ASSESSING THE LEVEL OF ADOLESCENTS’ PARTICIPATION IN SEXUAL AND
REPRODUCTIVE HEALTH IN ZIBAGWE, KWEKWE DISTRICT.

BY

ZINYONI COURAGE T

B1438940

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BACHELOR OF SCIENCE HONOURS DEGREE IN DEVELOPMENT STUDIES
Approval form

The undersigned certify that they have read and recommended to Bindura University of Science Education for acceptance a research project entitled “Assessing the level of adolescents’ participation in sexual and reproductive health in Zibagwe, Kwekwe district” submitted by Courage T. Zinyoni in partial fulfilment of the requirements for Bachelor of Science Honours Degree in Development Studies.

Supervisor……………………………… Date………………………………

Dr C. Mudavanhu
Declaration

I Courage T. Zinyoni (B1438940) declare that the research project submitted for the Bachelor of Science Honours Degree in Development Studies is my own work and has not been submitted for any examination before. All sources used or quoted have been indicated and acknowledged as complete references.

Signature………………………………

Student

Date……………………………………
Dedication

This dissertation is dedicated to my wonderful parents who supported me during my studies in all forms. May the almighty God continue to bless them.
Acknowledgements

I would like to give sincere gratitude to my supervisor Dr C. Mudavanhu for the patience, guidance and support throughout this research study. This work could not have been a success without the support from National AIDS Council, Plan International and the Department of Social Welfare in Kwekwe not forgetting the adolescents that participated in the research study.

Special mention goes to my parents Mr and Mrs Zinyoni who gave me support for this programme to become a success. My special appreciation also goes to my Bindura University of Science Education colleagues who made my studies memorable. Lastly and most importantly I would like to thank God for granting success to everything I have achieved.
Abstract

This research assessed the level of adolescents’ participation in Sexual and Reproductive Health (SRH) services and programmes in Zibagwe district. Although adolescents’ participation in SRH have been debated in development circles, there was limited research that was carried out to assess the level of adolescents’ participation in SRH services and programmes. Both qualitative and quantitative methodologies were used for the research. Questionnaires were administered to 50 participants who were purposively sampled. Ten key informant interviews were also carried out with four Adolescents Sexual and Reproductive Health (ASRH) project coordinators and six guidance and counselling teachers. Research findings indicated that 88% of adolescents had access to HIV testing and counselling services making them the most accessible. The research findings indicated that there is still 14% of ASRH programmes whereby adolescents are manipulated, and used as a form of decoration and tokenism in the name of adolescents’ participation. According to 80% of adolescents who participated in the research, health service providers are still unfriendly to adolescents seeking ASRH services. The research recommended that the Government should train health service providers to observe National Guidelines on Clinical Adolescents and Youth Friendly Sexual and Reproductive Health Service Provision and also include adolescents in decision making. Therefore the research concludes that adolescents need to be consulted and included in decision making despite their age.
## List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ASRH</td>
<td>Adolescents Sexual and Reproductive Health</td>
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<tr>
<td>DAC</td>
<td>District AIDS Coordinator</td>
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<tr>
<td>DSW</td>
<td>Department of Social Welfare</td>
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<tr>
<td>G&amp;C</td>
<td>Guidance and Counselling</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV Testing and Counselling</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MOHCC</td>
<td>Ministry of Health and Child Care</td>
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<tr>
<td>MOPSE</td>
<td>Ministry of Primary and Secondary Education</td>
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<td>NAC</td>
<td>National AIDS Council</td>
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<td>PSI</td>
<td>Population Service International</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>VMMC</td>
<td>Voluntary Medical Male Circumcision</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>YPNSRHHA</td>
<td>Young People’s Network on Sexual and Reproductive Health and HIV and AIDS</td>
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<td>ZNFPC</td>
<td>Zimbabwe National Family Planning Council</td>
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<td>ZRDC</td>
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CHAPTER ONE

INTRODUCTION

1.1 Introduction
Level of adolescents’ participation in Sexual and Reproductive Health (SRH) is vital in the successful implementation of Adolescent Sexual and Reproductive Health (ASRH) programmes, policies and adolescents’ wellbeing. This research seeks to assess the level of participation of adolescents in SRH programmes, services and its implications on the wellbeing of their sexual health. This chapter covers the background to the study, the study area, statement of the problem, research aim and scope of the study, objectives, research questions, justification of the study, the research’s limitations, definition of terms and the organisation of the study.

1.2 Background to the Study
For sustainable management of development projects to be successful, the participation of primary stakeholders is essential (Nastran and Pirnat, 2012). In regards to ASRH programmes, players in public health have been adopting a top down approach limiting the participation of the direct beneficiaries which are the adolescents. Where there is participation, it is restricted to a tokenism form of participation. Buy-in from youth and their communities can create the potential for programs’ longevity and success (Villa-Torres and Svanemyr, 2014). Adolescents are still facing a lot of challenges despite SRH youth friendly services being available, accessibility still remain a challenge which can be articulated by including the adolescents in the decision making process. Including adolescents in SRH would aid in understanding behavioural patterns of the adolescents themselves. The concern about ASRH has grown following reports that sexual activity, early pregnancies and sexually transmitted infections (STIs) including Human Immunodeficiency Virus (HIV) infection rates are increasing at unprecedented rates among adolescents (Sandoy et al., 2007).

In developing countries such as Zimbabwe, culture and religion has also played a great part in affecting the participation of adolescents in SRH issues. The level of adolescents’ participation in SRH services and programmes have been steadily improving in urban centres but in rural areas where there are more ASRH challenges it remains reduced where adolescents are involved in form of decoration and tokenism form of participation. Some of these ASRH challenges consist of early pregnancy which is mostly unwanted, complications of unsafe abortion, and complications of pregnancy and childbirth. Adolescents lack easy
access to quality and friendly health care, prevention and treatment of STIs, safe abortion services, antenatal care and skilled attendance during delivery, which result in higher rates of maternal and perinatal mortality (KNCHR, 2012). In rural area set ups these challenges are more severe and as a result there is a decline in school participation among youths. In most rural areas they consider the inclusion of adolescents in SRH education as promoting promiscuity hence it is a challenge to get ASRH programmes accepted in such communities and let alone for adolescents to take up SRH services.

Traditionally adults took up the role of ensuring the sexual wellbeing of adolescents but due to the effects of globalisation and cultural diffusion the roles of uncles and aunts who used to provide SRH information at adolescence phase has faded overtime. This now warrants an adaptation whereby active participation of adolescents in SRH education and programmes is now necessary to cover the information gap that was traditionally supplied by uncles and aunts. Although this can be articulated by improving parent to child communication most parents are still compelled by culture and religion to hide vital information about SRH to their children and where parent to child communication is practiced it includes adolescents as passive participants which is not enough to articulate some of the aforementioned ASRH challenges. Teachers and parents may be unwilling to discuss sexual health with adolescents, believing that they don’t need such information or that doing so will encourage them to become sexually active (Glinski et al., 2014).

There are institutional arrangements that facilitates the participation of adolescents that represent different levels of participation. Some of these include the Young People’s Network on Sexual Reproductive Health and HIV and AIDS (YPNSRHHA) coordinated by National AIDS Council (NAC), NAC coordination structures from national level to district level, ASRH committees coordinated by the Ministry of Health and Child Care (MOHCC), Zimbabwe National Family Planning Council (ZNFPC) that coordinates the ASRH strategy and through the Guidance and Counselling (G&C) included in the 2016 Primary and Secondary school curriculum that is coordinated by the Ministry of Primary and Secondary Education (MOPSE). These organisations largely influence the level of adolescents’ participation in SRH hence it is important for these to drive the inclusive approach and the research will also utilise ASRH services and programmes spear headed by the aforementioned organisations.
1.3 Research Scope
The research is targeting adolescents living in Zibagwe district (Kwekwe rural). The focus will be largely on the uptake of ASRH services, and the form of participation of adolescents in ASRH programmes and policies in Zibagwe.

1.4 Study Area
The research will be covering Kwekwe rural, natively known as Zibagwe by the local authorities and the community. Zibagwe has different communities that consists of Zhombe and Silobela where the population largely rely on gold mining and agriculture. There are also resettlement areas that include Sherwood, Sebakwe and also Munyati which is located in Kwekwe peri-urban. Zibagwe has a total population of 174 727 with 33 administrative wards, and is serviced by 18 clinics, 8 Rural Health Centres (RHC) and 2 hospitals (Silobela district hospital and Zhombe Mission hospital), which are mainly concentrated within the original communal areas and highly spaced within the resettlements and commercial farming areas (ZIMSTAT, 2013). With a total of 33 wards and 28 health facilities, some wards do not have health service delivery points (NAC Midlands, 2016). The same source also state that the district has a total of 135 primary schools and 55 secondary schools. Although farming is the major livelihood activity, the district is mostly under region four and five, and the district being rich in precious minerals, a lot of people also survive on gold panning, small scale mining, and cross boarder trading. According to ZIMSTAT (2013), 27.5% of adolescent girls in Zibagwe are already in marriage, the Age Specific Fertility Rate (15-19) is at an astounding 96.4 and has a youth school participation of 46.6% among the age of 15-19. A significant proportion of the population is sparsely placed.
**Figure 1. Zibagwe Map (QGIS 2.6.1 Brighton)**

### 1.5 Statement of the Problem
Development programmes should involve the targeted groups from the projects’ inception, implementation to their decommissioning (Mitchell et al., 2009). Many times in ASRH programmes, adolescents’ involvement is in the form of manipulation, decoration or tokenism which is all passive forms of participation yet active participation should be key to address the immediate needs of the targeted population. Literature available on ASRH services give much attention on socio-economic and cultural factors that affect access and utilisation of these services rather than concentrating on the efficiency of participation methods crafted by the projects coordinators from different organisations themselves. There has been limited research on the participation of adolescents yet it has largely contributed to lack of access and utilisation of ASRH services with as much gravity as of socio-economic and cultural barriers exposing adolescents to unwanted pregnancy, unsafe abortions, STIs and HIV and AIDS which lead to early marriages, teen morbidity and them dropping out of school. Therefore, this research seeks to assess the level of adolescent’s participation in SRH services and programmes.
1.6 Aim of the study
This study aims to assess the level of adolescents’ participation in sexual and reproductive health in services and programmes.

