

Knowledge And Perceptions Of Adolescent Sexual And Reproductive Health Issues Among Rural Adolescence In Gutu Rural District Of Zimbabwe

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ABSTRACT: This study was aimed at examining the knowledge and perceptions of adolescents on Adolescent Sexual and Reproductive Health (ASRH) rural Zimbabwe. Adolescents in Zimbabwe faces limited access to health information and services. Different factors like poverty, gender inequality, socio-cultural and economic status play a crucial role in determining adolescent's access to ASRH knowledge. Qualitative research methodology was used in the study. Data was gathered through key informant interviews and Focus Group Discussions (FGDs). The study found out that adolescents in Gutu rural district were aware about some of the common ASRH problems like HIV and AIDS, Sexually Transmitted Infections (STIs), early marriages, teenage pregnancy and gender inequality. The culture of communicating ASRH problems with parents was non-existent in most cases save for girls who indicated that they got information from their mothers during menstruation periods. Adolescents indicated that they had limited access to ASRH services available in their community. They further indicated that they were not utilising these services for various reasons such as social stigma, lack of information, poor quality service and the negative attitude displayed by some nurses and counsellors at the nearest health centre.

Key words: Adolescence, reproductive health, sexuality, sex, sexual health

1. INTRODUCTION

According to the World Health Organisation (WHO) (2002), 20 percent of the world's population are adolescents while the National Population Census of Zimbabwe (2012) indicated that adolescents aged 10-19 years constitutes 24% of the country's total population (Ministry of Health and Child Care, 2016). These young people face a number of challenges related to their development. According to the categorisation of WHO, adolescents are persons aged between 10 to 19 years (WHO, 2002). This period of adolescence is further categorised into three stages namely; early adolescence, mid adolescence and late adolescence. Early adolescence is the period between the ages 10 to 13 years which is characterised by growth along with sexual maturation. Mid adolescence is the period between the ages 14 to 15 years categorised by the development of stronger sense of identity while late adolescence are persons between ages 16 to 19 years categorised by the development of adult form (WHO, 2006). Adolescence period is considered as a time of transition from childhood to adulthood where various biological, psychological and social changes take place. Physical transition is reflected in appearance, voice and sexual activity, while psychological transition is reflected in individual thinking and social transition where individuals start thinking about their rights. There is rapid physical and cognitive growth during this phase (Steinberg, 1990). Adolescence is also referred as a phase of rapid physical and cognitive growth. Adolescence phase is a sensitive stage of life where both girls and boys experience hormonal changes in their bodies. Their bodies take adult shape and become sexually mature (Steinberg, 1990). As a result adolescents are often attracted towards opposite sexes which lead to intimate relationships (WHO, 2002). Dehne and Riedner (2001) argue that despite being delimited by age, adolescence period is primarily a social classification based on physical, mental and social markers of development. These markers are partly laid

in early childhood and embedded within the process of physical maturation and socialisation. The importance of the adolescence stage in life has far-reaching implications. Adolescence period is increasingly seen as the 'gateway to health' because behavioural patterns acquired during this period tend to last throughout adult life (Dehne and Riedner, 2001: 11). This stage often includes complex processes and rites of passage, such as the reaching of menarche and spermarche (often indicated by menstruation in girls and the first self-reported ejaculation in boys), developing close friendships, dealing with peer pressure, struggling with identity, becoming aware of one's sexuality, developing ideals, and adopting and taking examples from role models (Islam and Mahmud, 1995). The typical adolescence features like risk taking, curiosity and anxiety are less prevalent among late adolescents. Therefore late adolescence is also perceived as the period of opportunity (UNICEF, 2011). The adolescent period is usually fragile because the recently acquired sense of awareness and emotional independence are still in liquid state which require favourable family and socio-cultural environment to crystallise and take proper shape (Islam and Mahmud, 1995). The adolescent period is therefore a crucial phase of human development where one develops and assumes greater personal responsibility according to exposure and experimentation (WHO, 2002). Though sexual activity starts fairly at an early age, sex and sexuality issues are not an openly discussed topic in most rural communities in Zimbabwe because of strong traditional norms and beliefs (Mahat, 2001).

2. PURPOSE OF THE STUDY

The purpose of this study was to understand the knowledge and perceptions of late adolescents aged 15 to 19 years towards ASRH services in Gutu rural district of Zimbabwe.

