Utilization and Barriers among Adolescents and Young People

Family planning represents a 'best buy' in global efforts to achieve sustainable development and attain improvements in sexual and reproductive health. Ensuring access is amongst key transformative strategies that underpin health and sustainable development. It confers fertility choices on women and couples within a human rights framework. By meeting contraceptive needs of all women, significant public health impact and development gains accrue. At the same time, governments face the complex challenge of allocating finite resources to competing priorities, each of which presents known and unknown challenges and opportunities. As such, there is a need to carefully consider the estimated costs and benefits for each proposed investment in health, education, social welfare, and security. Zambia has experienced a slow but steady increase in contraceptive prevalence, with slight decline in total fertility rate (TFR), over the past 20 years. Increasing voluntary modern contraceptive use among women offers opportunities to reduce unintended pregnancy while effectively harnessing the demographic dividend in order to bolster socioeconomic outcomes for households and communities.

The African Union in 2017 declared a theme dubbed *harnessing demographic dividend through investing in the youth identified family planning as one of the key pillars of investments*. This means reduction in maternal mortality and encouraging economic independence as most investment will be in education instead of family responsibilities. Therefore, making investments in voluntary family planning (FP), underpinned by a human rights framework as a pillar for accelerating development and socio-economic advancement is of paramount importance. Through multilevel interventions aimed at averting unintended pregnancies, Zambia – and other low- and middle-income countries – can reduce their age dependency ratios and harness economic growth opportunities awarded by the demographic dividend while improving the health and quality of life of the population.

Among the goals set by the global community for sustainable development is Goal 3.7, "By 2030 ensure universal access to sexual and reproductive health care services,

including family planning (FP) information and education, and the integration of reproductive health into national strategies and programs." Meeting all contraceptive and maternal and newborn health care needs would result in substantial health and development gains, yielding dramatic reductions of unintended pregnancy, safe and unsafe abortions, maternal deaths, and newborn deaths. Investments in family planning offers benefits beyond fertility, further downstream of the maternal and newborn care continuum. Low-income countries with high fertility rates are at risk of having poor maternal and child health, economic stagnation, environmental degradation, and political unrest. Countries in general that do not utilize FP have been trapped in a vicious poverty cycle, with women bearing a disproportionate burden.

Despite the greater investments in family planning in Zambia, Adolescents' access to the services is not appealing. Data from the 2018 Zambia Demographic and Health Survey (DHS) reveal that 20% of women of childbearing age have an unmet need for FP, meaning that about 20% of married women of childbearing age wish to prevent or delay childbearing but are not using any form of family planning. In addressing unmet needs, efforts to expand FP access may focus either on the concerns and needs of women who have never used or women who discontinued the use due to stock-outs, side-effects, partner preferences, or other reasons.

In addition to having high levels of unmet needs, Zambian women commence childbearing early, with more than one-third reporting they gave birth before their 18th birthday and more than 50% by age 20. Among adolescent girls aged 15–19, 29% had given birth or been pregnant, with a median age of 19.1 years for first birth. While child marriage in Zambia has declined in recent years, over 30% of girls aged 20–24 reported being married before age 18, one of the highest rates in the world. The culmination of early childbearing and unmet needs for FP contribute to a high birth rate in Zambia, at 40 per 1,000 populations per year, by contrast with the worldwide average of 19 per 1,000. The Government of the Republic of Zambia (GRZ) has been actively working to generate demand, expand dialogue on FP, and improve FP access and quality in a coordinated effort guided by the national costed implementation plan. This plan emerged in response to the 2012 London Summit on Family Planning, where the government articulated several commitments to improving contraceptive outcomes by 2020, including a commitment to increasing voluntary FP access for those in need by doubling its budget for FP commodities and enhancing community-based outreach, with the goal of reaching a modern contraceptive prevalence rate of 58%. As of August 2016, GRZ reported substantial progress in securing FP commodities and building provider capacity, as well as engaging traditional and religious leaders in dialogues surrounding child marriage and adolescent pregnancy.