1.7 Objectives
1) To identify Adolescent Sexual and Reproductive Health services in Zibagwe.
2) To determine the level of adolescents’ participation in SRH programmes and policies in Zibagwe.
3) To explore the factors affecting the participation of adolescents in SRH in Zibagwe.

1.8 Research Questions
1) What are the Adolescents’ Sexual and Reproductive Health services in Zibagwe?
2) What is the level of adolescent participation in SRH programmes and policies in Zibagwe?
3) What are the factors affecting the participation of adolescents in SRH in Zibagwe?

1.9 Justification of the study
Emphasis is on adolescents living in rural areas, particularly girls who experience adverse impacts of SRH challenges that include lack of SRH knowledge, teen pregnancy, unsafe abortions, forced marriages, school drop outs and morbidity as a result of sexually transmitted diseases. Adolescents in rural areas unlike those in urban centres have limited participation in SRH programmes and policies if there is any and this has contributed significantly to their vulnerability to SRH challenges. Health, social and economic impacts as a result of insignificant participation of adolescents in SRH are more rampant in rural areas as compared to urban areas. Some of these impacts include an increase in maternal deaths among adolescents, high infant mortality rates, an increase in morbidity rate, high rates of school drop outs, increase in crime rates, an increase in HIV prevalence rate, high rates of unsafe abortions and high rates of adolescent suicides. Therefore there is need to carry out this study to address the aforementioned ASRH challenges in Zibagwe from an informed position through effective ASRH programming.

1.10 Limitations of the Research
The research encountered several obstacles such as biased information from elements such as adolescent peer educators who are mostly involved in most ASRH programmes and the researcher nevertheless overcame this obstacle by engaging various adolescents who were from the community and faith based organisations who attended ASRH activities. Several data collection techniques were also used to curb shortcomings of specific data collection
techniques such as the biases caused by questionnaires that were subsequently complimented by interviews. While the school setting constituted a significant number of adolescents certain topics were considered too sensitive to discuss because of the MOPSE policy and therefore to get more depth about such issues the researcher engaged the adolescents in school at their youth corners away from the school premises. Funding was initially a problem since Zibagwe is a large geographical area and some areas are difficult to reach. The researcher took advantage of his former employer’s resources NAC (transport and refreshments) and since the researcher is a member of the Young People’s Network on Sexual Reproductive Health and HIV and AIDS (YPNSRHHA), it was very easy to utilise NAC and their implementing partners’ activities to conduct the research. This also applies to the Focused Group Discussions (FGDs) that were conducted. YPNSRHHA is a youth led platform that facilitates dialogue among various youth sectors that is supported by NAC.

1.11 Definition of Terms

Adolescence is a transitional stage of physical and mental human development which, according to the World Health Organisation, falls between the ages of 10 and 19 years (WHO, 2010).

WHO (2010) describes sexual health as a state of physical, emotional, mental and social well-being in relation to sexuality and it is not merely the absence of disease, dysfunction or infirmity while reproductive health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity hence reproductive health deals with the reproductive processes, functions and system at all stages of life (ZNFPS, 2016).

Participation refers generally to the process of sharing decisions which affect one’s life and the life of the community in which one lives (Hart, 1991).

1.12 Organisation of the Study

Organisation of the study consist of the first chapter which basically include the introduction of the topic and description of the background information as well as what the research aims to achieve. The second chapter mainly include scholarly contribution on the participation of
adolescents in SRH while giving a background of the situation globally, and in Zimbabwe. Methods used to collect data for the study are highlighted in Chapter 3 and Chapter 4 will carry the results of data collected, the presentation of the results and analysis. The conclusion and recommendations will be in the final Chapter of the study.
CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction
This chapter seeks to look into the published literature concerning sexual and reproductive health services for adolescents. The chapter starts with the theoretical framework for this study. The level of participation of adolescents in SRH globally, regionally and in Zimbabwe is also going to be explored in this chapter. Finally the chapter will explore literature that covers factors influencing the participation of adolescents.

2.2 Theoretical Framework
There are many various participation models. However the research’s argument is best explained by the ladder of participation that was firstly propounded by Sherry Arnstein in 1969 and later developed by Roger Hart in 1992. According to Hart (1992) participation refers to the process of sharing decisions which affect one’s life and the life of the community in which one lives and it is the means by which a democracy is built and it is a standard against which democracies should be measured (Hart, 1992).

Figure 2.1 Ladder of participation (Hart, 1992)
Roger Hart’s ladder of participation is divided into two categories, the non-participation and participation models. As shown in figure (fig) 2.1, the non-participation model consists of the following rungs in respective order, manipulation, decoration, and tokenism. The aforementioned levels represent a form of participation that is not significant in influencing ASRH programmes, policies and the uptake of ASRH services. Their insignificance is shown by the rungs’ position on the ladder of participation. Genuine participation include the following: assigned but not informed, consulted and informed, adult initiated with decisions being shared with children, child initiated and directed and then the child initiated whereby decisions are shared with adults. The research study of assessing the level of adolescents’ participation in sexual and reproductive health will use the ladder of participation to determine the level of adolescents’ participation in Zibagwe district thereby forming a basis on factors that are affecting adolescents participation in SRH.

One of the key drivers for this research study was the belief that adolescents in rural areas are largely vulnerable to ASRH challenges because they are mostly involved in ASRH programmes in form of manipulation, decoration, and tokenism. According to Jones and Kardan (2013) manipulative participation refers to a pretence, with nominated representatives having no legitimacy or power. Hart (1992:9) stipulates that decoration which is the second rung on the ladder, refers, for example, to those frequent occasions when children are given t-shirts related to some cause, and may sing or dance at an event in such dress, but have little idea of what it is all about and no say in the organising of the occasion. Tokenism is used here to describe those instances in which children are apparently given a voice, but in fact have little or no choice about the subject or the style of communicating it, and little or no opportunity to formulate their own opinions (Hart, 1992). These levels of participation are retrogressive and hence the research seeks to expose such poor practices of ASRH programming in Zibagwe District since this approach short changes adolescents through abusing the participatory rural appraisal development approach.

The research advocates for the following participation levels in ASRH programmes, policies and service uptake; assigned but not informed, consulted and informed, adult initiated with decisions being shared with children, child initiated and directed and then the child initiated whereby decisions are shared with adults. At national level there are programmes that are including young people in genuine participation models, however this research will try to find out if the situation is the same in rural areas particularly in Zibagwe District. The level where adolescents initiate and direct an ASRH activity may be a challenge to reach in a rural setup,
however the research will attempt to explore if adolescents in Zibagwe try to conduct any initiatives towards ASRH especially initiating ASRH discussions amongst themselves. At the highest level where adolescents initiate and share decisions with adults, Hart (1992) states that teenage students from a school in Paranoá, a low income settlement on the outskirts of Brasilia, designed and directed a video report on how pregnant teenagers feel about being pregnant and what advice they have for other teenagers. The research strives to recommend ASRH programmers to operate their programmes at this level hence the study will determine factors affecting ASRH programmes to be at this level in terms of participation since it empowers the adolescents and also ensure continuity of initiatives and buy in from adolescents.

2.3 ASRH Services
There are several ASRH services that are offered by health service providers that range from government ministries and departments, international and local Non-Governmental Organisations (NGOs), as well as local institutions. ASRH services are measures that address reproductive health challenges that are encountered by adolescents that directly and indirectly affect their sexual reproductive health. According to the National Adolescent Fertility Study (NAFS) children born to very young mothers are at increased risk of illness and death which are due to complications during pregnancy, child birth and post-natal period (ZIMSTATS, 2013). About 1 million children born to adolescent mothers do not make it to their first birthday. Adolescents in rural areas are in need of SRH services that include antenatal care (ANC), post-natal care, post abortion services, family planning services, STI screening and treatment, Prevention of Mother to Child Transmission (PMTCT), Pre and Post Exposure Prophylaxis (PreEP and PEP), cervical cancer screening, HIV testing and counselling services, Voluntary Medical Male Circumcision (VMMC), SRH and HIV and AIDS education. This is critical because ignorance of such services is largely caused by exclusion in ASRH programmes and the lack of information that results from low levels of participation increases the vulnerabilities mentioned above that affect adolescents. The research seeks to identify the level of knowledge and how adolescents are involved in ASRH programmes and seek correlation with ASRH challenges facing adolescents in Zibagwe district.

