The Capacity of Adolescent-Friendly Reproductive Health Services to Promote Sexual Reproductive Health among Adolescents in Bindura Urban of Zimbabwe

Jeffrey Kurebwa[1]

[1] Bindura University of Science Education

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Abstract

This study seeks to understand the capacity of Adolescent-Friendly Reproductive Health services (AFRHS) in promoting Sexual Reproductive Health (SRP) among adolescents in Bindura Urban of Zimbabwe. Qualitative methodology was employed to understand the utilisation of AFRHS. Health service utilisation was assessed through key informant interviews, focus group discussions, observations and documentary search. The data collection methods used allowed the researcher to get insight on adolescents? experience and the factors associated with their accessing SRH services from AFRHS; the meaning of AFRHS for adolescents; health care providers? attitudes towards adolescents seeking SRH services; and community perceptions and readiness to accept AFRHS. The findings showed that both socio-cultural and health facility factors influence utilisation of SRH services. Many of these factors stem from the moral framework encapsulated in socio-cultural norms and values related to the sexual health of adolescents, and health care providers? poor value clarification. This study provides an empirical understanding of the reasons and factors associated with SRH service utilisation, which goes much deeper than program provision of AFRHS in Zimbabwe.

Index terms— adolescence, health friendly services, sexual reproductive health, sexuality, world health organization, socio-cultural norms.

1 Introduction

ne of the major contributions made in response to the SRH care needs of adolescents came from the health sector with the Adolescent-Friendly Reproductive Health Services (AFRHS) initiative. The concept was introduced following the 1994 Cairo conference that prioritised the SRHS of adolescents and young people (UN, 1995). Since then, attempts have been made globally by the health sector to address young people's SRH issues. The introduction of AFRHS into the current health delivery system is one example of healthcare improvements that were recommended, particularly for developing countries. The World Health Organization (WHO) defined AFRHS as an approach which brings together the qualities that young people demand, with the high standards that have to be achieved in the best public services" (McIntyre, 2002).

The concern about ASRH has grown following reports that sexual activity, early pregnancies and Sexually Transmitted Infections (STIs) including HIV infection rates are increasing at unprecedented rates among adolescents (UNICEF, 2007; Sandoy et al., 2007). The importance of facility-based AFRHS has long been recognised by health policy makers as manifested in an increasing number of countries. From its outset, AFRHS focused on improving the availability, accessibility and quality of SRH services because AFRHS were developed against the backdrop of inadequacies on the part of health systems to provide SRHS in an efficient, effective and equitable manner to young people ??UNFPA, 2003). While most barriers to adolescents' utilisation of SRHS

have been attributed to quality of SRHS; a critical analysis of the barriers to ARHS promotion reveals that cultural norms that influence people's behaviours and actions related to sexual and reproductive matters are also extremely important (Senderowitz, 1999). Furthermore, the current rapid social, political and economic transformations in Southern Africa appear to have a profound impact on the social norms affecting adolescents (Blum, 2007).

Previous research findings indicate that that socio-cultural norms influence adolescents to adopt unsafe sex practices in most African countries (Chimbiri, 2007). Other evidence also shows that some health workers become judgemental or hostile to unmarried people who come for SRHS. Health workers have also been accused of being reluctant to teach adolescents about SRH (Mbugua, 2007) and provide them with SRH services (Chirwa and Kudzala, 2001). This is because prevailing cultural norms in some countries proscribe young, unmarried people having sex (Chirwa and Kudzala, 2001). Some health facilities in some countries also have restrictive policies (such as consent requirement to access SRHS) that hinder unmarried adolescents to access SRHS **??**UNFPA, 2003). Moreover, in most societies, the SRH needs and rights of unmarried adolescents are not acknowledged. Thus, because of culture, government policies and plans do not include policies and resource allocations that can promote implementation of SRHS targeting unmarried adolescents **??**UNICEF, 2003).

2 a) Overview of Adolescent Reproductive Health Rights in Zimbabwe

This section looks at the current legal and policy provisions on sexual and reproductive health services in Zimbabwe. Section 76 (1) of the Constitution of Zimbabwe (2013) states that:

Every citizen and permanent resident of Zimbabwe has the right to have access to basic healthcare services, including reproductive health-care services.

