BARRIERS TO YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH IN ZIMBABWE WITH A FOCUS ON ACCESS AND UTILIZATION OF SERVICES.

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Zimbabwe

49th International Course in Health Development

September 19, 2012 – September 6, 2013

KIT (ROYAL TROPICAL INSTITUTE)

Development Policy & Practice/

Vrije Universities Amsterdam

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A thesis submitted in partial fulfillment of the requirement for the degree of Master of Public Health

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Declaration:

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The thesis "BARRIERS TO YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH IN ZIMBABWE WITH A FOCUS ON ACCESS AND UTILIZATION OF SERVICES'' is my own work.

Signature……

49th International Course in Health Development (ICHD)
September 19, 2012 – September 6, 2013
KIT (Royal Tropical Institute)/ Vrije Universiteit Amsterdam
Amsterdam, the Netherlands

September 2013

Organized by:
KIT (Royal Tropical Institute), Development Policy & Practice
Amsterdam, the Netherlands

In co-operation with:
Vrije Universiteit, Amsterdam/ Free University of Amsterdam (VU)
Amsterdam, the Netherlands

Table of Contents

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AYA	African Youth Alliance
ASRH	Adolescent Sexual and Reproductive Health
CDC	Centres for Disease Control
CLF	Child and Law Foundation
CRLP	Centre for Reproductive Law and Policy
CSO	Central Statistical Office
ECSA-HC	East Central and Southern African Health Community
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus,
IPPF	International Planned Parenthood Federation
MDGs	Millennium Development Goals
MoHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
PITC	Provider Initiated Testing and Counseling
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SAYWHAT	Student And Youths Working on Reproductive Health Action Team
SRH	Sexual & Reproductive Health
STIs	Sexually Transmitted Infections
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund

UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YFS	Youth friendly services
ZDHS	Zimbabwe National Family Planning Council
ZNASP	Zimbabwe National AIDS/HIV Strategic Plan
ZNFPC	Zimbabwe National Family Planning Council
ZNFPC	Zimbabwe National Family Planning Council

Acknowledgements

I am grateful to the Lord Almighty for allowing me the opportunity to advance in my education.

I would like to express my sincere gratitude to the Netherlands Government for awarding me the scholarship to study for ICHD/MPH course at Royal tropical Institute KIT in Amsterdam, the Netherlands.

I would like to convey my special thanks to my thesis advisor and back stopper for the technical advice and encouragement throughout my thesis writing.

My appreciation goes to the course coordinators for the support and guidance throughout my study period. Your expertise enabled me to learn a lot in an interactive environment.

To the course administrator, thank you for your guidance, efficiency and caring attitude. Keep it up.

To all my colleagues, 49th ICHD/MPH class from diverse backgrounds the friendship, moral support and solidarity made my stay comfortable.

DEDICATION

To my beloved husband, Innocent and my lovely children McDonald, Maria and Marcia, thank you for your support for you have always been my pillars of strength during my life and studies.

To my late parents Tracy and Geoffrey Chikwizo, thank you for laying the foundation and importance of education in my life.

To my daughter Sarah Chiritse, my appreciation for your outstanding support and commitment to my family.

To my siblings Vimbai, Barbrah, Gerald, Dadirai/Loraine, Cliff and families you were really my source of inspiration.

ABSTRACT

Young people constitute the majority of the Zimbabwean population. They face challenges during the transition period from childhood to adulthood. Young people depend on social institutions, and health service providers for information and services on Sexual and Reproductive Health (SRH). Better access and utilization help the young people get care, information and support on SRH and this will enable them to get better education, improve health and prevent risky behaviors. In addition this will help the country and in the attainment of Millennium Development Goals.

Methodology: This thesis is a literature review carried out to explore the barriers influencing poor reproductive health and access and utilization of SRH services among young people in Zimbabwe. Analysis was carried out using adapted an Andersen Model and data used was from Zimbabwe Demographic Health Survey, National AIDS council and Health Management Information System.

Findings: Mostly socio-demographic, cultural, community, government policies, and health system factors have implications for young people's access and utilization of sexual and reproductive health services in Zimbabwe. Overall, major barriers for young people's lack of access and utilization of SRH services lie within the organization of the existing public health system.

Conclusion: Young people are the future of the country and their SRH needs have been neglected in the past. They have multiple SRH problems which need to be addressed. There are a lot of obstacles noted in the implementation of SRH service delivery which hamper young people's access and utilization of SRH services.

Recommendations: The implementation of standardized SRH services needs to be scaled up. There is need to train service providers on adolescent SRH and restrictive laws and policies need to be reviewed and adapted where needed.

Key words: Young people, adolescents, Zimbabwe, access, utilization, sexual and reproductive health, youth friendly services, barriers,

Word count:--------

GLOSSARY

Abstinence (in this context) refers to the practice of voluntarily refraining from any form of sexual activity (MoHCW, 2009).

Adolescence is the period between the ages of 10-19 years

Child refers to anyone less than 18 years

Teenager refers to anyone aged 13-19 years

Gender refers to socially constructed women and men's roles and responsibilities. It also refers to how people are perceived and expected to think and act as women and men because of the way in which is organized, and not because of biological differences (MoHCW, 2001).

Reproductive health is a state of complete physical, mental and social well-being of an individual in all matters relating to the reproductive system and its processes and functions but not merely the absence of disease or infirmity. It also includes the sexual health, the purpose which enhancement of life and personal relations and not merely counseling and care related to reproduction and sexuality transmitted diseases (ICPD Program of Action, para 7.2).

Sexuality is the total expression of who we are as human beings. Encompasses one's whole psychological development that is, values, mental attitudes, physical appearances, beliefs, emotions, likes and dislikes, one's spiritual self and all the ways in which one has been socialized (MoHCW, 2009).

Young person refers to anyone between 10-24 years (MoHCW, 2009)

Service provider is any skilled worker who can provide or offer services according to the sexual and reproductive health needs of adolescence or young people. This term refer to both health and non-health workers

INTRODUCTION

World Health Organization (WHO) defines adolescence as the period between the ages of 10-19 years and young people as the period between the ages 10-24 years. Therefore for the purposes of this study the terms "**adolescents and young people**" will be used interchangeably. Adolescents face many reproductive health problems such as unwanted pregnancy, unsafe abortion, STIs including HIV/AIDS as they pass the transitional period from childhood to adulthood. Lack of support and guidance to the young generation may lead to risky behaviors which can lead to drastic consequences to their lives (Kasedde et al 2013).The reproductive health needs of the adolescents have been neglected because they are considered to be a healthy population since they have managed to survive the childhood killer diseases (WHO,2013). Failure to address sexual and reproductive health needs of young people is contributing to preventable premature deaths among young people.

Adolescents are increasingly becoming sexually active before 20 years. The International Conference on Population and Development (ICPD) 1994 emphasized the need to address the sexual and reproductive health needs of young people (Kamau, 2006).

About two thirds of premature deaths and one third of the total disease burden is associated with life threatening and unhealthy practices which adolescents are exposed to during the youthful days such as the tobacco use, exposure to violence and unprotected sex. The young people are exposed to the serious risks before they get enough information, skills and experience to avoid or make an informed choice (WHO, 2013).Young people ,aged 15-24 account for 45% of HIV new infections worldwide (WHO, 2010). Around 14 million of adolescents give birth each year globally and 90%of these occur in developing countries (UNFPA, 2011).

Globally, about 19-20 million abortions are performed annually and about 97 % occur in developed countries. Abortion complications account for 13% of maternal mortality worldwide (Tripney et al., 2013; Settergren, 2000).

An estimate of 10% (650 million) of the world's population lives with disability and their sexual reproductive health needs have been neglected by the society and health care providers although they have same sexual needs like their normal counterparts (UNFPA, 2006). There is evidence that low

socioeconomic status, lack of information, stigma and cultural factors are some of the factors that compromise adolescents' access and utilization of reproductive health services. Lack of information on sexuality and some myths related to use of family planning are some of the factors that discourage the youths from accessing the reproductive health services (Regmi et al 2010; Nyoni, 2008; UNFPA, 2005).

After getting the opportunity to work under an organization whose role includes provision of adolescent sexual and reproductive health (ASRH) I learned that adolescence is a critical stage with special needs which need to be addressed. During implementation of the ASRH program and communicating with the youths at different levels I have realized that there are factors that influence adolescents' access and utilization of sexual reproductive health services.

According to the Zimbabwean context, it used to be the aunts or uncles' role to talk to the young about sexuality. The practice has been eroded by internal and external migration, access to television, internet access, radio and print media (Marindo, 2003).

This thesis intends to explore factors that influence access and utilization of sexual and reproductive health services among young people in Zimbabwe in order to provide recommendations and suggest interventions to improve young people's access and utilization of youth friendly services.

CHAPTER ONE: BACKGROUND INFORMATION

1.1 Geography and Demography

Zimbabwe is a land locked country which is found in Sub-Saharan Africa which is one of the poorest regions in the world. The country shares borders with South Africa, Botswana, Mozambique and Zambia. Zimbabwe has ten political administrative provinces and these include Harare and Bulawayo which are metropolitan and the rural provinces include Mashonaland Central, Mashonaland East, Mashonaland West, Manicaland, Masvingo, Matabeleland North, Matebeland South and Midlands. Zimbabwe's population is estimated to be 12.8 million (CSO, 2010). The population is relatively young with over 62% of the country's population below 24 years (UNFPA, 2011). Ethnic groups comprise of 98% African and among this 82% are Shona, 18% Ndebele and 2 % (mixed Asian 1%while less than 1% are whites).

1.4 Religion

Majority of Zimbabweans are Christians and they constitute 80 percent of the population. Majority of the Christians identify themselves as Roman Catholics. The different denominations in Zimbabwe formed a Faith Based Organization (FBO) known as the Head of Denomination AIDS Committee whose mandate is to ensure that church ideas are included in the government policies (Marindo et al 2003).

1.4 Socioeconomic situation

Zimbabwe is in economic transition following over a decade of economic crisis. About 65% Zimbabwean population live in rural areas and they depend on peasant farming. Rural areas have higher unemployment rate of 62 percent whereas urban has 35 percent. The country's political situation is unpredictable and is currently working on a new constitution and expecting to hold elections sometime this year (World Bank, 2011).

The drought spells contributed in worsening the already existing economic crisis of Zimbabwe (UNICEF, 2010). The country experienced the worst economic crisis in 2008 which led to world record of hyperinflation .The economic crisis forced the introduction of user fees for accessing health care services. Studies have cited user fees as a barrier in accessing health services (Story, 2012; Jamil, 2010).

1.5 Health care system

Zimbabwe health services are almost at a point of collapse due to the drastic decline in funding of the health system by the government since 2008 when the country had the worst economic crisis. The government national expenditure on health is US15 million which is far below the proposed expenditure of US150. Ministry of Health and Child Welfare (MoHCW) is currently relying on external donor fund in the provision of preventative and clinical services (MoHCW, 2012).

The government of Zimbabwe offers integrated reproductive health services at all levels of care. The levels include primary health care which provide first level contact and provide linkage with the community services. Community linkage with the rural health centers is mainly through the village health workers (VHWs) and community based distributors (CBDs) who offer family planning services). The second level is at district level followed by a high tertiary level which is the provincial level and highest level is the tertiary at national level (MoHCW, 2007).

1.6 Health Financing

Zimbabwe's health system has been facing challenges on funding for almost a decade and this has led to compromised access of health services especially for the rural dwellers. The economic decline resulted in unprecedented deterioration of health infrastructure, loss of skilled and experienced health professionals, drug stock outs and poor quality health services (MoHCW, 2011).

1.7 Adolescent Sexual and Reproductive Health (ASRH)

Provision of adolescent sexual and reproductive health services is mainly through Ministry of Health and Child Welfare (MoHCW) under the Reproductive health unit and other major players being Zimbabwe National Family Planning council (ZNFPC) and National AIDS Council (NAC).

The Zimbabwe National Adolescent sexual and reproductive health strategy 2010-2015 indicates that ASRH is offered through three models and these are:

Health facility approach (integrated approach): This is a model where SRH services are provided to young people as part of the general public. Special arrangements are made in order to provide ASRH. It is a requirement in Zimbabwe that every public health facility should establish

and equip special room(s) (youth-friendly corners) for the provision of ASRH services. This is a pilot ASRH program being implemented in 16 districts out of the 62 districts in Zimbabwe. There are only 237 health facilities out of 1533 with established youth corners (UNFPA, 2011).

Community approach: This is a situation where SRH services are strictly designed for young people through (community youth centers).These are standalone youth centers which are only found in the rural areas and these are owned by ZNFPC. The youth program caters for in school and out of school youths. ZNFPC established 26 youth friendly centers throughout the country in 2005 with funding from Global Fund. Services provision is complimented by trained peer educators from within the surrounding communities (MoHCW, 2009).