2.4 ASRH Policies and Programmes
There are several policies and programmes that are tailor made to address ASRH challenges and also promote the uptake of ASRH services as well as providing guidelines on how ASRH
programmes should be carried out irrespective of which development agencies are implementing ASRH projects.

2.4.1 Global policies
Globally there are multiple policies and programmes that drives the efficiency in ASRH service uptake and promotion. According to the Amnesty International USA the 1994 International Conference on Population and Development (ICPD) Programme of Action which was held in Cairo, Egypt was a landmark in SRH rights promotion and the ICPD clearly spells out the need to enforce Sexual Reproductive Health Rights (SRHR). SRHR includes access to sexual and reproductive health care and information, as well as autonomy in sexual and reproductive decision making. This translates to the active involvement of adolescents in making decisions that affect their SRH hence the significance behind assessing the level of adolescents’ participation in SRH. Other international conventions include the International Covenant on Economic, Social and Cultural Rights, International Covenant on Civil and Political Rights, Convention on the Rights of the Child (CRC), United Nations General Assembly Special Session Declaration on HIV and AIDS, UN General Assembly Statement on Sexual Orientation and Gender Identity, and the Beijing Platform for Action of the 1995 Fourth World Conference on Women. GoZ (2016) also stipulates international conventions and commitments that support ASRH and these include the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) of 1979, United Nations Conventions on the Rights and Welfare of Children (1990), ICPD (1994), UNAIDS Universal Access to Treatment Care and Support: Roadmap (2011), and Sustainable Development Goals (2016-2030) goal number three that reaffirms action on ensuring healthy lives and promote well-being for all at all ages including adolescents. Zimbabwe is a signatory of these conventions and it is critical to assess some of the areas such as the inclusion of adolescents as stakeholders in ASRH programmes including at grassroots levels such as in Zibagwe District.

2.4.2 Regional frameworks
According to the GoZ (2016:20) Health and Education ministers from 20 countries in Eastern and Southern Africa declared a ground breaking commitment supporting sexuality education and sexual and reproductive health of adolescents and youths in December 2013 (The Eastern and Southern Africa Ministerial Commitment). The same source subsequently enlists regional frameworks that support ASRH and these consists of Sexual and Reproductive Health for the SADC Region (2006-2015), Africa Health Strategy (2016-2030), Maputo Plan
of Action on Reproductive Health Rights (2011), African Charter on the Rights and Welfare of the Child (1999) and the African Youth Charter (2009). Therefore it remains imperative to assess if these regional frameworks are being followed where the protection of adolescents SRHR are concerned and that their voice is heard especially considering how difficult it is for adolescents to be active in ASRH programmes because of the culture in Southern Africa which renders the topic sensitive.

2.4.3 ASRH policies and strategies in Zimbabwe
In Zimbabwe there are several key policies that theoretically promote the participation of adolescents in SRH. According to ZIMSTAT and ICF International (2016), some of the ASRH policies being implemented in Zimbabwe include the Primary and Secondary Education Life Skills, HIV and AIDS Education Strategy, and National ASRH Strategy. Guttmacher Institute (2014) also indicates programmes and policies that deal with ASRH and these include the National Adolescent Sexual and Reproductive Health Strategy (2010–2015), and the National Policy on HIV and AIDS. Other policies include the Zimbabwe National Strategy for HIV and AIDS Policy (ZNASP 3), which encompasses programmes such as the VMMC and PMTCT. Zimbabwe National Family Planning Strategy (ZNFPS 2016-2020) is also among policies enforcing ASRH programmes in Zimbabwe (ZNFPS, 2016). The GoZ (2016:20) commissioned, through the MoHCC and National Adolescent Sexual and Reproductive Health Coordination Forum, the process of developing national guidelines on the provision of youth friendly clinical SRH services in line with the 2015 WHO global standards for quality health care services for adolescents. Moreover these guidelines have also adopted the Eastern and Southern African (ESARO) region standards addressing policies, procedures and institutional support as an addition to the eight WHO standards for quality health care services for adolescents. The national guidelines on the provision of youth friendly clinical SRH services further aligned to the second National ASRH Strategy (2016-2020), the National Health Strategy (2016-2020) and the ZNASP 3 (2015-2018). Most of these policies and strategies include adolescents’ involvement but it is critical to understand how they facilitate the genuine participation of adolescents and how they are suppressing the levels of genuine participation through this research.

Roadmap (2007-2015), National Guidelines on HIV Testing and Counselling for Children and Adolescents (2014), National Guidelines on Family Planning (2007), and the MoPSE School Health Policy (2016). It is important to note that the policies above were developed recently hence they encourage community participation but the research will assess the implementation part of it in Zibagwe district.

Although there is a vast pool of policy and strategy resources, specifically in Zimbabwe there is still lack of policies that protect and promote SRH rights for adolescents living with disabilities, those in the Lesbian Gays Bisexual and Transgender (LGBT) community because of variations in terms of Zimbabwe’s laws, cultural and religious beliefs, inconsistencies that come along with adult-adolescents paradox whereby some adolescents are in marriage hence the need to be considered adults to access some of maternal reproductive health services, cooperation of socioeconomic influence on these policies and strategies and the practical implementation of youth economic empowerment aspect that helps adolescents to be able to leave child prostitution, have capacity to go back to school and be able to stand up against forced and child marriages. There is still need for Monitoring and Evaluation (M&E) of these policies to ensure effective implementation. It is also critical that adolescents are also included in M&E of their ASRH programmes. Hence the research will expose some of the issues that are hindering the successful implementation of ASRH programmes that can be solved by increased participation.

2.5 Adolescents’ Participation
Adolescents have the right to participate in SRH programmes that target them and adolescents’ involvement in the design, implementation and monitoring of programmes are key to ensuring that ASRH projects are both acceptable and accessible to them and that their SRH needs are being met (Mitchell et. al, 2009). The same authors also subsequently state that adolescents’ participation at all stages of the project cycle can lead to more relevant programming, strengthen project outcomes and contribute to meaningful partnerships between adolescents and adults.

One of the prominent stakeholders in ASRH programming is the United Nations Population Fund (UNFPA). The UNFPA is an international development agency that promotes the right of every woman, man, and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV and AIDS, every woman is treated with dignity and respect. Therefore the
development agency in 2007 developed a framework for Action on Adolescents and Youths opening doors with young people containing 4 key areas to strengthen ASRH programmes through the involvement of adolescents.

![Framework for Action on Adolescents and Youths](image)

**Figure 2. 2 Framework for Action on Adolescents and Youths (UNFPA, 2007)**

The four keys can be visualized as a pyramid as shown in fig 2.2. At the apex is the key on policy, population and poverty. The base of the pyramid is comprised of the two keys of SRH education and services. Youth participation is core to all of the keys and the two way arrows indicate that each key feeds into and reinforces the other (UNFPA, 2007:5). Therefore the research aims to direct the focus of this approach by improving ASRH programmes through participation of adolescents to make them effective and sustainable.

**2.6 Factors affecting the Participation of Adolescents in SRH Services**

Influence on accessing the ASRH services may be attributed to a decision made at the individual level, but is also influenced by peers and parents, community norms, accessibility and affordability of services, provider attitudes, and policies and regulations as best described by the ecological model (Svanemyr et al. 2015).

At individual level, UNFPA (2013) suggest that fear of side effects and the experience of side effects of contraceptive methods are the most common reasons for non-use or discontinuation
and discontinuation of family planning methods is more common among girls 15-19 than older women due to inconsistent access and lower tolerance for side effects. Fear and self-stigma associated with knowing HIV status is a major hindrance to testing for HIV while ignorance, misconceptions and negative attitude towards SRH information also act as barriers to accessing ASRH services (Evelia et al., 2016). The myths and misconceptions that have been attached to VMMC may also influence individual decisions. Therefore this research will establish individual factors from adolescents in Zibagwe.

Globally, societies are unaccepting of early sexual initiation, although they tend to be more permissive of boys’ sexual behaviour than girls’ and this has resulted in stigma around youth sexual activity which discourages adolescents from seeking information or services related to reproductive health, hence these may not be readily offered to them (Glinski et al., 2014). Other times a community’s religious beliefs may find contraceptive methods objectionable even after marriage (Glinski et al. 2014). Although condoms are the most accessible and affordable contraceptive method for most adolescents, in many contexts both boys and girls can be discouraged from carrying condoms because of their association with promiscuity and distrust (Chandra-Mouli et al. 2014).

A quantitative survey in Kenya about the barriers to seeking SRH rights services at Family Health Options Kenya (FHOK) health facilities established that the most critical barrier to SRH information and services uptake is limited access to such information and service (53.7%) followed by affordability of the services due to the high cost of getting such information and services (39.7%), low acceptability of the SRH services by the adults (36.2%) and the perceived lack of confidentiality and privacy among the service providers and privacy of their identity (33.3%). The survey also unearthed other barriers that included the perception by young people that young people are not expected to get SRH information (7.6%), perceived lack of need to visit the facilities (4.2%), unfriendly service providers (11.9%) and perceived lack of need for SRH services by unmarried youth was 2.6% (Evelia et al., 2016:25). This reveals the influence of sociocultural influence that affect access to information and the perception of communities towards ASRH services. Hence this research through its own survey will try to understand sociocultural factors that affect adolescents in Zibagwe district.

