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RESEARCH TOPIC

EFFECTIVENESS OF SEXUAL REPRODUCTIVE HEALTH AND RIGHTS SERVICES ON YOUNG PEOPLE IN SHURUGWI DISTRICT

By

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Dedication

This dissertation is dedicated to the Might one in heaven my Lord God for the undeserved grace. To my beloved mum and my brother Tongai Chibaya thank you for all the love, inspiration, wise words, comfort and unwavering support. You are my pillar of strength and you have truly shaped my life. To all my family members thank you for the encouragement, I owe you the whole world of gratitude.

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Abstract

The major objective of this study was to assess the effectiveness of sexual reproductive health and rights services among adolescents. The study used wards 5 urban and 24 rural of Shurugwi district as case study and a sample size of 60 respondents was used. Adolescents in secondary schools and out of schools together with service providers, respondents provided rich pooled data that informed the study findings. The researcher employed the qualitative research approach in the study. The study findings revealed that though adolescents are knowledgeable of existing SRH services they are not eager to access these services due to different challenges like lack of confidentiality and privacy among service providers, shyness, distance traveled to health centers among others. The study has surfaced several recommendations in order to establish an effective SRHR service up take among adolescents if teenage pregnancy and high rates of school drop outs are to be reduced.

List of acronyms

AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescents Sexual Reproductive Health
BCFs	Behaviour Change Facilitators
HBM	Health Belief Model
HIV	Human Immune deficiency Virus
HTC	HIV Testing and Counselling
IEC	Information, Education and Communication
MASO	Midlands AIDS Service Organisation
MCH/FP	Maternal & Child Health and Family Planning
SRHR	Sexual Reproductive Health and Rights
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infections
UNAIDS	United Nations program on HIV and AIDS
UNFPA	United Nations Fund for Population Activities
USAID	United States for international Development
VHW	Village Health Workers
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organisation

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Chapter 1

CONTEXTUALISING THE STUDY

1. Introduction

According to the UNAIDS (2014) Zimbabwe has the fifth highest HIV prevalence in sub-Saharan Africa at 15%. About 1.4 million people are living with HIV including 170,000 children, equating to 4% of the global total. Focusing on the target group of the research, UNAIDS (2014) states that 4.1% of young people aged 15-24 are living with HIV. However, only 45% of young women and 24% of young men having ever tested for HIV/AIDS. This therefore serves to say the HIV prevalence rate among this group is likely to be significantly higher (Zimbabwe National Statistics Agency 2012).

Zimbabwe has 10 administrative provinces and Midlands is geographically located in the middle of the country. It shares boundaries with Matabeleland South and North on the west, Mashonaland West on the north, Mashonaland east on the north east and then Masvingo Province to the east. In the Midlands province, Zvishavane district has poor sexual reproductive health service up-take evidenced with the highest HIV/AIDS rate in comparison with other districts in Midlands Province. At national level, HIV prevalence rate in Zvishavane stands at 14.2 %, a drop from 15.6 % in 2009 in the age group of 15 – 49 (HIV Estimates 2009 MOHCW). Shurugwi district which is the case study of this research is the second district in Midlands Province with poor sexual reproductive health. Its HIV prevalence rate stands at 9.4% (DAC Shurugwi district).

With regard to the health facilities, the district has one (1) district hospital, two (2) rural health centers and twenty-five (25) clinics. There are twenty-four (24) OI/ART sites while all sites offer PPTCT and HIV Testing and Counselling (HTC). The district has three (3) doctors and two (2) nurses trained to conduct Voluntary Medical Male Circumcision (VMMC) procedures and once in a while go for outreach operations at all sites. The district also has six (6) police officers, well trained and dedicated for Victim Friendly Unity (VFU) activities. All clinics are well equipped to manage STIs and provide Family Planning services and awareness is predominantly done by Behaviour Change Facilitators (BCFs) and Village Health Workers (VHWs). There is no cervical screening site in the district.

Apart from the SRHR services provided by clinics, Midlands AIDS Service Organisation (MASO), an NGO operating in Shurugwi district is carrying out a demand generating program on SRHR. The organisation is providing awareness on sexual and reproductive health through the means of community dialogues, door to door sessions, sista2sista groups just to mention a few. There are also some organisations like National AIDS Council which are working hand in glove with MASO in sensitizing and creating demand for SRHR service uptake in Shurugwi district. Therefore this study seeks to weigh whether SRHR services are effective or not. The study will measure if SRHR services are bringing in positive changes towards health and development of the district or not.

1.2.Background

According to United Nations, Population and Development, Programme of Action adopted at the International Conference on Population and Development, Cairo (1994) the concept of

Reproductive Health emerged following the 1994 International Conference on Population and Development (ICPD) held in Cairo, Egypt. ICPD also heralded Women's Sexual and Reproductive Rights and constituted the framework for the development of the United Nations Millennium Development Goals (MDGs) in 2000. Some of these MDGs have direct relationship with the reproductive health for instance MDGs number 3, 4, 5 and 6. Sexual Reproductive Health and Rights is a national programme which targets the young people, women and marginalized groups aiming at improving their Sexual Reproductive Health Rights since they are the most vulnerable groups. According to Shaw (2006), SRHR are an important element of development policies and processes which have been advanced within the development arena by the International Convention on Population and Development (ICPD) 1994 in Cairo.

Hardee, et al (1998) highlighted that many countries have worked to adopt the recommendations from the ICPD plan of action and to shift their population policies and programmes from an emphasis on achieving demographic targets for reduced population growth to a focus on improving the reproductive health of their populations. The SRHR program was established after governments in Africa realized that there were million deaths experienced each year due to maternal deaths, the statistics showed that 1 in 16 African women have a chance of dying or having serious complications during childbirth, secondly about 25 million people in the continent were infected with HIV and curable cases of STIs were recorded in Sub Saharan Africa and lastly there was high lack of access to comprehensive sexual reproductive health services such as voluntary HIV testing and counselling, voluntary medical male circumcision, contraception among others (Glasier and Gülmezoglu, 2006).

According to National Adolescent Sexual and Reproductive Health (ASRH) Advocacy Package and Implementation Plan (2014) in Zimbabwe, the health delivery arrangement of maternal and child health / family planning (MCH / FP) is designed primarily to cater mostly for mothers and under five children but it leaves out young people (adolescents). This therefore created a gap in meeting of the health needs of young people. This unattended Sexual reproductive health needs of these young people exert a negative impact on Zimbabwe's development potential. Due to this gap created, the consequences of early indulgence in sexual activities by adolescents has resulted in early parenting and a high incidence of HIV / AIDS with an ultimate negative impact on education, productivity and a general reduction in life expectancy. In a bid to correct this, government emphasizes on the importance of addressing the developmental needs of adolescents particularly those relating to sexual reproductive health rights.

Adolescent sexuality and its consequences is something which is already prevailing in Zimbabwe. There were concerns about high teenage pregnancy and their effects on individual and community at large for several years (Nyamakupa, et al 2003). Sebone (2001) concurs with Nyamakupa, et al that there is high prevalence rate of unwanted pregnancies among adolescents together with high spread of HIV/AIDS as revealed by several studies. The studies on knowledge, attitude and practice among young people show that there is high level of knowledge of HIV/AIDS but not congruent with actual behavioural practices.

Most of adolescents in Zimbabwe are experiencing early sexual indulgence thereby affecting their educational progress, pregnant related school drop outs have become an issue of concern in Zimbabwe just like in other sub Saharan countries. According to Dominique (2005) school girls who fall pregnant in most cases have resort to unsafe illegal abortions or they face official school

expulsion. As for boys no record is available to show how many dropped out as a result of pregnancy related issues or cases as most girls don't reveal the males responsible for the pregnancies. The statistics shows that in Zimbabwe, about 4.1% of young people aged 15-24 are living with HIV (Zimbabwe National Statistics Agency 2012).