GRZ's focus on adolescents and rural women is critical, since these groups have historically lagged in contraceptive uptake. Strategies to engage adolescents include continued support of comprehensive sexuality education in schools through capacity strengthening of teachers and peer educators, identifying youth-friendly service access points and address existing stigma at health facilities inhibiting youth FP uptake, and clarifying age of consent regulations to improve youth access. In addition to FP demand generation and securing FP commodities for these groups,

it is also important to combine FP efforts with other policy interventions, particularly those aimed at reducing early marriage and promoting school retention for girls.

Decades of research have clearly established the benefits of voluntary FP services as a health, development, and human rights priority. It has a direct impact on women's health and socio-economic development. There is a pressing need to invest more in voluntary FP services in general and, specific to the Zambian context, to realize the development potential associated with high and sustained contraceptive use. This requires the engagement of diverse stakeholders, economic and planning decision-makers, as well as traditional and religious leaders. With proper planning and investments in FP and related supportive programs the country is poised for improved health among its citizens especially the adolescents' girls, spurring long-term economic growth and continued improvements in education, and overall quality of life.

In order to address the various barriers responsible for these indicators i.e. teenage and unplanned pregnancies, maternal mortality, sexual transmitted infections, HIV, abortion among other, there is need to effectively understand and further engage the different actors especially the adolescents themselves and communities in order to address social and gender norms. Health system efficiencies and effective prioritization is key to attaining improved health outcomes for the Zambian population particularly adolescents. While a clear process for planning and budgeting is routinely followed and theoretically guides prioritization of health service delivery, guidance for administrators and clinicians in optimizing the impact of their programmatic decision making is insufficient especially due to absence of the data regarding adolescents perceptions of the intended program focus. Providing sufficient data-driven evidence and guidance to optimize programmatic decision making requires a systematic approach to strengthening systems and building capacity. It is therefore imperative to interrogate adolescents' perceptions of the SRH services as well so as not to be shooting in the air with the programs.

In relation to fertility, according to the Zambia Demographic Health Survey of 2018, Zambia has one of the highest total fertility rates in the world (4.7 children per women), urban areas have a lower TFR (3.4) than rural areas (5.8). This could be attributed to different reasons including lack of access to modern contraceptives, sexual gender-based violence, early marriages and teenage pregnancy. The percentage of women aged 15-19 who have begun childbearing increases with age, from 6% among those age 15 to 53% among those age 19. In Zambia currently about 20% of women in reproductive age group have unmet needs for modern contraceptives. The low utilization of contraceptives also contributes to the high fertility rate.

Adolescent fertility comes with its own challenges. The physiological, educational, or economic consequences of adolescent fertility do not occur in a social vacuum. Social contexts shape the consequences of physiological and demographic events in subtle yet profound ways. One much-discussed example of how biology and society interact is the "biosocial gap" between menarche and socially sanctioned childbearing. The wider this gap, the greater the likelihood of conceiving an unsanctioned child. More generally, society shapes key values that dictate when young women begin bearing children and how their giving birth is regarded by their families as well as

by health and welfare services. For very young married women living in rural areas, where society may define early childbearing as normal and even desirable, the social and economic risks of not bearing children probably outweigh the physical risks of bearing children. By contrast with remote rural areas, urban areas have better health care facilities, not to mention long-term educational and training opportunities—factors that should, in theory, improve health outcomes for young women and their children. The government through the Ministry of Health has made marked efforts to provide primary health care and maternity services for mothers and young girls in the past years. Yet although many of the risks of adolescent pregnancy can be offset by affordable prenatal care and the use of contraceptives, adolescents often avoid public medical facilities where their presence would expose the fact that they were engaging in illicit sexual activities.

