EAS Journal of Nursing and Midwifery
Abbreviated Key Title: EAS J Nurs Midwifery
ISSN: 2663-0966 (Print) & ISSN: 2663-6735 (Online)
Published By East African Scholars Publisher, Kenya

OPEN ACCESS

Volume-7 | Issue-4 | Jul-Aug -2025 | DOI: https://doi.org/10.36349/easjnm.2025.v07i04.003

Original Research Article

Factors Influencing Utilization of Adolescent Health Services among Adolescents in Mbala Township, Northern Zambia

Febiano Phiri[1*], Isabel Nyahoda[1], Bwalya Munjili[2], Juness Kachimba[1], Chisha Jones Simuyemba[1],Carolyne N.M Akakulubelwa[3], Stellah Siakapanga[4]

[1]School of Nursing and Midwifery Sciences, Eden University, Lusaka, Zambia
[2]National Institute of Public Administration, Health service management, Nursing, P.O Box, 31990, Lusaka, Zambia
[3]Mbala General Hospital, Northern Province, Zambia
[4]Mbala College of Nursing and Midwifery, Northern Province, Zambia

Article History
Received: 17.05.2025
Accepted: 29.06.2025
Published: 15.07.2025

Journal homepage:
https://www.easpublisher.com

Quick Response Code

Abstract: ***Introduction*****:** Adolescent Health Services (AHS), also known as Youth-Friendly Health Services (YFHS), aim to meet the unique health needs of individuals aged 10–19. Despite efforts to expand access, utilization remains suboptimal in many settings. This study aimed to determine factors influencing AHS utilization among adolescents in Mbala Township, Northern Zambia. ***Methods*****:** A descriptive cross-sectional study was conducted among 100 adolescents aged 10–19 years, selected through systematic sampling. Data were collected using a standardized interview schedule and analysed using SPSS version 27. Descriptive statistics summarized participant characteristics. Chi-square tests and binary logistic regression were used to identify factors associated with AHS utilization, with significance set at $p < 0.05$. ***Results*****:** While 75% reported having used AHS and 80% had access, only 43% demonstrated good utilization. Knowledge of AHS was high (83%), and 58% held positive attitudes toward their use. Major sources of information included health facilities (46%) and the community (30%). Barriers to utilization included shyness (43%), perceived discrimination by providers (42%), and health worker-related hindrances (73%). Distance to facilities was also a concern, with 50% requiring over 30 minutes to reach care. Utilization was significantly associated with gender ($p = 0.031$) and education level ($p = 0.001$). Logistic regression showed that being female (AOR = 1.75, $p = 0.031$), having secondary education (AOR = 2.90, $p = 0.018$), and a positive attitude (AOR = 1.84, $p = 0.047$) were significant predictors of AHS utilization. ***Conclusion*****:** Despite high awareness and access, effective utilization of AHS in Mbala remains limited, largely influenced by gender, educational attainment, and attitudes. Interventions should focus on promoting youth-friendly services, reducing stigma, and enhancing community and provider engagement to improve adolescent health outcomes.

Keywords: Utilization, Knowledge, Attitude, Adolescent Health Services, Zambia.

1. INTRODUCTION

Adolescents and young people constitute a substantial proportion of the global population, with 1.8 billion individuals aged 10–24 years worldwide approximately 90% of whom live in low- and middle-income countries [1]. In Zambia, adolescents and young people represent about 40% of the population [2]. Adolescence, defined by the World Health Organization (WHO) as the period between 10 and 19 years, is a critical developmental stage characterized by physical, emotional, and social changes [3]. It is during this period that many individuals begin engaging in behaviours that significantly impact their health, particularly in the domain of sexual and reproductive health (SRH) [4].

Adolescent and Youth-Friendly Health Services (AYFHS) sometimes referred to as Youth-Friendly Services (YFS) are designed to be accessible, acceptable, equitable, appropriate, and effective in meeting the unique needs of young people [5]. The

***Corresponding Author:** Febiano Phiri
School of Nursing and Midwifery Sciences, Eden University, Lusaka, Zambia

importance of AYFHS is underscored by the high rates of adolescent pregnancy, sexually transmitted infections (STIs), including HIV/AIDS, and unsafe abortions in sub-Saharan Africa [6]. In Zambia, teenage pregnancy remains a significant concern, with provincial rates as high as 42.5% in Southern Province and 39.5% in Eastern Province [7]. Contraceptive uptake among adolescent girls aged 13–19 is similarly low, with only 20.63% having ever used any contraceptive method [7].