Most facilities have been considered not to be youth friendly. Common barriers to access at the facility level include negative provider attitudes, limited availability of products, high
costs and negative attitude towards providing ASRH services to unmarried adolescents. Poverty and perceived high and unaffordable cost of services by the young people related to payment for consultation, laboratory testing and diagnosis, and purchase of the medicines also plays a role in affecting adolescents in participating in SRH services (Evelia et al., 2016). Evelia et al (2016) also hold the view that distance to the health facilities and lack of assurance to their privacy contributes to adolescents’ lack of participation in accessing ASRH services. This notion also applies to most Zimbabwean health facilities with most emphasis placed on rural health facilities. Therefore, the research study will also include an investigation on how health facilities in Zibagwe District contribute to levels of ASRH

2.7 Factors affecting the Participation of Adolescents in SRH Policies and Programmes

Including the intended beneficiaries in development is a progressive act because the primary beneficiaries understand their own needs and issues that affect them. IAWG (2007) argue that for more than 35 years, community involvement has been seen as essential to the success and sustainability of development programmes, including public health. This principle also applies to the participation of adolescents in SRH policies and programmes. The UN Convention on the Rights of the Child also endorses the rights of young people to participate as fully as possible in their society. The UNFPA (2007) also advocates that ownership in a programme is strengthened when young people are involved in all aspects of the process, from the conceptualisation, needs assessment, and design to implementation and evaluation. Common factors that affect the participation of adolescents in SRH policies and programmes consists of challenges in schools, community barriers, limitations at policy level, gender dynamics and shortcomings in the peer education programme.

Constraints to the full implementation of health programmes in school that are generally in many countries involve a deficiency of active support, the lack of coordination and commitment from ministries of health and education officials, lack of training among teachers concerning SRH issues, mechanisms to supervise, monitor and evaluate programmes, research and infrastructure in school health programmes, and well-defined national policies and strategies for promotion, support, coordination and management of school health programmes thereby affecting the participation of adolescents in school. WHO (2009) argue that in the last decade, many countries in Africa, Asia, Europe, the Middle East, the Caribbean and the Americas have attempted to implement reproductive health programmes in schools. In almost every country, the provision of sex education has faced legal, financial, cultural and religious barriers as well as opposition from school leaders,
teachers, parents and students themselves. According to UNFPA (2007) teachers, adult stakeholders and policy makers may have biases and fears about working with young people (and vice versa). The situation is most likely to be similar in Zibagwe hence the research will also probe how adolescents in school premises are participating and at what levels as well as challenges that affect them in participating in ASRH activities.

Cultural norms may favour hierarchical relationships between adults and young people. Young people may be considered as recipients of services and not active partners (UNFPA, 2007). This may rise as a challenge since adolescents are not allowed to lobby for active participation in Sub Saharan cultures and Zimbabwe including the area under study.

At the policy level, lack of institutional mechanisms may limit young people’s participation and even if they are invited to participate, it tends to reflect tokenism rather than a real capacity to influence decisions (UNFPA, 2007). In addition economic circumstances may prevent young people from participating in other than income generating activities especially in the rural parts of developing countries. UNFPA (2007) argues that although there could be a high turnover rate since young people are a floating population there are still discrepancies as far as including the vulnerable groups and adolescents in far and hard to reach areas.

Gender dynamics makes it sometimes impossible for young women to participate outside the family context (UNFPA, 2007). UNFPA (2013) holds the view that girls are affected more by gender norms and discomfort in advocating for sexual issues. Hart (1992) suggest that in many societies it is still assumed that boys will be decision-makers and girls will not (Hart, 1992). This is very relevant especially in Sub-Saharan cultures.

Some of the adolescents fail to participate in ASRH projects because of their difficult circumstances. UNICEF uses the term ‘children in especially difficult circumstances’ to describe those children with no family or who are from a family so traumatized by disaster, poverty, armed conflict, or family dissension that it cannot meet their basic needs (Hart, 1992). This may also include adolescents living in the streets and those living in key affected populations such as illegal mining settlements and those in the sex work trade.

2.8 Chapter Summary
Chapter two of the research highlighted the model used in this study to assess the level of participation of adolescents. Eight rungs (levels) were indicated by the Rodger Hart’s participation model. ASRH services were also factored out. The literature also indicated various ASRH policies and programmes that addresses ASRH challenges and factors that
affect adolescents’ participation. The next Chapter will articulate methods used to collect data for this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the methodology used for assessing the level of adolescents’ participation in SRH. It includes the research design, methods and instruments for data collection, sampling methods, and how the data will be presented. Data collection techniques used for the study were also highlighted.

3.2 Research Design

The research used both quantitative and qualitative methods. As supported by Ragin (2004) quantitative methods complement qualitative methods through the measurement of structural, institutional and contextual features. Hence the use of both methods facilitate the expansion of the research base by offering results and perceptions that can be uncovered by more than one method (Johnson, 2007).

3.3 Sampling Method

The research used both random and purposive sampling. According to Macree (2007) purposive sampling is often applied in special situations where by sampling is done with specific purpose in mind. Hence purposive sampling was used to select adolescents so as to get an appreciation of the level of adolescents’ participation for those who are involved in SRH advocacy that includes peer educators, members of the YPNSRHHA, and adolescents that attended ASRH activities in the district who were 500 youths according to activity attendance registers. According to Kevin (1999), 10% of the total population in an area gives a sample size to collect data in an area. Therefore 10% of the population was 50 in total. Random sampling was used for the key informants who were selected from the population of programmers (ARSH project officers) and guidance and counselling (G&C) teachers. Six (6) G&C teachers were chosen from different Schools out of the 55 Secondary schools and 4 ASRH project officers from NAC, DSW, Childline and PLAN International.
3.4 Research instruments
The researcher used four instruments to collect data from the respondents. The questionnaire was the main instrument used for this research. Questionnaires were administered to 50 adolescents in Zibagwe district. A questionnaire provides a way of eliciting the feelings, beliefs, experiences, perceptions and attitudes of individuals (Bryman, 2008). In addition, the data was gathered quickly from a large number of respondents. Since there were no names on the questionnaires, the responses were most likely to be honest. The questionnaire comprised of both closed and open ended questions. The process was completed through the help of 5 research assistants from Munyati, Sebakwe communal areas, Silobela and Zhombe.

Semi structured interviews were conducted with project coordinators (programmers) responsible for implementing ASRH projects and programmes. Key informants interviewed were 10 in total, the Kwekwe District AIDS Coordinator (DAC) from NAC, district officer from DSW, project officer from Childline, project coordinator from PLAN International, and six Guidance and Counselling (G&C) teachers from the MOPSE. Semi-structured interviews allow an in depth conversation to be achieved by providing the opportunity on the part of the interviewer to solicit and expand the interviewee's responses (Rubin and Rubin, 2005).

Two Focus Group Discussions (FGDs) were also conducted, the first with 8 secondary stakeholders of institutions responsible for ASRH in Kwekwe district, and health service providers. The second one comprised of teachers, traditional leaders, and parents who were 10 in total. Freitas et al., (1998) expresses Focus Group as a type of in-depth interview accomplished in a group, whose meetings present characteristics defined with respect to the proposal, size, composition, and interview procedures. Main topics discussed included the knowledge of SRH among adolescents in Zibagwe, factors affecting adolescents in seeking ASRH services at local health centres and clinics, adolescents’ involvement in ASRH programmes, ASRH challenges and how adolescents involvement in projects would influence the project’ success and failure.

Documents review complemented the data collected from FGDs, interviews and questionnaires. Documents reviewed were collected from National AIDS Council (NAC), Ministry of Primary and Secondary Education (MOPSE), Department of Social Welfare (DSW), PLAN International, and the Ministry of Health and Child Care (MOHCC). The documents collected from the aforementioned organisations included quarterly and annual reports, activity reports, bulletins and pamphlets. Information acquired constituted of adolescents statistics treated of STIs, tested for HIV, number of school drop outs and reasons,
number of adolescents being reached with SRH, HIV and AIDS education, adolescents being sexually abused and number of trained peer educators in Zibagwe district as well as schools with active peer educators. The data collected would have been expensive to acquire in the field hence the decision to collect them from organisations already involved in ASRH programming.

3.5 Validity and Reliability
The data collected can be considered reliable since the questionnaire, interviews, and FGDs’ objectives were set in such a way that they answered the research questions. Data was collected from renowned organisations that included national parastatals, government ministries and departments and international NGOs who have a wealthy of experience in ASRH programmes. Most of the data was also current.

3.6 Ethical Considerations
During the research, objectives behind the research were clearly indicated and emphasis was given in that it was for academic purposes. The population involved in the research was firmly assured of their privacy and confidentiality which made them comfortable in giving unbiased and confidential information. All elements received an explanation that their participation was voluntary and they were free to withdraw from the research at any stage. Teachers, parents, and church leaders were asked to sign informed consent forms for adolescents under their care with those at 19 years signing for themselves. Since the research included children, the researcher did not need permission from Medical Research Board since the research was done under the implementation of the ASRH activities by NAC the former researcher’s employer for a period of one year.