Access to health services at the health centers by adolescents has a lot of issues such as the crowdedness of the facilities. It is a good idea to have all services available at the center, yet the popularity of clinics is also a drawback to adolescents. The consulting area offers little privacy, especially, as is often the case, if it is separated from the waiting area only by a thin cloth. The crowded waiting room is constantly buzzing with gossip: whose child has been sent to secondary school, who was seen alone with whom, who may be pregnant, who is leaving her husband, and so on. The sheer lack of privacy surfaces in other ways as well. Clients know that records are written down and kept and that clinic staff are frequently their neighbors or relatives. It becomes more difficult if the pregnant adolescent with no sanctioned attachment to a man to fare in such a setting. Many pairs of eyes shrewdly appraise her condition and exchange contemptuous looks. Some women actually make comments, and all ears are trained to the consulting area as she enters. While being attended to, she is likely to be chastised by the attending staff for her condition, and her morals are likely to be loudly questioned.

Reducing adolescent fertility and addressing the multiple factors underlying it are essential for improving sexual and reproductive health and the social and economic well-being of adolescents. There is substantial agreement in the literature that women who become pregnant and give birth very early in their reproductive lives are subject to higher risks of complications or death during pregnancy and birth than their peers, and their children are also at greater risk of morbidity and death than children born to older women. Therefore, preventing births very early in a woman's life is an important measure to improve maternal health and reduce infant mortality. Furthermore, having children at an early age curtails a woman's opportunities for socio-economic improvement, particularly because young mothers are less likely to keep on studying and, if she needs to work, may find it especially difficult to combine family and work responsibilities. The adolescent birth rate also provides indirect evidence of young people's access to health services since youth, in particular unmarried adolescent women, often experience difficulties in access to sexual and reproductive health services.

1.1. Gaps in Literature

The absence of studies on the perspective of adolescents on sexual and reproductive health services was identified as a potential data gap. Although most studies have been done regarding adolescents' teenage pregnancy, factors affecting

teenage pregnancy, effective adolescent health programming, evaluation of school re-entry policy and health consequences of early sexual debut, none of the studies have been able to dig deeper and get the perspective of adolescents and young people on how they feel about the adolescent sexual and reproductive health services along with the role of parents/guardians and health care providers in addressing their plight. Most programs are designed and implemented to help address the sexual and reproductive health of adolescents and young people and yet the situation seems not to be changing for example teenage pregnancies still remain high at 29% according to the demographic health survey of 2018 (ZDHS 2018) which is a 1% increase from 2014 studies. School dropouts have also continued to increase. One wonders whether interventions are working or are not being executed to deal with the specific issues. Therefore, this research sought to explore the perspective of adolescents and young people on sexual and reproductive health services.

1.1. Theoretical Framework

Access to Health care services by adolescent and young people is dependent on a number of factors including attitude of the service providers, availability of the services, distance to the service delivery points and also awareness on the services. It is also the issue of behavioral change. This study was anchored on the behavior change theory by Piotrow *et al.* (1997) which claims that behavior change is a process and thus it must go through 5 stages. The professed stages are i.e. *Knowledge, Approval, Intention, Practice and Advocacy* (KAIPA). This model is believed to transform and facilitate behavior change in that it proposes that before change in practice and attitude, there is need for Knowledge. After acquiring knowledge, it must be approved, then intention to act develops, from intention they move to practice and then advocate for the issues. It is indeed difficult for a person to adopt new behavior. This theory will be tested in relation to adolescents' uptake of the sexual and reproductive health services.

Crucially, it is professed that sexual and reproductive health and rights (SRH) are essential for sustainable development because of their links to gender equality and women's wellbeing, their impact on maternal, newborn, child, and adolescent health, and their roles in shaping future economic development and environmental sustainability (www.government.nl). Yet, in many parts of the world, sexual and reproductive health and rights (SRH), are not universally protected, promoted and fulfilled because of weak political commitment, inadequate resources, persistent discrimination against women and girls, and an unwillingness to address issues related to sexuality openly and comprehensively. As a result, many people have inadequate sexual and reproductive health services over the course of their lives. The many manifestations of this lack of SRH include a high number of unwanted (teenage) pregnancies, many unsafe abortions, high maternal mortality and morbidity, a continuation of the HIV-epidemic.