1.3.Statement of the Problem

Globally, there is high spread of HIV / AIDS and other sexually transmitted diseases. In an effort to reduce the spread of HIV, governmental policies which cater for SRHR, for instance, licensing of civil societies, formation of National AIDS Council (NAC), training of nurses from every clinic or hospital to offer SRHR services and information to people were implemented. Shurugwi district has a high population of young people aged 15-24 due to economic activities such as gold and chrome mining selling clothes (flea markets) carried out within the district which attracts youths (survey by Department of Youth and Children under MASO 2015). In Shurugwi district almost every secondary school experiences dropouts due to teenage pregnancies every year despite the availability of the youth friendly health facilities that offer adolescents sexual and reproductive health services. This has resulted in early parenthood and school drop outs. Furthermore, there are also high rates of STI cases among young people as revealed by the statistics from clinics records. The maternal and mortality rates in Shurugwi district are also very high especially among young women who give birth at an early age thereby facing several complications when giving birth. Therefore the purpose of this research was to measure whether the SRHR services being offered in Shurugwi district are bringing out positive changes among young people's reproductive health and development or not.

1.4.Objectives of the Research

The main objectives of research were:

- To determine SRHR service being offered in Shurugwi district
- To determine the level of awareness among young people on the existing Sexual Reproductive Health and Rights services in Shurugwi district
- To identify those factors that affect access to Sexual Reproductive Health and Rights facilities in Shurugwi District
- To spot possible factors that would promote access and adequate utilization of Sexual Reproductive Health and Rights services by young people in Shurugwi district

1.5.Research Questions

Below are the questions used by the researcher to come up with data:

- What is the level of awareness on adolescents on the existing SRHR services and its impacts on development?
- What are the factors affecting effective service uptake on SRHR facilities and how do they hinder development in Shurugwi district?
- What possible factors can be adopted to improve the utilization of SRHR services by adolescents in Shurugwi district?

1.6.Justification

The importance of this study is to identify the effectiveness of sexual reproductive health services on adolescents in fighting against teenage pregnancies and its effects on health and

development in general. The study also fills the knowledge gap on how parents and adolescents as well as community can, through their own initiatives, take charge of their health development through the available SRHR services. The findings of this study will not only add to the literature on adolescents' sexual and reproductive health services but also provide relevant information on sustainable development that can be used not only for Shurugwi district but throughout the country. The research might also be important to the existing body of knowledge, to the nation at large and Non Governmental Organizations because it will give adequate information on how best SRHR programmes can be carried out in order to facilitate development.

1.7.Significance of the Study

The establishment of utilisation of the available adolescent sexual and reproductive health services and possible factors that affect the utilisation of sexual and reproductive health services by young people in Shurugwi district would assist in the planning for adolescents or young people's reproductive health services. Furthermore, the rendering of adolescent sexual and reproductive health services in an appropriate way would enable the secondary school adolescents and young people out of school to utilise the sexual and reproductive health services thereby reducing on the cases of unwanted pregnancies, sexually transmitted infections including HIV/AIDS and ultimately reduce the numbers of infection cases in the district and nation as a whole, hence development.

1.8.Theoretical Framework

The study is based on the Health Belief Model (HBM) as the framework. The model suggests that health seeking behaviour is influenced by a person's perception of the threat posed by a health problem and the value associated with the action aimed at reducing the threat. According to Polit and Hungler (1999) the main components of Health Believe Model include perceived susceptibility, perceived severity and cost, motivation and enabling or modifying factors.

The young people's health seeking behaviours are based on perceived benefit and costs, enabling or modifying factors that affect access and utilisation of services, influencing their decisions to seek the services.

Even though the HBM deals with illness and sick role behaviour the discussion will also deal with health behaviour. Health behaviour is any activity undertaken by individuals who believe themselves to be healthy for the purpose of detecting and preventing disease in any asymptomatic stage (Butler (1994). Therefore, in the context of this study the health behaviour is the activity undertaken by young people to seek sexual and reproductive health services for the purpose of preventing unwanted pregnancies and sexually transmitted infections including HIV/AIDS.

1.9.Limitations of the Study

The research was carried out in 2 wards only and the results obtained from the study may not be the representative of the whole district or Zimbabwe. Moreover, the structured tool for the data collection unknowingly made some respondents uncomfortable because of the sensitivity of the subject and especially that probing was not done on issues that needed clarification. Few other respondents did not complete the whole questionnaire despite volunteering to participate.

1.10. Conceptual Analysis

In this research the following key concepts or terms used have the following meanings unless indicated otherwise in the text:

Sexual and Reproductive Health Services: Are services that promote a state of physical, mental and emotional well being and not merely the absence of disease in all aspects of sexuality and the reproductive system.

Adolescents: These are young people or youths who are attending secondary school and some are out of school aged between 15 and 19 years.

Effectiveness: producing the intended or expected results of sexual reproductive health and rights services that are available.

Adolescent Friendly Health Facility/Facilities: These are facilities that offer adolescents services that are available, acceptable and appropriately provided in the right place and delivered in the right manner acceptable to adolescents.

1.11. Summary

This chapter covered various issues that form the basis of this study. The background of the study, statement of the problem, study objectives, research questions, justification, significance and delimitation of the study were covered. The theory that also guided the study was also surfaced.

Chapter 2

LITERATURE REVIEW

2.1.Introduction

According to University of Wisconsin Writing Center (no date), literature review is defined as a critical analysis of a segment of a published body of knowledge through summary, classification and comparison of prior research studies, reviews of literature and theoretical articles. LoBiondo-Wood & Haber (1994:110) states that literature review is traditionally considered a systematic and critical review of the most important published scholarly literature on a particular topic. This chapter seeks to introduce the literature reviewed on the effectiveness of sexual and reproductive health service on adolescents or young people from global, regional and national (local) perspectives.

2.2. Review of the Literature

2.2.1. The level of awareness among young people on the existing sexual reproductive health and rights services

A field work research conducted by young people in Benin 2005 for situational analysis revealed that both boys and girls have knowledge about SRH but discussions about sexuality and HIV showed that young people hardly ever use health services (Plan Benin [Sa]).

Adolescents lack adequate information or awareness on the existing sexual reproductive health and rights. According to Jegeebhoy, et al (1999), worldwide young people indulge in their first sexual intercourse or activities before and within marriage with inadequate information to protect

their reproductive and sexual health. In developing countries there are over billion young people between the ages 10 and 24 years yet they still continue to be a lag in the information on their sexual and reproductive health needs. Social Market for Adolescent Sexual Health (USAID 2000) states that the Sub –Saharan Africa region has about 630 million people with one third of the population aged between 10 and 24. This age group is highly vulnerable to health risks. The research shows that 22 million people are living with HIV and there are increased incidences of new HIV infections and young people aged 15 to 24 account for more than half of these new infections.

Sexually experienced young people (adolescents) are not aware of the effects of unprotected sexual intercourse and they lack adequate information of their sexuality and means of protecting themselves, thereby leading to unwanted pregnancies and abortions (Gubhaju 2002). These unplanned adolescent pregnancies usually result in high infant mortality rate, low birth weight infants and pre- term delivery.

In Asia, sexually active adolescents reported low level of contraceptive use. Gubhaju (2002) pointed out that a study was conducted among Vietnamese college students and only 32 percent of females and 28 percent of males used contraceptive method at first sexual intercourse. The report further states a research that was carried out among the countries and it was revealed that adolescent girls' knowledge was as high as 90% but only 10% were found to use any form of contraceptives.

According to Social Market for Adolescent Sexual Health by USAID (2000) in Cameroon, Guinea, South Africa and Botswana, it reveals that even though young people are aware that condoms are the dual protection of both HIV and STIs many still believe that condoms are for prostitutes. They portrayed use of condoms to a partner as lack of trust and faithfulness and many suggest that one is infected. Other adolescents believe that sexual intercourse with condoms is less pleasurable, artificial or too indirect (USAID 2000).

2.2.2. Factors that affect adolescents in accessing SRHR facilities

There are different researches conducted worldwide in order to find out how much young people access the sexual and reproductive health services in view of their level of understanding regarding contraceptives and risks of early sexual indulgency. Young people fear to disclose their sexual activity hence a major surfacing factor. This might result in reluctance among adolescents to report their sexual experiences. For instance, the leading reason cited by pregnant young women in Shanghai, China for non-use of contraception's was fear of disclosure or embarrassment (Jegeebhoy et al, 1999). This also may hold back sexually active adolescent from quest of contraception and other reproductive health services. This ultimately prevents pregnant adolescents from seeking family support and a safe resolution to pregnancy.

According to Grizzard et al, (2003), in Chile, the American Medical Women's Association highlighted that even though school officials were worried about adolescent pregnancy, they were unwilling to promote contraception and worried that such promotion might increase sexual activity, particularly among young women.