3.7 Data Presentation and Analysis
Quantitative data about the number of adolescents taking up ASRH services and those also involved in ASRH programmes was largely presented through graphs, tables and plates. Data collected during the study was analysed through Microsoft excel while tables and images were also used to present and analyse qualitative data.

3.8 Chapter Summary
The chapter highlighted several data collection techniques used in this study, the research sample method used was also indicated. The chapter also enlisted the ethical considerations that were observed during the research and how the data collected was presented in the next chapter.
CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 Introduction
This chapter presents the results of the data collected from the field as well as its analysis in assessing the level of adolescents’ participation in SRH. The results answered the objectives of the research mentioned in the first chapter. This chapter will include the demographic characteristics of the respondents, ASRH services and programmes that are offered in Zibagwe, the level of adolescents’ participation in ASRH services, and programmes, and the factors that are affecting adolescents’ participation in SRH services, policies and programmes.

4.2 Demographic Characteristics of Respondents
Demographic characteristics of the respondents from the research that included sex, age, level of education, marital status, and the current school participation status were indicated. The results showed the nexus between demographic characteristics and the research objectives.

Table 4.1 Demographic characteristics of the respondents, n=50

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Sample of</th>
<th>Frequency (n)</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-15</td>
<td>6</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>16-19</td>
<td>44</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>20</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>30</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>42</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>6</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Level of education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>3</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>47</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>Current school</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not going to school</td>
<td>12</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Currently going to</td>
<td>35</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Dropped out</td>
<td>3</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

*(Primary data source)*

Table 4.1 shows that all the respondents were between the ages 10-19. While 88% of the respondents were between 16-19 years, 12 % of them were between 10-15 years. Most of the population was between the ages 16-19 because this is when most of the adolescents start being curious about sexual and reproductive issues hence most ASRH activities target this particular cohort. Sixteen (16) years is also the legal age that empowers adolescents to
consent in sexual activities hence it is most probably logical to assume that meaningful responses would be from this age group and above.

The majority of respondents were female adolescents constituting 60% of the sample while male adolescents constituted 40%. Purposive sampling was used for this distribution because according to NAC’s Zibagwe (2017) ARSH activity reports females consistently dominate in attendance. This was also observed during data collection which was conducted during ASRH activities. Nevertheless, in terms of actively participating and contributing during ASRH activities, males contributed the most and females exhibited shyness because of the sensitivity of SRH issues. Furthermore, during the FGDs it was noted that the issue of attendance and contributing during SRH projects applied even with adult SRH activities. The major reason for this was suggested that it was because of the sensitivity of the SRH issues and the expected gender dynamics that comes with the African culture that male promiscuity is viewed as part of male behaviour as opposed to women and girls. Apparently the research noted that if female adolescents actively contribute during ASRH activities they are viewed as promiscuous by society. Views of both female and male adolescents were essential in establishing the level of adolescent participation in SRH activities.

Furthermore, 84% of the respondents were single something that is expected for adolescents. However, 12% of the respondents were married and all of them were females. This translated to 20% of all girls in the sample. This figure is worrying considering the responsibility of a mother in a rural set up such as Zibagwe. This explains why there is such a high Age Specific Fertility Rate (ASFR) for 15-19 year olds in Zibagwe which lies at 96.4 (ZIMSTATS, 2013). Four percent of the respondents were divorced. These were largely child marriages and did not last because of gender based violence and the husband fleeing responsibility. FGD also unearthed that some of the adolescent males would quickly get married and drop out of school if they get some money through artisanal mining that is prominent in the area. This is usually subsequently followed by divorce or gender based violence when that money runs out.

Table 4.1 shows a representation of 94% of respondents who have reached secondary school while 6% have only reached primary school. None of the respondents had attained any tertiary education most probably because of their age. The 6% representation of respondents who attended school up to primary level shows that there is a correlation between adolescents who participate in ASRH programmes hence education plays a great deal in promoting
adolescents’ participation and improving access to ASRH information. The absence of those who never attended school supports the aforementioned view. This indicates that education is important in the participation of adolescents. This assertion is also supported by that, all adolescent peer educators had attended school up to secondary level. Therefore, the level of adolescents’ participation is largely influenced by adolescents’ level of education.

With regards to current school participation status of the respondents, 70% were currently going to school where as 24% were not going to school and 3% dropped out of school as illustrated on table 4.1. Twenty-four percent of the respondents who were not going to school have either completed their Ordinary level and failed to proceed to Advanced level or tertiary because of difficult economic circumstances, while a few chose not to continue in academics and some have failed their Ordinary level and are waiting for an opportunity to supplement or have just given up on education. Among the 6% that have dropped out 2 of them were because of teen pregnancy while the other one dropped out because he chose to pursue artisanal mining since it offered him enough income. Moreover, 12% of those who were married still attended ASRH activities with other adolescents meaning that they are still in need of SRH information perhaps to avoid another unplanned pregnancy since all those who were married agreed to have been pushed into marriage as a result of unplanned pregnancy. The low turnout of those who dropped out of school may also have a bearing on their level of participation since they may be afraid of being discriminated by other peers. Those who are currently going to school made up most of those who participated giving weight to the assumption that going to school increase the need to actively engage in community development programmes hence these programmes should also be implemented within the school environment.

4.3 Adolescents Sexual and Reproductive Health Services and programmes in Zibagwe
The first objective of this study is to identify ASRH services. Section 4.3.1 presents the SRH services available for adolescents in Zibagwe, whilst section 4.3.2 explores the ASRH programmes responsible for facilitating and driving access to ASRH services.
Fig 4.1 shows the ASRH services that are accessible to adolescents and their uptake levels according to sex. According to fig 4.1, 88% of adolescents had access to HIV Testing and Counselling (HTC) services and these were most accessible because there are offered for free. Adolescents also have easy access to these because of HTC services that are offered by NAC, MoHCC and Family Health International 360 through HTC outreach programmes. Adolescents are most comfortable in accessing HTC services through these outreach programmes because they avoid local clinics who mostly constitute of someone they know and are not assured their privacy. According to secondary data sources in Zibagwe 3 957 adolescents (15-19) years were tested for HIV in 2016. This translated to 17.64% of people tested in 2016 in Zibagwe district. Therefore this may show that adolescents who participate have a higher chance of accessing ASRH services.

Furthermore, fig 4.1 also shows that 82% of adolescents have access to SRH information and education. The primary data source suggested that a greater percentage of adolescents who have access to SRH information and education had access from their secondary schools through their G&C lessons while a significant of those who do not go to school are the ones who largely comprise those adolescents who do not have access. This shows that adolescents
who are not going to school are more vulnerable to ASRH challenges as compared to the adolescents going to school. Their vulnerability may also be increased by the fact that they don’t have much to do while at home and their counterparts spend a significant portion of their time at school. Therefore adolescents not going to school have ample time to engage in risky sexual behaviours considering that they have limited or no access to SRH information and education.

Most adolescents in Zibagwe do not have access to condoms as shown in Fig 4.1 where only 46% have access to condoms. What is more worrying is that only 18% of the population sample had access to condoms. This partially explains why the ASFR (15-19) is very high at 96.4 in Zibagwe district (ZIMSTAT, 2013). The lack of access to condoms exposes adolescents to STIs including HIV and unplanned pregnancies that usually lead to dropping out of school and early marriage. In Zibagwe 27.5% of adolescents are already in marriage hence the importance to improve access to condoms.

Fig 4.1 also shows that 32% of the adolescents had access to STI testing with girls constituting the 28% of the population sample. This may be influenced by health seeking behaviour that is associated with gender and that girls are more vulnerable to STIs. Girls are more vulnerable to STIs because of their biological make up of their sexual reproductive health organs and intergenerational relationships. Secondary data sources in the district state that 672 males and 609 females were tested positive for STIs in 2016. However, during the same year among 59 adolescents with STIs, 79.66% were females. This shows how vulnerable adolescent females are vulnerable to STIs because they engage in sexual activities early with older men. Therefore 32% of adolescents who have access to STI testing remains significantly low and there is need to scale up knowledge awareness on where to get access to ASRH services.

Some of the ASRH services are sex based such as contraceptives, pregnancy testing, maternal care, cervical cancer screening and Voluntary Medical Male Circumcision (VMMC). Fig 4.1 shows that 37% of female adolescents in the survey had access to contraceptives. These mostly constituted adolescents in marriage and those who had divorced because for most adolescent girls contraceptives are only meant for women with families. Most of them were of the view that family planning services are for married women only. The same proportion (37%) of female adolescents also had access to pregnancy testing services. This could have been influenced by the fact that 84% of the adolescents both male and female were still
single. Twenty-seven percent of adolescent girls had access to maternal care and these comprised mostly of those who were in marriage. For cervical cancer screening, only 12% of girls who participated had knowledge about its accessibility. For male adolescents 80% of them had access to VMMC. This was largely because of the VMMC campaign conducted by the MOHCC and subsequently by Population Service International (PSI) as an HIV prevention initiative. In support, secondary sources state that of the total 22,426 males who were circumcised in Zibagwe (2016), 84.31% were adolescents.