It is assumed that young people face disproportionately large obstacles when it comes to their SRH. With the biggest cohort of young people ever, SRH for all cannot be achieved without taking the needs and aspirations of young people seriously and without informing them on their possibilities and available choices. If young people are better informed about their options,

and if this translates to change in attitude and behavior, they may be better equipped to make healthy choices. If, at the same time services are if addresses specific needs, the number of unwanted pregnancies, the number of (unsafe) abortions and the number of STI's, including HIV, and maternal mortality will decline. This will also contribute to gender equality, justice and generational equality on the longer run.

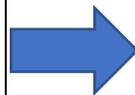
1.2. Conceptual Framework

Adolescent and young people whether male or female need sexual and reproductive health information and services in order to lead carefree lifestyles. However, the gender, sex and education levels have a bearing on their behavior according to how they are socialized. This can also affect their self-esteem which can be low,

moderate or high. The upbringing compounded with the attitude of the service providers can affect their perception of the adolescent sexual and reproductive health information and services. This may also have effect on the utilization of the sexual and reproductive health information and services. Figure 1 below depicts the study's conceptual model in which information / service availability, attitude of service providers, bio data and literacy levels (independent variables) are causal to effective utilization of sexual and reproductive health services (dependent variable). The perception of adolescents on sexual and reproductive health information and services is depicted as a moderating variable

Independent variables

- Information on SRH Services
- Attitude of the service providers i.e. Judgmental, authoritative,
- Availability of the services
- Age, Sex and Gender
- Literacy levels



Perception of adolescents on Sexual and reproductive Health information and Services



Dependent variable

Utilization of Sexual and Reproductive Health information and Service

Figure 1: Study's Conceptual Framework
Source: Researcher's Construction (2020)

III. METHODOLOGY

The study utilized the Case study research type. Yin (1984:23) defines the case study research method "as an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used. According to Block (1986) the detailed qualitative accounts often produced in case studies not only help to explore or describe the data in real-life environment, but also help to explain the complexities of real life situations which may not be captured through experimental or survey research. Although case study methods remain a controversial approach to data collection, they are widely recognised in many social science studies especially when in-depth explanations of a social behaviour are sought after (Yin, 1994). The target population for this study was the adolescent and young people aged between 16 years to 24 years. According to the world health organization adolescents and young people are defined as people aged between 10 – 24 years, www.who.int.

The study was targeted at the adolescents and young people in Lusaka's Chipata Compound which has a total population of about 45,000 people of which about 9,000 (20%) are adolescent and young people aged 15 – 24 year. The study was targeted at both girls' and boys' adolescents and young people in the compound. The sample was drawn from the adolescents and young people who frequent Chipata Health Centre through the youth friendly health corner as the main target group. Other secondary audience included the health care providers at the health center and adult parents through the neighborhood health committee (NHC) which is found at the Clinic. The neighborhood health committee of the clinic comprise different people from the communities where a clinic is. There main duties include governance of the community-based health programs such as health promotion and demand creation. The study sample size was purposively and conveniently sampled from this group based on the arguments by Altunisik et al., (2004) that a sample size between 30 and 500 at 5% confidence level is generally enough for a qualitative research. The data collection tools included in-depth interviews with health care providers, adolescents, parents/guardians and monkey methods to a limited degree. In order to come to a conclusion of the findings, the study

utilized content and narrative analysis method (Thematic analysis). This method is used to analyze content from various sources, such as interviews of respondents, observations from the field, or surveys thus making it more appropriate to use this method for this study according to Mike Allen (2017).

Ethically, the study ensured that all the study participants were aware of the study and willingly offered themselves to participate without being forced or coerced. Interviews were then administered after appointments were scheduled so as not to inconvenience anyone. To ensure maximum protection of the research participants, the study endeavored to adhere to study ethics. Anonymity and informed consent were upheld in this study. According to Bryman & Bell (2007), it is important to consider the following: research participants should not be subjected to harm in any way whatsoever, respect for the dignity of research participants should be prioritised, full consent should be obtained from the participants prior to the study and the protection of the privacy of research participants has to be ensured.