In other parts of the world, researches have shown that young people are not comfortable in mainstreaming family planning clinics which are mostly government owned maternal and child health/ family planning (MCH/FP) facilities. Many adolescents often feel unwelcome citing that they come across service providers who are judgmental, who treat them rudely or offensively or who deny them services (Erulkar, et al 2005).

Lack of privacy is another threat that causes adolescents not to access SRH facilities or services. In studies carried out in Botswana the findings revealed that most health providers have negative attitude towards youth when seeking SRH services (http://www.ayaonline.org accessed 17 Oct 2016). The study found most facilities lacking privacy, not having staff of the same sex, having health workers with negative attitudes, stigma and discrimination, providers lacking confidentiality (Erulkar, at el 2005). According to Suneth, at el (2008) confidentiality has been found to be a contributing factor associated with utilization of sexual reproductive health services among young people in several studies (Regmi 2008). There is need to train staff on principles such as privacy and confidentiality, this helps improve utilization of health services among youth (Kumi-Kyereme, at el 2007). Youth friendly service provision needs to be integrated in the district since these skills will change health providers' attitude towards youth when seeking health services. Youth friendly services are provided to young people to meet their needs in an environment that attracts their rights in utilizing the services (Senderowitz 1999).

Another study carried out in 1999 Cote d`voire in four districts, two from rural and another two from urban health districts. A total population of 160 000 including 24 000 adolescents was reached. Different interesting findings were revealed, young people evidently need sexual and

reproductive health services. Almost half of the adolescents attending general health facilities reported having sexual experience, with an average age of sexual debut of 25 years. The statistics show that about 33% of all women requiring delivery services were adolescents. Yet, there is considerable under-utilisation of reproductive health services. The challenges raised in this study were poor quality of care for adolescent at the health centers, persistent absenteeism of staff, long waiting period, high cost of consultation and care, unfriendly treatment by the staff and lack of privacy at the facilities. Adolescents reported hardhearted treatment from service providers, statistics show that about 18% of male adolescents and 13% of females reported uncaring treatment by providers (Jegeebhoy et al 1999:92-93).

Nare, et al (1997), highlighted that in a research carried out in Dakar, Senegal on the adolescents' accessibility to reproductive health services among mystery clients, the young people were sent away and asked to go to pharmacies, others were asked just to focus on studies. Moreover, findings also revealed that young people were afraid, embarrassed or disappointed with the kind of reception or welcome they received at service providers centers.

In Lesotho there are service gaps pertaining to the provision of reproductive health services for female adolescents and youths. The same report also stipulates that services are not user friendly, although adolescent reproductive health services corner had been opened in almost all hospitals. They were perceived as antenatal clinics and are therefore not accessible to the non-pregnant adolescents. Furthermore, another baseline study in Lesotho reported that teenagers aged 13 to 19 formed 13% of all hospital admissions, 23% premature deliveries while 23% of all antenatal care visitors (W.H.O Southern Africa Multi- Country Case Study [Sa]).

According to Neema, et al (2004), in Uganda the research findings reveal other barriers like lack of knowledge about condoms use, costs, availability, fears and distrust about condom effectiveness including the fear that condoms themselves are the sources of HIV viruses. However, on the other hand attitudes and social norms appear to be more important barriers to reproductive health than lack of knowledge alone. In Ghana, condoms are generally available at low cost and they are given at no cost at clinics, community based health workers and peer educators but social and religious barriers may constrain when accessibility and cost may not (Kofi, et al 2002).

According to the Kenya Service Provision Assessment Survey (2010), provision of SRH services to adolescents in Kenya was done via three types of service providers which are Public or Ministry of Health Managed Services, NGOs and Faith Based Organisations. The availability of Youth friendly services was assessed at national level and estimates reveal that only 7% of facilities are able to provide youth friendly HIV testing and counselling services, a decline from 12% facilities reported in 2014. This therefore saves to say shortage of health centers that offer ASRHS stand as a threat or a barrier to adolescents in accessing SRHR facilities. This shortage in health centers that offer ASRH services also result in long distance travel to health centers which worsen the situation in accessing SRH service among adolescents.

Inadequate access to appropriate sexual reproductive health information is also another barrier among adolescents in accessing SRH facilities. According to Issacs et al (2003) in Mtwara district in Tanzania the research findings showed that there is low knowledge on ASRH right among health service providers whilst many people consider them the best sources of such

information thus being major influence on public's sexual reproductive health. ‘Tanzania's national ASRH guideline demands proper and quality ASRHS, that all adolescents have to be informed on their SRH rights, such rights should be made known first to service providers and significant others so as to prevent unprotected sexual practices among youth,’ Homans (2010).

Many girls in Tanzania reported starting sex at any age between 9-10 years indicating a young age as compared to findings from central Asia and Europe where girls have first sexual intercourse at an age between 15 and 19 years (United Republic of Tanzania, Ministry of Health and Social Welfare 2011). This is so because in most developing countries there is inadequate access to SRHR information among adolescents. This therefore shows that there is a need for introducing SRH interventions focused on health education in order to change attitude towards youth when seeking SRH services thereby reducing unprotected sexual practices which are leading to unwanted pregnancies, HIV/AIDS and STIs among adolescents.

According to W.H.O Southern Africa Multi- Country Case Study (Sa) in another survey conducted in Zimbabwe young people were also asked if there had been time when they wanted to get reproductive health services but could not do so, the majority of the adolescents did not obtain the services because they did not know where to get such services, others failed because the services were too expensive and that the clinics were too far. According to the SRHR programme report (2015) by Midlands AIDS Service Organisation, young people are failing to access reproductive health services because of lack of privacy and confidentiality among service providers. Nurses, Behaviour Change Facilitators and Village Health Workers are said to disclose HIV status and other confidential reproductive issues of adolescents to the parents and

local people. Other barriers reported were that parents do not allow young people to use condoms or family planning before they got married, shyness and fear of being laughed at with others if found accessing services like HTC, STI screening, condoms among others and also service providers do not want adolescents to access family planning or any contraception, they judge them and encourage young people to focus on their education first. These alone stand as a stumbling block to young people towards the attainment of sexual and reproductive health services.

Besides the general lack of information, in Zimbabwe cultural beliefs that deter parents from talking to their children about SRHR also stand as a barrier for not accessing SRH services among adolescents. Parents find it difficult to address their children about SRHR services, in a survey by WAG on adolescents' sexuality and violence in Guruve district, a woman was quoted asking the following question "Is it possible to talk to a grade seven pupil on issues of sexuality?" All this points to the fact that parents are not comfortable to talk to their children at a family level. The findings from that survey revealed that the community still has certain cultural practices which contributed to early sexual debut. Furthermore the findings from that study show that participants reflected on the Muslim sex initiation which makes the youths to rush into sexual activities as they would want to experiment on what they have been taught. The practice of early marriages put the youths at higher risk of serious health complications related pregnancies, HIV and STIs.

2.2.3. Factors that would promote access and adequate utilisation of sexual reproductive health services

Community should have positive attitude on ASRHS. In Tanzania, 'community members and service providers in Mtara district think it is inappropriate for girls of age 10 - 18 to access SRHS especially the family planning' (http://www.ayaonline.org. Accessed 17 Oct 2016). Through focus group discussions conducted during the study, adults and community members confirmed or reported that there is stigma and discrimination to SRHS, adolescents found accessing SRH services as neglected in the community. For example one adult male at Kiromba ward stated that; *"I do not think if its right for young people to use family planning methods since it will affect their reproductive system and unable them to get children."* (The Pan African Medical Journal 2012 accessed on 17 Oct 2016). This therefore shows that community attitude towards SRH services should be positive so that they will encourage adolescents to access adolescent sexual reproductive health services.

Improving on SRH information dissemination among adolescents might also improve the adolescents' access and utilization of SRH services. According to Lou CH, et al (2004) information distribution and awareness-building activities targeting unmarried Chinese youth and the distribution of free contraceptives had improved SRH among young people in China. The statistics show that these measures resulted in a 14-fold increased odds of contraceptive and condom use among those in the intervention compared with the control community.