3. RESEARCH METHODOLOGY

Qualitative research methodology was used in this study. Purposive sampling was used in the selection of key respondents who included two nurses from a local clinic, two school teachers responsible for teaching Guidance and Counselling and three parents from the community. Key informants were chosen because of their in-depth knowledge of ASRH. The target group of this study were late adolescents between the ages of 15 to 19 years. The choice for late adolescents was that they are more composed and mature, have acquired major physical changes and obtained cognitive maturity. Three Focus Group Discussions (FGDs) with a total of 30 late adolescents comprised of 18 females and 12 males selected from the community youth networks and school Interact Clubs participated in the study. For participants below 18 years, consent from the parent or guardian was obtained after which an assent was obtained from the adolescent. Documentary search was used to review various instruments and legislations on ASRH such as Constitution of Zimbabwe, Sexual Offences Act, and the Zimbabwe National Population Policy.

4. THEORETICAL FRAMEWORK

This research was guided by the Health Belief Model (HBM). The model is mainly used in health education and health promotion (Glanz, Rimer and Lewis, 2002). The underlying concept of the HBM is that health behaviour is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence (Hochbaum, 1958). Personal perception is influenced by the whole range of intrapersonal factors affecting health behaviour. Four perceptions serve as the main constructs of the model. These are perceived seriousness, perceived susceptibility, perceived benefits, and perceived barriers. Each of these perceptions individually or in combination can be used to explain health behaviour (Hochbaum, 1958). Perceived seriousness-this construct focuses on an individual's belief about the seriousness or severity of a disease. While the perception of seriousness is often based on medical information or knowledge, it may also come from beliefs a person has about the difficulties a disease would create or the effects it would have on his or her life in general (McCormick- Brown, 1999). Perceived susceptibility/ personal risk- this is one of the more powerful perceptions which prompt people to adopt healthier behaviours. The greater the perceived risk, the higher the likelihood of engaging in behaviours that decreases the risk. It is only logical that when people believe they are at risk for a disease, they will be more likely to do something to prevent it from happening. Unfortunately the opposite also occurs. When people believe they are not at risk or have a low risk of susceptibility, unhealthy behaviours tend to result. Perceived benefits- this is a person's opinion of the value or usefulness of a new behaviour in decreasing the risk of developing a disease. People tend to adopt healthier behaviours when they believe the new behaviour will decrease their chances of developing a certain disease (Graham, 2002). Perceived barriers to change- this is an individual's own evaluation of the obstacles in the way of him or her adopting a new behaviour. Perceived barriers are the most significant in determining behaviour change (Janz and Becker, 1984). In order for a new behaviour to be adopted, a person needs to believe the benefits of the new behaviour outweigh the

consequences of continuing the old behaviour. This enables barriers to be overcome and the new behaviour to be adopted (Centre for Disease Control and Prevention, 2004). In addition to the four beliefs or perceptions and modifying variables mentioned above, the HBM suggests that behaviour is also influenced by cues to action and self-efficacy. Cues to action- these are events, people or issues that move people to change their behaviour. Examples include illness of a family member, media reports, mass media campaigns, advice from other people or health warning labels on a product (Ali, 2002; Graham, 2002). Self efficacy- This was added to the original four beliefs of the HBM in 1988 (Rosenstock, Strecher, and Becker, 1988). Self efficacy is the belief in one's own ability to do something (Bandura, 1977). People generally do not try to do something new unless they think they can do it. If someone believes a new behaviour is useful (perceived benefit), but does not think he or she is capable of doing it (perceived barrier), chances are that it will not be tried.

4.1 Sexual and Reproductive Health

According to WHO (2006) sexual health is defined as a state of physical, emotional, mental and social well-being in relation to sexuality. It is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable safe sexual experience, free from coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. The International Conference on Population and Development (ICPD) (1994) defined reproductive health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a 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. Implicit in this last condition are the rights of adolescents to be informed and to have access to appropriate health care services that are safe, effective, affordable and acceptable methods of family planning of their choice. During the 1994 ICPD, countries agreed on the need to promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies. Sex education which is often referred as sexuality education is the process of getting information and developing attitudes and belief about sexual identity, sex, relationships and intimacy (Kirby, 2001). Sex education helps in developing skills about informed choices and sexual behaviour among young people and adolescents which makes them more capable about acting on these choices. Adolescents are exposed to various attitudes and beliefs concerning sex and sexuality. Health messages on sexuality at school emphasise the risks and dangers linked with engaging in early sex. Highly effective sex education and HIV and AIDS prevention programmes affect multiple risk behaviours and can achieve positive health impacts (Kirby, 2005). ASRH service providers should offer comprehensive sex education in order for adolescence to make healthy decisions about their behaviours. Global evidence shows that these programmes on ASRH help adolescents to refrain from or delay sex, reduce the frequency