To address these challenges, the Zambian Ministry of Health introduced the National Standards and Guidelines for the Provision of Adolescent-Friendly Health Services in 2009 and recently launched the Adolescent Health Strategic Plan (2022–2026). The plan aims to increase the number of health facilities offering functional AYFHS from 964 to 1,550 and raise the proportion of facilities with trained adolescent health providers from 39% in 2021 to 60% by 2026 [7]. Despite these efforts, studies have found that adolescents continue to face multiple barriers in accessing SRH services, including fear of judgment, lack of confidentiality, inconvenient service hours, and a lack of awareness of available services [8, 9].

Evidence from Mbala Township in Northern Zambia highlights the depth of this problem. Hospital records from Mbala General Hospital show that adolescent utilization of designated adolescent health services has remained extremely low only 0.6% of adolescents accessed these services in 2019, 0.7% in 2020, and 0.5% in 2021 despite a growing adolescent population [10]. Many adolescents instead choose to visit general outpatient departments, which may not be tailored to their specific SRH needs. This discrepancy suggests a lack of awareness or trust in existing AYFHS and may reflect insufficient youth engagement or poor service delivery models [11].

Globally, efforts to achieve Universal Health Coverage (UHC) through the Sustainable Development Goals (SDGs) have underscored the importance of improving adolescent health outcomes. The WHO and UNICEF have emphasized that UHC cannot be achieved without addressing the distinct needs of adolescents, especially in SRH [6-12]. Studies from similar contexts, such as Nepal, reveal that creating an enabling environment that ensures privacy, same-sex service providers, and adolescent-centered education can significantly improve AYFHS utilization [9].

Given this context, it was imperative to investigate the factors influencing the utilization of adolescent health services in Zambia. This study specifically assessed the barriers and facilitators to AYFHS usage in Mbala Township, with the goal of informing targeted interventions to enhance service delivery and improve adolescent health outcomes.

2. MATERIALS AND METHODS

2.1 Study Design, Setting, and Participants

The study employed a descriptive cross-sectional design to assess factors influencing utilization of adolescent health services at Mbala Hospital, Zambia. This design allowed collection of quantitative data at a single point in time through structured questionnaires administered to adolescent participants, providing a profile of relevant factors affecting health service use.

The study was conducted at Mbala Hospital, Northern Province of Zambia, which serves a catchment population of approximately 111,637 people (Mbala Action Plan, 2017). Mbala Hospital was selected due to its large adolescent patient population and comprehensive adolescent health services. The hospital operates 24/7 and offers services including Maternal and Child Health, ART clinics, medical and surgical care, with referrals to specialized facilities as needed. Interviews were conducted in a private room within Mbala Hospital to ensure confidentiality.

The study population comprised adolescents aged 10 to 19 years who were seeking medical services or routine medical check-ups at Mbala Hospital during the study period. Participants were eligible if they were present at the hospital between December 2023 and January 2024 and willing to participate in the study. Adolescents who were mentally ill, as confirmed through a brief mental state examination, or those too ill to participate in an interview were excluded.

A sample size of 100 participants was determined using Yamane's formula for a finite population with a 95% confidence interval and 5% margin of error. Systematic sampling was employed to select participants, with a sampling interval of 2 calculated by dividing the. The first participant was randomly selected within the first two adolescents, and every 2nd adolescent thereafter was included until the sample size was met.

2.2 Data Collection Procedure

Ethical approval was obtained from the University of Zambia School of Medicine Research Ethics Committee and Mbala Hospital authorities. Data were collected over thirty days through face-to-face interviews using a structured standardised interview schedule. Interviews were conducted privately after participants gave informed consent. The researcher clarified questions as needed and recorded responses accurately. Confidentiality and anonymity were maintained by using serial numbers and securely storing data.

2.3 Instruments

Data for this study were collected using a standardised interview schedule comprising structured, closed-ended questions designed to capture participants' demographic details, knowledge, competence, and practices related to the phenomenon under study. The

interview schedule was administered face-to-face, allowing the researcher to clarify any questions without changing their meaning.

To ensure validity, the same interview schedule was consistently used for all participants, minimizing interviewer bias and maintaining uniformity. Questions were developed to be clear, concise, and unambiguous to accurately measure the intended variables. Internal validity was enhanced through random selection of participants and standardized administration procedures, while external validity was upheld by including participants from varied socioeconomic, educational, and religious backgrounds.

Reliability was ensured by ensuring consistent interview techniques and using the same interview schedule throughout the study. Prior to the main study, a pilot study was conducted with 16 adolescents at Mbala General Hospital, which shares similar characteristics with the main study setting. Participants for the pilot were selected through simple random sampling. This pilot helped identify and correct unclear or inconsistent questions, thereby improving the reliability and validity of the instrument.