School-based approach: This is provision of life skills education and counseling by teachers/lecturers and peer educators in schools (both public and private) and tertiary and vocational institutes. For detailed information on the packages offered by different approaches see Annex 2.

Non-governmental organization, for example the Student And Youth Working on Reproductive Health Action Team (SAYWHAT) and Sustainability Hope Action Prevention Education (SHAPE) Zimbabwe and the programs focus on prevention of HIV. The organizations offer services to tertiary colleges in urban areas (MoHCW, 2009).

CHAPTER 2: PROBLEM STATEMENT, OBJECTIVES AND METHODOLOGY

The chapter will focus on the problem statement, justification, factors influencing young people's access and utilization to ASRH services, objectives of the thesis, methodology search strategy, key words, conceptual framework and limitations of this study.

2.1 Problem statement

Young people's reproductive health needs are often neglected by existing reproductive health services as they are considered to be the healthy population (UNFPA, 2011; Dehne and Reidner, 2005). The population of Zimbabwe is relatively young with more than 62 percent of its population below the age of 24 (UNFPA, 2011). Adolescents constitute 47 percent of the total population (MoHCW, 2011). The challenges for young sexual active people in Zimbabwe include unintended pregnancy, unsafe abortion, and early marriage or school drop-out, sexually transmitted infections (STIs) including HIV/AIDS (Save the children, 2004). Early childbearing leads to obstetric complications which eventually lead to high maternal mortality and morbidity. Failure to address the SRH challenges have negative repercussions on social, economic development and can be life threatening.

According to ZDHS 2005/6, Zimbabwe reported a high rate of teen pregnancy which stood at 21% for the 15 to 19 years and this revealed limited access to family planning services among the adolescents (CSO, 2007).Approximately 70 000 illegal abortions take place in Zimbabwe annually. Reports indicated that the majority of clients seeking post abortion care were within the 15-24 age group (IRIN, 2005). Restrictive law on abortion still exists in Zimbabwe and many women are dying because of the complications associated with unsafe abortion (IRIN, 2005). In addition there is stigma attached to abortion through religious or political leaders hence the cases of abortion are under reported in most countries (Grimes et al 2006).

Women and girls in Zimbabwe continue to suffer from gender based violence. In 2006 more than 8 600 cases of child abuse were reported in Zimbabwe (IRIN, 2006; (Gwirayi, 2013). Neighbors and relatives were found to be perpetrators of sexual abuse in which neighbors account for 41% and relatives 27% of the sexual abuses (Langa, 2012).

HIV/AIDS prevalence has declined to 15.6% from 25% in 2003, 20% in 2005 and 16% in 2007. HIV prevalence among young people in Zimbabwe is estimated to be three times higher in women aged 15 to 24 (11%) than men of the same age with (4.2%), (UNFPA 2011; CSO, 2010). The young generation remains vulnerable as they do not perceive themselves to be at risk of contracting HIV (Ministry of Youth Development, Gender and Employment creation, 2000). Number of children orphaned by HIV/AIDS continue to increase reached an estimate of 1 008 542 in 2006 (UNDP, 2013).

Young people tend to experiment and practice risky sexual behaviors due to peer pressure. Adolescents in Zimbabwe engage into premarital sex and most of them have early sexual debut girls the average is 18.6 and boys is 20.8 years (CSO, 2012). Unprotected sex puts young people at higher risk of getting unwanted pregnancies and STIs including HIV/AIDS (Senderowitz et al., 2004). Unmet need for planning remains static at 13% for almost a decade (CSO, 2012).

Zimbabweans consider virginity among the young unmarried girls as precious and therefore premarital sex is discouraged since the payment dowry is linked to virginity (Marindo et al., 2003; Nyoni 2008). However, traditional practices force girls into premarital sex and forced marriage for ritual purposes for appeasing the avenging spirits (kuripa ngozi) (Kachere, 2013). About 21% of children (mostly girls) are married before attainment of 18 years (Womensphere, 2009).

Adolescent sexual reproductive health programs are relatively a new phenomenon in Zimbabwe and most of the African countries (Erulkar et al., 2005). Addressing young people's sexual reproductive health needs will help Zimbabwe to achieve the Millennium Development Goals (MDGs).

2.2 Justification

Adolescence is a transitional stage faced with many dilemmas. When needs of the adolescents are not addressed, this will derail the health goal of improving the health of the community. It hinders the focus for achieving targets for Millennium Development Goals and other health strategies. Focusing on factors that influence adolescents' access and utilization will reduce vulnerability to risk behaviors and negative consequences which can

affect their present and future. There is evidence that provision of ASRH services will yield positive reproductive health outcomes (Stone &Ingraham 2003; Hocklong et al., 2003).

Improvement in utilization and access to young people's sexual reproductive health services in Zimbabwe will reduce some of the critical problems such as school drop outs, STIs including HIV and AIDS, unintended pregnancy which leads to unsafe abortion and high maternal mortality rate. Young people's sexual reproductive health needs have been neglected and yet their crucial and complex stage needs efforts of parents, community and health service providers.

Increased focus on ASRH services, however little research has been conducted to assess what characteristics of RH services are most important to the young people (Erulkar et al., 2005).

Therefore exploring barriers to young people's access and utilization to sexual reproductive health services in Zimbabwe is essential not only because of the size of their population. It is also because of need to meet the sexual reproductive health needs of young people and their roles in shaping the future of their different communities as well and the nation at large.

2.4 Main objective

To identify factors influencing access and utilization of sexual and reproductive health services by young people in Zimbabwe in order to make recommendations for improving the ASRH program.

2.5 Specific objectives

1. To describe the current situation on access and utilization of adolescent sexual and reproductive health services in Zimbabwe.
2. To explore the socio-economic, socio-cultural and health sector factors influencing access and utilization of ASRH services in Zimbabwe.
3. To find evidence based interventions in the region to be applied in Zimbabwe.

4. To explore current strategies, strengths and weaknesses in addressing the sexual and reproductive health needs of young people in Zimbabwe.

5. To make recommendations to inform policies and programs to make them more responsive to sexual and reproductive health needs of young people in Zimbabwe.

2.7 Methodology of the study

A literature review will be carried out. It will try by all means to include literature from Zimbabwe although there is limited literature from Zimbabwe on the topic of interest therefore will include countries within the Sub-Saharan Africa because the countries have similar context with Zimbabwe. The study will focus on unmarried young people.

Search strategy

Search engines to be used during the study will include Google, Google scholar, pub Med and various websites such as Family Health International (FHI), WHO, UNFPA, IPPF/RHO, Alan Guttmacher Institute. Organizational information which includes Ministry of Health and Child Welfare (MOHCW) Zimbabwe, Zimbabwe National Family Planning (ZNFPC) and KIT library will be used during thesis writing. Also major documents which include the ZDHS, Adolescent sexual and reproductive health strategy, Zimbabwe National AIDS Strategic plan will be reviewed.

2.8 Conceptual model

After reviewing different conceptual frameworks the chose Andersen's Behavioral model (1995) (see Annex 4) to guide me in exploring factors influencing access and utilization of sexual and reproductive health services among young people in Zimbabwe.

The framework assisted the writer in understanding and explaining the factors that influence access and utilization of ASRH in Zimbabwe. The original Andersen's behavioral model categorized the factors into four main categories which include environment, population characteristics, and health behavior and health outcome.

The same categories will be used although there are some variables which are important such as cultural and economic factors that are to be included in the study which were not included in the original Andersen model as the original model focused on family whilst the thesis will focus on individual factors.

Environment: Environmental factors that influence utilization of health care system include laws, policies, infrastructure and health care system.

External factors according to Andersen's behavioral model include economical and physical factors.

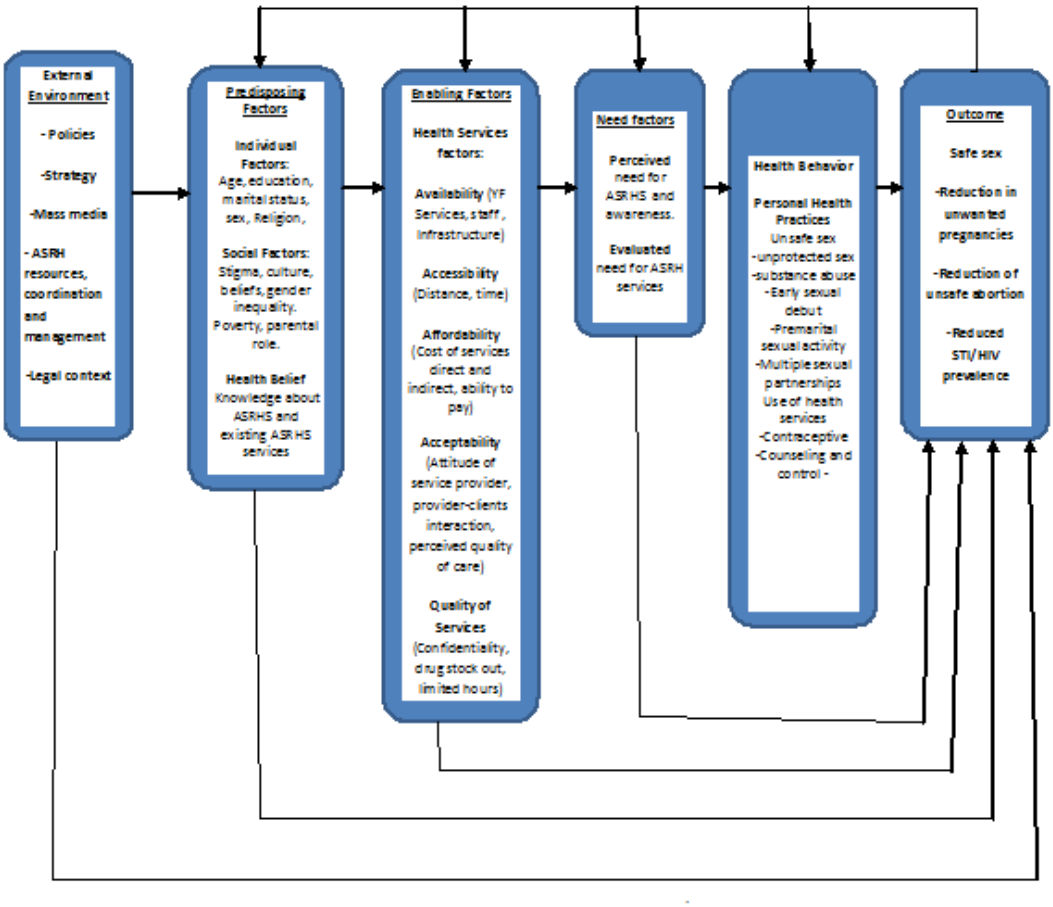
Population characteristics: Andersen's model the individual's use of health services is determined by population particularly the factors that can enable or impede use (Andersen, 1995). The predisposing factors to be discussed in this study include age, gender inequality, education and knowledge about services. The enabling factors will include affordability (income), geographical location, and accessibility of services to the community.

Health behavior: According to Andersen health behavior includes health practices and utilization of health services. Health practices determine utilization of health services and health outcome (Andersen, 1995). In this study personal health practices to be discussed will include early sexual debut, unsafe sex, substance abuse and multiple concurrent partnerships.

Outcome: Utilization of health services is the main focus of Andersen's model and will also be the main focus of this study. Utilization of health services will determine the outcome thus the health status and consumer satisfaction. In this study the outcomes will be having safe sex, reduction in the prevalence of unwanted pregnancies, STIs including HIV, unsafe abortions and client/consumer satisfaction.

FIGURE: I

The conceptual Framework of the study explaining Access to and utilization of services, adapted from Anderson, 1995.



2.9 Study limitations

This study is based on literature review from Zimbabwe, sub-Saharan Africa including other countries worldwide. Only English written publications were used. Grey literature will also be considered in writing this thesis. There are very few studies carried on ASRH program in Zimbabwe therefore it was difficult to find current studies. The information on sexual behavior for young people cannot be relied upon because discussing sexuality issues is a taboo in Zimbabwe hence there is possibility of underestimating the actual behavior.

Logistical issues mainly on the legal processes, cost and time frame limited the possibility of collecting primary data on the topic of interest therefore secondary data will be used only.

CHAPTER THREE: SEXUAL AND REPRODUCTIVE HEALTH SITUATION AND CAUSES OF POOR SEXUAL HEALTH AMONG YOUNG PEOPLE IN ZIMBABWE

This chapter will focus on reviewing the current issues related to the sexual and reproductive health situation of young people in Zimbabwe.

The results from Zimbabwe Demographic Health Survey (ZDHS) 2005/6, ZDHS 2010/11 and other sources will be presented in this chapter in order to illustrate the current status of ASRH in Zimbabwe. The selected indicators to be presented are based on available data.