The Public Health Act of 2018 is not particularly explicit, but its Section 35 has been read to provide that children -defined as persons under the age of 18require parental or adult consent to access medical health services. Where extra-marital sexual intercourse or an indecent act occurs between young persons who are both over the age of twelve years but below the age of sixteen years at the time of the sexual intercourse or the indecent act, neither of them shall be charged with sexual intercourse or performing an indecent act with a young person except upon a report of a probation officer appointed in terms of the Children's Act **??**Chapter 5:06] showing that it is appropriate to charge one of them with that crime.

A child under the age of 16 years cannot legally consent to sexual intercourse at law; it is then presumed that a child under the age of 16 years does not need contraceptives or other SRHS, which is a belief that prejudices children. This is because children between 12 and 16 years can among themselves have consensual sexual intercourse without offending any penal provision. That legal position aside -and most children are in fact not aware of that legal position -it is fact that children are engaging in sexual activity among themselves at early ages. Such children require access to sexual and reproductive health services as an intervention. In Zimbabwe, the push to remove age restrictions from access to sexual and reproductive health has been conflated with the lowering of the age of consent. This confusion is compounded by the government's stated intention to raise the age of sexual consent from 16 to 18, in line with the constitutional provision that only people aged 18 and above are allowed to marry. The conflation of sexual consent and the age of marriage, informed by cultural and religious attitudes, is evident in the government's position on the matter.

3 b) Key statistics

In Zimbabwe the following estimates have been made with regards to ASRHS:

? That the 15-24 age group population of girls and young women is 1.365 million. ? HIV prevalence for the 15-24 demographic is around 7.04%.

4 c) Purpose of the Study

This study seeks to understand the capacity of AFRHS to promote SRH among adolescence in Bindura Urban of Zimbabwe.

5 d) Research Objectives

i. To identify the capacity of the ASRHS providers in meeting the SRHR needs of adolescents in Binndura urban of Zimbabwe. ii. To examine the impact of socio-cultural norms in influencing adolescent sexual behaviours.

6 II. Literature Review and Theoretical Framework

Researchers have tried to understand adolescents from different theoretical viewpoints focusing particularly on biological and neurological development and the influence of socio-ecological environments as determinants of their behaviour. The sociological view understands adolescence emerging from the socio-economic changes resulting from the arrival of institutionalised schooling practices in the 20th century (Caldwell et al., 1998;Demos & Demos, 1969;Modell & Goodman, 1990). The biological view of adolescence highlights physical maturation due to hormonal and emotional changes at puberty as an important signal of this period (Patton & Viner, 2007;Spear,

2012). The biological maturation perspective, introduced by Hall (1916), explains that the development of the individual throughout adolescence is determined by biological and genetic forces. Patton et al. (2016) explains that during adolescence brain development occurs together with pubertial process including gonadal hormone change along with maturation of subcortical structure in brain that allows understanding sex differences. Yet socio-cultural, nutritional environmental context and exposure such as substance use also influence adolescents' expressions and experiences of this period (Patton et al., 2016;Steinberg, 2001). The biological maturity perspective is also associated with elevated rates of risky behaviours due to the hormonal changes characterising this period (Kipke, 1999).

Ecological perspectives have similarly explained that contextual social and environmental factors like economic status, cultural background, and the general environment contribute to the social norms and values, opportunities and reinforcements the condition that determine the behaviours of adolescents (Millstein & Igra, 1995). Often, risky behaviours including high-risk sexual behaviour like early and unprotected sexual intercourse, forced sex and multiple sexual partners, and inter-generational sex, sexually transmitted infections and HIV are associated with family poverty, poor parental monitoring, peer influence and poor exposure of adolescents to SRH information (Ssewanyana, 2018; Underwood, Skinner, Osman, & Schwandt, 2011).