2.4. Data Analysis

Data were coded and entered into the Statistical Package for the Social Sciences (SPSS) version 23 for Windows. The analysis included running frequencies, descriptive statistics, and cross-tabulations on various variables. Chi-square tests were performed for categorical variables, and p-values were obtained from the cross-tabulations, with the significance level set at a 95% confidence interval ($p < 0.05$). The results are presented according to the sections of the questionnaire, which included demographic characteristics (age, marital status, employment status, education level, and income), utilization of adolescent health services, knowledge of adolescent health services, attitudes towards the utilization of these services, and service-related factors. Furthermore, binary logistic regression was conducted to identify factors associated with the utilization of adolescent health services.

3. RESULTS

Demographic Characteristics:

Table 1 presents the demographic characteristics of the 100 respondents. Slightly more than half were male (51%), while females accounted for 49%. Most participants (91%) were aged 15 to 19 years. Almost all respondents were single (99%). The majority lived in urban Mbala (84%), with 16% residing in rural areas. Educational attainment was predominantly at the secondary level (90%). Most respondents were not employed (79%), with smaller proportions self-employed (13%) or employed for wages (8%). The sample was primarily Christian (98%).

Table 1: Demographic Characteristics (n=100)

Gender	**Frequency**	**Percentage**
Male	51	51
Female	49	49
Age		
10 - 14 Years	9	9.0
15 -19 Years	91	91.0
Marital Status		
Married	1	1.0
Single	99	99.0
Residence		
Mbala Urban	84	84.0
Mbala Rural	16	16.0
Education Level		
Never been to school	4	4.0
Primary Level	6	6.0
Secondary Level	90	90.0
Employment Status		
Employed For Wages	8	8.0
Self-Employed	13	13.0
Not Employed	79	79.0
Religion		
Christian	98	98.0
Muslim	2	2.0
Total	**100**	**100.0**

Utilization of Adolescent Health Services

As summarized in Table 2, 80% of respondents reported access to health services. Hygiene-related

services were the most commonly accessed (65%). While 77% affirmed they could access services when needed, 75% reported actual utilization. Shyness was the most frequent hindrance to seeking services (43%).

Table 2: Utilization of Adolescent Health Services (n=100)

Questions	Frequency (n)	Percentage (%)
Accessibility to Health Services		
Yes	80	80.0
No	20	20.0
Services Received by Respondents		
Circumcision	35	35.0
Hygiene	65	65.0
Access to Service When in Need		
Yes	77	77.0
No	23	23.0
Hindrance From Seeking Adolescent Health Service		
Shyness	43	43.0
Discrimination by Health Providers	42	42.0
Bleach of Confidentiality	15	15.0
Utilization of Health Services		
Yes	75	75.0
No	25	25.0
Total	**100**	**100**

Overall Utilization of AHS (n=100)