4.3.2 Adolescents Sexual and Reproductive Health Programmes in Zibagwe

Table 4.2 Platforms facilitating adolescents’ participation

<table>
<thead>
<tr>
<th>Programme</th>
<th>Heard about it</th>
<th>Never heard about it</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES Games</td>
<td>38</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Zvandiri (support groups)</td>
<td>10</td>
<td>28</td>
<td>12</td>
</tr>
<tr>
<td>Peer educators</td>
<td>40</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Ending child marriage</td>
<td>44</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>ASRH dialogues</td>
<td>36</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>HTC Roadshows</td>
<td>46</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Adolescents selling sex forum</td>
<td>4</td>
<td>46</td>
<td>0</td>
</tr>
<tr>
<td>Video screening (Youth Corners)</td>
<td>50</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Primary data source)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.2 shows a list of ASRH programmes whereby adolescents participate in SRH and the number of adolescents who are aware of these activities. The most known programme by adolescents (100%) was the youth sensitisation through video screenings conducted by the Young People’s Network on SRH, HIV and AIDS (YPNSRHHA). This was largely because the YPNSRHHA are mostly involved in all ASRH activities done by various organisations in the district. They conduct their SRH education using videos in schools, churches and the community targeting the youth out of school. Their activities are initiated by adolescents and they also direct their projects and often share their decisions with adults.

Ninety-two percent of adolescents have heard about the NAC roadshows that target the youth (see table 4.2). The roadshows usually use entertainment as a mobilisation strategy to educate young people while offering HTC services onsite. The roadshows are done across the district hence most of the adolescents have heard about them and most probably participated through HTC, and learning while enjoying the entertainment that will be offered. The roadshows often have adolescents participating although they are largely initiated by adults while adolescents are assigned specific roles and informed of their role.
As illustrated on table 4.2, 88% of adolescents have heard about the ending child marriage campaigns in Zibagwe. This is largely because the activity included all secondary schools and youth out of school from various communities. The campaigns were widespread in Zhombe and Silobela. Adolescents were assigned specific roles and informed of their roles such that they led the proceedings while adults were just advising and giving technical input.

Plate 4.1 “Ending child marriages Campaign” in Zhombe (Photo taken by Zinyoni, C.T)

Plate 4.1 shows adolescents taking part during the campaign for ending child marriages in Zhombe. According to primary data sources, PLAN International in partnership with the Department of Social Welfare (DSW) also consulted adolescents during planning.

As shown on table 4.2, 80% of adolescents heard about the peer educator’s programme. This is largely because most peer educators are active at school. This is the same with Youth Education through Sports (YES) games whereby 76% of adolescents heard about the programme. Seventy percent of the adolescents had heard about the youth corner as well. The youth corner pilot project was initiated under the ASRH and HIV project whereby 2 youth corners were installed in Zibagwe in 2016 by Plan International (secondary data source). Youth were consulted for this activity and this was supported during a FGD:

“People from PLAN International, NAC, ZNFPC and Zibagwe RDC came and consulted the students on whether they need a youth corner, the convenient site for it and the sort of recreational activities they would need. I personally think that was a
good idea because only the adolescents understand what they need exactly because things are now different with our generation” (G&C teacher)

The research noted that only 8% and 20% of adolescents had heard about the forum for adolescents selling sex by PLAN International and the support groups by Afracaid Zvandiri respectively. Perhaps the lack of knowledge regarding these programmes had to do with sensitivity of the special populations involved that consists of adolescents selling sex and adolescents living with HIV.

4.4 Level of Adolescents’ Participation
The aim of this study was to assess the level of adolescents’ participation in SRH services and programmes. To address this aim, the second objective determines the level of adolescents’ participation in SRH programmes and policies. Therefore this section presents the level of adolescents’ participation based on Hart’s ladder of participation.

![Figure 4. 2 Levels of adolescents’ participation](primary data source)

Below is the key highlighting the hierarchical levels of participation as per Hart’s ladder of participation.
Table 4.3 Key: Levels of adolescents’ participation

<table>
<thead>
<tr>
<th>Levels of Adolescent Participation</th>
<th>Roger Hart’s Rungs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents initiate ASRH programmes and share decisions with adults</td>
<td>Rung 7</td>
</tr>
<tr>
<td>Adolescents initiate ASRH activities and direct the project</td>
<td>Rung 6</td>
</tr>
<tr>
<td>Adults initiate ASRH activities and share decisions with adolescents</td>
<td>Rung 5</td>
</tr>
<tr>
<td>Adolescents are consulted and informed</td>
<td>Rung 4</td>
</tr>
<tr>
<td>Adolescents are assigned specific roles and informed of their role</td>
<td>Rung 3</td>
</tr>
<tr>
<td>Manipulation, decoration and tokenism</td>
<td>None participation</td>
</tr>
</tbody>
</table>

(Hart, 1992)

Fig 4.2 shows the proportion of adolescents in how they expressed their opinions in how best to describe the current level of adolescents’ participation in SRH programmes in Zibagwe. The above table shows that 6% of adolescents are of the view that ASRH programmes are being initiated by adolescents and decisions being shared with adults. This could be because adolescents in Zibagwe do not yet feel empowered that they take their projects to adults. An example cited by Hart (1992) states that teenage students from a school in Paranoá, a low income settlement on the outskirts of Brasilia, designed and directed a video report on how pregnant teenagers feel about being pregnant and what advice they have for other teenagers. Hence there is need to upscale projects that empowers adolescents to reach the highest level of participation.

As shown on fig 4.2, 24% of adolescents indicated that most of the ASRH projects that are currently being implemented are adolescents initiated and also directed by adolescents. This also came out during a FGD held with ASRH project coordinators:

“During our annual District Planning Process (DPP) every year the YPNSRHHA present their concept note and if their proposals are approved NAC avails funds for them whereby the adolescents get to direct the ASRH activities such as the youth in and out of school sensitisations through video screenings, roadshows, and ASRH dialogues” (Kwekwe District AIDS Coordinator).
The survey indicated that the majority of adolescents (32%) were of the view that ASRH projects that were implemented in Zibagwe are initiated by adults and decisions are shared with adolescents. Hart (1992) affirms that this level is true participation because, although the projects at this level are initiated by adults, the decision making is shared with the young people. However 13% of the respondents among the adolescents were of the view that the 4th and 5th level from the top on Roger Hart’s ladder of participation model where adolescents are consulted and informed and adolescents are assigned specific roles and informed of their role respectively were the levels that could best describe the levels of participation in Zibagwe. According to Hart (1992) on the 4th level adolescents work as consultants for adults in a manner which has great integrity while the project is designed and run by adults, but children understand the process and their opinions are treated seriously (Hart, 1992). The 5th level where adolescents are assigned specific roles and informed of their role is the most common in ASRH programmes that are conducted within school premises.

Nevertheless 14 % of the adolescents in Zibagwe District indicated that none of the above participation levels could be used to describe how ASRH projects were being implemented meaning that the form of “participation” was in form of manipulation, decoration or tokenism. They expressed a different opinion in that as adolescents they had no time to commit to ASRH programmes to allow meaningful participation. Hence this may suggest that the ASRH project coordinators may end up being compelled to involve adolescents in form of manipulation, decoration, and tokenism. One of them was quoted saying:

“Adolescents in Zibagwe are preoccupied with either household chores for females and males are into artisanal mining. For those at school, activities are forced on them by the teacher and school authorities” (ASRH project officer)

Therefore it is critical to acknowledge the levels of adolescents’ participation in ASRH projects since it shows that most of their projects have adolescents being actively involved. Although there may still be other projects still lagging behind it remains imperative for such projects to actively involve adolescents and find a way to work around factors that may be hindering their active involvement and increasing their level of participation.

4.5 Factors Affecting Adolescents’ Participation in Zibagwe

The last objective as stated in the first chapter that is to explore the factors affecting the participation of adolescents in SRH will be addressed in this section. Therefore this section presents the factors affecting adolescents in participating in ASRH services and programmes.
Table 4.4 Factors hindering ASRH service uptake and participation

<table>
<thead>
<tr>
<th>Factors affecting adolescents’ participation</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of parent to child communication</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>Lack of knowledge on SRH</td>
<td>9</td>
<td>41</td>
</tr>
<tr>
<td>No access to youth friendly corners</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>Lack of access to trained peer educators</td>
<td>13</td>
<td>37</td>
</tr>
<tr>
<td>Unfriendly health service providers</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>Distance to health facilities</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Age of the facilitator</td>
<td>41</td>
<td>9</td>
</tr>
<tr>
<td>Centralisation of programmes in Kwekwe Urban</td>
<td>30</td>
<td>20</td>
</tr>
</tbody>
</table>

*Primary data source*

Table 4.4 shows that 80% of adolescents in the population sample never discussed about their SRH with their parents, relatives or guardians. Parent to child communication is often key for adolescents to access key information on SRH. Traditionally ASRH information and education was offered by aunts and uncles but with the globalisation and cultural divergence this particular trait has ceased to exist. Therefore it is really a cause for concern when parents avoid talking about ASRH issues in the name of culture to educate their children about their SRH.