Furthermore, making use of outreaches is also vital. According to Coplan et al (1999), health services can also be delivered in the community taking the services to where adolescents live and

congregate. Potential locations for outreach services include schools, workplace, streets, malls, homes, youth centers, pharmacies and storefronts. In Kenya, the delivery of messages regarding abstinence, faithfulness and condom use to students from primary to university levels was combined with mobile HIV testing within school settings an annual HIV testing day (Miller et al 2008). This improved the SRH service up take among adolescents.

2.3. Summary

This chapter covered the review of literature. Different scholarly views were discussed basing on the following sub topics or themes; the level of awareness among young people on the existing sexual reproductive health and rights services, factor that affect young people from accessing and utilizing the available sexual and reproductive health services and possible factors that would promote access and adequate utilization of Sexual Reproductive Health services among adolescents.

Chapter 3

RESEARCH DESIGN AND METHODOLOGY

3.1. Introduction

This chapter is going to give details of the research methodology that was employed by the researcher in conducting this study. Discussions on the research design, study population, sampling, data collection techniques, ethical considerations as well as data analysis were surfaced in this chapter

3.2. Methodology

3.2.1. Research approach

Research methods include the steps, procedures and strategies for gathering and analyzing the data in a research investigation (Polit & Hungler 1999). The study was conducted using the qualitative nature of research. The researcher adopted this approach because the entity studied is the life world of human being as it is experienced individually. So the researcher was studying the life experience of adolescents in health service up take hence the reason why she adopted the qualitative research method that is important in studying life worlds instead of an objective. The qualitative research has its roots in social science and is further alarmed with considering why people act as they do, their knowledge, attitudes, way of life and suspicions among others. The major advantages of qualitative research are it enhances

the subjects being studied to give much vital solutions to questions asked by the investigator, and may provide important insights which might have been missed by any other technique (May and Pope1995). According to Hammersley (1990) qualitative research methods normally include

interviews and observations but may also include case studies and surveys though they are regarded as methods on their own. Qualitative methods make use of open-ended and closed questions. In the study the researcher made use of both methods. By using open ended questions and probing it gives respondents the chance to respond in their own words, rather than forcing them to choose from guided responses. Furthermore, open-ended questions helped the researcher to suggest responses that are meaningful and culturally significant to the participant, unexpected by the researcher, rich and fully clarified.

3.2.1.1. Study population

According to Hammersley (1990) study population contains members of a group that the researcher is interested in studying. The results of the study are generalised to this population because they have significant traits in common. The researcher targeted both male and female adolescents in schools and out of school age 15-19 years but adolescents under age of 15 years were not included in the research even though they are facing premarital sex and teenage pregnancies. The reason behind this is that adolescents below 15 years of age require parental consent to participate in the study (Moremi Personal Interview.13 June Gaborone). The involvement of parents would not have allowed free expression by the adolescents due to the sensitivity of the subject under study and the likelihood of biases would have been high. Therefore this age group was excluded. Moreover, the researcher also targeted service providers such as the health institutions like nurses and District Nurse Officer (DNO) as well as NGOs.

3.2.2. Research design

The word 'design" means the presentation of elements into a masterful work of art which incorporates the processes and techniques that are used to reach this goal (LoBiondo- Wood &

Haber 1994). According to Trochim (2006) research design gives the glue that holds the research project together and is used to structure the research in order to show all the major parts of the research project. The purpose of a research design is to provide a map for answering the research questions and serves as blue print in which the control mechanisms are included that one would use in the study so that the answer(s) to the question(s) would be clear and valid (Brink & Wood 2001).

The research was carried out in the form of a survey. Survey refers to the selection of a relatively large sample of people from a pre-determined population that is the population of interest to the researcher. The researcher employed surveys because surveys are dependable, the anonymity of survey allows respondents to answer with more candid or openness and provide valid answers. With survey the respondents were open in answering interview questions and questionnaires. Moreover, survey research is common in studies of health or health service (London school of Economics 2003 accessed 22 Oct 2016), that is the other reason why the researcher adopted it. In surveys data can be gathered in different ways that include telephone interview, personal interviews and interviews which could be used by the researcher to interview a respondent or in the form of a self-administered questionnaire where the respondent completes the questionnaire without any help or interference with the researcher.

The advantages of a design of this nature are that a great deal of information can be obtained. If a sample is representative of the population, a relatively small number of respondents can provide an accurate picture of the total population involved. The possible disadvantage is that information obtained in a survey tends to be superficial and breadth rather than depth of

information is emphasised. It also requires a lot of expertise in a variety of research areas like techniques, development of a questionnaire and interviewing skills, including data analysis to produce a reliable and valid study. In order to avert this scenario, a questionnaire was developed and pre-tested in another setting in order to establish validity and reliability of the tool (Burns & Grove 2001).

The aim of this research was to establish an effective utilisation of available Adolescent Friendly Health facilities that provide adolescent SRHR services to adolescents in Shurugwi district. The intention was to establish an effective utilisation of the services in this particular area because there was a gap previously. The researcher wanted to determine factors that either promoted or prevented adolescents from accessing and utilizing the available sexual and reproductive health services in Shurugwi district.

3.2.3. Sampling

According to Kish (1965) 'sampling is linked with the selection of a subset of individuals from within a population to estimate the characteristics of whole population'. There are two main advantages of sampling which are that it is the faster data collection and lower cost. In carrying out the study the researcher was not able to consult each and every individual for it is difficult and expensive but sampling was done. In Shurugwi district there are nearly 1000 adolescents so it was difficult for the researcher to consult each and every adolescent in the district and sampling was employed.

3.2.3.1. Sample size

Regarding sample size the researcher targeted sixty (60) respondents which comprised of 54 adolescents and 6 service providers. A sample size of 54 adolescents respondents was used out of a total population of 1000 adolescents aged 15 to 19 so that the researcher would manage to consult every member. Moreover, a small sample was chosen so that the researcher would save time and costs since there were limited resources to use during the study.

The table below shows the sample sizes for each category of respondents that were selected for each ward.

Table1. Sample sizes of respondents selected to participate

Respondents	**Ward**	**Number of respondents**
Chrome High School	5 urban	13
Parkinson Secondary Sch	5 urban	11
Kushinga Secondary Sch	24 rural	12
Others	5 urban	14
Others	24 rural	10
Total		**60**

Source: Field survey

Others included the adolescents out of whether school drop outs due to pregnancies or financial issues or those who completed ‘O’ and ‘A’ levels, and service providers like members from MASO, clinics and hospitals.

3.2.3.2. Sampling techniques

The researcher adopted the non random sampling technique in carrying out the study because the study was explorative in nature. The researcher conveniently chose wards 5 urban and 24 rural because in these wards there are Sexual Reproductive Health and Rights Demand Generation programs which are already carried out by an NGO called MASO with the compliments of National AIDS Council, so data gathering and triangulation were made easier. The researcher however adopted the convenient sampling whereby every secondary school and every health center within the mentioned wards was visited for the purpose of research. This was done in order to come up with representative sample. Using the convenient sampling technique benefited the researcher in the sense that subjects were convenient and accessible to her. Furthermore, the advantage of using convenient sample is that it is easier for the researcher to obtain subjects. However the risk of bias is greater because samples tend to be self-selected and that representativeness is questionable (LoBiondo- Wood & Haber 1994).

3.2.4. Data Collection Techniques

Data collection is the process of selecting subjects and gathering data from these subjects (Burns & Grove 2001). In this study all those processes that the researcher used to collect data are fully explained below such as the researcher planned to administer self-administered questionnaires to adolescents aged 15 -19 years who would consent to participate in the study and interviews to service providers. Document analysis is also another technique used.

3.2.4.1. Questionnaires

According to Mile (2010), a questionnaire is a gathering information instrument through which respondents answer questions or respond to statements in writing. Burns & Grove (2005) further defined questionnaire as a printed self-report form designed to elicit information through a written response of tie subject. The researcher used mixed questionnaire which consisted of both open ended questions and closed questions. This type of questionnaire normally used in the field of social research. With the open ended questions the researcher wanted the respondents to explore or explain further their views without given boundaries, this helped the researcher to obtain detailed information so that the objectives of the research would be surfaced. In administering the questionnaires in secondary schools, the researcher gave a maximum of 13 questionnaires at every school to the first 13 volunteers. The process was carried out during the lunch hour so that the researcher would not disturb the progress of the school lessons. Secondary school adolescents were given questionnaires so that the researcher would not take much of their time since questionnaires do not take time to fill in and also not disturb the progress of school lessons. Pertaining to adolescents out of school a maximum of 9 questionnaires per ward were given to the first 9 volunteers again. Questionnaires were given to adolescents so that the researcher would not take much of their time since they wanted to continue with their ball games.