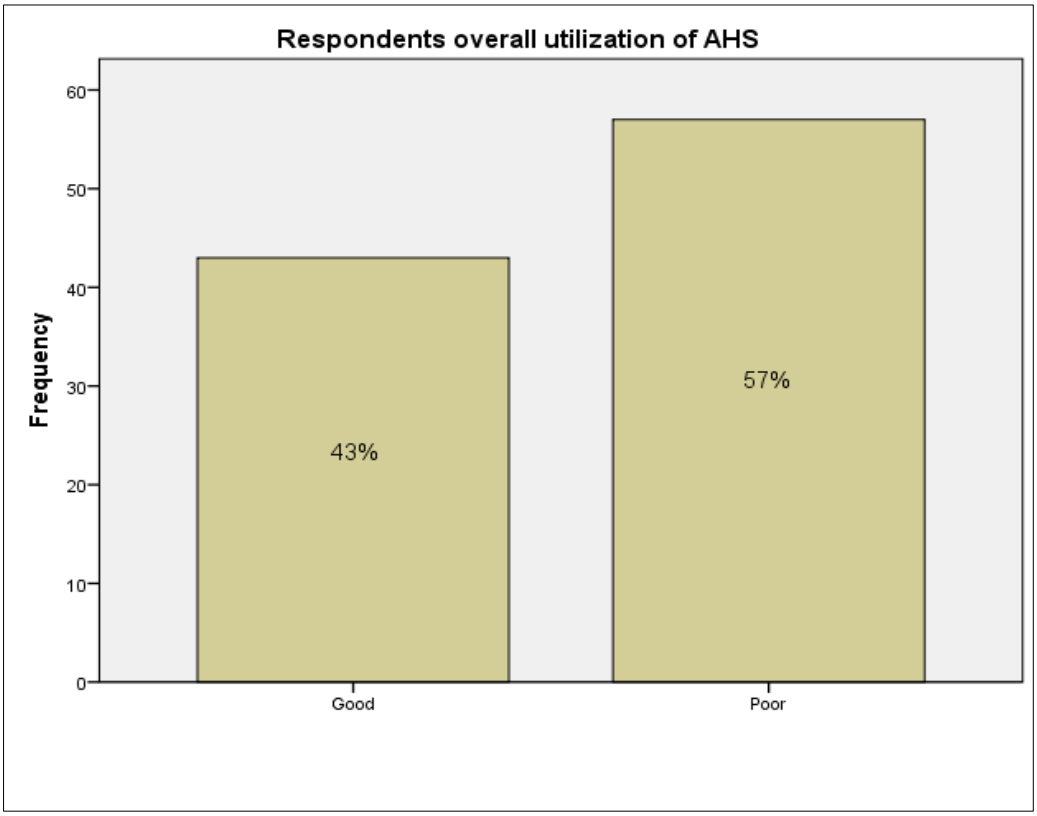

Figure 1: Overall Utilization of Adolescents Health Care Services (n=100)

Figure 1 above shows that out of 100 respondents, slightly more than half 57 (57%), had poor utilization of AHS while 43 (43%) had good utilization.

Knowledge Questions on AHS

Table 3 presents the respondents' knowledge of Adolescent Health Services (AHS). The majority of participants, 83% (n=83), reported having heard of AHS. The most common source of information was health facilities, cited by 46% (n=46) of the respondents. When asked about past visits to AHS, 64% (n=64) confirmed

having visited such services. Furthermore, 76% (n=76) knew that adolescents are allowed to visit AHS. Knowledge about the availability of free AHS was reported by 65% (n=65) of the respondents.

Table 3: Knowledge on AHS (n=100)

Questions	Frequency (n)	Percentage %
Heard of Adolescent Health Service		
Yes	83	83.0
No	17	17.0
Source of Information		
Health Facility	46	46.0
Community	30	30.0
Media	10	10.0
Youth Clubs	14	14.0
Ever Visited AHS		
Yes	64	64.0
No	36	36.0
Knowledge if one can visit AHS		
Yes	76	76.0
No	24	24.0
Respondent Knowing About Free AHS		
Yes	65	65.0
No	35	35.0
Total	**100**	**100**

