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Participatory and learning action as a tool to explore adolescent sexual and reproductive health

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• Introduction

When CARE Zambia used participatory research techniques to explore issues around adolescent sexual and reproductive health (SRH) (Kaul Shah, Zambezi and Simasiku 1998), the findings that emerged were worrying.

- Adolescents reported early initiation of sexual relations.
- Despite this, their information about reproductive health was often incomplete and incorrect.
- Sex among young people typically involved some type of an exchange, for example, money, test answers or sweets.
- Sources of information were frequently unreliable ones.
- Young people seldom used clinic services because they found service providers to be unwelcoming.

Involving young people in the research was the first step in the design of appropriate adolescent reproductive health programmes in CARE supported Ministry of Health clinics and their catchment areas. This article discusses CARE's experiences.

• The context

Zambia has high HIV prevalence with 19.9 percent of the population over 15 years of age estimated to be HIV positive. Among 15-19 year-old girls, infection rates are five times that of boys. Sexually transmitted infections (STIs) are also widespread, although their prevalence is not well documented. By the age of 20, one-third of Zambian girls will have initiated their childbearing careers and there is considerable unwanted teenage pregnancy.

Despite the fact that service providers are mandated to provide SRH information and services to young people by the Zambia Family Planning in Reproductive Health Policy, service statistics showed that few adolescents sought reproductive health information or care from clinics. CARE embarked upon a sexual and reproductive health project because of these issues.

Involving youth through participatory research

CARE chose to adopt a participatory research approach as it was felt this would provide richer baseline information from the point of view of the young people that would then be fed into the project design. Thus adolescents, their communities and service providers were involved from the outset, not only as subjects but also as researchers.

Participatory methods help participants carry out their own analysis and appraise their own situation. The emphasis is on allowing people to feel free to identify and explore their concerns. Unlike most research, there are no predetermined questions. The process is left open ended and flexible in order to follow concerns and issues brought up during the research process. CARE chose a participatory methodology because:

- we had successfully used participation in other health and livelihood projects;
- adolescent reproductive health is a sensitive issue and we felt that we would be more likely to find out the truth if we worked with adolescents on their own terms;
- there was little qualitative data on adolescent sexual and reproductive health based on their own perceptions of their sexual behaviour; and,

- involving adolescents at this level would be a starting point for youth empowerment.

We used and adapted participatory tools to work with young people. Alongside 'standard' PRA tools, such as transect walks, social and body mapping, matrix ranking and scoring and Venn diagrams, the team used focus group discussions and in-depth interviews to understand young people's perspectives. Picture stories made up and illustrated by the adolescents gave further insights. By analysing the stories together, we were able to start to understand adolescent sexual behaviour, the types of sexual relations among the boys and girls and the consequences of these relationships.

One innovation that generated rich insights was the use of a participatory sex census. During group discussions it became clear that while boys spoke about their sexual behaviour and experiences freely, girls tended to be secretive about their experiences. So a secret ballot was used to explore issues such as the age of sexual initiation. The method uses slips of paper depending on the number of questions one has to ask. One question is asked at a time and the response is written on the slip of paper. The responses are kept anonymous so that participants feel comfortable writing honest answers. The slips are destroyed in front of the group. New slips of paper are then passed round for each question. The results were analysed with the young participants and then discussed. This method allowed us to generate qualitative information that was used for comparison with the results of other analyses, which were based on perceptions.

What did we find out?

Research findings indicated that adolescents have incomplete, inaccurate and distorted information on sex and reproduction (see Box 1). They mainly depended on unreliable sources of information such as friends, grandparent, elder siblings, traditional healers, science teachers, community-based organisations and pornographic video films. Very rarely were parents and clinics mentioned as sources of information. We found differences when working with boys and girls. Boys were more open when discussing their personal experiences. Girls, on the other

hand, were shy to talk about sexual matters. They always answered questions in the 'third person'. It was also difficult to have discussions with girls very early in the morning or towards lunch, because they were busy with household chores, while the boys spent several hours with us.