IV. FINDINGS AND DISCUSSION

1.1. Adolescents Perception of SRH Services

Generally, the study established that there is an understanding of what sexual and reproductive health is among most adolescents. Even though most adolescents could not give a precise definition as per World Health Organization, they were able to state what it implies including giving examples. It was commonly understood as a complete wellbeing of an individual in relation to reproductive health process. "Sexual and reproductive health is a state of physical, mental and social well-being in relation to sexuality. Reproductive health is the complete state of physical, mental and social well-being and not merely the absence of disease or infirmity with relation to the reproductive system", stated one participant. Another participant indicated that it is a holistic state of health which encompasses not only the physical but the mental and social state relating to the reproductive system of a human being. According to Amnesty international (Amnestyus.org), Sexual and reproductive health (SRH) is an essential component of the universal right to the highest attainable standard of physical and mental health enshrined in the Universal Declaration of Human Rights and in other international human rights conventions, declarations, and consensus agreements. Sexual and reproductive health needs must be met for both men and women.

On the other hand, most adolescents and young people indicated that trained adolescents or young people should provide the SRH services. This is because they can relate at personal level. *"I can express myself very well because they are able to relate to my situation than adults who only lecture you", adolescent girl.* Others stressed that peer educators or someone who is trained in ADH can be best suited to render such services as they are free to interact with them. It's easier for adolescents to talk to a fellow youth on matters affecting them even in the case of accessing SRH services. There is no judgmental tone from fellow young people especially those that are SRH activist as earlier mentioned. A young advocate who can render services to fellow young people in a user-friendly manner is of utmost significance to them. Nevertheless, others still felt that trained health care workers such as nurses, clinical officers and counsellors can also make good

providers including teachers, trained health personnel should be the best service providers, reason being they will give accurate and correct information once an adolescent want to access a service.

1.3. SRH services which Adolescents Seek and Why

Adolescents seek several sexual and reproductive health services. The services should be provided on a need basis. Among the many services that adolescents seek, the following were prominently stressed: Contraceptives such as condoms, pill, implants and injectables; menstrual health management, sex education, HIV information and testing services, emergency contraception, circumcision, family planning and IEC on SRHR, mental health, safe abortion services, counseling services including on alcohol and substance abuse, screening and treatment for sexually transmitted infections and access to information on how to use modern contraceptives. Indeed, adolescents equally have the right to health care services (IPPF, 2008) and their privacy must be respected. Human rights standards require states to respect, protect, and fulfill the right to sexual and reproductive health, and states must also ensure that individuals have the opportunity to actively participate in the development of health care policy and in individual care decisions according to Amnesty International US (Amnestyus.org).

Furthermore, the study established many reasons why adolescents and young people seek out the SRH services. Prominent among them being: to prevent pregnancies; to prevent STIs; curiosity; peer pressure e.g. testing for HIV because others have tested; HIV/AIDS prevention; voluntary medical male circumcision; seeking information for decision making around their reproductive health. To gain more knowledge on sexual reproductive health while others it's because they feel they are of age to seek information on certain service's so that they get well informed. An adolescent would seek for an SRH service to get informed on the effects and use of condoms. So in short they seek SRH services in order to be well informed on service and the desire to be healthy.

1.4. Critical barriers to seeking or utilizing SRH services by adolescents

There are several factors that hinder adolescents and young people from accessing the sexual and reproductive health services. Lack of trust in services providers, lack of confidentiality and privacy by service providers, inadequate knowledge of where the services are provided, lack of youth friendly facilities, lack of information on SRH rights, Stigma and discrimination and negative cultural norms that prevent adolescents from freely talking about sex and anything related to reproductive health are some of the fundamental reasons that hinder adolescents from accessing the sexual and reproductive health services. Some adolescents are shy while others lack awareness and lack of sexuality education. The negative attitude from the health workers, fear and even the location of the facilities and the fees at which those services are being provided are also a barrier. Other barriers include "Judgmental tone from the service providers. You find that a young person goes to a clinic to access contraceptives. Then they find a friend to their mother/father/guardian. It becomes so difficult for them to access services because mostly they are judged and told " you're still young to access such a service. " As a result, such an adolescent will never go back to that health center.