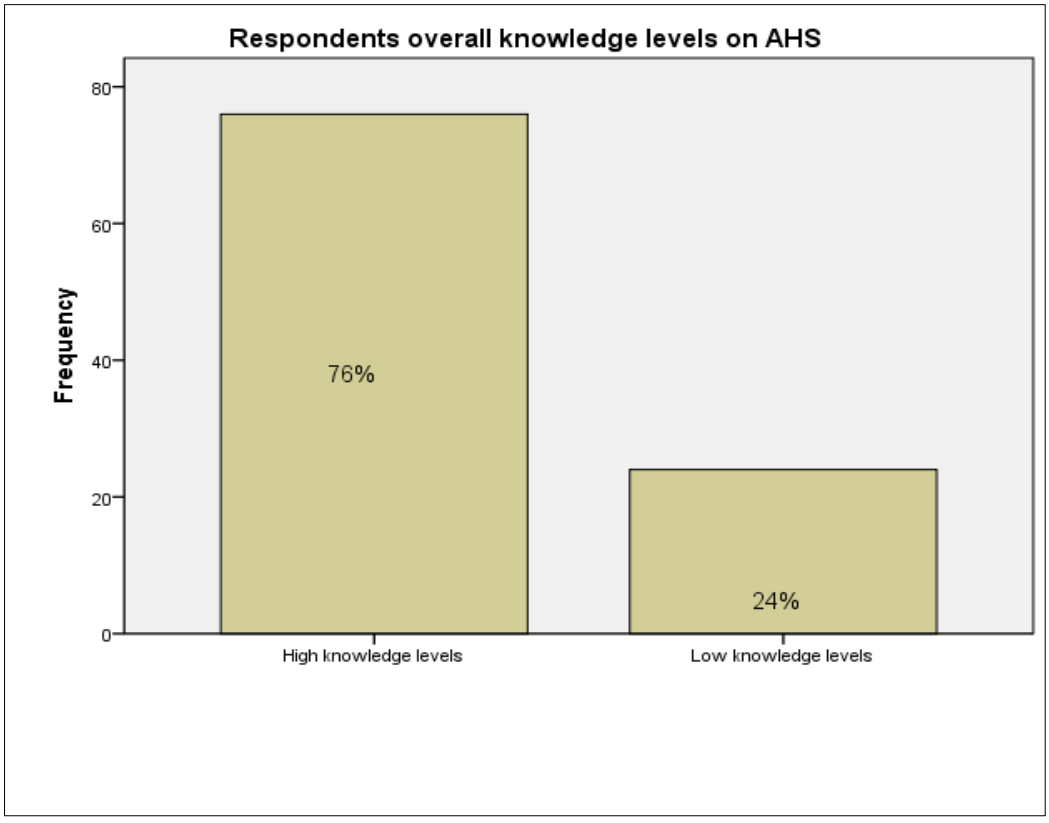

Figure 3: Overall, Knowledge Levels of AHS (n=100)

Figure 3 above shows that majority 76 (76%), had high knowledge levels on AHS while 24 (24%) had low knowledge levels.

Attitude towards Utilization of AHS

Table 4 illustrates respondents' perceptions regarding Adolescent Health Services. Over half of the participants, 57% (n=57), reported thinking of using AHS all the time. The belief that AHS is beneficial was strong, with 66% (n=66) affirming this sentiment consistently. Similarly, 63% (n=63) considered AHS to be important at all times. A majority, 65% (n=65), believed AHS can help preserve life, while 62% (n=62) thought adolescents should always have access to such

services. Lastly, 60% (n=60) felt that adolescents should have access to AHS whenever they are sick.

Table 4: Adolescents attitude Towards Utilization of AHS (n=100)

Questions	Frequency (n)	Percentage %
Respondents Thought of Using AHS		
All the time	57	57.0
Sometimes	32	32.0
Not all the time	11	11.0
Respondents Thought of AHS Being Beneficial		
All the time	66	66.0
Sometimes	28	28.0
Not all the time	6	6.0
Respondents Thought of AHS Being Important		
All the time	63	63.0
Sometimes	30	30.0
Not all the time	7	7.0
Respondents Thought of AHS Helping in Preserving Life		
All the time	65	65.0
Sometimes	25	25.0
Not all the time	10	10.0
Respondents Thought of Adolescents Having Access to AHS		
All the time	62	62.0
Sometimes	29	29.0
Not all the time	9	9.0
Respondents Thought of Access to AHS Whenever sick		
All the time	60	60.0
Sometimes	34	34.0
Not all the time	6	6.0
Total	**100**	**100**