In addition the chapter will review the causes of poor sexual and reproductive for young people in Zimbabwe.

3.1 Sexual behavior of young people in Zimbabwe

3.1.1 Abstinence

Policy makers, traditional and religious leaders promote abstinence as exclusive intervention for unmarried young people to prevent STIs and pregnancy (Marindo et al., 2003). Abstinence is defined with religious connotation as "no sex until marriage", and therefore young people tend to hide that they are sexually active in order not to disappoint their parents. The traditional and religious norm encourages young women to maintain their virginity until marriage. However studies proved that abstinence can be difficult to practice (Marindo, et al 2003).

In the 18 to 24 age group about 39% of young women and 25% of young men had sex by the age of 18.The ZDHS 2010-11 reported a slight decline in the percentage of young people who had sex by age 15 since 2005-06, thus from 5% to 4% among both young women and men. Contrary to this a slight increase was observed in the women aged 18-19 years as 36% reported that they had sex before age 18 in ZDHS 2005/6, which increased to 39% in the ZDHS 2010-11, whereas a decline from 32% in 2005-06 to 30% in 2010-11 was marked among young men (CSO, 2012).

3.1.2 Early sexual debut

About 4% of adolescents in Zimbabwe initiate sex when they are still physically and emotionally immature to make decisions on sexuality and parenthood. Globally, in 2010, 12% of 135 million children born that year were born to mothers aged 15-19 and 32% were born to mothers aged 20-

24 (UNAIDS, 2012). Young people who initiate sex at an early age are less likely to use condoms and contraception because they lack information (McNeely et al., 2002). About 6% of women and 2% of men have had sex by the age of 15. The median age of first sexual intercourse Zimbabwe is 18.9 years for women and 20.6 years for men (CSO, 2012). Young women start sexual activity almost two years earlier than men. However there is variance between young people of the same age who reside in urban youths, initiate sex 2 years later than their rural counterparts (CSO, 2012).

3.1.3 Premarital sexual activity

Although, abstinence is encouraged the truth is premarital sex exists among young unmarried people in Zimbabwe and other countries. Premarital sex exposes young people to health problems such as STIs including HIV/AIDS, unintended pregnancies, unsafe abortions because young people lack information and access to SRH services (Marindo et al 2003).

In Zimbabwe, premarital sex is not socially condoned; hence there is an assumption that it is mostly underreported in surveys. The masculinity and belief that male desire for sex is uncontrollable makes it an acceptable practice for young men to engage in casual and premarital sex. Contrary, for unmarried young women the idea of payment of bride price and avoiding embarrassment of premarital pregnancy leads to strict measures to discourage premarital sex. In the event of premarital conception, the couple is forced to marry urgently or alternatively the man pays woman's family compensation usually referred to as "damage" (Marindo et al., 2003).

3.1.4 Unwanted pregnancy and unsafe abortion

Young women are more susceptible to unintended pregnancy due to the increased rate of premarital sexual activity and also limited access to contraception and related information (Tripney et al., 2013). According to ZDHS 2010-11 of all the births which occurred in Zimbabwe, about 68% births were wanted and 25% unplanned. The ZDHS 2005/6 reported a high rate of teen pregnancy of 21% among the 15 to 19 age group. In addition fertility is higher in rural girls where it was reported to be 12% than in urban (7%) (UNFPA, 2011). The high statistics indicate limited access to family planning services. Limited availability of youth friendly services, social norms and values were also cited as contributing factors towards low access to SRH information.

Pregnancy and child bearing pose serious complications to the young people especially those who are below 16 years since their physically immaturity makes them more susceptible to serious obstetric complications. Approximately 6% of the 15-19 years old adolescents and 9% of young people aged 20-24 were pregnant at the time of the ZDHS 2005/6 (MoHCW, 2009). Majority of these were from the rural population. Seventy two percent of the female young people (15-24) who had begun child bearing were aged 15-19 years when they first gave birth. During the ZDHS 2005/6 approximately 4% of the young people who were interviewed reported that they had terminated a pregnancy.

According to ZDHS 2010/11 unmet need for contraception in Zimbabwe remains static at 13 percent. Information on unmet need gives information on family planning efforts. Reasons for unmet include fear of side effects, religious objection, lack of knowledge and inaccessibility (Gribble, 2012).

An estimate of 70 000 abortions occur in Zimbabwe annually (IRIN, 2013). The proportion of young people who ever had a terminated pregnancy was 2.5% in urban areas and 5% in rural areas (MoHCW, 2009). Although most of the abortions are done secretly, most of the community members are aware that it is a serious public health problem. Abortion is illegal in Zimbabwe unless the mother's life is threatened. Abortions have serious implications on women's health as they account for 13 % of maternal deaths worldwide (Settergren et al., 2000).

3.1.5 Sexually transmitted infections, HIV and AIDS

The HIV pandemic has affected the females more than males. Young women are more vulnerable to HIV transmission because of their biological set up and early sexual debut (MoHCW, 2009; NAC, 2011). Furthermore inability to negotiate for safer sex and poverty make them more susceptible to HIV. STIs especially genital ulcer disease increases the risk of HIV transmission due to poor skin integrity facilitates easy entry of HIV (Beaten et al; Freeman et al; NAC, 2006). Approximately 3.2% of female adolescents 15-19 and 2.5% male adolescents of the same age reported having an STI in the past 12 months preceding the 2005/6 survey (MoHCW, 2009).

Zimbabwe like most of the Sub-Saharan Africa countries is experiencing the heavy burden of HIV prevalence. Within the 15-24 age group a significant decline in HIV prevalence was observed from 12.5% in 2006 to 11.6 in 2009 (MOHCW, 2011). According to ZDHS 2005/6, the HIV rate for young people

aged 15-24 was 11%, 8% for women and 4% for men. Young people in the urban were likely to be infected than rural youths thus 8% and 7.6% respectively. Knowledge on HIV transmission among young women aged 15-24 is still relatively low at 35% (MIMS, 2009).

HIV prevalence for adults aged 15 to 49 continued to show a gradual decline as it reduced from 23.7% in 2001 to 18.1% (ZDHS 2005/6) then to 15% (ZDHS 2010/11). The significant decline is attributable to behavior change (NAC, 2011; UNDP, 2010).

3.1.6 Gender based violence (GBV)

Most victims of GBV are afraid to report because they are often blamed or stigmatized. In Zimbabwe about 25% of women aged 15-49 have been victims of sexual violence and 21% reported that their first sexual intercourse was forced (UN Zimbabwe, 2013). GBV is a major public health problem in sub-Saharan Africa where 30% of women reported high rate of physical violence of 30% (ECSA HC, 2010). Evidence indicates that gender based violence increases the vulnerability of young women to HIV infection. Sexual violence, early sexual debut and child marriage limit the young people's opportunity of educational and social development (Kasedde et al., 2013).The ZDHS 2010/11 reported slight decline in women who reported spousal violence from 31 to 29%. It is also reported that 1 in 4 women experience sexual violence and 9 out of 10 of the cases the woman's current or former husband, partner or boyfriend is usually the perpetrator. One in three women aged 15-49 have experienced physical violence since the age of 15 (UN, 2013).

Orphans and neglected children (street children) have often been victims of sexual violence because they lack protection. Adolescents with disability have also been victims of GBV. Mostly their SRH needs are not addressed as they are perceived to be asexual (Greydanus, 2008). Some are sexually abused basing on the assumption that they are still virgins since the myth that sleeping with a virgin will cure someone from HIV exists in Zimbabwe (Nyakanyanga, 2013). The aggravating effects of forced sex makes these risk populations susceptible to injuries, unwanted pregnancy, STIs including HIV/AIDS and lack of socio-economic development (UNFPA, 2006).

3.1.7 Condom use at last higher risk sex

Condom use is one of the strategies for preventing HIV transmission. ZDHS 2005-06 reported that 42% of young women (15-24 years) used condoms

the last time they had sex with a high risk partner compared to 68 % of men of same age. Condom use is relatively high in high-risk sex (non-regular partners) since the 1990s, whilst it remains low in regular partners and married people (Gregson et al 2010).

3.1.8 Contraceptive use among sexually active unmarried young people

Contraception plays a vital role in fertility control. In Zimbabwe contraception knowledge is almost universal (97%) women and (98%) men. Contraceptive use is pill dominated (41%), injectable use 8%, male condom and implant use increased by 1% to 3% (CSO, 2012).

According to ZDHS 2010-11, contraceptive use among unmarried sexually active women was 35.1% in the 15-19 age group and 57.7% among the 20-24 age group. Slight increase in the total contraceptive prevalence rate (CPR) was noted the last surveys 2000 (59%), 2005/6 (60%) and 61.7% (ZDHS 2010/11) (CSO, 2012). The level of support for teaching children about condoms remained unchanged from the one reported in ZDHS 2005/6 thus 41% among women aged 18-49 and 48% among men age 18-49 (CSO, 2012). The contraceptive use is positively associated with women's level of education as the ZDHS 2010-11 reported that 43% of currently married women with no education use contraception whilst 67% of those with more than secondary education use contraception. A study conducted in Zimbabwe identified that poor young people were among the people with the highest prevalence of unmet need of contraception (Magure et al., 2010).

3.2 Causes of poor sexual and reproductive health for young people in Zimbabwe

3.2.1 Early marriage and teen pregnancy

Early marriage makes individuals more susceptible to STIs including HIV. Early marriage is associated with early childbearing who leads to high fertility rates and obstetric complications. The median age at first marriage among women and men in Zimbabwe is 19.7 and 24.8 years respectively (CSO, 2011).

Teen pregnancy is one of the leading cause of death among young women aged 15-19 mainly because of child birth complications and unsafe abortions (Chineduari, 2012). In the last decade more than 58 million girls worldwide were married before 18 years and 15 million were aged 10-14. The majority

of women were married against their choice. However, there is evidence that girls who have access to education are less likely to marry early. Forced marriages among adolescent girls globally ranges between 11 and 48% (UNAIDS, 2012). Zimbabwe is one of the countries with the highest child marriage prevalence and average being one out of three girls is likely to be married before attaining 18 years. However, current data show a decline from 34% in 2006 to 9% in 2012. In 2011, about 31%of women aged 20-24were married or in union before their 18th birth day (UNFPA, 2012)

According to the 2010-11 ZDHS, 24% of young women aged 15-19 years have already started childbearing, 19% are already mothers and 5 % pregnant with their first child. Young motherhood is higher in the rural areas than urban areas. Young women in the poorest households are four times likely to have started child bearing by the age of 19. The median age at first birth for women age 25-49 is 20.2.Women living in the urban areas have their first birth later than the women living in the rural areas .Women with no education have their first birth at median age of 18.6 compared to 24.3 among those with secondary or higher education(CSO, 2012).

3.1.2 Causes of premarital sex

Poverty usually linked to premarital sex as young girls engage in survival sex in Zimbabwe and other countries. There are certain cultural norms which promote premarital sex. For example a recent study in Zimbabwe, revealed that some young girls undergo training sessions so that they become sexually competent (chinamwari) especially descendants from Malawi and Zambia (Moyo and Zvoushe, 2012). Also cultural norms related to masculinity promote youths to engage in premarital sex. Surveys also revealed that young people face a lot of pressure from peers and love partners to engage in premarital sex (SAfAIDS, 2011).

3.1.3 Multiple concurrent partnerships

Multiple concurrent partnerships involve risky sexual behavior which makes individuals vulnerable to STIs including HIV. There is evidence that the significant decline in HIV prevalence in Zimbabwe is attributable to behavior change. However multiple concurrent sexual partnerships are still marked in some communities in Zimbabwe. For example universities and colleges and the main motive being economic benefits (Gregson et al., 2006; Mahomva et al., 2006). ZDHS 2010-11 reported that men are more likely to engage in multiple sex partners than women (8% and 1% respectively) and among

men who had multiple sex partners in the last twelve months, 51% reported use of condoms in their recent sexual intercourse. As for women it was reported that the number was too small to measure (CSO, 2012). Young males engage in concurrent partnership with the intention of gaining sexual experience through experimentation with different females. The study also revealed that young females are catching up with men in concurrent sexual partnerships and society is gradually becoming permissive to premarital sex (Mavhu et al., 2011; Shumba et al., 2011). Masculinity also promotes multiple concurrent partnerships among young men (Skovdal et al., 2011).