The survey showed that 18% of adolescents had challenges in participating in ASRH services because they are ignorant about SRH. Furthermore, 82% are adolescents who access SRH information at school where they are only taught about condoms as a prevention method from an academic perspective and in the process information on where to actually access them brings about the fear of the practical part of it hence the youth in school are short changed. The MOPSE education policy in Zimbabwe does not allow the demonstration of condoms within school premises hence the issue of condoms is often sensitive among adolescents who are still going to school. Therefore adolescents in school find themselves vulnerable when they engage in sexual activities without condoms hence significant numbers are still dropping out of school every term because of teen pregnancy. Gliński et al. (2014) stipulate that many adolescents don’t know where they can find products and youth-friendly services and this emanates from lack of knowledge concerning access and availability of ASRH service.

In addition, table 4.4 also shows that 60% of adolescents had no access to youth corners. Only 40% of adolescents had access to youth corners in Zibagwe. The youth corners were recently set up in 2017 as a pilot project to assess their effectiveness as a recreational area and a platform for ASRH dialogue and education at Malisa Josepha (Zhombe) and Sidakeni
(Zhombe East). According to 40% of the adolescents, the youth corner has been currently active hence they have been getting ASRH information and education easily. However, 60% is still significant for those adolescents in Zhombe West, Sebakwe communal areas and Munyati who currently don’t have any youth centres or youth corners with trained peer educators.

Only 26% of adolescents had no access to trained peer educators. Adolescents with access to trained peer educators constituted 74%. This was largely attributed to youth in school peer educators and various secondary stakeholders who make an effort to include adolescents. According to secondary data sources a total of 127 male youth in school peer educators and 180 female peer educators were active across all the 55 secondary schools in 2016. Where as 3212 and 3358 male and female pupils respectively participated in school AIDS action clubs in 2016. Therefore due the MOPSE health policy adolescents now have various platforms for participation in ASRH activities.

Nevertheless, the community sometimes misinterprets ASRH programmes as activities that promote promiscuity among adolescents. Some traditional and community leaders were of the view that adolescents tend to experiment on information provided by ASRH projects such as condom use. The following was said at a FGD with parents and community leaders:

“The challenge we have with the use of condom demonstration is that adolescents are quick to experiment on what they have learnt such that as soon as they are taught on how to put on a condom they want to try it on a girl practically and as a result the adolescents become promiscuous” (Village head).

Some would then argue that already the adolescents are already engaging hence it is better for adolescents to be educated on the consequences of sexual activities and make informed decisions rather than engage in health risk behaviour because of ignorance. This problem has also been felt by youth in faith based organisations (FBOs) whom Pastors try to guide using biblical principles but the youth continue to disregard the biblical laws and because they were denied ASRH related information they are exposed to unplanned pregnancies and STIs.

Most adolescents (80%) experienced unfriendly youth health services. Eighty percent of adolescents expressed their opinion suggesting the health facilities they attended to had no youth friendly health services. This is despite the GoZ (2016) stipulating the 9 standards for national guidelines on clinical adolescents and youth friendly SRH provision. Perhaps the
MOHCC has not initiated wide spread training on the 2016 guidelines on youth friendly services. One of the adolescents was quoted saying:

“The health staff is very hostile to adolescents seeking STI treatment to the extent that adolescents resort to the clinic when the STI has progressed and on top of that your privacy is likely to be violated because around here if a young person visit a clinic for an STI treatment we would all know” (Adolescent)

This is a significant factor affecting adolescents and causes delay of adolescents in seeking treatment. Furthermore, rural areas are culturally close in terms of social relations and everyone knows each other and this causes challenges for youth to visit the health facility with an ASRH challenge.

Table 4.4 shows that 25% of adolescents have to walk a minimum distance of 5km to access the nearest health facility. Fifty percent of adolescents indicated that the closest clinic from their residential homes were between 700metres and 4kilometres while the other 50% indicated that their closest clinics were between 5km and 10km. Although half of the respondents can walk to their clinics the other half may face challenges considering the state of the roads in rural areas. This can be one of the reasons why adolescents may find it difficult to access ASRH services. Distance can also cause a challenge when adolescents are invited to attend ASRH programmes since most of them are held close to a health facility. Whenever they attend the programmes are supposed to end early to allow adolescents to travel long distances back home in busy roads.

During a FGD parents seemed not to be aware of the new MOPSE policy that allows a female student to come back to school after giving birth for a second chance at education. It could be observed that most school passively resisted the new policy and were reluctant to enforce it. The new education policy that states that if a female student is impregnated during school days is given maternity leave and resume her studies after giving birth. The policy also compels the male student if he is responsible for the pregnancy at the same school to also go on paternal leave and support the female student carrying his unborn child. The new policy received mixed feelings from the community representatives hence it will be a challenge to enforce. This is despite the fact that it is in the interest of the adolescent.

A significant proportion of adolescents (82%) were of the view that it is easier to have an adolescent facilitator during ASRH activities because it is easier to open up. ASRH project coordinators unanimously agreed that the age of the facilitator has a great impact on an
ASRH activity citing the following: “Young people need people who can associate well with them preferably someone who is of their age” (ASRH project officer)

“Adolescents have a tendency to view older people as backward and if ASRH programmes are facilitated by someone who is a youthful person the information is easily accepted” (ASRH project officer)

With the above in mind it is logical to argue that the age of facilitators has a negative impact on ASRH activities hence the reason why it is important for adolescents to direct their ASRH activities.

Adolescents were of the view that most ASRH programmes are centralised in Kwekwe urban and 60% of them supported this view (see table 4.4). All administrative offices of Zibagwe including the Zibagwe Rural District Council (ZRDC) are all located in Kwekwe urban. Therefore adolescents felt that most of the programmes benefit more adolescents who live in Kwekwe urban.

4.6 Chapter Summary
This chapter presented the data findings that were collected in the field by various research instruments. The chapter also provided an in depth analysis of the data collected and interpreted it addressing the research questions of the research study. The data was presented in various ways that included tables, plates and bar graphs. The following chapter constitute the summary of key findings, research conclusions and the way forward.
CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction
This chapter provides a summary on key findings, conclusions and also proffer recommendations of the study. The research set out to identify ASRH services that are offered in Zibagwe district, to determine the level of adolescents’ participation in SRH programmes and policies and also to explore the factors affecting the participation of adolescents in SRH.

5.2 Summary of Key Findings
The research study addressed its first objective concerning the identification of ASRH services that are offered by various stakeholders in Zibagwe. These included ASRH information and education which is important in the reproductive wellbeing because it empowers them in making informed and responsible decisions. The study showed that 88% of adolescents had access to HIV Testing and Counselling (HTC) services. It also showed that 82% of adolescents had access to SRH information and education. Nevertheless the study also showed that most adolescents in Zibagwe do not have access to condoms since only 46% of them had access to condoms. It also noted that 32% of the adolescents had access to STI testing with girls constituting the 28% of the population sample. Furthermore 37% of female adolescents in the survey had access to contraceptives and most of these constituted adolescents in marriage. The same proportion (37%) of female adolescents also had access to pregnancy testing services. The study also showed that 27% of adolescent girls had access to maternal care.

The research aim of the study of assessing the level of adolescents’ participation in SRH programmes was also articulated. Various levels of adolescents’ participation in SRH services, programmes and policies were being implemented. The research showed that 6% of adolescents were of the view that ASRH programmes in Zibagwe operated at the highest level of Hart’s ladder of participation. Twenty-four percent of adolescents indicated that ASRH programmes had adolescents initiate ASRH activities and direct the projects. Nevertheless the research also showed that most of the adolescents (32%) were of the view that ASRH programmes in Zibagwe District operated at the 5th rung whereby adults initiate
ASRH activities and share decisions with adolescents. However it was also noted that 14% of the programmes included adolescents as a form of manipulation, decoration or tokenism.

The last objective of the research that seek to explore the factors affecting adolescents in participating in SRH service uptake and SRH programmes was also addressed. Factors affecting adolescents’ participation in SRH were also explored by the study. The research showed that 80% of adolescents in the population sample never discussed about their SRH with their parents, relatives or guardians indicating a serious lack of parent to child communication. The research study also showed that 18% of adolescents had difficulties in participating in ASRH services because they are ignorant about SRH with the 82% benefiting from mostly G&C lessons at school. Furthermore, the survey also showed that 60% of adolescents had no access to youth corners. The research also noted that 80% of adolescents were of the view that health service providers exhibit negative attitudes against adolescents seeking SRH services such as STI treatment. Half of adolescents indicated that the closest clinic from their residential homes were between 700m and 4km while the other 50% indicated that their closest clinics were between 5km and 10km. The majority of adolescents (82%) preferred to have a youthful facilitator during ASRH activities for easy interaction.