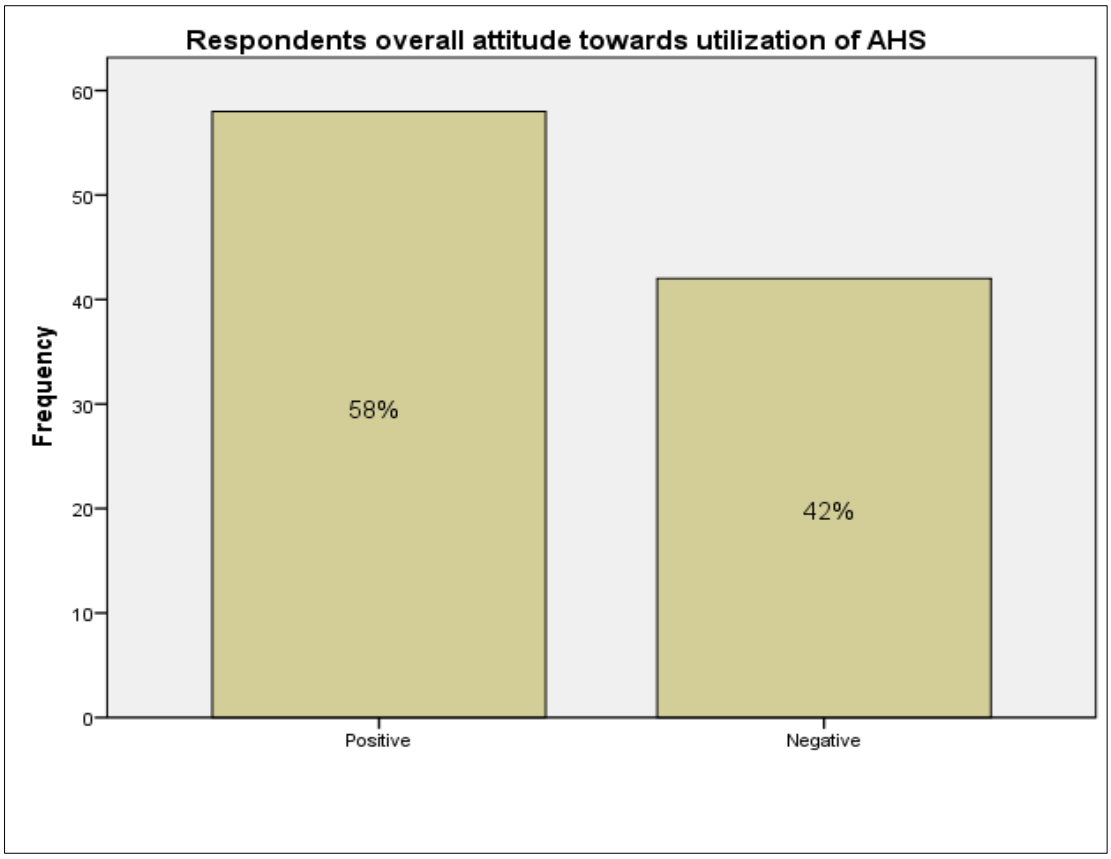

Figure 4: Respondents overall attitude towards utilization of AHS (n=100)

Figure 4 above shows that out of 100 respondents, slightly more than half 58 (58%), had a positive attitude towards utilization of AHS while 42 (42%) had a negative attitude.

Service-Related Factors

Table 5 highlights barriers and access-related challenges to AHS among respondents. A significant proportion, 73% (n=73), reported being hindered by health care workers when trying to access AHS. Additionally, 65% (n=65) indicated that distance to the health facility limited their access. The most common means of transport to the nearest health facility was walking, reported by 58% (n=58) of the participants. Travel time was evenly split, with 50% (n=50) reaching the facility in less than 30 minutes, and the other 50% (n=50) requiring 30 to 60 minutes.

Table 5: Service-Related Factors (n=100)

Questions	Frequency (n)	Percentage %
Respondents Hindered by Health Care Workers From AHS		
Yes	73	73.0
No	27	27.0
Respondents Failure to Access AHS Due to Distance		
Yes	65	65.0
No	35	35.0
Respondents Means of Transport to Nearest Health Facility		
Walking	58	58.0
Public Transport	32	32.0
Private Transport	10	10.0
Respondents Average Time to Reach the Nearest Health Facility		
Less Than 30 Minutes	50	50.0
30 To 60 Minutes	50	50.0
Total	**100**	**100**

Associations with Utilization

Chi square test analysis (Table 6) showed that gender (p = 0.031) and education level (p = 0.001) were significantly associated with AHS utilization, with females and those with secondary education more likely to utilize services. Knowledge and attitude showed no

significant bivariate associations.

Table 6: Relationship between utilization of AHS and Independent variables

Variable	Utilization of AHS			P-value
	Good, n (%)	Poor, n (%)	TOTAL	
Gender				
Male	21(41.2%)	30 (58.8%)	51(51%)	
Female	22 (44.9%)	27 (55.1%)	49 (49%)	0.031*
Total	**43 (43%)**	**57 (57%)**	**100**	
Education level				
Never been to school	2 (50%)	2 (50%)	4 (4%)	
Primary level	2 (33.3%)	4 (66.7%)	6 (6%)	
Secondary level	39 (43.3%)	51 (56.7%)	90 (90%)	0.001*
Total	**43 (43%)**	**57 (57%)**	**100**	
Knowledge levels				
High knowledge levels	34 (44.7%)	42 (55.3%)	76 (76%)	0.351
Low knowledge levels	9 (37.5%)	15 (62.5%)	24 (24%)	
Total	**43 (43%)**	**57 (57%)**	**100**	
Attitude				
Positive	26 (44.8%)	32 (55.2%)	58 (58%)	0.410
Negative	17 (40.5%)	25 (59.5%)	42 (42%)	
Total	**43 (43%)**	**57 (57%)**	**100**	

Multivariate Analysis: Binary logistic regression (Table 7) included gender, education, knowledge, and attitude. Positive attitude (AOR = 1.84, p = 0.047), female gender (AOR = 1.75, p = 0.031), and secondary education (AOR = 2.90, p = 0.018) were significant predictors of good utilization. Knowledge level was not significant.