3.1.4 Cross-generational sex

Sexual practices differ in context because of cultural and social environmental difference; however in many societies' young women engage in sexual relationships with men who are older than their age (WHO, 2005; CSO, 2012). The practice contributes to the transmission of STIs including HIV because the age difference introduces uneven safer sex negotiation power. In the year preceding the 2010-11 ZDHS, 15% young women aged 15-19 had sexual intercourse with a men (sugar daddies) who are 10 or more years older (CSO, 2012). Studies carried at the University of Zimbabwe showed that young people engage in a cross-generational sexual relationship mainly for economic benefits such as cash and other resources. The practice makes the young people susceptible to contracting HIV as they fail to negotiate for safer sex (Shumba et al., 2011).

3.1.5 Causes of unprotected sex

Norms related to femininity discourage young women to have knowledge on sexuality and preventing themselves from controlling their bodies. Fear of intimate partner violence prevents some women from negotiating for safer sex through condom use (UNICEF, 2008). Risky sexual behavior among young people is due to lack of factual knowledge which leads to myths that condoms reduce sexual desire and girls fear being labeled as prostitutes (Mashamba et al., 2002). The stereotyped norm of masculinity among young men leads to unprotected sex whilst on the other hand girls' subservient norm makes them fail to negotiate for condom use (Marindo, 2003).

CHAPTER FOUR: HEALTH SYSTEM FACTORS THAT INFLUENCE ACCESS AND UTILIZATION OF SRH SERVICES BY YOUNG PEOLPLE.

4.1 Health system factors that influence access and utilization of sexual and reproductive health services by young people

Young people in Zimbabwe face several health system related barriers to access SRH services and information. The factors will be discussed mainly in relation to availability, affordability and accessibility.

4.2.1 Availability of services

Availability of ASRH health at all levels of care enables adolescents to access SRH services. Only 237 out of the 1533 health facilities have managed to establish youth corners in Zimbabwe. In additional there are 26 community based youth centers throughout the country. The existing centers are very few to cater for the whole population of youth people in Zimbabwe. Geographical distance of heath facility was reported to be barrier for access and utilization (Obrist et al 2007). An assessment conducted in Zimbabwe on SRH revealed that contraceptives were usually available. However, stock outs were reported on drugs for treatment of STIs, pregnancy test kits and emergency contraception. Absence of standardized package for ASRH services was also a major gap noted in Zimbabwe (MoHCW, 2009).

Catholic run mission hospitals in Zimbabwe do not support distribution of contraceptives including condoms basing on the belief that it promotes promiscuity and prostitution and this has compromised access to contraception (Smith, 2011; Feldman and Maposhere, 2003

Unmet need for family planning among young women: The unmet need for family planning in Zimbabwe remains static at 13 percent for the past 20 years. The challenge being experienced is that the modern methods of contraception are dominated by the oral contraceptives (pill). This is limiting on the contraceptive method mix and eventually limits the clients' choice. The situation is further worsened by inadequate number of Community Based Distributors (CBDs) who are key drivers of family planning program in Zimbabwe at community level and are expected to reach clients in the hard to reach rural areas. For the past decade the contribution of CBDs in Zimbabwe has declined to below 5% (UNDP, 2013) The only option for the clients is to access from public health facilities thus making them less accessible especially for the rural population. The

coverage have been also been hindered by failure to replace those who retire.

Significant achievement has been noted in the demand for modern methods of contraception in Zimbabwe which rose from 63% in 1994 to 71% in 2006. Furthermore an increase in the contraceptive prevalence was 48% in 1994 and 60% in 2009 and subsequently 65% in 2009 (UNDP, 2010). The mentioned achievements have contributed in gradually reducing fertility rate from 4.3 to 3.6 children per woman including the adolescent fertility which gradually declined from 102 births per 1,000 women to 99 births for women aged between 15 and 19. However it has been noted that disparities exist within the indicators according to social status, place of residence and age group (UNDP, 2010).

4.2.2 Affordability

The level of income is an essential determinant for access to SRH. Most young people in Zimbabwe are unemployed and live below the poverty line and this makes it difficult for them to afford the medical expenses.

Poverty: This is a barrier for access to SRH as it tends to inhibit young people from making a journey to the health facilities and fees for the services (Restless Development, 2012

Cost of services: Health service utilization is strongly associated with socioeconomic status particularly services that require payment of user fees which is usually a barrier for access for health services. Most of the adolescents are not employed and depend on their parents or guardians for financial resources (MOHCW, 2009). Furthermore majority of the Zimbabwean population live below the poverty line therefore cannot afford payment for medical services. Studies have confirmed that cost of health services can hinder adolescents' access to contraceptives as some costs are not affordable.

According to a recent assessment carried out on reproductive health, it was also noted that council, district, provincial and central hospital were charging for health services irrespective of age and social status of adolescents. The adolescent expressed much concern on transport costs when referred to higher levels of care.

4.2.3 Accessibility and utilization of ASRH services

As cited before the majority of Zimbabweans live in rural areas where most of the rural health centers are situated in or near business centers and are spaced within a distance of about 20 to 30 kilometers. The clinics offer integrated package of primary health care services including reproductive health care (Laryhaug et al 2003). The 2008, MoHCW ASRH assessment in five of the ten provinces revealed that young people were more concerned about transport costs when referred to higher levels of care and also the 16 years age restriction for voluntary counseling and testing for HIV (MoHCW, 2009).

Outreach services: An assessment conducted revealed that targeted community outreach was weak at all levels of care and were mostly limited to STIs, HIV and AIDS talks and distribution of condoms.

4.2.4 Staff competencies and quality of services

Adequate, appropriately trained and motivated service providers are a critical component in the provision of more efficient health services (MoHCW, 2009). Zimbabwe health service delivery is currently facing a critical shortage of qualified and experienced due to high staff attrition due to poor remuneration especially in the rural areas. Some health institutions are run by untrained staff and newly qualified staff that lack experience to deliver services (MoHCW, 2009). In response to crisis Zimbabwe introduced the Primary care nursing (PCN) mandated to work in the rural health centers. Also as task shifting strategy a new cadre the primary care counselors to increase the uptake of HIV testing and counseling (NAC, 2011

Service providers' competencies, attitudes towards clients, and ability to offer confidentiality and privacy are fundamental determinants which can promote or hinder adolescents to access SRH services. All these factors are centered on client satisfaction. Erulkar et al. (2005) in as study carried out carried out in Zimbabwe and Kenya to determine the factors which the adolescents considered to be important for them as they seek ASRH services. The adolescents revealed that they value short waiting time, friendliness of staff and confidentiality.

Attitude of staff service providers' hostility, judgmental and unwelcoming attitude have impact on young people utilization of services in Zimbabwe (Erulkar et al 2005). Similar obstacles for adolescents' utilization of youth

friendly services were found in a study conducted South Africa (Baloyi, 2009).

4.2.5 Clinic operating times

Convenient opening times promote access and utilization of ASRH (Regmi et al., 2010). Opening hours at ASRH facilities are 0730 to 1600 hours and this was found to be inconvenient time for the young people since they will be at school or at work during the operating times (MoHCW, 2009; Erulkar et al., 2005).

The availability of trained service providers is an essential aspect since friendliness of services depends on staff competencies and receptiveness and this motivates and enables adolescents to use and also recommend their peers to utilize the ASRH services (WHO, 2002). A study conducted out on preferences of adolescents in Zimbabwe and Kenya revealed that young people value ASRH services where confidentiality is guaranteed, service providers are friendly, short waiting time and low cost (Erulkar et al 2005). Quality and consistency of ASRH services is guaranteed by ensuring availability of trained service providers. An assessment to explore provision of ASRH services in Zimbabwe noted that there was no standardized package for provision of comprehensive ASRH services at all facilities. In addition the assessment revealed that there was no standard definition of "youth friendly corners"

4.2.6 Supplies and equipment

Availability of diagnostic equipment and essential drugs is necessary for implementation of ASRH. An assessment carried out revealed that there were no stock outs of contraceptives , however drugs for treating STIs and pregnancy testing kits were unavailable at all levels of care. Drug and equipment limit access for the services and usually leads to transfer to the next level of care which is costly to the young people (MoHCW, 2009).

4.2.7 Financial resources

Funding plays a critical role in the implementation of programs. Within the health system of Zimbabwe inadequate funds have let to shortage of drugs, laboratory and diagnostic equipment is hampering the provision of effective integrated SRH and HIV services. For example in the recent assessment for SRH and HIV integration the service providers indicated that sometimes clients had to walk long distances to access inter-facility referred services (MoHCW, 2011).

4.2.8 Mass media

The tradition practice where young people used to get information on sexuality from paternal aunt, uncle or grandparents is gradually weakening in Zimbabwe because of urbanization (Marindo et al., 2003). SRH information is essential in order to empower young people to make informed decisions on SRH issues. Zimbabwe National ASRH strategy (2010-2015) emphases the need for young people to be empowered with correct updated and age appropriate information. In Zimbabwe, mass media widely used to reach the target audience in several programs because of its potential to disseminate information to a larger audience. Information Education and Communication (IEC) material is being distributed through the ASRH program in (MoHCW, 2009). An assessment carried out in 2008 revealed scarcity of social and behavior change communication (SBCC) materials.

4.2.9 HIV and AIDS awareness and testing

Approximately 97% female and 99% male of young people in Zimbabwe had heard of HIV or AIDS and only 44% and 46% for female and male young people had comprehensive knowledge about HIV and AIDS. The majority of the young people thus 86% males and 79% women mentioned abstinence as an HIV prevention strategy (MoHCW, 2009). Condom use in 2005 by men aged 15-24 was 45.6% and 43.7 for women.

According to the ZDHS 2010-11, about 73% of female and 69% male young people were aware of where to get HIV test and approximately 25% of female adolescents (15-19) and 15% of male adolescents had undergone HIV testing before 2010-11 ZDHS. Comparing with 1999 ZDHS the number of those who were tested for HIV increased from 6% for females and from 2% for males (MoHCW, 2009).

Early identification enables young people to start early treatment leading to better health outcomes and prolonged lives (CDC, 2009).There are different models for entry to HIV testing in Zimbabwe and these include voluntary testing and counseling (VCT) which is client initiated and provider initiated testing and counseling (PITC) where a service providers routinely offer HIV testing. The challenges for HIV testing and treatment for adolescent include late presentation due to lack of HIV diagnosis facilities, non-adherence, stigma and discrimination, late or non-disclosure, denial and limited information (NAC, 2011).

4.2.10 Peer educators

Peer education concept is recognized worldwide as an effective program for imparting correct SRH messages to young people. Peers programs have been supported in many countries by organization such as UNFPA and IPPF. Peer education program also exist in Zimbabwe where the peer educators aged 18 to 24 are volunteers. HIV clubs were initiated where the school children share information on HIV. Peer education program example is Restless Development program which is being implemented in Sierra Leone, Zambia, USA and Tanzania.

Studies found trained peer educators to be more credible source of information than adults (Angwersen, 2001, Mason, 2003; WHO 2007). Therefore young people are likely to ask their peers on sexuality issues. Generally, peers can influence good or bad behavior among young people.

4.2.11 Monitoring and Evaluation

An assessment conducted reported poor coordination and weak National Health Management Information System (NHMS) as service providers used different data collection tool, thus making it difficult to monitor key ASRH indicators (MoHCW, 2009). Poor coordination at national level also resulted in confusion at service delivery level as health workers receive instructions from different people because of fragmented of programmes (MoHCW, 2011).

4.3 Best Practices Examples

TANZANIA African Youth Alliance (AYA) PROJECT:

Integrating Youth friendly sexual and reproductive health services in public health facilities: A success story and lessons learned in Tanzania (2005)

The aim of the project was to improve overall SRH for young people aged 10-24 years and reduce the incidence of HIV/AIDS and other STIs. The project was implemented in selected districts targeting 1.2 million youth aged 10-24 in both rural and urban areas. Policy makers and parents were included as secondary beneficiaries of the AYA project. The objective was to increase use of youth friendly adolescent sexual and reproductive health services.

AYA worked with government to strengthen the health system in an attempt to establish sustainable quality Youth Friendly Services (YFS) SRH. Achievements included increased awareness, transport for supported

provider supervision. Training of service providers, developed training manuals, renovated facilities and created rooms for consulting the youths and some facilities have waiting rooms with equipped with TVs, videos and reading materials. They also managed to advertise facilities. In addition communication between parents, young people and the service provider also improved. Through the innovations the facilities managed to increase the number of facility based SRH services from 113 083 to 243 070 in 2004. Since Tanzania is in the same region and has almost same economic hardships as Zimbabwe, this type of best practice implemented in Tanzania can be strengthened to improve the access and utilization of ASRH services in Zimbabwe by young people. Scaling up of similar interventions would bring success since Zimbabwe has already initiated similar strategies (Pathfinder International, 2005).

CHAPTER FIVE: SOCIO-DEMOGRAPHIC FACTORS INFLUENCING ACCESS AND UTILIZATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES BY YOUNG PEOPLE

5.1 Predisposing factors

Here the predisposing factors include individual, social and health belief factors that exist.

