International Journal of Applied Research on Public Health Management
Volume 7 • Issue 1

Adolescent Sexual Reproductive Health Rights Issues in Rural Zimbabwe

Jeffrey Kurebwa, Bindura University of Science Education, Zimbabwe
https://orcid.org/0000-0002-8371-8055

ABSTRACT

This study examined the knowledge and perceptions of adolescents on adolescent sexual and reproductive health (ASRH) in rural Zimbabwe. Adolescents in Zimbabwe face limited access to health information and services. Different factors like poverty, gender inequality, socio-cultural, and economic status play a crucial role in determining adolescent access to ASRH knowledge. Qualitative research methodology was used in the study. Data was gathered through key informant interviews and focus group discussions (FGDs). The culture of communicating ASRH problems with parents was non-existent in most cases save for girls who indicated that they got information from their mothers during menstruation periods. Adolescents indicated that they had limited access to ASRH services available in their community. They further indicated that they were not utilising these services for various reasons such as social stigma, lack of information, poor quality service, and the negative attitude displayed by some nurses and counsellors at the nearest health centre.

KEYWORDS

Adolescence, Reproductive Health, Rural Areas, Sex, Sexual Health, Sexuality, Zimbabwe

INTRODUCTION

Since the 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt, adolescent-friendly reproductive health services have been recognized as an appropriate and effective strategy to address the sexual and reproductive health (SRH) needs of adolescents (UNFPA 2003). 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 (UNFPA 2003; UNICEF 2007). The importance of adolescents' reproductive health rights has long been recognized by health policy makers as manifested in an increasing number of countries including Zimbabwe (UNFPA, 2003).

According to the World Health Organization (WHO) (2002), 20 percent of the world population are adolescents while the National Population Census of Zimbabwe (2012) indicated that adolescents aged 10-19 years constitutes 24% of the country's total population (Ministry of Health and Child Care, 2016). These young people face a number of challenges related to their development. In a research carried out by the Ministry of Health and Child Care in Zimbabwe in 2016, it was found that

DOI: 10.4018/IJARPHM.2022010101

adolescent pregnancy was not a major challenge in Zimbabwe. The adolescent fertility rate for women aged 15-19 years was 115 births per 1,000 women of the same age in 2015. It was also revealed that 9 percent of adolescents aged 10-19 years had never been pregnant and 17 percent of the adolescents aged 15-19 years had experienced pregnancy. Adolescents in rural areas were more likely to be at risk of pregnancy compared to their urban counterparts. The factors associated with pregnancy among adolescents include age, marital status, self-efficacy, alcohol and drug abuse, knowledge of pregnancy, attitude of adolescents towards pregnancy and condoms, peer pressure, poverty, social media and socio-cultural practices (ZIMSTATS, 2015). Though sexual activity starts fairly at an early age, sex and sexuality issues are not an openly discussed topic in most rural communities in Zimbabwe because of strong traditional norms and beliefs (Mahat, 2001).

PURPOSE OF THE STUDY

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

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

This research was guided by the Health Belief Model (HBM). The model is mainly used in health education and health promotion (Glanz, Rimer and Lewis, 2002). The underlying concept of the HBM is that health behaviour is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence. Personal perception is influenced by the whole range of intrapersonal factors affecting health behaviour. Four perceptions serve as the main constructs of the model. These are perceived seriousness, perceived susceptibility, perceived benefits, and perceived barriers. Each of these perceptions individually or in combination can be used to explain health behaviour.

Perceived seriousness-this construct focuses on an individual's belief about the seriousness or severity of a disease. While the perception of seriousness is often based on medical information or knowledge, it may also come from beliefs a person has about the difficulties a disease would create or the effects it would have on his or her life in general (McCormick- Brown, 1999).

Perceived susceptibility/ personal risk- this is one of the more powerful perceptions which prompt people to adopt healthier behaviours. The greater the perceived risk, the higher the likelihood of engaging in behaviours that decreases the risk. It is only logical that when people believe they are at risk for a disease, they will be more likely to do something to prevent it from happening. Unfortunately the opposite also occurs. When people believe they are not at risk or have a low risk of susceptibility, unhealthy behaviours tend to result.

Perceived benefits- this is a person's opinion of the value or usefulness of a new behaviour in decreasing the risk of developing a disease. People tend to adopt healthier behaviours when they believe the new behaviour will decrease their chances of developing a certain disease (Graham, 2002).

Perceived barriers to change- this is an individual's own evaluation of the obstacles in the way of him or her adopting a new behaviour. Perceived barriers are the most significant in determining behaviour change (Janz and Becker, 1984). In order for a new behaviour to be adopted, a person needs to believe the benefits of the new behaviour outweigh the consequences of continuing the old behaviour. This enables barriers to be overcome and the new behaviour to be adopted (Centre for Disease Control and Prevention, 2004). In addition to the four beliefs or perceptions and modifying variables mentioned above, the HBM suggests that behaviour is also influenced by cues to action and self-efficacy.

Cues to action- these are events, people or issues that move people to change their behaviour. Examples include illness of a family member, media reports, mass media campaigns, advice from other people or health warning labels on a product (Ali, 2002; Graham, 2002).