Table 7: Association between Selected Variables and Utilization of Adolescent Health Services (n = 100)

Variable	Utilization of AHS		UOR	AOR	95% CI (AOR)	p-value
	Good, n (%)	Poor, n (%)				
Gender						
Female	22 (44.9%)	27 (55.1%)	1.17	1.75	1.04–2.96	0.031*
Male (ref)	21 (41.2%)	30 (58.8%)	Ref	Ref		
Education Level						
Secondary	39 (43.3%)	51 (56.7%)	1.78	2.90	1.21–6.95	0.018*
Primary	2 (33.3%)	4 (66.7%)	1.00	2.10	0.75–5.89	0.152
None (ref)	2 (50.0%)	2 (50.0%)	Ref	Ref		
Knowledge Level						
High Knowledge	34 (44.7%)	42 (55.3%)	1.34	1.36	0.70–2.65	0.351
Low Knowledge (ref)	9 (37.5%)	15 (62.5%)	Ref	Ref		
Attitude						
Positive Attitude	26 (44.8%)	32 (55.2%)	1.18	1.84	1.01–3.35	0.047*
Negative (ref)	17 (40.5%)	25 (59.5%)	Ref	Ref		

Note: UOR = Unadjusted Odds Ratio; AOR = Adjusted Odds Ratio; CI = Confidence Interval; *p < 0.05 indicates statistical significance.

4. DISCUSSION OF FINDINGS

This study assessed the utilization of Adolescent Health Services (AHS) and associated factors among adolescents in Mbala district, Zambia. Despite relatively high levels of awareness and reported access, more than half (57%) of respondents demonstrated poor utilization, indicating a persistent disconnect between the availability of services and actual, consistent engagement. These findings reflect broader trends in low- and middle-income countries, where adolescent health services remain underutilized despite growing investment in infrastructure and youth-targeted policies [13].

Although 80% of participants reported having access to health services and 75% had used AHS at least once, only 43% showed good overall utilization. Barriers such as shyness (43%) and perceived discrimination by healthcare workers (42%) emerged as significant deterrents. Notably, 73% of respondents reported that their interactions with health care providers hindered service utilization. This mirrors findings in similar African settings where adolescents frequently express

concerns about being judged, misunderstood, or shamed during clinical encounters [14, 15].

Service accessibility posed an additional barrier. While 58% of adolescents walked to health facilities and most reported travel times between 30 and 60 minutes, 65% still perceived distance as a major challenge. These findings highlight the infrastructural and geographic barriers common in rural Zambia and across Sub-Saharan Africa. Research from Kenya and Ethiopia has similarly shown that long distances, poor roads, and limited transportation options deter adolescents from seeking timely health services [15, 16].

Awareness of AHS was high, with 83% of participants having heard of these services, primarily through health facilities (46%) and community sources (30%). Additionally, 76% of respondents knew that adolescents could access the services, and 65% were aware that they were provided free of charge. Despite this, knowledge alone was not significantly associated with service utilization ($p = 0.351$). This reflects findings from other studies showing that awareness is often insufficient to change behavior in the absence of enabling social and environmental conditions [17].

Attitudinal factors also played a complex role. While 58% of adolescents had a positive attitude towards AHS recognizing them as beneficial (66%), important (63%), and life-preserving (65%) bivariate analysis did not show a significant association between attitude and utilization ($p = 0.410$). However, multivariate logistic regression revealed that adolescents with a positive attitude were significantly more likely to utilize AHS (AOR = 1.84, 95% CI: 1.01–3.35, $p = 0.047$). This suggests that positive attitudes, when adjusted for other variables such as gender and education, may act as facilitators for health-seeking behavior. The distinction between statistical significance in bivariate and multivariate models underscores the nuanced interplay of multiple determinants a finding consistent with research in Ghana and Tanzania [13, 12].

Gender and education were notable determinants of AHS use. Females were more likely than males to utilize services ($p = 0.031$), possibly due to targeted reproductive health campaigns and the higher perceived need for health services among adolescent girls. Similar findings have been reported in multiple studies, where female adolescents exhibit higher engagement with SRH services than their male counterparts, who often remain overlooked in public health outreach [16]. Education also significantly influenced utilization, with adolescents holding secondary education being nearly three times more likely to use AHS (AOR = 2.90, $p = 0.018$) than those with no formal education. These findings are supported by studies from Uganda and Malawi that emphasize the pivotal role of education in improving adolescent health outcomes [17].

Finally, service-related characteristics such as long wait times, lack of privacy, and the judgmental behavior of health workers discouraged service uptake. These structural issues call for comprehensive reforms aimed at enhancing the youth-friendliness of services. Ensuring confidentiality, training staff in adolescent-cantered communication, and creating welcoming environments are critical for increasing adolescent engagement with health systems [12]. Peer education programs and adolescent participation in service design may also help build trust and bridge the gap between knowledge and utilization.