5.1.2 Age

Young people are less likely to utilize health care facilities than older people because most of public health facilities do not have services that are address their needs (WHO, 2002). In Zimbabwe, SRH services are integrated under maternal and child health family (MCH) unit where the young people mix with adults. A study conducted in Zimbabwe revealed that young people are not comfortable to use SRH services in the presence adults. This is because they do want parents to know that they are sexually active. Also young people lack experience in accessing services for themselves since they are guided by their parents/guardians when seeking medical care in most cases (CSO, 2012).

5.1.3 Sex

Men often fail to get routine checkups or preventative, counseling because they often ignore or delay seeking attention when sick. This is because they ignore pain. In some cultures is men are socialized to endure the pain threshold (Nyoni, 2009).

5.1.4 Marital status:

Marital status is also an important determinant for adolescents' access to SRH services since marriage is highly valued in Zimbabwe. Unmarried boys and girls feel shy and embarrassed to talk about sexuality issues and even to access condoms and contraceptives. Use of condoms by young unmarried people leads to stigmatization since premarital sex is socially unacceptable (Regmi et al, 2010).

5.1.4 Poverty

Poverty and ill health are associated and poor people have less access to health services (Regmi et al 2010; Peters et al., 2008). Poverty deprives many people of their fundamental human rights on health to have access to health care services.

5.2 Enabling factors

5.2.1 Income

Income is determines the material resource and socioeconomic status of an individual (WHO, 2010).The income determines the capability of young people to pay for services. A study conducted in Zimbabwe, revealed young people indicated that they cannot afford the ASRH services costs (Erulkar etal, 2005).

5.2.2 Education

Zimbabwe literacy level is among the best in the region. Many studies show the association between education level and health service utilization. Also continuation with education keeps young people occupied and empowers young people with life skills and information and reduces prevalence of unplanned and early pregnancy, STIs and HIV (SAfAIDS, 2011). Evidence shows that people who are educated are likely to seek health information and use it including information on disease prevention (CSO, 2012). Findings from survey on young people in Zimbabwe revealed that out-of school youth and those with low level of education lack knowledge on condoms and are less likely to use the condoms (SAfAIDS, 2011). For example in Pakistan about 50% of sex workers who were not educated lacked awareness on HIV transmission. This led to low utilization of voluntary testing and counseling (VCT) (Afridi et al. 2010). A study carried out on HIV knowledge noted that 4% of grade six students in Zimbabwe had desirable knowledge against 93% of teachers who had knowledge (NAC, 2011).

5.2.3 Knowledge and information

Knowledge of existence of services by place, type and importance of services on SRH empowers adolescents to make informed decisions and also promotes access and utilization of ASRH services. Young people receive SRH information from different sources such as the media, parents, teachers, peers and health facilities (Ingwersen, 2001). Many studies confirmed that education and awareness program are effective means of addressing ASRH needs.

Young people do not have adequate information on sexual related issues (Erulkar et al., 2005). For example findings from ZDHS 2010-11 confirmed that young unmarried people aged 15-19 had less knowledge of HIV in comparison to older respondents. The same survey noted that young people 15-24 have lower levels of HIV knowledge than those in older age groups (CSO, 2012).

5.2.4 Place of residence

There are disparities as far as access to SRH services is concerned between the rural and urban inhabitants (NAC, 2011). People in areas have fewer alternatives for getting SRH services than urban. For example a study carried in Zimbabwe revealed that some young people who failed to access condoms resorted to use of empty "freezit" fizzy drink plastics or plastic wrappers to improvise condoms (Marindo et al 2003).

5.2.5 Religion

In Zimbabwe religion is a major determinant for access to SRH services as the FBOs (Faith Based Organizations) influence development of health policies (MoHCW, 2009; MoHCW, 2011; MoHCW, 2003). Religion has to a greater extent influence on parent-child communication concerning sex and contraception. The church doctrine of moral chastity promotes abstinence as the only solution for HIV transmission among young people despite high HIV prevalence and fact that young people engage in premarital sex (Regnerus, 2005; Marindo et al., 2003).Reluctance to promote condom use limits young people option and makes them more susceptible to STIs and HIV.

5.3 Community role

The community plays a major role in the implementation of health programs including health seeking behavior, acceptability of services, sustainability and influence implementation of certain policies (Kesterton and de Mello, 2010).

Some countries such as Rwanda, Kenya and Cameroon have realized the need for empowering the teachers, community leaders, parents to help them understand the SRH needs of adolescents and become supportive of their needs. Empowerment of their training has been supported by UNFPA (Ingwersen, 2001).

5.3.1 Parental role

Parents play a critical role in determining the health outcomes of the young people. As primary care givers or gatekeepers they protect their children from negative outcomes through behavior control and appropriate information dissemination. An assessment carried out in 2008 on ASRH in five of the ten provinces in Zimbabwe indicated that parents' involvement in provision of ASRH services was weak (MoHCW, 2009). A study in Zimbabwe noted that some parents in Zimbabwe are willing to discuss information on sexuality with their children but they lack skills and accurate information on SRH (MOHCW, 2009).

Although the young people are expected to get information from their parents, cultural norms and values have been obstacles since discussing about sexuality issues between parents and young people has remained a taboo. (MoHCW, 2009; UNFPA, 2011; Chinyanganya and Muguti, 2013). Alternatively young people SRH information from media such as television, radio, internet and print media (MoHCW, 2009

Parental consent for young people below 16 years seeking STI treatment and contraception compromise minors' confidentiality and autonomy (CRLP and CLF, 2002). Such restrictive circumstances may force young people to resort to unauthorized street markets where they risk getting expired contraceptive and condoms which are provided by unskilled service providers. This has promoted mushrooming of illegal vendors at Mupedzanhamo (local market in the Capital city- Harare). The role of parents is therefore crucial as far as access and utilization of ASRH services are concerned and program managers cannot implement any effective program without involving the parents.

5.3.2 Gender inequality

In Zimbabwe like in other societies women and girls are affected more by GBV than men. Cultural and traditional practices have perpetuated the subservient position of women which makes them more vulnerable to GBV. Traditional practices which violate women's reproductive rights include forced virginity testing, child marriage and pledging of girls for the purpose of appeasing spirits (Tripney, 2013). Girls suffer more criticism if discover their possession or use of condoms, stigmatized as prostitute, by boyfriend and community at large. Boys tend to dominate in sexual relationships for

instance, girls do not anticipate having sex but are usually caught unaware (UNICEF, 2008).

Young girls accept the stereotyped subservient relationships to men. Therefore they fail to negotiate for safer sex especially enforcing use of condoms during sexual intercourse. By being submissive young women lack autonomy and decision making on SRH issues and increase vulnerability. Some young people are forced into marriages and experience forced sexual intercourse (Angwersen, 2001).

5.3.3 Stigma and discrimination

Stigma is a complex concept which is rooted in the values and social norms of a community. It involves negative labeling and usually leads to discrimination and social inequity. Stigma and discrimination are factors which are prevalent worldwide which hinder access to medical services especially HIV services. (Campbell et al., 2005; Sayles et al., 2009).

Young people fear that they may encounter service providers who may be judgmental and also are worried that confidentiality may be compromised. Because most adolescents lack information on reproductive health they may have fear of side effects of contraceptives or misconceptions attached to use of contraceptives (WHO, 2012). In a country where premarital sex is prohibited, some young people do not feel comfortable to visit the clinics because they might be ridiculed or denied services by service providers. Similarly in Kenya adolescents have experienced the same treatment which discourages them to access SRH services at health facilities (Kamau, 2006).

5.3.4 Health beliefs

The beliefs, knowledge and attitude influence the health seeking behavior of individuals and use of health services (Andersen, 1995). The Health Belief Model suggests that people take right decision concerning their health if they perceive themselves to be at risk. Some Zimbabweans believe in the traditional healers, spiritual healers through prophets and hospitals and clinics (Machinga, 2011). Evidence has shown that people delay seeking appropriate treatment because of misconceptions related to certain diseases (Baloyi, 2009). The delay in seeking treatment for disease such as STI will lead to continuous spread of the disease and complications.

CHAPTER SIX: LAWS, POLICIES AND STRATEGIES INFLUENCING ACCESS AND UTILIZATION OF ASRH SERVICES

This section will focus on discussing laws, policies and strategies developed to address young people's sexual and reproductive health needs in Zimbabwe. Policies and laws are important determinants to aid access of adolescents' sexual and reproductive health.

6.1 Adolescent Sexual and Reproductive Health policies and strategies

The goal of Reproductive health Policy is attainment of highest level of RH to all Zimbabweans implementation of the policy is expected to bring development to individuals and the nation. The policy promotes multi-sectorial approach in order to improve SRH. It points out that both private and public sector should provide youth friendly services, life skills and information that will allow the adolescents to fight against unwanted pregnancies, HIV and AIDS (MoHCW, 2002).

The Zimbabwe National Adolescent Sexual and Reproductive Heath Strategy 2010-2015 was developed in response to the International Conference on Population and Development (ICPD) which embraced the new broader concept of reproductive health and rights including Adolescent Sexual and Reproductive Health (ASRH).The strategy emphases the government's commitment in the improvement of reproductive health of young people aged 10-24 years.

Zimbabwe has several policies and guidelines for SRH and HIV. Some of the policy documents include Reproductive Health (RH) policy and RH guidelines, ASRH strategic plan, RH BCC strategic, Family planning guidelines and training manuals. Also the National HIV Policy and the Zimbabwe National HIV Strategic Plan(ZNASP).These two documents are complimented by Health sector HIV/AIDS Prevention Strategy, HIV testing and Counseling Strategic plan, ART Strategic plan and SBCC strategy. In addition the National Condom Strategy including STI Guidelines have been influential documents in the implementation of ASRH programs in Zimbabwe (MoHCW, 2011).

6.1.2 The National HIV/AIDS Policy (1999)

Zimbabwe continued to show her commitment to reproductive health through fighting against HIV/AIDS by developing the National HIV and AIDS Policy in 1999 and in the same year introduced the policy on 3% AIDS levy.

The HIV/AIDS policy promotes universal access to HIV services, however the policy contains contradictory statement concerning the right of children below the legal age of consent (18). The adolescents below the legal age of majority need parental consent to be tested for HIV. The policy also states that children and young people below 16 years have the right to seek STI/HIV counseling, advise and care "depending on each young person's circumstances and potential risks of STIs/HIV''. On this note the policy gives the service provider opportunity to weigh the circumstances to his/her best interest to control service delivery (CRLP and CLP; 2002).
Through the leadership of National AIDS Council also the Zimbabwe National Strategic Plan (ZNASP) 2006-2010 was developed which was reviewed and came up with ZNASP II 2011-15. The strategy calls for implementation of a comprehensive multi-sectoral response to HIV and AIDS.

Social Behavior Change Communication (SBCC): SBCC is an intervention which promotes behavior SRH behavior change among young people in a more preventative approach. Approach also promotes abstinence and other sexual practices being faithful in relationships and increased utilization of SRH services. It was noted that behavior change contributed tremendously in the reduction of HIV in Zimbabwe. NAC report pointed out that there was partial shift in social norms such as reduced casual and commercial sex and reduced ability of men to engage in multiple partnerships. According to a base line survey conducted in Zimbabwe in 2008, 28% of men and 9% of women reported having two or more partners in past twelve months and 10% of men and 3% of women reported having had multiple concurrent partnerships by the year 2010 (NAC, 2011).

6.1.3 Adolescent Sexual and Reproductive Health Strategy 2010-2015

Zimbabwe developed the National Adolescent Sexual and Reproductive Heath Strategy 2010-2015 in response to the International Conference on Population and Development (ICPD) which embraced the new broader concept of sexual and reproductive health to include Adolescent Sexual and Reproductive Health (ASRH). The strategy emphases the government's commitment to improve reproductive health of young people aged 10-24 years (MoHCW, 2009).

An assessment which was carried out on ASRH noted that service providers below national level had limited knowledge of ASRH related laws, policies and strategies which govern their practice. It was also noted that most

programs policies are typically designed for older adolescents (15-24) (MoHCW, 2009).

It was also noted that there is no standard definition in Zimbabwe of ASRH services in Zimbabwe (MoHCW, 2009). However, World Health Organization describes ASRH services as:

"Services that are accessible and appropriate for adolescents .They are in the right place, at right price (free where necessary) and delivered in the right style to be acceptable to young people. They are effective, safe and affordable. They meet the individual needs young people who return when they need to and recommend these services to friends "(MoHCW, 2009).

6.1.4 Child Protection Act

The Act specifies the rights of children and defines a child as anyone below the age of 18.The Child Protection Act stipulates that any Zimbabwean under the age of 18 years is regarded as a minor hence cannot engage/consent for any legal agreement. It protects children and reinforces the children's to human rights (CRLP and CLF, 2002).