of unsafe sex and the number of sexual partners, increase the use of contraception to prevent unwanted pregnancies and STIs, and in turn, help delay the first birth to ensure a safer pregnancy and delivery (Nanatte, 2009). The *Framework of Action on Sexual Health* developed by WHO in 2014 indicated the correlation between education level and sexual health. One of the most effective ways to improve sexual health in the long-term commitment is to ensure that adolescents and young people are sufficiently educated to make healthy decisions about their sexual lives. Accurate, evidence based, appropriate sexual health information and counselling should be available to all young people. This should be free from discrimination, gender bias and stigma. Such education can be provided in schools, workplaces, community and through health providers and religious leaders (WHO, 2014). Growing evidence has shown that the most important precondition for girls and women to achieve reproductive health is a social and economic environment where they are able to obtain their claims to reproductive health and the ownership over the conditions under which they live (Hartmann, 1987). In most African countries girls and women face difficulties in pursuing the need for their own health especially where there is little control over social and household resources (Schwartz, 2000). Social changes in Zimbabwe influence sexual behaviour and relationships among adolescents. These changes include rapid urbanisation, isolated life with less importance attached to family institution, early puberty, increasing access and influence of mass media. Such changes in behaviour have caused new health problems arising from unprotected sex, while traditional problems such as child marriage, pregnancy and childbirth are still existing in Zimbabwe (WHO, 2014).

4.2 Legislations on ASRH in Zimbabwe

Zimbabwe has formulated policies and laws related to ASRH. These include the Constitution of Zimbabwe, Sexual Offences Act, National Population Policy and the Ministry of Primary and Secondary Education School Health Policy.

4.2.1 The Constitution of Zimbabwe Amendment (No. 20) Act, 2013

The Constitution of Zimbabwe (2013) guarantees the right to health, including reproductive health to all citizens. It contains a Declaration of Rights that seeks to protect “the fundamental rights of the individual”, but not specifically of adolescents. Section 78(1) sets 18 years as the minimum age of marriage in Zimbabwe while Section 26 on marriage provides that no marriage must be entered into without the free and full consent of the intending spouses. This means that forced marriages and child marriages are prohibited under the Constitution and children must not be pledged into marriage.

4.2.2 The National Population Policy (1998)

The National Population Policy of 1988 recognises women’s right to control their fertility. It acknowledges that adolescent fertility is an important issue on both health and social grounds. The policy states that individual rights to choose freely and responsibly the number, spacing and timing of children must be fully respected and that it is essential to recognise the aspirations of women and youth in particular. The policy specifically states the need to address adolescent

health, with particular emphasis on reproductive health. One of its major goals is to “reduce prevalence of high risk sexual behaviour among the youth” (National Economic Planning Commission, 1998). Some of the specific goals on youth and adolescents are to promote adolescent health with particular emphasis on reproductive health, provision of reproductive health services for all and promotion of male involvement in reproductive health issues (National Economic Planning Commission, 1998).

4.2.3 The Sexual Offences Act (2001)

According to the Sexual Offences Act, sexual intercourse with a girl who is younger than 16 is a crime of statutory rape. It is a crime for anyone over 16 years of age to have sexual intercourse with a ‘young person’, that is anyone under the age of 16 years. The law in this regard has been made to protect girls because at that age even if they consent, they are not old enough to fully realise what it will mean in their lives if they have a sexual relationship. However, there is need for harmonisation of this law with the Constitution of Zimbabwe which sets 18 years as the minimum age of marriage.

4.2.4 Ministry of Primary and Secondary Education School Health Policy

The objective of the Health Policy is to ensure that children are empowered by being taught SRH at an early age so that knowledge can translate into behaviour. However, the challenge is that schools promote abstinence among pupils, hence assuming no access to ASRH services, yet these adolescents are engaging in sexual activity. In addition, school-based interventions often miss out-of-school youths who occupy a significant proportion of the late adolescent population.

5 DISCUSSION OF FINDINGS

This section is concerned with discussing findings from the study. It focuses on knowledge of ASRH, knowledge on available ASRH services, challenges in accessing ASRH services, adolescent pregnancy and menstrual related issues.