7 a) Definition of Adolescence

Generally, adolescence is considered a time of transition from childhood to adulthood during which there are physical changes associated with puberty (Adamchak., et al 2000;Senderowitz and Paxman, 1985). From this biological perspective, adolescence is defined as a period of lifespan of between the ages 10 to 19 years (WHO, 2003b). The period of adolescence is characterised by a number of changes including physical and emotional changes, the search for identity and greater maturity in reasoning. It is considered as the period during which the individual progresses from the initial appearance of secondary sex characteristics to that of sexual maturity, whereby individual's psychological processes and patterns of identification develop from those of a child to an adult. Thus, adolescence is considered as a time of transition from childhood to adulthood, during which young people experience changes following puberty, but do not immediately assume the roles, privileges and responsibilities of adulthood **??**Jejebhoy and Bott, 2003).

Socially, the notion of adolescence is not the same everywhere. Although the utilization of the concept of adolescence is so widespread in SRH literature, the term usually alludes to different phenomena. Because it is a culturally defined phenomenon, adolescence is a term whose meaning is variously defined in the literature (Dawes and Donald, 1994;Schlegel 1995;Caldwell et al., 1998). Furthermore because adolescence is experienced differently in every society; and even within societies there may be vast differences in how some youth experience adolescence as compared to others. Adolescents and young people are not a homogenous group; their lives vary enormously by age, sex, marital status, class, region and cultural context.

Due to the variations in the definition, adolescence is both a period of opportunity as well as time of vulnerability and risk. Schlegel (1995) defines adolescence as a life phase that involves the management of sexuality among unmarried individuals, social organisation and peer group influence among adolescents, and training in occupational and life skills. It is the time when new options and ideas are explored. As such, it is a phase in life marked by vulnerability to health risks, especially those related to unsafe sexual activity and related reproductive health outcomes like unwanted and unplanned pregnancy and STIs, and by obstacles to the exercise of informed reproductive choice **??**Munthali et al., 2004).

Adolescence is the life stage crucial for the opportunity of lifelong good health, a time when future patterns of adult health are established (Sawyer et al., 2012). At the same time, adolescents are often associated with increased risk-taking behaviour due to hormonal changes, neurological changes and exposure to social environment during puberty (Galvan et al., 2006;Patton et al., 2016;Steinberg, 2011). During this period, adolescents seek greater independence and responsibility, and more autonomy over their decisions and actions as they try to form identities and become conscious that choices can be of their own making (Marcia, 1980;Montgomery, 2005). Sawyer et al. (**??**012) define adolescence as a life phase that is mostly exciting and comes with numerous opportunities, where adolescents learn from peers, parents, society, and communication technologies which, as a whole, shape and direct their future. From another side, researchers emphasise that adolescence is also a phase when young people begin to explore their sexuality and may engage in early sexual activities as part of their sexual curiosity **??**Regmi et **??**008). The ongoing decline in the age at which sex is first had, and an increased instance of sexually active adolescents in many countries has raised serious concerns among global public health experts, who associate these factors with negative health outcomes for these individuals as they reach adulthood.

8 b) Factors influencing access to and utilisation of adolescent sexual and reproductive health services

Despite the focus given to the provision of SRH services, adolescents continue to face challenges in accessing reproductive health services (Chandra-Mouli et al., 2015b). The challenges that impact on SRH utilisation are often a result of complex social, environmental, cultural, economic and psychosocial factors (WHO, 2011). A review conducted by Tylee et al. (2007) for a Lancet series on adolescent health noted that research, mainly from developing countries, has indicated that almost 70-90% of young people visit primary health care facilities at

least once a year, but rarely for SRH issues; the major reasons were for treatment of respiratory or dermatological problems. The review further noted that in developing countries young people are not willing to seek professional help for sensitive SRH issues and, furthermore, it is adults who would decide their SRH needs (Tylee et al., 2007).

There could be various reasons why young people are not willing to seek services for SRH issues, and research that endeavours to understand this nonutilisation is key to improving the quality of life for young people. This understanding could help prevent SRH morbidity, and provide an evidence base for designing health promotion interventions. The complexity of SRH service utilisation could be clarified by different models of health care utilisation. There are several models that explain health care utilisation. For example, the psychosocial health belief model (Rosenstock, 1974) is based on individuals' beliefs about health problems and perceptions of the benefit that motivates health seeking; the Andersen-Newman behavioural model of health service use (Andersen & Newman, 1973) emphasises social determinants, the health service system and individual determinants that influence health service utilisation; and in Kroeger's model (Kroeger, 1983) the major elements are the characteristics of the patient, of disorder perception, and of the health service.