6.1.5 GBV Act

Zimbabwe is one of the countries commented for its success in setting a policy framework for GBV prevention and response (ECSA-HC, 2010). However GBV remains a challenge although the 2010/11 ZDHS reported slight decline in women who reported spousal violence from 31 to 29%.

6.1.6 Termination of pregnancy Act (1974)

The policy does not permit medical abortion for social or personal reasons. Procedure is only permitted in circumstances where either the condition the life of the pregnant woman or unborn baby is endangered. Termination of pregnancy may also be permissible in cases where pregnancy resulted due to unlawful sexual intercourse such as rape or incest (CRLP and CLF, 2002).

6.1.7 User fees

Policies and strategy documents support universal access for the Zimbabwean community. However payment of user fees was cited as one of the major obstacles for access and utilization of health services especially for the rural poor population. A study carried in Zimbabwe noted that majority (66%) of the population cannot afford paying for the charged fees (MoHCW, 2009). User fees reduce the actual demand for services especially to the

young unemployed population in Zimbabwe. A system of exemption from user fees at certain levels was created but its implementation has never been a success (NAC, 2011). Although the community based youth friendly centers are offering free services most of the clinical services are not yet available therefore the young people still cannot access the needed SRH services.

6.1.8 Patient's Charter

The assurance of privacy and confidentiality is emphasized in the Patient's Charter of Zimbabwe which was developed through recommendations from Consumer Council of Zimbabwe and Ministry of Health. The document spells out the rights of the clients to access medical care. It includes clients' rights to confidentiality, consent, privacy and respect (Mpofu and Shumba, 2012).

6.1.9 Ministry of Education, Sports and Culture Policy

The policy shows support for HIV prevention, life skills building and abstinence. The policy does not mention condom use among the prevention interventions despite that, young people are sexually active (Marindo, 2003).

An analysis carried out indicated that Government of Zimbabwe has no laws that explicitly refer to adolescent SRH issues and constitution offers no protection to the adolescents (CRLP and CLF, 2002). In addition a recent study revealed that Zimbabwe's policies are not user friendly to people with disability (Mpofu and Shumba; 2012).

CHAPTER SEVEN: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

7.1 Discussion

The main focus of this study was to explore the barriers for access and utilization of sexual and reproductive health services by young people in Zimbabwe. Initially some background characteristics of Zimbabwe were presented, and then the SRH challenges faced by young people in Zimbabwe were explored. The current situation of young people's sexual and reproductive health and the risk behaviors were summarized. The study also looked at the existing services provided in public health institutions, school health programs and NGOs to find out if they offer comprehensive packages. The research further explored the major barriers for access and utilization of SRH services by young people. The strategies, policies and interventions to address SRH needs were looked at and how they act as enablers and barriers for young people to access and utilize SRH services.

This study noted that young people have been a neglected population and they face the risk of SRH problems which are preventable. However they face many obstacles which compromise their access and utilization of ASRH services. According to Andersen's health belief model utilization of health services is determined by the health care system, external environment and population characteristics which include predisposing and enabling factors.

ASRH related laws and policies

Generally, most policies and strategies in Zimbabwe recognize SRH needs of young people. However the government of Zimbabwe is failing to effectively implement and reinforce laws and policies and this compromises access of SRH services by young people. Also service providers have limited knowledge of ASRH related laws, policies, regulations and strategies that govern their work hence they tend to interpret the laws differently and sometimes deny SRH services to young people. Young people lack information on legal policies that protect their sexual and reproductive rights (MoHCW, 2009). Some restrictive laws hinder young people from accessing services such as STI treatment and HIV testing and abortion services. These laws do not consider the young people's vulnerability to unwanted pregnancies and STIs. This study also noted that young people below 18 years cannot make autonomous decisions when seeking SRH as they require parental consent. Some young people therefore have to resort to unsafe

abortions which lead to high maternal morbidity and mortality thereby compromising the attainment of set targets for MDG 5.

The review noted that service costs were hampering access to SRH services by young people in Zimbabwe as they cannot afford (NAC, 2011).

Health system

Major obstacles for young people to access and utilize SRH services were found to be within the health care system. These are the following:

Low government funding was identified as a major factor hampering implementation of ASRH program in Zimbabwe. Lack of funding is hampering scaling up of pilot ASRH programs. There is a mismatch between available services (supply side) and the number of young people who need SRH services (demand side). Youth friendly facilities are not providing adequate coverage since they are few, thereby compromising young people's access to the needed ASRH services

Young people value confidentiality and privacy when they seek SRH services. However confidentiality and privacy was a major problem highlighted by young people.

Although 73% of clients access medication from public health facilities, shortage of essential drugs and medical equipment was experienced. Young people were referred to next level of care (MoHCW, 2009).

The review noted that medical expenses were hampering access to SRH services by young people in Zimbabwe as they cannot afford (NAC, 2011).

According to the ASRH assessment none of the youth centers is offering outreach services. Outreach services are convenient, cost-effective and could improve access of ASRH in hard to reach areas. Outreach services are also a better intervention to reach also young people with disability with services such as information on SRH, condom distribution, contraceptives, HIV testing and counseling. For example the AYA program in Tanzania was successfully implemented by peer educators and it improved improved on youths' knowledge and proper condom use (Pathfinder, 2005).

Human resources

Most public health care facilities are understaffed. Provision of quality health services requires availability of trained and skilled health providers. Shortage of staff was noted to be one of the factors hampering ASRH services in Zimbabwe. Unavailability of adequate staff compromises the quality of health services including ASRH. In addition it increases the workload resulting in long waiting time, shorter counseling time and staff burnout syndrome. Consequently unwelcoming behavior by service providers will lead to low utilization and uptake of ASRH services.

Besides having the skills most service providers are guided by personal values and beliefs when dealing with young people's SRH needs (Hobcraft and Baker, 2006). Service providers' attitude was also discovered to be one of the major determinants of young people's limited access and utilization of services. Young people fear lack of confidentiality. Also the involvement of parents may hinder minors from accessing contraception and treatment of STIs.

Support, Supervision and Monitoring

Lack of support and supervision for the ASRH program was cited to be lacking. This is an essential component which improves on quality of services, staff performance, including accountability.

ASRH information and education through schools and other channels

A school based reproductive health program in Zimbabwe has proved not to work as teaching of reproductive health focuses on HIV whilst neglecting other SRH issues which are equally important such as contraception, condom use and life skills. Failure to fully implement the school health program is a missed opportunity because school children are an already existing audience which needs comprehensive reproductive health education.

The study revealed that young people lack information on ASRH. Evidence shows that the use of mass media can be effective in reaching large populations.

Socio- demographic factors determine the ability to access and utilize SRH services among young people. Most young people access RH services from public health facilities. Socio-demographic factors influence the health seeking behavior of the Zimbabwean community.

Community level

Parents as gatekeepers for the young people, have the powers to approve or disapprove where their children can get information on SRH. The study revealed that most parents in Zimbabwe and other African countries do not sufficiently fulfill their role in educating their children on sexuality.

Gender factors make the girl child more vulnerable and also hamper access to SRH services. Stereotyped gender norms hinder young females from accessing services.

Sociocultural factors have influence on health seeking behaviors and some practices such as early marriage. The study further established that socioeconomic and socio-cultural factors influence young people's access and utilization of existing SRH services.

Peer education

This is a widely used approach especially in low resource countries. The concept has been tried in Zimbabwe through beer halls. However the effectiveness depend commitment of community and key stakeholders (Pebody, 2011). The program is mainly implemented through the NGOs for example UNFPA and ZNFPC. However, it was proven to have merits in other developing countries (Pathfinder, 2005).

Among the discussed factors, people's perceptions about health services influence their utilization. In this study stigma, lack of confidentiality, provider's attitude and embarrassment were among some of the factors which hinder young people from accessing SRH services.

Overall, the reviewed studies, surveys, reports, all factors which include health system organization, socio-demographic, policies, laws, individual and community level factors have implications on young people's access and utilization of RH services. However, health system barriers are major obstacles to utilization of SRH services.

7.2 Conclusion

Young people in Zimbabwe represent the majority of the Zimbabwean population and are a special group with special SRH needs. ASRH services are inadequate and unappealing and they do not address the SRH needs of young people in Zimbabwe. Failure to access and utilize ASRH services by young people results in high prevalence of unwanted pregnancies, unsafe abortions and STIs including HIV/AIDS. Consequently derail attainment of MDGs and lead to less social and economic development.

This study described and analyzed the ASRH services in regard to access and utilization and identified that there are barriers which hinder access to ASRH services in Zimbabwe. The factors determining poor access and utilization of ASRH services include lack of funding, coordination, shortage of skilled staff, restrictive and conflicting laws and policies, poor knowledge and awareness of services, as well as socioeconomic factors, religious and cultural beliefs including individual and community perception.

Zimbabwe ratified a number of international declarations and managed to develop policies, strategies, guidelines to guide the implementation of ASRH. Despite the SRH challenges faced by the young people they still meet barriers as they try to access and utilize SRH existing services.

Lack of equipment and essential drugs compromise quality of SRH services. Adolescents require information on sexuality, life skills and access to promotion, preventative and curative RH services and these can be provided by different partners in different setups in order to compliment the government's effort.

In as much as the adolescents would like to access and utilize the services there are several barriers that inhibit them such as unavailability of services, lack of confidentiality, privacy, costs and inconvenient working hours including some policies .

Certainly there is need for improved ASRH services/program which offers a holistic and comprehensive approach. In order for the program to be more effective there is need for multi-sector approach not only on basis of implementation or funding but to assess effectiveness of assisting adolescents to access sexual and reproductive health services in order to improve their ability to communicate about sexual issues in different settings.

7.3 Recommendations

Service delivery level

- There is need raise awareness on current problems faced by young people and advise on how they can be reduced. Increase awareness and create demand for ASRH services through mass media.
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- There is need for government to scale up the number of facilities that are providing youth friendly services. This will improve on coverage and facilitate both access and utilization of ASRH services.
- The service providers need to be trained so that they attain appropriate skills
- There is need to review staff establishment and incentives for service providers and introduce better financial incentives for employees and fill the vacant posts for service providers including community health workers (CBDs) and peer educators.
- MoHCW need to strengthen the supply chain of reproductive health commodities including contraception method mix

The Ministry of Health should consider improving funding for ASRH program.

- To lobby the policy makers to review the reproductive health education policy and curriculum so that comprehensive information and skills are provided to the in-school youths. In addition the teachers need training on ASRH.

Research recommendations

- The Ministry of Health should conduct a study to evaluate the impact of ASRH program and find effective means of implementing the program.

- There is need to re-design the monitoring and evaluation tools in order facilitate capturing of integrated ASRH data. Need to do an assessment not merely based on implementation and funding but also on effectiveness on assisting young people in accessing and utilizing SRH services in Zimbabwe.

Policy level

- There is need to review policies which restrict access to ASRH services. The termination of pregnancy law so that it facilitates the young people access to safe abortion.
- Review the age of consent for HIV testing and other services.

Community level

- Train and retain essential community cadres (CBDs and Peer educators).

- Create awareness on the importance of ASRH and discourage cultural barriers for imparting information on sexuality to young people.

- Meaningful involvement and participation of young people, parents, schools and community (including leaders) at all levels in order to promote program ownership and sustainability.

REFERENCES

Abortion care in Zimbabwe :Community Perspectives;Available from www.policyproject,com/pubs/policymakers/pmo1 pdf[Accessed on 2 June 2013].

Afridi, N.K., Khan ,S.,Fatima, S. (2010) Factors affecting accessibility and acceptability of Voluntary Counselling and Testing among High Risk Group (HRG) for Human Immunodeficiency Virus (HIV) in NWFP Pakistan, JPMA, 60(265),PP.265-269.

Andersen, R.M. (1995). Revisiting the behavioural model and access to medical care:does it matter. Journal of Health and Social Behavoiur [online] 36(1).pp1-10. Available from: http://globalhealth.stanford.edu/resources/Revisiting_Behavioral_Model_and_Access.pdf [Accessed 26 June 2013].

Baeten,J.M.,Strick,L.B,.Lucchetti,A.(2008)Herpes Simplex virus suppressive treatmentdecreases plasma HIV-1viral load in HSV-2/HIV-1 co-infected women: a randomized, placebo-controlled, crossover trial. Journal of infectious Diseases 2008, (198) pp.1804-1808

Baloyi,G.,O. (2009) The Evaluation of the National Adolescent-friendly clinic Initiative(NAFCI) Programme in Greater Tzaneen sub-District, Limpopo, Province South Africa. Masters Thesis. Unisa. [online]Available from http://uir.unisa.ac.za/bitstream/handle/10500/1640/dissertation.pdf?sequence=1[Accessed on 27 July 2013**].**

Brown, D.W,. Reiley, L., Butchart, A., Kann, L. (2008). Bullying among Youth eight African Countries and Associations with Adverse Health behaviours; pediatric Health 2, 289-299.