The researcher explained the purpose of the study to adolescents and after that she distributed the questionnaire to adolescents who would consent to participate in the study. At schools the process took place in the classroom where the participants were given the questionnaires to fill individually to avoid influence from one another when answering them. Regarding adolescents

out of school the researcher made use of Thursdays where adolescents would gather at play grounds having ball games competition in their wards for both sexes. The questionnaire would not bear names but rather numbers that would represent the total number of participation. After filling the questionnaires the researcher would collect them for analysis.

3.2.4.2. Interviews

The researcher also used the interviews as data collection technique. Kahn and Cannell (1957) define the interviews as “a conversation with a purpose”. In interviews the researcher will make use of key informants to get objective information in the area under study. According to Dunch (2004), there are practical aspects of interviewing that need to be considered which are: the selection of interview respondents, managing the interview and recording. The researcher adopted the in depth interviews and key informant interviews (KIIs). Given that qualitative, in-depth interviews typically are much more like conversations than formal events with pre-determined response categories, the researcher explored a few general topics on SRH service uptake among adolescents and strategies used to disseminate SRH information to help uncover the participant’s views. The researcher made use of open ended questions that extracted depth of information from few respondents.

In the study the researcher selected the respondents with relevant knowledge pertaining to adolescent sexual and reproductive health thereby basing on the Key informant interview (KIIs). The Key informants included 3 nurses, 1 District Nurse Officer (DNO) and 2 NGOs (MASO and NAC). This gave the researcher an opportunity to explore the subject in-depth and the major aim

of these discussions was for the researcher to determine how key informants contribute to the effectiveness of SRHR services among adolescents in Shurugwi district.

Therefore service providers were the targeted group on this interview technique. Subjects were to be interviewed one on one at their workplaces or homestead. The researcher visited several institutions in conducting these interviews. Probably interviews in qualitative research are usually wide ranging, snooping issues in detail and they give confidence to subjects that they articulate their views at length. Interviews provide flexibility to rephrase questions and they also allow researcher to observe non verbal clues such as questions and facial expressions this can help to assess the validity of the respondent's answer. The interviews were conducted in the respondent's language of preference and the researcher transcribed the data.

3.2.4.3. Document analysis

The researcher performed detailed document analysis of clinical records on adolescents accessed SRH services like STI screenings, HTC, birth records among adolescent mothers to mention a few. The researcher also performed document analysis of MASO's reports on adolescents SRHR community dialogues conducted, sista2sista groups' reports and Young Peoples' Network reports. The aim was to collect numerical data that would aid in triangulation of results.

3.3. Ethical Considerations

In conducting the study the researcher observed research values as supported by Soltis (1989) of "honesty, fairness, respect for persons and beneficence. Privacy and confidentiality was guaranteed to all the participants throughout the research. To that end participants were not

forced to participate, freedom to withdraw from the study was spelt out. Participation was voluntary among respondents and also importance of giving honest answers to all questions was stressed. The researcher was also careful to observe local customs and social rules. The importance of this ethical consideration was to avoid raising the community's antagonism and making mistakes that may endanger the rapport with the study population before a study sample could be extracted from this population.

Furthermore, as part of ethical requirement, the plans to obtain informed consents to enable the researcher to conduct the research among secondary school adolescents from the Ministry of Health Research Unit and Ministry of Education offices were included in the proposal. These were to be in written form. As for the respondents they would be free to participate, a written consent would explain the importance of the study to them. The information obtained from the participants would be treated with privacy and confidentiality. The researcher would explain to the participants that no names of individuals or school would be quoted or written alongside the responses and on the questionnaires. No cell phone numbers or initials would be written on the questionnaires. Regarding to school respondents, they were asked to fill in the questionnaires during their free time, for example during lunch hour to avoid disruption of school programs.

3.4. Data Analysis

Computer packages were used to collect data from the field. Descriptive statistics from adolescents in schools and out of school respondents were generated. Data has been presented in form of frequency tables, pie charts, graphs for all the questions interviewed.

3.5. Delimitation of the Study

This study is limited to wards 24 rural and 5 urban of Shurugwi district because of their accessibility and also the researcher once worked as a field officer during her year of internship under Midlands AIDS Service Organisation so the researcher was familiar with the place. Shurugwi district is divided into two authorities which are the Shurugwi Town Council covering 13 wards and the Tongogara Rural District Council covering 24 wards. This therefore means that Shurugwi District comprises of 37 wards. The district population stood at 99916 consisting of 49134 males and 50782 females (census 2012). The district lies along the Great Dyke and is predominately a mining area. The major economic activity is gold, platinum and chrome mining. Other activities conducted in the district are commercial farming, small-scale subsistence farming and formal and informal sector small scale business activities for their survival. In addition, two health development NGOs are already supporting the Adolescents Sexual Reproductive Health and Rights development.

3.6. Summary

This chapter described the research design and research methodology that the researcher undertook in order to answer the questions in this study in detail. The study was also described as being qualitative in nature. The sampling was also surfaced in this chapter where the researcher adopted the non random sampling technique and the convenient sampling technique where every secondary school and every health center within the targeted wards was reached. The data gathering techniques, ethical considerations and data analysis were also clearly discussed in this chapter.

Chapter 4

RESULTS AND DISCUSSIONS OF THE RESEACH FINDINGS

4.1. Introduction

This chapter provides a synthesis of responses obtained through questionnaires, interviews and document analysis. Findings have been presented in narrative form. In a bid to make the findings clearer extensive use of statistical tables were made. The chapter is based on the responses that were obtained from the 58 participants that completed the questionnaires and interviewed. The respondents involved service providers, adolescents out of school as well as adolescents from three secondary schools namely Chrome High School, Parkinson Secondary School and Kushinga Secondary School.

4.2. Research Results

4.2.1. Demographic data of respondents

The table below summarizes the results of the study on the respondents participated and questionnaires distributed.

Table 2.Demographic data of respondents

Group of Respondents	Number of questionnaire distributed	Number of questionnaire responded to	Response rate
Adolescents in school	36	34	94%
Adolescents out of school	18	18	100%
Service providers	6	6	100%

Source: field survey 2016

As shown in table 2 above 94% of adolescents in school questionnaires were responded to. The shortfall was as a result of failure of 2 respondents from Kushinga Secondary school to fill in the questionnaire, which they submitted with blank spaces. There was a 100% response rate by adolescents out of school. The questionnaires were administered to respondents who had gathered for ball games matches (netball and football). A 100% response rate was realized on service providers, the contributing factor being that the researcher had booked appointments with service providers and she managed to meet the appointment time and date in all offices

4.2.2. Characteristics of the respondents:

Out of 58 respondents who participated in the study which include adolescents in and out of secondary school and service providers 26 were males and 32 females. From these numbers 6 were service providers which compromise of 3 males and 3 females. Girls were more than boys in the study, there were 29 adolescent girls from both in and out of school and then 23 boys. The reason being that girls were more willingly to participate than boys.

4.2.3. Awareness of Sexual and Reproductive Health Services

All the participants were asked questions to establish the awareness of the available sexual and reproductive health facilities in Shurugwi district. The major aim was to establish how much the adolescents knew about the clinics or health centers that offer the reproductive health services, thereby measuring the effectiveness of sexual and reproductive health services among them. Most adolescents revealed that they were much aware of the health centers that offer sexual reproductive health services. Health centers like local clinics, hospitals, Village Health Workers and Behaviour Change Facilitators were cited as sources of reproductive health services. Respondents highlighted that Behaviour Change Facilitators and Village Health Workers are specialized in condom distribution and information dissemination on reproductive health and they said there was nearness to adolescents as compared to clinics and hospitals.

Regarding the general awareness on the availability of adolescent sexual reproductive health services, the research findings show some evenness among all the secondary schools and wards with the exception of ward 24. The ward is very remote with bad networking and this probably has an effect on the low levels of awareness and some adolescents may not have ample time to

familiarize themselves with service centres located in the ward because of long distance travelled to those centers and consistent absenteeism of the service provider at the work place. Furthermore, the findings show better levels of SRHR awareness among adolescents although differences were noted between sexes. These disparities may depend upon individualized interest and exposure to information on the various sexual and reproductive health services available.