The health service utilisation of adolescents is embedded in complex contextual elements related to demographics and social structures, and health system factors that influence adolescent SRH. Hence, the focus in discussing SRH service utilisation is on identifying factors that may influence the health-seeking behaviours of adolescents. The health belief model of Rosenstock (1974) centres on an individual's belief and perceptions and omits the environmental influences and social structures that might influence the decision of adolescents to utilise SRH services. Therefore, this model is not appropriate to understanding the factors affecting adolescent SRH service utilisation. Andersen and Newman (1973) emphasises social determinants, and Kroeger (1983) emphasises patient characteristics and demographic and social variables, and hence, these two models might best explain factors associated with adolescents' SRH service utilisation. However, these models are not sufficiently comprehensive when considered on their own. Health service utilisation is likely to be better understood when a combination of both models is applied.

The Andersen-Newman (1973) model of health service utilisation established that an individual's health care seeking is influenced by three components: predisposing, enabling and need as factors that facilitate or impede utilisation of services by individuals. In this model predisposing factors are demographic and social structures; enabling factors are those allowing the use of services such as income, access to service and availability; and need factors such as conditions of illhealth or disease motivate service seeking. This model has been previously applied and tested in investigations of a range of health services and in health systems research, including adolescent SRH care seeking.

Azfredrick (2016), using this model to examined reproductive health service utilisation by adolescent girls, showed that enabling factors like parental support, finances, and type of health facility were important determinants of adolescents deciding to seek SRH services.

Shabani, Moleki, and Thupayagale-Tshweneagae (2018), in their exploratory descriptive and contextual qualitative research among 20 male adolescents in South Africa, noted that predisposing factors like health belief, and enabling factors like the availability of quality ASRH services were important for SRH service utilisation.

Similarly, Kroeger's (1983) model emphasised patient characteristics, which embrace features of predisposing factors from Anderson-Newman (1973), and demographic and social variables. It then considers the characteristics of disorders such as the nature and severity of a disease. The third most important aspect of the framework which is particularly relevant for adolescent SRH service utilisation is the focus on the enabling environment of health facilities, including geographical accessibility, acceptability, quality of care, and cost associated with services (Kroeger, 1983).

While the Anderson-Newman and Kroeger models provide comprehensive frameworks for looking at the factors associated with adolescents' SRH service utilisation, the WHO's "quality of care" framework expands on Kroeger's enabling factors. The quality of care framework is a guide to improving health services provision such that patients' service utilisation improves **??**WHO, 2006b). This framework was utilised to define the AFHS domain for quality health care that includes accessible, acceptable, equitable, appropriate and effective services (WHO, 2012). Components include accessibility and acceptability, which also feature in Kroeger's model, but in addition, quality of care includes equitable, appropriate and effective service.

9 III. Research Design and Methodology

A case study research design of Bindura urban was utilised in order to understand the capacity utilisation of adolescent reproductive health rights services. In Bindura there are very few adolescent reproductive health service providers as evidenced by the field work research. Qualitative research methodology was used. The advantage of qualitative research is that it takes a naturalistic approach concerned with understanding reality and assumes that reality is a complex and dynamic phenomenon which is constructed through the interactions of human agents in their social world (Creswell, 1994; **??**itchie & Lewis, 2003). This study was interested in understanding the reasons for the low utilisation of sexual and reproductive health services by adolescents from adolescent-friendly health services. Thus, a qualitative approach is wellsuited to achieving this insight.

Creswell (2013) reiterates that qualitative researchers typically gather data in multiple forms and, drawing on Creswell, the study chose to apply data collection methods such as key informant interviews, observations, focus group discussions, and document analysis. As Creswell argues, employing multiple forms of data collection,

rather than relying on a single source of data is an aid to making sense of the issue under study, in this case, the complexities surrounding the utilisation of adolescent-friendly health services. Key informants were drawn from employees of health care facilities (such as nurses, peer counsellors and home based care providers), parents and guardians while focus group discussions were held with adolescents from Bindura urban.

10 IV.

11 Discussion of Findings

This section presents findings from the study. Various views from different research participants will be indicated as expressed by the participants.