The other barrier is the age gap between the adolescent and Service providers. Service providers might be free and flexible but it gets tough for an adolescent to confidently talk to someone older than them especially when accessing services like the IUDs, Condoms etc.

1.1. Roles of Parents/Guardians and Health Care Providers in ADH

Parents and guardians are major stakeholders in the adolescent sexual and reproductive health and their roles cannot be over emphasized according to the responses. Their roles stem from information provision to care and support. Parents and guardians are the first contacts for any adolescents hence they should be the first informational contact for adolescents. The parents are expected to train and teach their children about sexual health, the dos and don'ts because most children listen to parents first. Parents and guardians can also take part in talking to their children about sex and the options they have in order to prevent pregnancy and other sexually transmitted infections including HIV. Parents need to be talking to the adolescents especially when they notice that they are becoming very active, create a safe space for them. The talks should also include academics, health education such as practicing good hygiene and drugs and substance abuse. Parents and guardians can also encourage adolescents to seek sexual and reproductive health information and services. When parents are closed, adolescents and young people may end up getting information from their friends and sometimes may not even be the correct information regarding their sexuality. Open communication between parents and young people can unlock their potential and help them discover their true self. It also helps build their self-esteem. It is, therefore, important that parents develop skills that will enable them to communicate with their children amicably without infiltrating cultural values. Puberty and menarche may be difficult stages for adolescents' emotional and physical development therefore parents and guardians need to be extra skilled to handle the pressure that comes along with these developments.

On the other hand, health care providers are very important in adolescent health services provision. They may hinder or promote access to health services by adolescents and young people. The following are some responses regarding the role of health care services providers in adolescent health. Their role is to ensure they provide information and services to adolescents without prejudice. They should ensure confidentiality and privacy to adolescents who need information and services. Their role should also be to ensure a welcoming and assuring environment to adolescents – in order to encourage those who might be scared and not confident enough to approach them. Health care services providers can also stop discriminating and stigmatizing adolescents rather they can try to empathize with them to offer better advice and the tailored services the adolescent requires. *“Since they are health care workers, they know the human body and how it functions, apart from parents, best advice comes from them because they have vast knowledge about sexual health”*, adolescent girl. The information they provide should include how adolescents and young people should keep their bodies, understanding body changes, ensuring they are less vulnerable on sexual & reproductive health risks with an open heart because sometimes they can be rude. To a large extent, nurses are said to

have a negative attitude towards adolescents, if they change they can make greater impact in the lives of the adolescents.

V. CONCLUSION AND RECOMMENDATION(S)

The study on the perception of adolescents on sexual and reproductive health has really given pertinent insights into the factors which contribute to adolescents and young people to seek adolescent sexual and reproductive health information and services. The factors include; fear of getting pregnant by adolescent girls, to postponed early marriages, to be healthy, to be free from STIs, to access condoms, to find someone to talk to and to know more about sexuality. This can help the programmers including stakeholders involved in sexual and reproductive health to refocus their efforts in reprogramming in order to respond to adolescent health problems in a more holistic and pragmatic manner. Besides, it is also important to address the identified barriers to adolescents' seeking for services such as negative attitude by service providers, lack of information on the services and their availability, long waiting hours and long distances to the health centers, lack of confidentiality among service providers which lead to lack of trust, non-availability of most essential contraceptives in health centers (Method mix), cultural norms which prevent adolescents from accessing contraceptives e.g. no sex before marriage and providers being adults only. Parents, Guardians and health service providers are essential stakeholders in adolescent health. Parents and guardians are part of the supportive community structures that adolescents need in order to access the sexual and reproductive health services while health service providers should provide curative services as well as promote and respect sexual and reproductive health rights of adolescents without any aorta of prejudice, discrimination and stigma.

Finally, the involvement of adolescents and young people in any efforts aimed at bettering their plight vis-à-vis in SRH should be of utmost significance among policy-makers, planners, politicians and civil society organisations if meaningful results are to be attained from the discrepancies noted in this study. Their involvement should stem from planning, designing, implementation, monitoring and evaluation of the programs.

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