The average age of sexual initiation found was 10 years for girls and 12 years for boys. Reasons for indulging in early sex ranged from the need for money (especially among girls), peer pressure, curiosity, for pleasure or fun to obtaining favours such as sweets or assistance with homework. The major impact of adolescent sexual activity upon these youths was the spread of sexually transmitted infections and teenage pregnancy, 75% of which had ended up in abortions. Many young people reported the use of unsafe abortion methods. This was exacerbated by the low use of contraceptives, especially condoms and the general lack of information about services.

Clinic utilisation among adolescents was found to be very low especially for sexual and reproductive health. Only about 30% of the boys with sexually transmitted infections reported that they would seek treatment at a clinic. The proportion of infected girls seeking treatment at the clinic was even lower. Reasons identified for this low utilisation were fear of clinicians' attitudes and lack of knowledge about the services available.

• Next steps

Our participatory research led to CARE implementing adolescent sexual and reproductive health programmes in peri-urban compounds (shanty towns) of three cities, Lusaka, Ndola and Livingstone. We are continuing to work with and through adolescents and clinicians as a further step in the participatory research.

At clinic level, health workers are supported to provide youth friendly services, to form youth corners in clinics, to conduct outreach activities and to work towards improving the record keeping system.

BOX 1

QUOTES FROM YOUNG PEOPLE

'Sometimes they only want to touch parts of our body and sometimes they also pinch us. They also ask us to have sex' explained a group of 9-15 year old school girls. They added *'When they ask us to have sex, we have to agree.'* *'Because if a girl refuses, the boy will not help her with homework and may refuse to lend her a pencil when she wants one'.*

'The Kasai or the Zairien sex workers have a more or less fixed rate for the services they provide. For the night they charge K4000 (\$1.6), for half the day they charge K1,500 (\$0.6) and for one round of sex you have to pay K1,000 (\$0.4)' - boys in Chawama compound

'Rape is when an older man has sex with a much smaller girl and in the process tears her vaginathe vagina tears because the man's penis is large' - Definition of rape by a group of 9-15 year old school girls in Chawama

'What have you been doing so far?' Group of 13-17 year old boys discussing their sexual experiences when one 13 year old boy mentioned that he had not had sex up to this point.

'Having sex with a condom on is like chewing a sweet with its wrapper on' On why there is low condom use among adolescents

'If a boy has an STI, everyone comes to know about it. However, if a girl has an STI, it is not possible to tell for a long time. Boys have to be very careful otherwise the girls will give us all the diseases. I make sure she is clean every time I have sex with a girl.....before having sex with a girl, I put some cigarette ash in her vagina...if she has a disease it will hurt and she will scream'. A group of 13-17 year old boys in Chawama.

At the community level, the project has facilitated and supported groups of trained peer counsellors in community based adolescent health education activities. When the results of the research were disseminated to the community, young people suggested that one of the activities they would want to be included in this project was health education. They were then encouraged to form discussion groups, each of which had 10-15 members. They determined their own criteria for selecting group members. The same discussion groups were used to brainstorm the qualities of a good peer counsellor. Some of the qualities listed included being respected, responsible, accessible, of the same age group and not having many girl/boyfriends. Then the groups were asked to select one or two people from their group to be their leader and these were trained as peer counsellors. Peer counsellors also work in the youth friendly corners and act as a link between service providers and youths.

Things we might have done differently

We have learnt that it would have been good to develop strategies that help peer counsellors become economically active in order to reduce

attrition rates. It would have also been good to focus on a small geographical area and stagger the training sessions for adequate follow up.

• Conclusion

Adolescent sexual behaviour has serious implications, demanding an extensive range of interventions. This requires adolescents themselves, the community, health workers and facilitating agencies to work continuously together in partnership. CARE has taken steps to address this in partnership with the Ministry of Health.

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