12 a) Factors influencing access to and utilisation of adolescent sexual and reproductive health services

Despite the focus given to the provision of ASRH services, adolescents continue to face challenges in accessing reproductive health services (Chandra-Mouli et al., 2015b). The challenges that impact on SRH utilisation are often a result of complex social, environmental, cultural, economic and psychosocial factors (WHO, 2011). A review conducted by Tylee et al. (**??**007) for a Lancet series on adolescent health noted that research, mainly from developing countries, has indicated that almost 70-90% of young people visit primary health care facilities at least once a year, but rarely for SRH issues; the major reasons were for treatment of respiratory or dermatological problems. The review further noted that in developing countries young people are not willing to seek professional help for sensitive SRH issues and, furthermore, it is adults who would decide their SRH needs (Tylee et al., 2007).

13 b) Individual factors for adolescents' sexual and reproductive health service utilisation

Although there are several individual-level determinants associated with health service utilisation, by young people, the literature emphasises education level and sexual relationship status, as major factors.

14 c) Education

Education was ranked as one of the most important factors contributing to capacity utilisation of AFRHS by the research participants. One of the nurses interviewed during the study indicated that: "To me education is very important. I have realised that most of the adolescents who come here seeking our services have gone up to secondary level. This is different from the rural areas and farming communities where some adolescents have only gone up to Grade seven while others are not even able to read and write."

The above sentiments were also supported by a Peer Educator who mentioned that: "The most likely explanation is that educated adolescents had better access to information, more knowledge about the availability of the services, and a better understanding that their sexual health could benefit from preventive health care."

Adolescents from one focus group discussion indicated the importance of education. They highlighted that:

"At school we learn about sexual reproductive health rights in our guidance and counselling classes. We know our sexual reproductive rights."

A number of studies have identified that adolescents who are educated at least up to higher secondary level are more likely to use SRH services, especially family planning and voluntary counselling and testing services **??**

15 d) Adolescent sexual relationships

Young people's sexual relationships are strongly associated with SRH service utilisation, and hence, this has led researchers to look more closely at this link. Falling in love, being in a romantic relationship, and the first experiences of sexual intimacy and sex are universal and normal during adolescence. In fact, being in an adolescent relationship is a powerful predictor of sexual activity. One of the adolescents who participated in the study mentioned that: "At our age we need to experiment about adult life by falling in love. Some of us want to feel how sex is. We read a lot about sex and relationships; we watch romantic movies where we see people getting into intimate relationships." A parent who participated in the study argued that: "Although premarital relationships and sexual activities have traditionally not been acceptable in Zimbabwe, urbanisation and exposure to international media and the internet have slowly changed the way young people in Zimbabwe think about sex and relationships."

Being in an adolescent relationship is a powerful predictor of sexual activity. These relationships are central to young people's lives and play an important developmental role, signalling implications for their future health and adjustment (Furman & Shaffer, 2003). Adolescents now have more liberal attitudes towards relationships and sex (Regmi et al., 2011). Regmi et al. (2011) also found that adolescent girls in romantic relationships often tend to feel intimacy with their male partners more intensely than their partners and prefer long-term relationships, while males prefer short-term relationships that fulfil their sexual desire (Regmi et al., 2011). Being in a sexual relationship is reported to be a powerful catalyst for young people to seek SRH care, especially

for contraceptives (Feleke et al., 2013). Relationship length, partner communication, and intimacy are also consistently associated with contraceptive practices (Feleke et al., 2013). In their community-based quantitative cross-sectional study, Feleke at al. (2103) observed that adolescents aged 15-19 years who were in long-term, romantic sexual relationships were 6.5 times more likely to use family planning services from health care facilities compared to those who were not.

16 e) Gender Norms

Both Anderson-Newman and Kroeger models place gender in their frameworks as one of the factors influencing health-seeking behaviour. Whether one is male or female, gender norms are likely to have an influence on various SRH behaviours and health service utilisation. Generally, girls use more SRH services at health facilities since they offer more contraceptive options, and for maternal health care services.

One Counsellor at a Youth-friendly centre mentioned that: "At this centre we have more girls coming for our services than boys. Girls are in need of contraceptives than boys. There more services for girls than for boys."