Campbell, C., Nair, Y., Maimane, S., Sibiya, Z. (2005)Understanding and challenging HIV and AIDS Stigma, Stigma in HIVAN Community Booklet Series, Centre for HIV and AIDS Networking (HIVAN). Durban: University of Kwa-Zulu Natal.

Center for Disease Control and Prevention (CDC),(2009).Available on http://www.usfca.edu/uploadedFiles/Destinations/Offices_and_services/HPS/PDF_Files/hiv%20testing pdf.[Accessed 2 July 2013].

Central Statistics Office (2000) Zimbabwe Demographic Health Survey, http://www.measuredhs.com/pubs/pdf/FR116/FR116.pdf.Harare, Zimbabwe Macro International Inc. Calverton, Maryland, U.S.A.
Central Statistics Office (2012) Zimbabwe Demographic Health Survey, Available on: http://www.zimstat.co.zw/dmdocuments/Census/ZDHS2011/ZDHS2011KEY.pdf [Accessed on 2 March 2013]
Chineduari, (2012). Teenage Pregnancy Still a Challenge for Zambia; Available on http://www.keycorrespondents.org/2012/03/21/teenage-pregnancy-still-a-challenge-for-zambia[Accessed 26 May 2013].

Chinyanganya ,T. L and Muguti, J. (2013) Taboos and the pragmatics of teaching HIV and AIDS at primary school: Views from selected primary school teachers in Chipaze, Bindura ,Available from; http://www.gjournals.org/GJER/GJER%20PDF/2013/April/Chinyanganya%20and%20Muguti.pdf [Accessed on 22 July 2013].

Dehne K.L and Riedner G (2005).Sexually Transmitted Infections Among Adolescents :The need for Adequate health services; [Online]whqlibdoc.who.int/publications/2005/9241562889.pdf [Accessed on 30 June 2013].

Denhe, K. L & Gabriele R (2005). Sexually Transmitted infections among Adolescents: The need for adequate Health services; Available from http://www.giz.de/Theme/de/documente/en-sexually- transmitted-infections -2005pdf[Accessed 18 May 20, 2013]

East, Central and Southern Eastern Health Community (ECSA-HC). (2002). Rapid analysis of Adolescent Sexual and Reproductive Health (ASRH) and HIV/AIDS related policies in Zimbabwe [online] http://www.youth-policy.com/documents/Joint_Report_Zim_Zamb_Ug_Final.pdf[Accessed on 29 June 2013].

Erulkar, S., Onoka, J. and Phiri A. (2005) what is Youth- Friendly? Adolescents Preferences for Reproductive Health Services in Kenya and Zimbabwe. *Africa Journal of Reproductive Health* 2005, 9(3), pp.51-58.

Feldman, R. and Maposhere, C. (2003). Safer Sex and Reproductive Choice: Findings from "Positive Women : Voices and Choices '' in Zimbabwe. Reproductive Health Matters 2003;11(22):162-173[Accessed 25 July 2013].

Freeman, E., Orroth, K., White, R., Glynn, J., Bakker, R., Marie-Claude,B.,Habbema,D.,Buve, A. and Haye, R. (2007)Proportion of new HIV infections attributable to herpes simplex 2 increases over time: simulations of the changing role of sexually transmitted infections in sub-Saharan Africa HIV epidemics. Journal of Sexually Transmitted Infections 2007,83(suppl),pp.17-24.

Government of Zimbabwe and UNDP (2010). 2010 Millennium Development Goals Status Report Zimbabwe; [Online]; Available on http://www.undp.org.zw/images/stories/mdg/mdgreport2010.pdf?3a1ed061a28f8a5e62fd4865066ea7fa=1c58ca9bf415c25dfe053366f135afc2 [Accessed on 20 July 2013**].**

Gregson, S.,Gonese, E., Hallet,T.B et al.(2010) HIV decline in Zimbabwe due to reductions in risky sex? Evidence from a comprehensive epidemiological review. International Journal of Epidemiology 2010;39:1311-23.
Gregson,S.,Gonese, E., Hallet,T.B et al.(2010) HIV decline in Zimbabwe due to reductions in risky sex? Evidence from a comprehensive epidemiological review From Morris Martin and Hellen Epistein.International Journal of Epidemiology 2011;40:836-841.
Gribble, J.N (2012) Fact Sheet, Unmet Need For Family Planning [online] http://www.prb.org/Publications/Datasheets/2012/world-population-data-sheet/fact-sheet-unmet-need.aspx[Accessed on 15 June 2013].

Hobcraft, G. and Baker, T.(2006). Special needs of adolescent and young women in accessing reproductive health: Promoting partnerships between young people and health care providers. *Internatinal Journal of Gynecology* & *Obstetrics*, [online] 94(3). pp.350-356.Available from:

http://www.ijgo.org/article/S0020-7292(06)00187-1/fulltext[Accessed on 24 July 2013].

Ingwersen, R. (2001) Adolescent Reproductive and Sexual Health in Developing World [online] http://www.arha.org.au/papersandarticles/OP%204.pdf [Accessed 27 July 2013].

International Planned Parenthood Federation (IPPF) (2007)

IRIN ,(2013).ZIMBABWE: Abortion Figures Underscore need for more Reproductive Health Education; Available from

www.irinnews.org/Report/53659/zimbabwe-Abortion -figures-underscore-need-for-more-reproductive-health-education[Accessed on 21 May 2013]

IRIN ,(2013).ZIMBABWE: Abortion Figures Underscore need for more Reproductive Health Education; Available from www.irinnews.org/Report/53659/zimbabwe-Abortion -figures-underscore-need-for-more-reproductive-health-education[Accessed on 21 May 2013]

IRIN,(2006). ZIMBABWE: Child Abused every hour, new data Reveals;www,irinnews.org/printreport,aspx?=61612[Accessed on 1 June 2013]

Kamau, W.A. (2006). Factors influencing access and utilization of preventive reproductive health services by adolescents in Kenya; A case study of Murang'a district.PhD Thesis.Bielelefeld.

Kasedde, S., Luo C., McClure, C., Chandan, U. Reducing HIV and AIDS in Adolescents : Opportunities and Challenges ;Available on link.springer.com/article/Doi10.1007/s11904-013-0159-7[Accessed on 18 May 20, 2013]

Kesterton, A. J and de Mello, M.C.(2010). Generating demand and community support for sexual and reproductive health services for young people: A review of Literature and Programs. Reproductive Health [online] 7(25).pp. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2954841/ [Accessed on 30 June 2013]

Kevany S, Murima B, Singh, Hlubinka D, Kulich M, Morin S.F, Sweat M, (2012).Socio-economic status and health care utilization in rural Zimbabwe: findings from Project Accept(HPTN 043 Journal of Public Health in Africa.2012;Vol3:e13

Laryhaug L .F, Cowan. F.M, Nyamurera .T, Power R,(2003).on behalf of Regai Dzive Shiri Study Group: Improving Young People 's access to reproductive health care in rural Zimbabwe ,AIDS care: Psychological and socio-medical Aspects of AIDS/HIV, Vol 15:2;2003.doi10.1080/09540120310000682 90[Accessed on 5 June 2013].

Machinga, M. (2011) Religion, Health and Healing in the Traditional Culture of Zimbabwe; Practical Matters, Spring 2011,Issue 4,pp.1-8 . [online]Available from http://www.practicalmattersjournal.org/sites/practicalmattersjournal.org/files/pdf/issue2/Machinga_Shona_FINAL.pdf [Accessed on 27 Jul 2013].

Manson , H.(2003) Peer Education : Promoting Health Behaviours; Available on http://www.advocates foryouth.org.publications/444?task=views

Mashamba, A., Robson, E (2002) Youth reproductive health services in Bulawayo, Zimbabwe; Available on http://dx.doi.org/10.1016/s1353-8292(02)00007-2, Health & Place, Vol8, Issue4,December2002,pp273-283.

McNeely C, Sieving R, Blum R,W,M(2002).Mothers influence on the Timing of First Sex Among 14-and 15-Year-Olds;Available from www.sceincedirect.com/science/article/pii/S1054139x(02)00350-6-1-s2-S[Accessed 22 May 2013]

Ministry of Health and Child Welfare (2009).National Adolescent Sexual and Reproductive Health Strategy 2010-2015; Harare, Zimbabwe

Ministry of Health and Child Welfare (2010) The Zimbabwe Health Sector Investment Case (2010- 2012) Accelerating progress towards the Millennium Development Goals: Equity and Quality in Health [online] http://www.unicef.org/zimbabwe/Health_Investment_Case_Report.pdf.

Ministry of Health and Child Welfare (2011) Zimbabwe Analysis of HIV Epidemic, Response and Mode of Transmission; Available on http://ms-hiv-gdc.org/wp-content/uploads/group-documents/1/1314808832-Zimbabwesynthesisreport.pdf[Accessed 24 July 2013]

Ministry of Health and Child Welfare (2011) Zimbabwe Analysis of HIV Epidemic, Response and Mode of Transmission; Available on http://ms-hiv-gdc.org/wp-content/uploads/group-documents/1/1314808832-Zimbabwesynthesisreport.pdf[Accessed 24 July 2013]

Ministry of Health and Child Welfare, (2011).Zimbabwe National Rapid Assessment on SRH and HIV Integration and Links; Harare, Zimbabwe

Ministry of Health and Child Welfare,(2006).The National Female Condom Strategy 2006-2010;Harare

Moyo , S and Zvoushe , A. (2008) Factors underlying Early sexual Initiation among adolescents .A case study of Mbare District ,Harare, Zimbabwe. International Multidisciplinary Research Journal 2012,2(12):22-30 Available on http://irjs.info/ [Accessed 22 June 2013]

Mpofu, J,.Shumba, A,(2012).The Zimbabwe Patients Charter of Rights :Effectiveness on Health CARE access by People with Disabilities Living with

HIV and AIDS; Available online www.kreppublishers.com/02journals /JHE-38(2)2012/jhe-2308pmd-JHE-38-2-135-144-12-2308-shumba-A-Tx(6).pdf

Mpofu,J and Shumba, A (2012) The Patient's Charter of Rights: Effects on Health Care Access by People with Disabilities Living with HIV and AIDS; [online] http://www.krepublishers.com/02-Journals/JHE/JHE-38-0-000-12-Web/JHE-38-2-000-12-Abst-PDF/JHE-38-2-135-12-2308-Shumba-A/JHE-38-2-135-144-12-2308-Shumba-A-Tx[6].pdf

Munjanja, S. P. (2007). Ministry of Health and Child Welfare Zimbabwe Maternal and Perinatal Mortality Study; www.unicef.org/zimbabwe/ZMPMS_report.pdf[Accessed 17 July 2013].

Nyakanyanga S,(2013). Pregnancy among Zimbabwean disabled teenagers; Exchange HIV and AIDS Sexuality and Gender; Available on www.kit.nl/net/KIT_Publications_output/showFiles2.aspx?e=2074 [Accessed on 28 April 2013]

Nyoni, C (2009) SOCIOCULTURAL FACTORS AND PRACTICES THAT IMPEDE UPON BEHAVOIURAL CHANGE OF ZIMBABWEAN WOMEN IN AN ERA OF HIV/AIDS ;Available on http://uir.unisa.ac.za/bitstream/handle/10500/2323/thesis.pdf;jsessionid=652A8EE8BF12DE285510D70E7999F196?sequence=1[Accessed on 30 March 2013].Ph D Thesis. University of South Africa.

Parry C.D.H., Morojele N.K., Saban A., Flisher A.L,(2004). Brief Report:Social and neighbourhood correlates of adolescent drunkenness:A pilot study in Capetown,South Africa.Journal of Adolescence 27(3),369-374

Pathfinder International. (2005). Youth–friendly services: Tanzania End of Program Evaluation Report. [Online] Pathfinder International: Watertown, USA. Available from http://www.pathfinder.org/publications-tools/pdfs/AYA-Final-Institutional-Capacity-Building-Reports-The-Tanzania-Report.pdf [Accessed 25 July 2013].

Pebody , R (2011). Disappointing results from two peer education projects in southern Africa; http://www.aidsmap.com/Disappointing-results-from-two-peer-education-projects-in-southern-Africa/page/2077261/#item2077264

Peters, D.H., Garg, A., Bloom, G., Walker,D.G.,Brieger,W.R.,Rahman ,M.H.(2008) Poverty and access to health care in developing countries, *Annals Of The New York*

Academy of Sciences,1136(8),161-171.Available onhttp://onlinelibrary.wiley.com/doi/10.1196/annals.1425.011/pdf[Accessed 28 July 2013].