Across all schools and wards, females scored higher than males on the awareness of adolescents' sexual reproductive health services. Chrome high school and ward 5 scored the highest overall score regarding respondents on knowledge of adolescent sexual reproductive health services offered in Shurugwi district. The reason behind this being that the organisations which offer SRHR programs like MASO and NAC are cited in urban areas so citizens from urban areas are the ones who benefited more from these programs because they are close to sources of information and services.

The research findings reflect high levels of Sexual Reproductive Health awareness among the adolescents especially on services like HIV Testing and Counselling (HTC), Voluntary Medical Male Circumcision (VMMC), STI screening as well as condom collection. This could be attributed to a lot of effort that has been made in the district to disseminate information by NGOs like Midlands AIDS Service Organisation (MASO) and National AIDS Council (NAC). During the course of interviews conducted with service providers the District Officer from MASO said,

> 'As an organisation we disseminate SRHR information with
> the means of community dialogues where we target groups
> like young people, disabled, sex workers and adults. We

also carry out sensitization meetings as another form of disseminating sexual reproductive health information, with sensitization meetings our target groups are community leaders, Sexual Reproductive Health and Rights service providers like nurses, Village Health Workers (VHW) and Behaviour Change Facilitators (BCFs). Besides conducting these activities we also distribute IEC materials like pamphlets and flyers and in carrying all these activities NAC complements our activities, we work hand in glove in creating demand for service up take among young people.'

Through responding to questionnaires adolescents highlighted that these community dialogues offered with NGOs are of paramount importance to them because that's where they got empowered on Sexual Reproductive Health and Rights information and service up take.

According to Sebone (2001), studies have shown high rates of unwanted pregnancies among adolescents, HIV/AIDS and other risk behaviours like early initiation of sexual intercourse. It is further stated that knowledge/awareness of sexual risks among adolescents has been found to be as high as 95% but the scenario was found to be incongruent with the actual behaviour practices of the youth. Just like in Shurugwi district there are high rates of unwanted pregnancies among secondary school adolescents despite the fact that they are aware of sexual reproductive health and rights risks, this is due to different factors to be discussed in this study.

According to Langille (2000), sexual and reproductive health awareness is essential for adolescents to be able to take action to protect their sexual health but is not in itself sufficient to cause behavioural change. Therefore, other factors may need to be looked into, in addition to the awareness that is prevalent among adolescents, if sufficient equilibrium between their awareness and behavioural practice is to be attained.

4.2.4. Availability of sexual and reproductive health services

To establish whether there is any existing sexual reproductive health service facility in Shurugwi district was another aim of this study. Questions were asked to adolescents in and out of school together with service providers to gather data regarding availability of SRH service facilities. Some of the questions asked were to:

(a) To indicate whether they had knowledge of organisations that offer adolescent sexual and reproductive health services in Shurugwi district

(b) Describe kinds of adolescent sexual and reproductive health services offered in Shurugwi district

(c) Service provider were asked to list SRH services they offer to adolescents and

(d) To indicate the service uptake rate for each and every service offered to adolescents

Almost all adolescents both in and out of school confirmed the availability of sexual and reproductive health service facilities in Shurugwi district. Adolescents hardly cited the availability of Sexual Reproductive Health services like Voluntary Medical Male Circumcision (VMMC), HIV Testing and Counselling (HTC) and condom collection, they mentioned that outreaches for service provision were conducted in their wards and made it easier for them to

access the services listed above, though these outreaches come once in a blue moon in their wards. Moreover, findings from service providers showed that health facilities are offering Sexual Reproductive Health services to adolescents. Through the questionnaires given to nurses it was revealed that there are different Sexual Reproductive Health services that are offered in every clinic no matter how remote the area is. These Sexual Reproductive Health services include HIV Test and Counselling (HTC), Sexually Transmitted Infection (STI) screening and condom collection. Therefore, this shows the availability of reproductive health services within the district.

Some adolescents identified hospitals, clinics, youth clubs, sista2sista clubs, youth friendly corners and some non- governmental organisations as sources for provision of reproductive health services and information. Some adolescents identified School Guidance and Counselling Departments as source of information on adolescents' sexual and reproductive health.

However, one would expect the School Guidance and Counselling Departments in the secondary schools to have been the main source of their knowledge but the opposite would appear to be true as only few respondents indicated the School Guidance and Counselling Departments in the secondary schools as sources of information regarding adolescent sexual and reproductive health services. Generally the research findings show that community dialogues are the most common source of the Adolescent Sexual Reproductive Health and Rights (ASRHR) information as most respondents indicated community dialogues as their main source of information. This therefore indicates that a lot needs to be done in the schools to create awareness regarding diverse sources

and services related to adolescent sexual and reproductive health in the district if unwanted pregnancies and sexually transmitted infections are to be prevented from all angles in schools.

4.2.5. Types of sexual and reproductive health services made use of by adolescents in Shurugwi district

The respondents (adolescents) mentioned different services which they made use of at various health facilities. Higher proportion of adolescents mentioned condom collection and other forms of family planning (contraceptives) as the major services they received.

From every school, almost every respondent mentioned HIV Testing and Counselling (HTC) as services which they made use of. Regarding STI screenings and treatment, 13% of adolescents cited that they accessed this service. Moreover, document analysis also revealed that adolescents are seeking STI screening and treatment at a very low rate. A few adolescents mentioned pre- and post abortion counselling as services that are provided and made use of. Other services received by adolescents include antenatal and postnatal care.

Table3. Sexual Reproductive Health services received by adolescents

Service	Percentage
Condoms and family planning (contraceptives)	53.6
HIV Testing and Counselling (HTC)	29.5
Sexually Transmitted Infections treatment	13.0
Voluntary Male Circumcision	25.7
Pre and post abortion counselling	2.7

Source: Field survey 2016

Senderowitz, et al (2003) state that young people face bigger sexual reproductive health risks than adults yet they are not eager and able to access reproductive services. Inadequate information, lack of awareness and major barriers posed by the current state of most sexual reproductive health services are unwelcoming to most young people.

In a survey by WAG (2015) on promoting social dialogue to inform ASRHR programs in Guruve district, the research findings revealed that although adolescents are much aware of condom use, they are not eager to access or use them. The report further states that despite the high levels of awareness by the adolescents of the modern methods of contraception, contraceptive use among them is generally low.

4.2.6. Factors that Affect Access and Utilisation of ASRH in Shurugwi District

4.2.6.1. Utilisation of adolescents' sexual and reproductive health facilities (ASRH)

Many questions were asked among adolescents on whether they had used any sexual and reproductive health services. The major aim was to assess whether adolescents' knowledge about available services resulted in their use of the services or not. This assessment emanated from the views in literature which highlight that adolescents are predominantly vulnerable to Sexual Reproductive Health risks due to factors like young age, ignorance of matters related to sexuality and reproductive health, lack of factual knowledge about contraception and inability or unwillingness to use most family planning and health services (Mago, et al 2005).

Regarding HIV Testing and Counselling (HTC), fear to live with HIV is affecting access and utilisation of Adolescent Sexual Reproductive Health in Shurugwi district as indicated by

respondents on questionnaires. Moreover, male respondents highlighted that fear of too many injections on Voluntary Medical Male Circumcision (VMMC) stands as a barrier in accessing or utilizing some of the adolescent sexual reproductive health services like voluntary medical male circumcision. Some respondents also mentioned the issue of centralizing VMMC centers to big hospitals as a barrier for not utilizing Adolescents Sexual Reproductive Health service. In rural areas there are no VMMC centers so adolescents find it expensive to go to urban centers for male circumcision. Furthermore, male respondents also cited that they believe their foreskins are used to make mince meat and that is the reason why they are not willing to get circumcised.

Furthermore, respondents highlighted that parents do not allow youths to use condoms or family planning before they got married. This alone leads to some adolescents not accessing or utilizing adolescents sexual reproductive health services. However, the study findings revealed condom collection among adolescents as the most services being accessed even though parents are blocking them to condom use. Findings from ward 24 rural showed that most of the adolescents in the ward lack knowhow on condom use. They lack adequate information on how to use condoms, this therefore affects utilization of condoms as reproductive health service.