Another Counsellor also indicated that: "Gendered norms often give men a dominant position which they can use to limit women's ability to control their own SRH." Adolescents who participated in the focus group discussions highlighted the importance of gender norms in accessing SRH services. One focus group member mentioned that: "In most cases boys do now want to seek reproductive health services. They are shy to be seen collecting condoms for example. As for girls I think it's easy to go to these youth friendly centres because they have a lot to gain."

Several studies have demonstrated that gender differences and unequal power relationships between men and women hinder communication between partners about SRH issues, which may be an obstacle for women's access to SRH services, resulting in poor sexual health (Pulerwitz et al., 2010; **??**uri et al., 2010;Woog, Singh, Browne, & Philbin, 2015). Woog et al. (2015) in their review of 70 national representative surveys of developing countries highlighted that in most of these countries, husbands or partners are the primary decision makers on the use of reproductive health services for adolescent women, overriding the female voice in those decisions. Much of the evidence to date indicates that this lack of power in decision making results in poor utilisation of SRH services by women. However, a study conducted among 1290 male and female adolescents in northwest Ethiopia found that more than half of sexually active adolescents who used voluntary counselling and testing (VCT) services were females (Feleke et al., 2013).

17 f) Peer influence on adolescents' SRH service utilisation

There is extensive literature explicating the influence of peers on adolescents' SRH. Peers are a crucial element in adolescence; adolescents often pay close attention to their peers' behaviour to gain their approval, and peers' opinions often hold the most weight (Drolet & Arcand, 2013). Research participants in the study emphasised on the importance of peer influence. One focus group discussion participant argued that: "We learn more from our peers. We want to imitate each other. So there is much competition and pressure among us. In most cases we listen more to our peers than our parents."

A parent who participated in the study indicated that: "Here in our community of Chipadze suburb we have problems of peer pressure. Our children listen more to their friends than us parents. They engage in a lot of activities such as drug and substance abuse and sexual intercourses because of peer pressure."

A Peer Educator who participated in the study argued that: "The support system offered by strong peer connections has been documented as leading to positive health strategies such as protecting against a broad range of risky behaviours during adolescence."

Peers are often the main source of information about sex for young people and influence the way that information is spread (Bam et al., 2015; **??**egmi et al., 2010b). However, peers are also associated with increased risk, since they not only provide information on sex but may also encourage and pressure friends to initiate sexual activities **??**Adhikari et **??**018) in their research among Nepalese adolescents noted that adolescents who had discussed sexual matters with their peers had a 2.6-fold higher chance of having pre-marital sex compared to those who had not discussed sex.

18 g) Family influence on adolescents SRH service utilisation

The literature consistently shows a clear and strong link between the family environment, adolescent sexual behaviour and SRH service utilisation (Adebayo Ayodeji, Ajuonu Ezidinma, & Betiku Benson, 2016; Challa et al., 2018;Feleke et al., 2013).

A Peer Counsellor who participated in the study mentioned that:

"Family structures such as single-parent households, changes to parents' marital status through divorce or remarriage, and having an older sexually active sibling at home, have all been closely related to early initiation of sexual activity among adolescents."

Research participants from focus group discussions also highlighted that: "Most of us here come from single parent homes. Some from child headed households. We have no one to provide us information on sexual reproductive health. We mainly rely on our friends."

For example, a descriptive cross-sectional study conducted in southwest Nigeria among secondary school students showed a significant association between mother-child communication, parental monitoring and parental disapproval of sex and the sexual experience of adolescents (Adebayo Ayodeji et al., 2016). While the actual mechanisms of the relationship between family structure and adolescent sexual behaviour have not been comprehensively explained, lower parental supervision and greater independence has been proposed as a potential conditioning factor for early initiation of sexual activity and poor preventive health care seeking **??**Adhikari & Tamang, 2009;Biddlecom et al., 2009;Marchand & Smolkowski, 2013). This suggests that parental monitoring and involvement in young people's lives plays a supportive role in adolescent development and sexual behaviour (DeVore & Ginsburg, 2005).