5. CONCLUSION

This study identified that despite high awareness and access to adolescent health services (AHS), utilization remains low, influenced significantly by factors such as gender, education level, and attitudes towards AHS. Female adolescents and those with secondary education were more likely to use AHS, while barriers including shyness, perceived discrimination, and service-related challenges hindered effective utilization. These findings underscore the importance of implementing youth-friendly health services that address psychological and infrastructural barriers. Strengthening education on AHS, fostering positive attitudes, and training healthcare workers in adolescent-friendly approaches are essential to improve service uptake. Continuous community engagement and supportive health policies will be vital in ensuring adolescents receive the comprehensive care they need to enhance their health outcomes.

6. Limitations of the Study

The study's cross-sectional design limits causal inferences. Self-reported data may be subject to recall and social desirability bias. Despite these limitations, the study provides critical insights into the barriers and enablers of AHS utilization in a rural Zambian context.

Acknowledgements

The authors express their sincere gratitude to Eden University, the National Institute of Public Administration, and Mbala General Hospital for their academic and institutional support throughout the course of this research. Special thanks are extended to the management and staff at Eden University for their continued encouragement and facilitation, and to the administration of Mbala General Hospital for their cooperation and logistical assistance during the data collection phase. The authors are particularly grateful to all the adolescents who participated in this study. Your willingness to share your experiences made this work possible. Appreciation is also extended to colleagues and workmates for their moral and professional support during the research process.

Conflicts of Interest: The authors declare no conflicts of interest related to the publication of this article.

REFERENCES

1. Tilahun M, Mengistie B, Egata G, Reda AA. Assessment of access and utilization of adolescent and youth sexual and reproductive health services in Western Ethiopia. Reprod Health. 2021;18(1):1-9.
2. Central Statistical Office (CSO) Zambia. Zambia Demographic and Health Survey 2013–14. Rockville, Maryland, USA: CSO, Ministry of Health (MOH), and ICF International; 2014.
3. World Health Organization. Adolescent health. Geneva: WHO; 2022. Available from: https://www.who.int/health-topics/adolescent-health/ (World Health Organization)
4. Bwalya BB. Factors affecting access to and utilisation of reproductive health services among adolescents in Lusaka District.
5. International Planned Parenthood Federation (IPPF). Provide: Strengthening youth friendly services. London: IPPF; 2008. Available from: https://www.ippf.org/sites/default/files/inspire_provide.pdf
6. UNICEF. Early childbearing and teenage pregnancy rates by country. New York: UNICEF; 2018. Available from: https://data.unicef.org/topic/child-health/early-childbearing/ (UNICEF DATA)
7. Ministry of Health (MOH) Zambia. Adolescent Health Strategic Plan 2022–2026. Lusaka: MOH; 2022.
8. Napit K, Sharma N, Bhattarai R, et al. Exploring the barriers, facilitators, and opportunities to enhance uptake of HIV, GBV, and SRH services among Adolescent Girls and Young Women (AGYW) in selected districts in Zambia. BMC Public Health. 2024;24:2191
9. Sharma N, Napit K, Bhattarai R, et al. Exploring the barriers, facilitators, and opportunities to enhance uptake of HIV, GBV, and SRH services among Adolescent Girls and Young Women (AGYW) in selected districts in Zambia. BMC Public Health. 2024;24:2191.
10. Mbala General Hospital Records. Adolescent Health Service Utilization Data 2019–2021. Mbala: Mbala General Hospital; 2022.
11. Whitfield K, et al. Perceptions of youth-friendly sexual and reproductive health services in Zambia: a qualitative study. PLOS Glob Public Health. 2023;3(1)
12. World Health Organization. WHO recommendations on adolescent sexual and reproductive health and rights. Geneva: WHO; 2018. Available from: https://apps.who.int/iris/bitstream/handle/10665/275374/9789241514606-eng.pdf (WHO Apps)
13. Muriithi P, Agot K. Utilization of adolescent friendly health services and its associated factors among adolescents in Kenya. PLOS Glob Public Health. 2023;3(1)
14. Ngure K, et al. Utilization of adolescent health services during the COVID-19 pandemic in Kenya. BMC Public Health. 2023;23:493.
15. Abebe A, et al. Determinants of adolescent pregnancy in sub-Saharan Africa: a systematic review and meta-analysis. Reprod Health. 2018;15(1):1-15.
16. Addai-Donkor J, et al. Prevalence and factors associated with adolescent pregnancies in Zambia: a systematic review. Arch Public Health. 2023;81:45

Cite This Article: Febiano Phiri, Isabel Nyahoda, Bwalya Munjili, Juness Kachimba, Chisha Jones Simuyemba,Carolyne N.M Akakulubelwa, Stellah Siakapanga (2025). Factors Influencing Utilization of Adolescent Health Services among Adolescents in Mbala Township, Northern Zambia. *EAS J Nurs Midwifery, 7*(4), 87-96.