Prata N & Bellows B(2008).Potential of dual –use policies to meet family planning and HIV prevention needs : a case study of Zimbabwe and Mozambique ;Available from jfprhc.bmj.com/content/34/4/219-260 doi:10:1783/147118908786000406[Accessed on 19 May 20, 2013

Regmi, P. R., van Teijlingen, E., Simkhada., Acharya,D.R (2010). Barriers to Sexual Health Services for Young people in Nepal:Available from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2995031/[Accessed on 5 June 2013].

Restless Development (2012). Understanding the Barriers to Young People's Access to Sexual Reproductive Health Services in Sierra Leone: A Youth-led Research Study. Available from http://www.restlessdevelopment.org/file/barriers-to-access-findings-final-email-pdf [Accessed on 27 July 2013].

Rupp, R & Rosenthal, S.L.(2007).Parental Influences on adolescent sexual behaviours. Adolescent Medicine: State of the Art Reviews 18,460-470.

SAfAIDS (Undated) A Sexual and Reproductive Health Success Story.Youth Leading Youth :SAYWHAT Reclaiming Sexual and Reproductive Health Rights for Young People in Zimbabwe's Tertiary Institutions. Available from: http://catalogue.safaids.net/sites/default/files/publications/A-Sexual-and-Reproductive-Health-Success-Story-Youth-Leading-Youth_SAfAIDS-SAYWHAT.pdf [Accessed on 01 August 2013].

Save the children (2004) Children having children: Where young people mothers are most at risk, available from http://www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/SOWM_2004_final.pdf [Accessed on 21 July 2013].

Sayles J. N, Wong, M. D, Kinsler, J. J Martins , D and Cunningham, W.E(2009). The Association of Stigma with Self-Reported Access to Medical Care and Antiretroviral Therapy Adherence in Persons Living with HIV/AIDS 2009;Journal Gen Med Volume24, Issue (10): pp.1101 DOI:10.1007/s11606-009-1068- Journal of General Internal Medicine

Senderowitz, J., Solter., Hainsworth G (2004) Module 16:Reproductive Health Services for Adolescents; available online www2.pathfinder.org/site/Docserver?doc1D=2481[Accessed 28 June 2013].

Settergren S, Mhlanga C, Mpofu J, Ncube D, Woodseng C(2000).Unsafe .

Skovdal, M., Campbell, C., Madanhire, C., Mupambireyi, Z., Nyamukapa, C., Gregson, S. (2011) Masculinity as a barrier to men's use of HIV services in Zimbabwe; *Globalization and Health* 2011, **7**:13 doi:10.1186/1744-8603-7-13.

Smith E. J. (2011). Contraception: Why Not. Available online:www.catholiceducation.org/articles/sexuality/se0002.html. [Accessed on 17 July 2013].

UNAIDS (2013)FACT SHEET.Availble on http://www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2012/20120417_FS_adolescentsyoungpeoplehiv_en.pdf[Accessed on 23 May 2013]

UNAIDS (2013)FACT SHEET.Availble on http://www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2012/20120417_FS_adolescentsyoungpeoplehiv_en.pdf[Accessed on 23 May 2013]

UNDP (2013) Zimbabwe Millennium Development Goal Report[online]:http://www.undp.org.zw/millennium-development-goals/goal-five-maternal-health[Accessed 28 July 2013].

UNFPA(2012).Child Marriage Profile Zimbabwe.Available on www.devinfo.info/mdg5b/profiles/en/4/child_Marriage-country profile_AFRZWE_Zimbabwe.pdf

UNFPA(2012).Child Marriage Profile Zimbabwe.Available on www.devinfo.info/mdg5b/profiles/en/4/child_Marriage-country profile_AFRZWE_Zimbabwe.pdf

United Nations (2013).[Zimbabwe][UN Statement] on 16 Days Activism Against Gender Based Violence; available on www.zw.one.un.org/newsroom/news/unct-statement-16-days-activism-against-gender-based-violence[Accessed on 22 May 2013]

United Nations (2013).[Zimbabwe][UN Statement] on 16 Days Activism Against Gender Based Violence; available on www.zw.one.un.org/newsroom/news/unct-statement-16-days-activism-against-gender-based-violence[Accessed on 22 May 2013]

United Nations Children's Fund, (2011). Adolescence An Age of Opportunity. Available on:www.unicef.org/publications, New York: UNICEF.

WHO (2010). A Conceptual Framework For Action on the Social Determinant of Health ;Available from:http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf[Accessed on 29 July 2013].

Women sphere (2009).Religion and Poverty Force Girls into early Marriages In Zimbabwe; Available on womansphere.word press.com/2009/04/22/religion_and_povert_force_girls_into_early_marriages_in _zimbabwe [Accessed on 2 June 2013]

Women sphere (2009).Religion and Poverty Force Girls into early Marriages In Zimbabwe; Available on womansphere.word press.com/2009/04/22/religion_and_povert_force_girls_into_early_marriages_in _zimbabwe [Accessed on 2 June 2013]

World Health Organization (2002) Adolescent Friendly Health Services –An Agenda for Change. Geneva: WHO

World Health Organization (2006) .The World health report 2006: working together for health. Geneva; WHO.

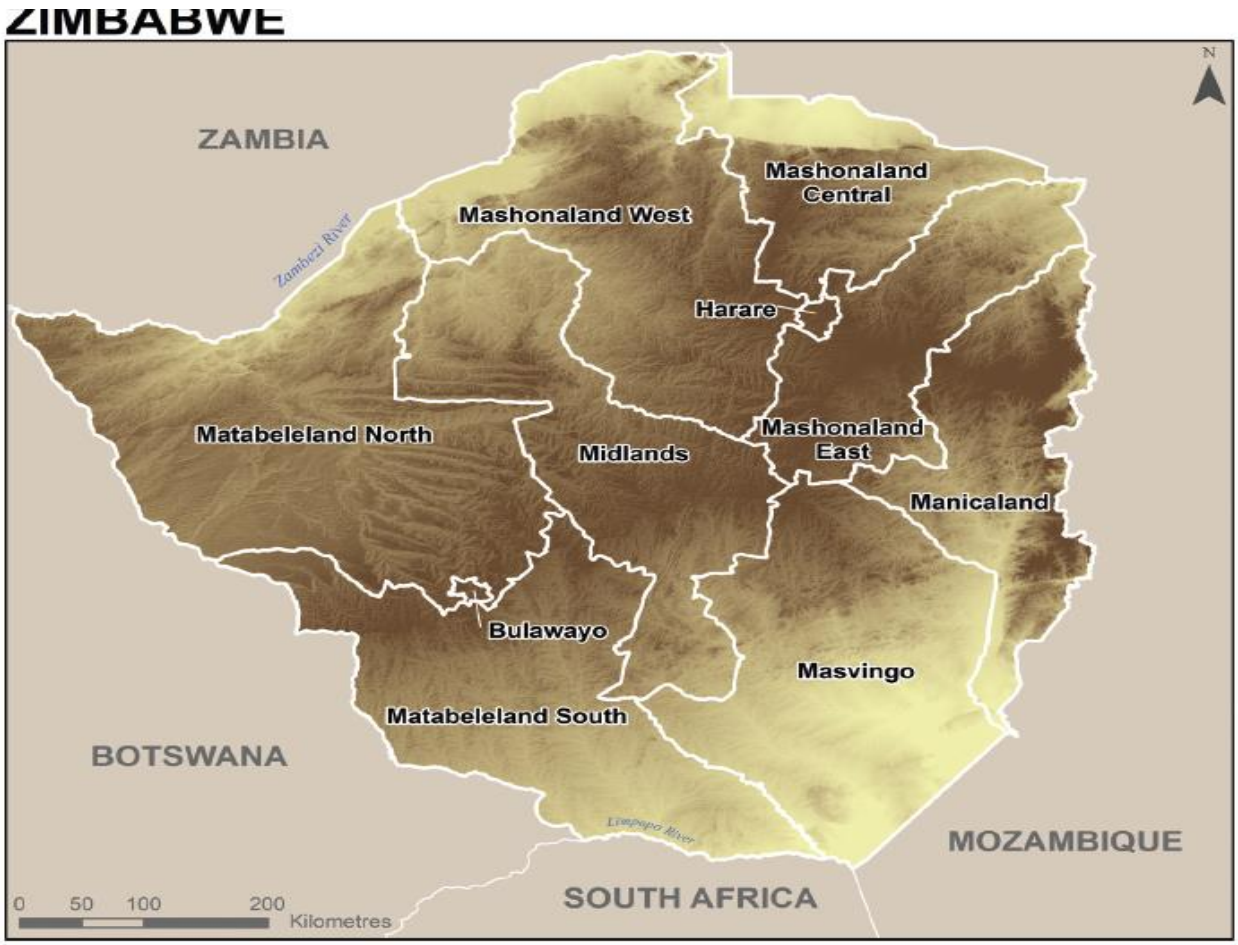
World Health Organization (2007) Helping parents in developing countries improve adolescents' health .Geneva: http://hrweb.mit.edu/worklife/raising-teens/pdfs/helping parents.pdf.tt/hweb.mit.edu/worklife/raising-ns/pdfs/heling-parents.pdfolume

World Health Organization, (2012). From Evidence to policy: Expanding access to contraceptive services for adolescents;[Online] Available from; apps.who.int/ins/bitstream/lobs/75160/1/WHO_RHR_HRP.12.21_eng.pdf.

World Health Organization.(2002).Adolescent friendly health services: An agenda for change[Online] World Health Organization: Geneva. Available from:http://whqlibdoc.who.int/hq/2003/WHO_FCH_CAH_02.14.pdf.

Zimbabwe National Statistical Agency (ZIMSTAT)(2009) .Multiple Indicator Monitoring Survey(MIMS), Harare, Zimbabwe.

ANNEX 1: MAP OF ZIMBABWE



Source: ZDHS 2010

ANNEX 2 : THE MINIMUM OR ESSENTIAL PACKAGE FOR ASRH IN ZIMBABWE

HEALTH FACILITY APPROACH	COMMUNITY APPROACH	SCHOOL BASED APPROACH
Education and counseling services on • Sexuality and growing up • Abstinence ,consequences of abortion • Contraception, STIs/HIV • Skilled attendance • Ante and postnatal care • Nutrition	Education and counseling services e.g. on • Sexuality and growing up ,relationships ,abstinence, consequences of abortion • Contraception, STIs/HIV • Substance and drug abuse	Education and counseling services e.g. on: • Sexuality and growing up, relationships • Prevention of pregnancy and STIs • Abstinence ,consequences of early pregnancy ,abortion • Substance and drug abuse
Provision of information and education on SRH	Provision of information and education on SRH	Life skill training e.g. On goal setting ,decision making negotiation and assertiveness
Provision of life and livelihood skills	Provision of life and livelihood skills	School health talks on issues like: sexuality and growing up, STIs/HIV prevention, rape prevention, careers
Provision of SBCC ,audio /visual materials	Provision of SBCC ,audio /visual materials	Facilitate a strong and effective linkage with health facilities and community youth centers
Provision of contraception	Provision of contraceptives	
Pregnancy testing	Pregnancy testing	
Screening and treatment of STIs		
Comprehensive Post Rape Care		
Voluntary counseling and Testing (VCT) services, including PMTCT	Provision of voluntary Counseling and Testing (VCT) services	
Essential obstetric care		
Post Natal Care	Facilitate a strong and effective linkage with schools and health facilities	
Abortion Care Services		
Promoting community based/school based SBCC activities(outreach services)	Integrate ASRH services with other services	
Male circumcision (13 year olds and above)	Male circumcision(13 year olds and above)	
Recreational activities	Recreational activities	
Facilitate a strong and effective linkage with schools and community youth center's	Promoting community based/school based SBCC activities (outreach services)	
Integrate ASRH services with other services		
Refer where necessary	Refer where necessary	Refer where necessary

Adapted: From Zimbabwe National Adolescent Sexual and Reproductive Health Strategy 2010-2015

ANNEX: 3 **The Minimum Requirements for the Youth Friendly Corner (in all approaches)**

(Adapted from The National Adolescent Sexual and Reproductive Health Strategy 2010-2015)

- At least one room with adequate furniture (at least 1 chair, 1 table and standard bench)
- At least 2 ARSH services providers
- At least 2 trained peer counselors (1 male and 1 female)
- Adequate and comprehensive ASRH Social Behavior Change Communication (SBCC) material.
- A television set, including videos cassette recorder and tapes, a radio and cassettes
- Recreational material(e.g. balls), where infrastructure and proper security is available

ANNEX 4: ORIGINAL ANDERSEN BEHAVOIURAL MODEL (1995)