19 h) Socio-cultural beliefs and values influencing the SRH of adolescents

The socio-cultural environment of many societies is the container of norms around what are acceptable and unacceptable sexual behaviours, especially for unmarried adolescents. Those who do not observe these social norms may face social ostracism which effectively acts as a form of social control over adolescents' sexual behaviour (Marston & King, 2006). A Counbsellor who participated in the study noted that: "Most Zimbabwean societies are very conservative. It is taboo to talk about sex before marriage. Unmarried adolescents seeking sexual health services are stigmatised, discriminated against, and socially isolated. Discrimination, which may be self-, socially-or institutionally-imposed, can hamper young people's access to SRH services."

A research participant from one focus group discussion indicated that: "It's very difficult for me to just be seen walking into a youth-friendly centre. People will think I need to collect contraceptives or I am pregnant. Most of us are shy. So sometimes we pretend to be accompanying our married friends so that we are also able to access these services." **??**enderowitz (2000) reported that in developing countries the provision of reproductive health information, education and counselling services has been challenging because these are matters of great cultural sensitivity. In some societies, including Nepal, providing SRH information is considered taboo because this is believed to encourage premarital sexual activity **??**Pradhan & Strachan, 2003; **??**uri et al., 2010; **??**oss, 2006). Therefore, many societies tend to withhold sexual health information from young people until it is felt necessary to provide it, typically during puberty or on marriage **??**Senderowitz, 2000). While schools and health workers could act as mediators of SRH information for young people (Bearinger et al., 2007), several studies reveal that the cultural background of teachers and health workers significantly influences the way they provide such information. In Nepal, although school curricula include reproductive health education for grades 9 and 10 (adolescents aged 15-16 years), teachers are often reluctant to discuss sensitive topics such as SRH because they are concerned about being censured by their own colleagues and society for teaching these topics (Pokharel, Kulczycki, & Shakya, 2006). Researchers have also found that some health workers refuse to provide contraceptive services because they do not approve of premarital sexual activity (Challa et al., 2018; Rivera, Cabral de Mello, Johnson, & Chandra-Mouli, 2001).

20 i) Availability of SHR Services

This study noted that there were a lot of SHR services in Bindura urban. These included the Zimbabwe National Family Planning Council (ZNFPC), Hope Humana, and Bindura Municipality clinics and various Non Governmental Organisations offering reproductive health services.

A counsellor who participated in the study mentioned that: "We have so many youth-friendly centres here in Bindura urban that youth can utilise. What is worrying is the low uptake of our services. Most of these adolescents are engaging in unprotected premarital sex. In most cases they their services from the informal market." A nurse indicated that: "The service centres are many. Unfortunately we only see these adolescents coming here when they fell pregnant or have an STI. In most cases they would have sought for treatment from people in their community. So in some cases when they come here it will be too late."

The availability of health services and adequate supplies to support these services are considered essential components for fulfilling young people's rights to health care. However, in many developing countries, adolescents are unable to obtain health services for their SRH, and one of the most commonly cited reasons is that primary health care services are not available in their communities and/or they live in areas where restrictive laws and policies might prevent access (for example, laws prohibiting the supply of contraceptives to unmarried young people) (Tylee et al., 2007; **??**orld Health Organization, 2001).

21 j) Accessibility of health services

It is obvious that for young people to utilise SRH services, they need to be adolescent-friendly. At the same time, it is essential that these services are accessible to young people. A Counsellor who participated in the study highlighted that: "Our services are easily available and accessible. We also offer privacy. Clients can come in and are guaranteed of that privacy. We also have peer educators who move around communities offering reproductive health services such as distribution of condoms."

A nurse who participated in the study indicated that: "Our services are easily available and accessible. We also offer these services at very low prices in order to cater for those who cannot afford. Some of the services are offered for free while others require a minimal fee."

Accessibility of health services is explained in relation to costs associated with the services and the distance that people need to travel to reach them **??**Sawyer & Patton, 2015;Tylee et al., 2007). Available services may not be accessible to young people for a variety of reasons. First of all is cost, as discussed by Morreale, Kapphahn, Elster, Juszczak, and Klein (2004). Kennedy et al. (2013) noted in their study that cost is associated not only with the services and commodities provided by the facility but also with transport. Young people, as a group affected by high rates of unemployment and having little access to household resources, are particularly vulnerable to cost. A largescale population-based survey conducted in Kenya and Zimbabwe showed that low cost was one of the most important features for young people deciding whether to use reproductive health services (Erulkar, Onoka, & Phiri, 2005).