Langille (2000) states that levels of awareness and use of sexual and reproductive health services can be used to weigh up the acceptability and success of sexual and reproductive health services. Knowledge is a crucial (though not in itself sufficient) factor for adolescents to be able to take action to protect their sexual health and the educational system plays a vital role in creating that knowledge. Awusabo-Asare, et al (2004) highlight that several studies carried out in Ghana reveal that the awareness of adolescents on contraceptives is high. In spite of the high levels of

awareness among adolescents of modern methods of contraception, contraception use among them is generally low.

Furthermore, the study findings showed that adolescents are sexually active and can access the services if an enabling environment is provided for them. This therefore calls for the provision of the social structures including policies that would appropriately encourage and promote utilisation of the services among secondary school adolescents, if unwanted pregnancies and sexually transmitted infections are to be avoided. For example in Chile, the American Medical Association states that although school officials were concerned about adolescent pregnancies, they were resistant to being seen to be promoting contraception and worried that such promotion might increase sexual activities, particularly among young women (Gizzard et al 2003).

4.2.7. Challenges in Accessing Sexual and Reproductive Health Services

In this research, participating adolescents were asked if there had ever been a time when they wanted to get sexual and reproductive health services but encountered some difficulties. The questionnaire gave the informants an allowance to express challenges they face in accessing Sexual Reproductive Health and Rights services from service providers (questions asked are clearly listed in the self administered questionnaire attached at the back). These questions were used to determine whether or not any of the respondents had experienced any problem(s) that may keep young people away from visiting clinics or health centers that provide adolescent sexual and reproductive health services.

The majority of the adolescents did not reach the clinics for sexual and reproductive health services because they felt shy and were uncomfortable. They indicated that their peers would laugh at them if found accessing sexual reproductive health service and they could be labeled as of weak character and a prostitute. To this end adolescents do not want to be known that they are sexually active through accessing sexual reproductive health services. This therefore marked one of the barriers for adolescents not to access sexual reproductive health services.

Some respondents indicated the attitude of health staff as a challenge to them. They pointed out that staff is unfriendly to them. Adolescents stated that the staff referred them as under age to access sexual reproductive health services and they encourage adolescents to focus on their studies than sexual matters. This therefore deprived adolescents in reaching out sexual reproductive health services.

Lack of privacy and confidentiality was also cited as another barrier in reaching out for sexual and reproductive health services among adolescents. The service providers both nurses and Behavior Change Facilitators who operate in every ward tend to disclose the adolescents sexual related issues to their parents which might cause problems among parents and their adolescent children. For example, through document analysis of Midlands AIDS Service Organisation community dialogues reports, there was a community dialogue with young people aged 15-20 held in Mazivisa ward 24 rural and there were several barriers among adolescents in reaching out SRH services that were raised. On lack of privacy and confidentiality among service providers a certain girl said,

> ‘The service providers are friends to our parents to such an extent that by the moment I access any type of service from them they will tell my parents about that service and labeled me a prostitute or not obedient). So with this lack of privacy and confidentiality adolescents tend not to seek sexual reproductive health services’.

Furthermore, some participants highlighted inadequate resources at the health centers as another barrier to reaching out for sexual reproductive health services. They mentioned shortage of resources like injectable contraceptives and condoms which were not available at all times as well as no personnel to attend the adolescents when they visited the clinics.

Another reason mentioned for having difficulties in reaching out for sexual and reproductive health services was distance travelled to service providers and long waiting time in queues. The respondents from rural wards mentioned this as their major barrier. They stated that in a ward you might find only one or no clinic at all and in most cases that one clinic is located away from their villages and they find it difficult to walk for more than 15 kilometers to the clinic and at the same time spending more time in queues to access services. To this end the effectiveness of sexual reproductive health service may be affected.

The findings in this study do tally with the Cote d’Ivoire study of 1999 which was conducted in two rural and two urban health districts which surfaced the obstacles like poor quality of care for adolescents at health centres, persistent absenteeism of staff, long waiting periods, high cost of

consultation and care, unfriendly treatment by staff and lack of privacy in the facilities (Jegeebhoy, etal 1999).

To this end the young people therefore faced barriers in accessing adolescent sexual and reproductive health services that extended beyond the clinic walls. The feeling that clinics are too far is also related to the time spent in accessing services, which is also reflected in their desire for shorter waiting times while at the clinic.

4.2.8. Possible Factors that Would Promote the Effectiveness of ASRH Services

4.2.8.1. Access to youth friendly health services

The access to youth friendly services is another factor that would promote the effective of SRHR services among adolescents. In the study the participants highlighted barriers like unfriendly service providers, lack of privacy and confidentiality among service providers, limited resources among other factors in reaching out sexual reproductive health services. In order to promote the effectiveness of Adolescent Sexual Reproductive Health services the researcher recommends the training of service providers on public relations. Adolescents must not be judged and services received must not be disclosed to any one so there is need for training of health staff so as to improve youth friendly services. According to the WHO, adolescent-friendly services must be "accessible, acceptable, equitable, appropriate, and effective". There should be trained service providers and other clinic staff to reduce discomfort associated with serving adolescents, build better communication skills for working with this age group and make services more attractive to adolescent users. Moreover, economic barriers that adolescents face in accessing contraception

should be improved maybe by providing contraceptive methods and services for free or at a reduced cost.

4.2.8.2. Dissemination of SRH awareness and establishing demand generation of services

In the study some participants (adolescents) revealed that they are not aware of sexual reproductive health services offered in Shurugwi district. There is need for effective dissemination of SRHR information among adolescents. In schools adolescents should be taught about sexual reproductive health and be encouraged to seek SHR services in order to reduce high rates of school drop outs due to teenage pregnancies. Furthermore, NGOs should make sure that their community dialogues are reaching every corner of the district for effective access and utilisation of SRHR services among adolescents.

4.3. Summary

The research findings reveal that the majority of adolescents are knowledgeable or aware of the availability of adolescent sexual and reproductive health services offered in Shurugwi district. They are also aware of the actual providers of these services. Despite the awareness, however, not many of the adolescents access the services for various reasons like shyness and lack of confidence, long distance travelled to clinics or service providers, time involved in service delivery, lack of privacy and confidentiality among service providers, negative attitude of service providers, parents do not allow adolescents to use condoms or family planning before they get married to mention just a few. To this end the outcomes of the study seem to confirm that adolescents do indulge in premarital sex but fail to utilise the available services adequately due to many hindrances which they encounter.

Chapter 5

SUMMARY, CONCLUSION AND RECOMMANDATION

5.1. Introduction

This chapter gives a summary of the researcher's conclusions and recommendations following the findings of the study on the effectiveness of Sexual reproductive health and rights services on adolescents in Shurugwi district wards 5 urban and 24 rural. These recommendations are appropriate to the existing body of knowledge, to the nation at large and Non Governmental Organizations because it will give adequate information on how best SRHR programmes can be carried out in order to facilitate sustainable development.

5.2. Summary

A study on the effectiveness of Sexual Reproductive Health and Rights among adolescents in Shurugwi district wards 5 urban and 24 rural was conducted using the methodology outlined in Chapter 3. The main focus of the research was to determine the effectiveness of available sexual and reproductive health services by adolescents aged 15-19 years. This was done mainly in view of the increasing number of unwanted pregnancies which occur among the secondary school adolescents and high incidences of HIV and AIDS. The objectives were to determine SRHR service being offered in Shurugwi district, to determine the level of awareness among young people on the existing Sexual Reproductive Health and Rights services, to identify those factors that affect access and utilisation of Sexual Reproductive Health and Rights facilities and also to spot possible factors that would promote access and adequate utilization of Sexual Reproductive Health and Rights services by adolescents in Shurugwi district. A comprehensive review of

literature on the ability to access reproductive health services and factors that affect access to SRHR services as well as possible factors that would promote utilisation of SRH services among adolescents provided a solid background to this study. The main research techniques that were used to collect data were survey questionnaires, interviews and document analysis. The study examined responses by adolescents in and out of school and service providers in Shurugwi district to a questionnaire about the effectiveness of the available adolescent sexual reproductive health services.