5.1 Knowledge of ASRH

All the respondents who participated in the three FGDs showed their knowledge of ASRH. They explained ASRH in terms of sex organs, sexual activities and sexual health problems. The most common terms that were used to define ASRH were sexual intercourse, family planning, and contraceptive use, STIs, HIV and AIDS. Adolescent girls also mentioned menstruation as part of ASRH. With regards to their major source of information, the adolescents mentioned that they had heard about ASRH from their Guidance and Counselling teachers at school while others mentioned radio and television programmes. The most common method of family planning identified by adolescents was the condom. Adolescents also showed little knowledge about other family planning methods such as *depo provera*, loop, and pills. They were not aware of how to use them, which methods best suit them, and the effects of using such methods. One male respondent indicated that: “I only know the male condom because I have used it and its most commonly used by men. But as for other methods I don’t know.” Female adolescents also indicated that they were not

familiar with other methods of family planning. One female respondent mentioned that: "I am not familiar of most methods that are used by women because these are mainly reserved for married people." Late adolescents indicated that they had received at least some of the ASRH information from Guidance and Counselling lessons and social clubs from their schools and peers. Such information included issues on how to say no to sex, methods of birth control such as condoms and where to get them, STIs, and how to prevent HIV infection. One female respondent remarked that: "In most cases we discuss these issues in our Guidance and Counselling classes. But outside the class we only discuss such issues with our peers. In these classes we are discouraged from indulging in premarital sex." From the research it was revealed that premarital sexual relations among adolescents are quiet common. One male respondent indicated that: "As adolescents we engage in sex but it is kept a secret because it is not allowed for people who are not married. If you are caught there is severe punishment for that." Despite the social norms and ethics, these activities tend to occur secretly. It was however, noted that most adolescents lack information and understanding of ASRH issues despite their risk taking and experimenting desire which makes them vulnerable to sexual health problems. In the absence of adequate knowledge late adolescents usually choose not to use any methods or even believe false information. Adolescents are particularly vulnerable to ASRH risks due to factors such as their young age, ignorance of matters related to sexuality and reproductive health, lack of factual knowledge about contraception and their inability or unwillingness to use most family planning and health services (Mago, Ganesh, and Mukhopdhyay, 2005).

5.2 Available ASRH services

The majority of the respondents had limited knowledge about ASRH services available in their community. One male respondent indicated that; "I know when you need these services you go to the nearest clinic. But I have not been to the clinic to look for such services. As boys we usually look for condoms which we get easily from our shops." Only a few female respondents indicated the role of the Zimbabwe National Family Planning Council (ZNFPC) which provides family planning services through its Community Based Distributors (CBDs) in their community. The major services offered by CBDs are family planning pills, condoms, counselling and education on the best family planning methods. However, adolescents indicated that these CBDs were not accessible as they only targeted married couples. One male respondent highlighted that: "It's very difficult to access the CBD especially if you are male and single. How do you justify the need for condoms when we are being discouraged from indulging in pre-marital sex?" The knowledge and use of ASRH services can be used to evaluate the acceptability and success of such services. Knowledge is an essential (though not in itself sufficient) component for adolescents to be able to take action to protect their sexual health and the educational system plays a major role in creating that knowledge (Langille, 2000).

5.3 Challenges in Accessing ASRH Services

The major challenges that were faced by adolescents included communication gaps with parents and guardians, stigma