22 k) Trust between Health Care Providers and Adolescents

In a society where premarital sexual activity is not socially sanctioned, for adolescents to access and utilise SRH facilities they must be able to trust the health care providers. One participant from the focus group discussions indicated that: "Privacy and confidentiality are currently inadequate, substantiated not only by the adolescents' experiences and what they have stated, but also by my observations of the health facilities." Another participant argued that: "I don't feel comfortable visiting those youth friendly centres. You never know what they will do with the information. Sometimes my parents would end up hearing that I have been to the centre to collect condoms or to seek treatment for an STI."

The lack of privacy and confidentiality experienced by adolescents contribute to a lack of trust in health care providers. Trust is identified as an essential element in a successful provider-patient relationship (Birkhäuer et al., 2017;Gopichandran & Chetlapalli, 2013) which determines adolescents' willingness to seek care and utilise health services (Mohseni & Lindstrom, 2007;Russell & medicine, 2005). Having trust in their local health care providers is crucial for unmarried adolescents in a culturally conservative society wherein their sexual behaviour is not acceptable.

V.

23 Conclusion

The following conclusions can be drawn from the study:

Adolescents are people aged 10-19 years, the period of the phase of life called adolescence. How adolescence is defined will vary according to perspectives such as biological development and social and ecological factors that shape the behaviour of adolescents. There is, however, limited information available in a developing country like Zimbabwe about how the socio-cultural context shapes the sexual health of adolescents.

Adolescents in developing countries face negative consequences due to gender inequality, less educational opportunity, early marriage and early childbearing, and vulnerability to STI and HIV/AIDS as risks to their SRH and well-being. AFRHS is one of the global responses to the need to address adolescents' SRH issues. Over time, AFRHS have been bundled with additional interventions such as community engagement, school education and peer support programs to fit unique cultural contexts respective to country and geography. Literature suggests that AFRHS alone has not brought about significant SRH service utilisation by adolescents. Health system factors also significantly affect SRH service utilisation by adolescents.

The current evidence emphasises the importance of context-specific research to understand the issues around adolescents' SRH and health service utilisation. Such research would provide an evidence base for the design of health programs to increase utilisation of health services by young people (Agampodi et al., 2008;Bearinger et al., 2007;Kennedy et al., 2013). Adolescents' perceptions and experiences of seeking SRH services, and the meaning of AFHS were explored.

Adolescent-friendly health services may conceptually be the ideal way of providing effective SRH services to adolescents. However, as this study has shown, their implementation requires revisiting and rethinking what "adolescent-friendly" means within the Zimbabwean context, particularly from the viewpoint of the socio-cultural setting. While the WHO's guidebook for developing national quality standards for AFHS gives emphasis to the physical structure of facilities, their geographical location, the cost of services to adolescents, and ready availability of supplies, this study has raised the question of how "friendly" these facilities truly are for adolescents living in a society which views adolescent sexual behaviour through a moral lens. Services provided can be physically accessible and affordable to adolescents, but unless the moral framework of those providing the services changes, these services are unlikely to be fully utilized by adolescents. Thus, there is a need to address not only the structural components of these facilities, but also build the capacity of health care providers to set aside their own moral values in favour of professional practices that put the needs of the adolescents first without judgment and in a manner that develops trust in them and the services they provide. At the same time, it is essential to involve whole communities and policymakers in raising awareness of the gendered nature of the prevailing ideology underpinning the moral framework around adolescent sexual behaviour.

Section 70 (2a) of the Criminal Law (Codification and Reform Act) reads:

[Note: a) In the case of a household remedy or a medicine listed in Part I of the Twelfth Schedule, except upon production of a written order signed by the parent or guardian of the child known to such person; b) In the case of any other medicine not referred to in paragraph (a) except upon production and in terms of a prescription issued by a medical practitioner, dental practitioner or veterinary surgeon.]

Figure 1:

Figure 2:

Figure 3:

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