5.3. Conclusion

Literature revealed that, in spite of the high levels of awareness among adolescents of modern methods of contraception, contraception use among them is generally low. However the analysis in Chapter 4 has shown that adolescents have several barriers in reaching out for sexual reproductive health services. Regarding knowledge or awareness of the available adolescent sexual and reproductive health services in Shurugwi district, the study findings reveal that both adolescents in and out of school were aware of the existence of these health services and they are aware of health centers to access services. However, the awareness may not be congruent with the sexual behaviour of all of the adolescents in terms of seeking assistance from adolescent sexual and reproductive health services. On access and utilisation of SRHR services, just few adolescents reported having visited the health facilities to receive sexual reproductive health services in the district. The majority of participants indicated not having visited any of the health facilities for SRH services due to various challenges. Adolescents are sexually active but not using any contraceptive method. The use of condoms was predominantly high among the services that the adolescents utilised. Accessing adolescent sexual and reproductive health services seem to pose a greater challenge for adolescents in modern times. In this study

respondents surfaced a number of challenges encountered in reaching out SRHR service, these difficulties include lack of confidence and shyness, lack of privacy and confidentiality, distance travelled to clinics, long periods of waiting, unfriendly staff, parents who do not allow youths to use condoms or family planning before they got married to list a few.

5.4. Recommendations of the Study

According to Lloyd (2007) in many circumstances poor health is the outcome of many forces beyond a person's control. These forces may be associated with disease environment, family circumstances and personal vulnerability. To this end, however, the individual behaviour stands out to be the greatest factor of growing importance to health during adolescence. In particular, unprotected sex and its consequences of sexually transmitted infections, HIV/AIDS and unwanted pregnancy, carry a lot of risks for adolescents including the risk of dropping out of school and early parenthood to list a few.

Community support is very important within the adolescents lives because it marks the successful maintenance of their SRH. The thinking around this is adolescents with supportive families and those who receive back up from teachers would be more likely than others to take health related behaviours seriously in order to avoid the risk of school dropout by either avoiding sex, engaging in protected sex or avoiding risky relationships like age mixing that could predispose them to all the risks associated with premarital sex.

Interventions should be made to improve or make SRHR services effective in Shurugwi district Zimbabwe. In other parts of the world, the following interventions have been tested and tried and

positive results were yielded. Therefore, in order to come up with effective SRHR services similar interventions could be applied to adolescents in Shurugwi district.

- ***Health Related Programmes in Schools***: it is crucial to provide preventive or curative health services to schools including reproductive health services within schools. For instance in Tanzania, SRH curriculum was introduced to students, as part of the program teachers took students to a local health facility to familiarise them with services available and to allow them to see condom demonstrations which were not allowed in the classroom situation because of parental sensitivities (Lloyd 2007). More importantly the provision of SRH information as part of the life skills and family life education is vital in schools.

- ***Health Clubs in Schools***: These clubs are a means of bringing health services closer to adolescents although direct measurements of its benefits on reproductive health have not yet been measured. Such clubs would act as resource centres within schools for promotion of behavioural change.

- ***Establishment of 'Youth–Friendly' Health Services and Facilities:***

Young people are likely to use sexual and reproductive health services available if they are youth–friendly or adolescent friendly. These facilities must be accessible in terms of physical location and hours of operation, affordability, confidentiality and credibility to both users and health providers. These clinics need health workers who can understand young people and ones they can communicate with and that are not judgmental. In order to improve, these service

providers should be trained in public relations and also these trained staff should also be relocated even in remote areas so that every adolescent would access sexual reproductive health information or services freely at any given time.

- ***Young and adults SRHR related community dialogues should be adopted***

NGOs who are engaged in SRHR information disseminating should focus or target combined age groups community dialogues so as to break the communication barrier between parents and their adolescent children. The research findings revealed that parents do not allow youths to access condoms or any family planning method before they get married and the study findings also showed that adolescent are sexually active but with limited access to SRH services. So with the combined SRHR related community dialogues where parents would discuss on the importance of allowing their adolescents to access and utilize reproductive services, they might be a decrease in school drop outs rates due to teenage pregnancies and also a decrease in high incidents of HIV among young people.

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CONSENT FORM

By signing this document, I am giving consent to be interviewed by the researcher. I understand that I will be part of the research study that is looking on the effectiveness of Sexual Reproductive Health and Rights services on young people in Shurugwi district. I understand that I have been selected to participate in the study because am in the group of young people between the age range of 15 to 24 in Shurugwi district where the researcher is conducting the research. I was informed that the participation would be entirely voluntary and that am free to withdraw at anytime. I have been informed that the answers I will give will not show my name. I will also not be identified in the final research report.

I also understand that results can be given to me if I ask for them and that Miss. P. Chibaya is the person to contact if I have questions about my rights as a participant. Miss. P. Chibaya can be reached through cell number +263773815647.

Participant's Name_________________________ Researcher's Name____________________

Participant's signature______________________ Researcher's Signature___________________

Date: __________________________________ Date: ______________________________

SELF ADMINISTERED QUESTIONAIRE

A research to determine the effectiveness of Sexual Reproductive Health and Rights services on young people in Shurugwi district.

DEMOGRAPHIC DATA

1. What is your gender?

Male ☐

Female ☐

2. Are you aged between 15 and 24 years?

Yes ☐

No ☐

3. Are you at school or out school?

At school ☐

Out of school ☐

4. Are you aware that there are clinics that provide adolescent and youth friendly sexual reproductive health Services in Shurugwi district?

Yes ☐

No ☐

5. If yes have you visited any clinic to receive sexual and reproductive health services?

Yes ☐

No ☐

6. If yes was it a government clinic or NGO clinic?

Government ☐

NGO ☐

7. Are you aware of another place in Shurugwi district where you can get SRHR service other than at the clinics?

Yes ☐

No ☐

8. If yes which other places do you get these services from other than the clinics?

____

____

9. If you have used the clinic facilities or any other apart from the clinics, were you happy or satisfied with the services you received?

Yes ☐

No ☐

10. Please explain your answer to the above question

____

11. Which of the following services did you receive?

Please tick under Yes or No

REPRODUCTIVE HEALTH SERVICE	**YES**	**NO**
HIV Testing and Counseling (HTC)		
Condom Collection		
Voluntary Medical Male Circumcision (VMMC)		
Family Planning (FP)		
Sexually Transmitted Infections screening or treatment		
Pre and Post abortion counselling		
Postnatal care		
Antenatal care		

If there are any other services please specify__________________________________

____

12. Do you have any challenges in reaching the clinic or any other service provider for sexual and reproductive health services of your choice?

Yes ☐

No ☐

13. If yes what challenges do you experience?

____

____

____

14. Are you aware of NGOs that offer SRHR information?

Yes ☐

No ☐

15. If yes list down strategies they use to disseminate information to young people

____

____

____

____

QUESTIONNAIRE FOR SERVICE PROVIDERS

A research to determine the effective of sexual and reproductive health services on adolescents in Shurugwi district.

<u>Section A – (hospital/clinics service providers)</u>

1. Do you offer SRH services to adolescents at this health center?

   Yes ☐

   No ☐

2. What is the SRHR service uptake rate among adolescents of the following services?

Service	Low: below 50%	High: above 60%
Voluntary medical male circumcision (VMMC)		
HIV Testing and Counselling (HTC)		
Sexual Transmitted Infections (STI) treatment		
Condom and family planning (contraceptives)		
Antenatal and postnatal care		
Pre and post abortion counselling		
If other specify		

3. What was the rate of adolescents pregnant before the coming in of SRHR program and what was the mortality rate among young women?

   ____

   ____

4. What changes observed so far in terms of adolescents pregnancy and mortality rate?

____

____

____

SECTION B - (NGOs)

5. What strategies do you use to disseminate SRHR information to adolescents?

____

____

6. Are the methods effective?

YES ☐

NO ☐

7. If YES what are the most significant change stories observed on adolescents' SRHR?

____

____

____

Interview Guide

MHoC

1. Do you have youth friendly corner at this clinic?
2. What is the young people attendance and do they cooperate or participate in programs?
3. How does the youth friendly corner help adolescents on SRHR issues?
4. What is the contribution of youth friendly corners in reducing teenage pregnancy and STIs?
5. What other factors do you think can lead to a decrease in teenage pregnancy and mortality rate?
6. As MHoC what do you think needs to be done to ensure the effective access and utilisation of SRH among adolescents?

NGOs

1. What is the participation of adolescents during the awareness campaigns?
2. Do the program benefit both boys and girls and how?
3. Since adolescents girls are the most affected group, what efforts are you putting to improve their reproductive health?
4. What do you think need to be done to ensure to ensure effective service up take among adolescents?