related to ASRH issues and accessibility of health institutions and other health related problems such as adolescent pregnancies and menstruation. The majority of the respondents in the three FGDs indicated that it was impossible for them to discuss ASRH issues with their parents, guardians or relatives. Female respondents felt that cultural norms have suppressed them in terms of various health rights. A female respondent in one FGD mentioned that: "I find it very difficult to talk of such issues like menstruation with my father or any other male person. Another issue is that these things are not freely talked about in our culture because of the taboos related to the topic." A male respondent was of the view that: "As young people we can openly talk of these issues but I can't discuss with my father or an elder person. My mother is not open to such topics." One parent from the community indicated that as parents they discussed these issues with adolescents but the focus was on discouraging sex. She further highlighted that: "In as much as we know that our children are engaging in sexual activities, we cannot openly discuss with them. What we can only do is to discourage them from engaging in premarital sex." A school teacher who participated in the study indicated that as teachers they felt they had a moral duty to teach children on ASRH issues but most students were not open especially on issues to do with sex. She mentioned that; "The issue of sex is not an easy topic. School children are not comfortable to discuss about it with older people. But during Guidance and Counselling classes we freely discuss such issues especially with boys." Sex education is taught in schools without the involvement of parents and guardians. It should assist adolescents in delaying sexual activities and to increase safer sexual practices which will eventually contribute to improved well-being of young people. This leads to better decision-making by the youth, empowerment and self determination. A lot of adolescents indulge in premarital sex and mostly use sex as a means of pleasure and economic survival. Lack of access to information, inadequate life skills, lack of access or inability to persist in the use of protective measures and unpredictable sexual encounters, based on non-lasting love affairs, makes adolescents vulnerable to risk. One of the biggest challenges noted by respondents was lack of adolescent friendly centres where they can meet and discuss on issues of ASRH. A female respondent from the study mentioned that; "It would be better if we can have a centre where we can meet as young people. It's very easy to share information with your peers than with teachers, parents or relatives." A nurse from the local clinic supported the above comment by indicating that: "At our clinic we rarely have adolescents coming to discuss such questions. In most cases we attend to adolescent mothers whom we provide with maternal health education. But for those who are not married we always discourage premarital sex." All the female respondents who participated in the study mentioned some of the challenges they had experienced during their first menstrual cycle. The most commonly cited were pre-menstrual syndrome and dysmenorrhoea. One female respondent highlighted that "I didn't know what it was. I only shared the experience with my best friend and my mother. It's not a good experience especially if you mess yourself up boys will laugh at you." A female teacher who participated in the study said that "men do not understand menstruation and its implications especially

to girls and so they laugh and mock girls who would mess themselves especially those who would have menstruated for the first time.” A female respondent further argued that “A major challenge is that girls do not have access to sanitary ware. Sanitary ware is not easily accessible and affordable to these rural girls. In most cases they use pieces of cloth which is not health.” Socio-cultural norms are the most significant reason why most adolescents are reluctant to seek ASRH services. Social norms play a particularly strong significant role in shaping young people’s sexual behaviours and form a strong control upon the expression of sexuality (UNICEF, 2011). In rural communities, adolescents are regarded as too young and not allowed to discuss openly about sexual health issues. This creates challenges for young people to access information and services concerning ASRH. The tradition, customs, values and socio-cultural practices have created a boundary between adolescents and older people. This has contributed to stigma around their sexual behaviour, service seeking, and also prevented them in openly discussing sexual matters affecting them. Parent’s lack of ASRH knowledge, socio-cultural belief, faith, gender discrimination among other factors makes open discussion about sexual and reproductive health very difficult (Taffa, 2002). In a research by Taffa (2002) in Ethiopia, only 20 percent of parents indicated that they had discussed about SRH issues with their children. Parents-youth communication in sex issues in most rural communities is socially and culturally unacceptable. Socio-cultural and traditional norms make it almost impossible for young people and adolescents to talk about puberty and sex with their parents or teachers (WHO, 2004). During the study, it was noted that most adolescents were not accessing ASRH services. The major reasons cited included insufficient drugs at clinics, long distances to health care centres, shortage of nurses and counsellors at clinics, lack of convenience, and money. One nurse from the local clinic cited that; “We don’t have drugs here especially for problems such as STIs. In most cases we ask patients to buy their own medicine from pharmacies at Mupandawana growth point so that we are able to treat them.” The CBD for the area indicated that services such as family planning were available but they cannot be accessed by single adolescents. She further highlighted that: “As a CBD I only provide education and counselling, distribute condoms and family planning pills to women and men who are married. I can’t be seen giving condoms and pills to children of school going age. That’s unacceptable.” In a research carried out by the Ministry of Health and Child Care in 2016, it was found that adolescent pregnancy was not a major challenge in Zimbabwe. The adolescent fertility rate for women aged 15-19 years was 115 births per 1,000 women of the same age in 2015. It was also revealed that 9 percent of adolescents aged 10-19 years had never been pregnant and 17 percent of the adolescents aged 15-19 years had experienced pregnancy. Adolescents in rural areas were more likely to be at risk of pregnancy compared to their urban counterparts. The factors associated with pregnancy among adolescents include age, marital status, self-efficacy, alcohol and drug abuse, knowledge of pregnancy, attitude of adolescents towards pregnancy and condoms, peer pressure, poverty, social media and socio-cultural practices (ZIMSTATS, 2015). Access to primary health services is seen as an important component of care and preventive health for adolescents. In most rural communities, there is still lack