5.3 Conclusion
ASRH services are now readily available even in rural areas but their accessibility remains questionable. Adolescents still find it difficult to access ASRH services that are meant for them because of hostile attitudes by health service personal. Health service providers tend to be hostile towards adolescents who visit health facilities seeking ASRH services through judgements on adolescents and harassments. Adolescents experience hostility from health service providers because society expects them to abstain such that even when adolescents just want ASRH information and education they are judged and labelled promiscuous. Parents also do not educate their children about their SRH because they see it as culturally inappropriate. Adolescence stage is characterised by experiments since adolescents will be experiencing puberty. If adolescents do not get proper guidance they will listen to these developments and subsequently act on them. Due do globalisation, adolescents now find ideas from western television programmes, the internet, social media and their peers. With so much access to information it has become easy to engage in sexual activities and when they do not have access to ASRH services such as condoms their actions will lead them to health risk behaviours. Unprotected sex will expose them to teen pregnancies, leading them to early child marriages. They will also be exposed to sexually transmitted diseases. Some of them
will drop out of school and for males they will be forced into artisanal mining to take care of their responsibilities or migrate to South Africa.

There are no doubts that adolescents are included in ASRH programmes. However, the argument is how they are involved. Traditionally in an attempt to justify donor funds ASRH project officers would use Information, Education and Communication (IEC) material in form of t-shirts, caps, hats, wrists bands to manipulate and decorate adolescents during ASRH activities. Pictures would seem as if adolescents are actively participating and yet in praxis they would be participating in form of tokenism. Although adolescents are young, they are the ones that are in touch with ASRH challenges facing their age and hence it is critical to involve them in needs assessment, planning, project design, implementation and also during M&E. Excluding adolescents in such essential processes may have consequences that include lack of sustainability, adolescents may finish the project without acquiring the intended information and they will continue to be marginalised because they will get used to adults doing everything for them. Having adults doing everything will keep important information from coming out since adolescents easily open up to fellow peers who understand them. Adolescents also participate freely when another adolescent is facilitating the activity and information is easily disseminated and it is also easier to express ASRH challenges they are facing and how they would also like those challenges to be addressed.

5.4 Recommendations
A couple of recommendations can be drawn from the research findings that seeks to improve the uptake of ASRH service uptake and improve the level of adolescents’ participation in ASRH programmes and policies to achieve effectiveness and sustainability in ASRH programmes. These recommendations can also be applied to communities with a rural set up like Zibagwe in Sub-Sahara Africa.

- The government can establish health centres in remote areas to ensure that adolescents in hard to reach areas have access to ASRH services within a walking distance.
- There should be programmes that target youth out of school and this will also help to cover the knowledge gap that cannot be covered at school such as the issue of condom demonstration that is not allowed within school premises.
- ASRH secondary stakeholders need to use an approach that includes adolescents in decision making so as to have projects that serve the wellbeing of adolescents.
- ASRH programmes should be designed such that they empower adolescents to initiate their own ASRH activities and eliminate issues such as stigma and discrimination on their own.
- ASRH should include parents so as to promote parent to child communication thereby reducing the influence of globalisation on adolescents.
- Government should train health service providers to observe National Guidelines on Clinical Adolescents and Youth Friendly Sexual and Reproductive Health Service Provision to have at least one health service provider equipped to handle ASRH issues.

This research was based on a case study which was assessing the level of adolescents’ participation in SRH services, and programmes. The research can contribute in improving ASRH service uptake and assist government departments, NGOs, and parastatals that are into ASRH programming in assessing their projects and improve the level of participation for adolescents to achieve maximum project outcomes and sustainability.
REFERENCES


Muzadzi, T (2013). Barriers to Young People’s Sexual and Reproductive Health in Zimbabwe with a focus on Access and Utilization of Services. Royal Tropical Institute, Amsterdam


Appendix 1

Questionnaire for ASRH Adolescents in Zibagwe District

My name is Courage T Zinyoni a student from Bindura University of Science Education. I am doing a research that is assessing adolescents’ participation level in Sexual and Reproductive Health services and programmes in Zibagwe district. Your privacy and confidentiality will be protected. Your name will not be required. You are also not compelled to participate, however your participation would be greatly appreciated. The research is for assessing adolescents’ participation level in Sexual and Reproductive Health services and programmes in Zibagwe district.

Where boxes are available, tick where it is applicable

SECTION A

Demographic Information

1. How old are you?.............
2. Sex?

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. What is your marital status?

<table>
<thead>
<tr>
<th>Single</th>
<th>Married</th>
<th>Divorced</th>
<th>Widowed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Level of education?

<table>
<thead>
<tr>
<th>None</th>
<th>Primary</th>
<th>Secondary</th>
<th>High School</th>
<th>Tertiary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Current school participation status?
Not going to School | Currently at School | Dropped Out
---|---|---

SECTION B

6. Do you have access to any of the following ASRH services?

<table>
<thead>
<tr>
<th>Adolescents Sexual and Reproductive Health services</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV testing and counselling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STI testing and treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual and Reproductive Health information and education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary Medical Male Circumcision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condoms</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Have ever heard about the following Adolescents Sexual and Reproductive Health Programmes in Zibagwe district?

<table>
<thead>
<tr>
<th>Programmes</th>
<th>Heard about it</th>
<th>Never heard about it</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Education through Sport games</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zvandiri</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer educators training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ending child marriage campaigns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASRH dialogues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roadshows</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex work forums</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Video screenings (youth sensitisations)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. How best can you describe the level of participation of students in ASRH activities?

- [ ] Adolescent initiate ASRH programmes and share decisions with adults
- [ ] Adolescents initiate ASRH activities and direct the programme
- [ ] Adults initiate ASRH activities and share decisions with adolescents
- [ ] Adolescents are consulted and informed
- [ ] Adolescents are assigned specific roles and informed of their role
- [ ] None of the above. Specify
SECTION C

9. What are the factors that are affecting you to access ASRH services and participating in ASRH activities?

<table>
<thead>
<tr>
<th>Factors affecting adolescents’ participation</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of parent to child communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of knowledge on Sexual and Reproductive Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No access to youth friendly corners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of access to trained peer educators</td>
<td></td>
<td></td>
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<tr>
<td>Unfriendly health service providers</td>
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<td></td>
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<tr>
<td>Distance to health facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age of the facilitator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centralisation of programmes in Kwekwe</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. How far is the closest clinic or rural health centre from your residential home?

....................

11. How far is the closest hospital from your residential home?

....................

12. Do you know where to access condoms?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

General comments

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........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
Appendix 2

Interview guide for Key Informants

1. Sex

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Which organisation do you work for?

………………………………………………………………………………………

3. Ever received training in relation to ASRH?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. What are the ASRH services that are offered in Zibagwe District?

<table>
<thead>
<tr>
<th>ASRH Services</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexuality counselling services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV counselling and testing &amp; Sexually transmitted infection testing and treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information on HIV and STI prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services relating to experiences of sexual, physical or emotional violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-abortion care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VMMC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. What is being done by the School to promote ASRH?

6. Are the students given a platform to advocate for their SRH Rights?

7. Does the new MoPSE curriculum support ASRH programmes (i) if yes how? (ii) if not, what may be the reasons?

8. What are the education policies/programmes that support adolescents’ participation in SRH?

9. How best can you describe the level of participation of students in ASRH activities?
   - Adolescent initiate ASRH programmes and share decisions with adults
   - Adolescents initiate ASRH activities and direct the programme
   - Adults initiate ASRH activities and share decisions with adolescents
   - Adolescents are consulted and informed
Adolescents are assigned specific roles and informed of their role
None of the above. Specify

10. What can be done to enhance the uptake of (i) ASRH services and enhance the level of participation of adolescents in (ii) ASRH programmes?
   i) .................................................................................................................................
   .................................................................................................................................
   .................................................................................................................................
   .................................................................................................................................
   ii) .................................................................................................................................
   .................................................................................................................................
   .................................................................................................................................
   .................................................................................................................................
   .................................................................................................................................

11. Are they any adolescents in special populations that are involved in ASRH programmes?
   Adolescents living with HIV and AIDS
   Adolescents living with disabilities
   Adolescents living in the streets
   Adolescents in the sex work trade
   Adolescents in marriages
   Adolescents living in mining compounds

12. Which platforms and ASRH programmes are adolescents participating in?
   .................................................................................................................................
   .................................................................................................................................
   .................................................................................................................................
13. What factors are affecting the participation of adolescents in Zibagwe District?

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

14. How does decoration and tokenised participation of adolescents affect the effectiveness and efficiency of ASRH programmes?

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

15. Does the age and gender of the facilitator affect the participation of adolescents during ASRH programmes? If yes, elaborate.

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

16. Is your organisation implementing the National Adolescent Sexual and Reproductive Health Strategy (2016-2020)?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

If no, why?
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
Appendix 3

Focused Group Discussion Guide with Key informants

- What are the ASRH services offered in Zibagwe District?
- What is the rate at which adolescents are taking up ASRH services?
- What are the ASRH programmes being implemented in Zibagwe District?
- What is the current level of involvement of adolescents in ASRH programmes?
- What are the factors that affect the participation of adolescents in ASRH services and programmes in Zibagwe District?
- What are the opportunities that results in involving adolescents in early stages of projects?

Focused Group discussions with teachers, parents and community leaders

- Does adolescents have access to SRH services among adolescents in Zibagwe?
- What are the factors affecting adolescents in seeking ASRH services at local health centres and clinics?
- How are adolescents being involved in ASRH programmes in?
- Do you consult adolescents in ASRH programmes?
- As parents, do ever find time to discuss SRH with your children?
- Is the church facilitating knowledge on ASRH?