of primary health care services. Where these services are available, a number of reasons prevent adolescents from accessing them. These include the cost and lack of convenience (Society of Adolescent Medicine, 2004). There is a wide gap between the nature services adolescents seek from health care centres and the actual diseases they endure such as STIs. Much of the work has been directed at understanding the barriers adolescents face in accessing health care (Veit, 1996). Studies by WHO indicates that young people and adolescents are often unwilling or unable to obtain health services due to the barriers related to availability, accessibility, acceptability and equity in health services (WHO, 2001). One of the major reasons cited by respondents for not accessing the health care facilities by adolescents was lack of confidentiality even though it is guaranteed by law. The fear of parents or a family member finding out about the visit to a local clinic was a challenge. Other respondents indicated that they were afraid that nurses may not maintain confidentiality especially to their parents or guardians. One male respondent indicated that it was very difficult to get assistance from nurses at these clinics because of the stigma associated with problems such as STIs. He mentioned that “Sometimes nurses are to blame. I know of a friend who had an STI. He went to the clinic and the nurses laughed at him. They mocked him for being irresponsible. After that they told him to go to Gutu Mission hospital where drugs are available. I would rather look for traditional herbs than to face such embarrassment.” Another male respondent highlighted that “imagine if my parents heard that I have been treated of an STI at a local clinic. I will not seek treatment from a local clinic.” A female respondent indicated that “there is no privacy at the local clinic. All the people from the community are treated there. The nurses know you and will tell your parents if you visit the clinic.” The respondents indicated that in most cases they prefer sharing information on ASRH trusted friends, siblings or seek medical help from clinics far away from their homes. In a study to evaluate the factors that discouraged youth from using the youth friendly services in South Africa, it was revealed that inconvenient hours of locations, unfriendly staff and lack of privacy were among the reason adolescents and young people were not using the services (FHI, 2006). In a similar study in Nepal, adolescents believed that service providers at health centres do not keep information confidential (Regmi, 2010). A study conducted in Uganda by Matatu, Njau and Yumkella (2001) found gaps in the skill and knowledge by providers of ARHS. They concluded that at district health centres, the vast majority of adolescent clients sought only antenatal or maternal services. The reasons for not seeking other reproductive health services included little knowledge of available reproductive health services; a perception of negative provider attitudes towards adolescent sexuality; inconvenient health care centre schedules; lack of anonymity and confidentiality in health care centres; fear of ostracism by peers; and embarrassment about disclosing sexually transmitted infections and fear for screening for HIV and Aids (Matatu, Njau and Yumkella, 2001).

6. Conclusion

The study focused on ASRH issues among adolescents in rural Zimbabwe. It revealed that adolescents in rural areas do not have adequate knowledge about ASRH. Late adolescents

who participated in the study cited some of the major challenges they face in accessing ASRH services such as accessibility of health institutions, stigma, communication gap between parents/guardian and adolescents. The major sources of information cited were schools, friends/peers and media. Legal instruments on adolescent reproductive health were also reviewed. The findings from this study and the supporting evidence from other countries underscore the need for change in the approaches employed in service delivery in order to meet ASRH needs if unwanted pregnancies, transmission of STIs, HIV and AIDS and other dangerous practices like abortions are to be minimised (Erulkar, Onoka, and Phiri, 2005; Ministry of Health and Child Care, 2016; ZIMSTATS, 2015). Adolescents would become empowered to make the right decisions regarding their sexuality through sex education. Sex education does not necessarily go against the cultural beliefs and values, religious commitments and traditional norms of society. Rather, it perfectly supports to promote sexual abstinence, responsible sexual and reproductive life and a reduction in sexual risk-taking behaviour (Taffa, Inge- Klepp, Austveg and Sundby, 1999). Adolescent reproductive health needs would be better served in environments specifically for them such as adolescent-only clinics or health centres that are adolescent friendly. Findings from this study indicate that youth preferred such facilities. The facilities should observe the key principles of privacy, confidentiality and respect for young people, accessibility, gender-friendliness, specially trained service providers and the involvement of adolescents in implementing as well as evaluation of adolescent friendly services and programmes (Taffa, 1999; Regmi, 2010). Adolescent friendly health services should ensure that there is adequate time for client – provider interaction, where peer counsellors are available, and facilities should have convenient hours of operation. The location should be convenient, not overcrowded and shorter waiting for services.

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