Effects Of Social Norms and Cultural Practices In Adolescents Accessing SRH Information And Services To Prevent Teenage Pregnancies And Child Marriages In Murewa And Shamva Districts: A Consolidated Rapid Assessment Report

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SRHR Africa Trust

Table of Abbreviations

AIDS	Acquired Immuno Deficiency Virus
ANC	Ante Natal Care
ART	Anti-Retroviral Therapy
ASRH	Adolescent Sexual Reproductive Health
ASRHR	Adolescent Sexual Reproductive Health Rights
CCW	Community Childcare Worker
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
DDC	District Development Committee
ECD	Early Childhood Development
FGD	Focus Group Discussion
HIV	Human Immuno Virus
MOHCC	Ministry of Health and Child Care
MOHCW	Ministry of Health and Child Welfare
NAC	National Aids Council
REPSSI	Regional Psychosocial Support Initiative
RMT	Rozaria Memorial Trust
STI	Sexually Transmitted Infection
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VFU	Victim Friendly Unit
WHO	World Health Organisation
ZAPSO	Zimbabwe AIDS Prevention and Support Organisation
ZIMSTAT	Zimbabwe National Statistics Agency
ZNASP	Zimbabwe National HIV and Aids Strategic Plan

Chapter 1: Background to the Study

Introduction

Adolescents represent a growing and increasingly key segment of the Zimbabwean population. In fact, the adolescent and youth population below the age of 25 years is the largest group in the country, representing 62% of the total population. Despite constituting the highest percentage, adolescents, especially girls face significant challenges related to access of Adolescents' Sexual and Reproductive Health services leading to teenage pregnancies, child marriages and Sexually Transmitted Infections (STIs). There is a gap between policy and lived realities in communities of Murewa and Shamva Districts with adolescent girls at higher risk of experiencing the burden of ASRHR problems that include teenage pregnancies, child marriages and HIV. Murewa and Shamva Districts have rates of 25% and 31% of adolescents falling pregnant respecively. In addition, the child marriage rates in the districts are 36% (Murewa) and 50% (Shamva) which is a cause of great concern. (ZIMSTAT 2015)

Background

Contemporary philosophy and practice gaining currency the world over is the investment in ASRHR programmes deliberately targeted at adolescents as well as enacting laws and policies guiding its implementation. Such a socio-ecological environment will enable the adolescents to unlock their human capabilities and potentialities. Prevailing circumstancies in Zimbabwe especially in Shamva as alluded above, prove contrary. Indications are that there are several factors at play ranging from inadequate implementation of laws and policies on ASRHR, social and cultural practices as the major root causes inhibiting adolescents from enjoying the Sexual and Reproductive Health and rights. There are structural barriers in various institutions including hospitals, clinics, schools, families and traditional institutions entrenched in negative social forms, cultural and religious practices towards ASRHR especially for girls. In addition, there has been less innovation in harnessing positive power of culture to positively shift norms, to enhance access of ASRHR services towards prevention of teenage pregnancies and child marriages. Girls' and adolescents' sexual reproductive health is related to multiple human rights including the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education and the prohibition of discrimination. (www.girlsnotbrides.org)

Statement of the Problem

The Zimbabwean constitution and government proclaim education as a right for every child and to which no child shall be denied access. By the same token, access to health is a guarranteed right and entitlement. In this regard, a vast infrastructural network has been put in place to ensure that education and health services are accessed by all. To this end, the country is on record of having achieved the highest literacy rate in Africa. (UNESCO 2014 and ZIMSTAT 2018) Contrary to this amazing feat of success, it is appalling that Murewa and Shamva Districts have such high worrisome prevalence of child marriage and adolescents pregnancy rates. Inadequate implentation of laws and policies on ASRHR, social-cultural practices have been cited as responsible for this.

This study by way of a **Rapid Assessments** set out to establish the **Effects of Social Norms and Cultural Practices in Adolescents Accessing SRH Information and Services to Prevent Teenage Pregnancies and Child Marriages in Murewa and Shamva Districts,** which is articulated in the following objectives:

Obectives of the Rapid Assessment

- To identify major cultural factors influencing the Sexual and Reproductive Health of Adolescents in order to inform development of by-laws in promoting ASRHR including ending child marriages in Murewa and Shamva District.
- To assess the current ASRHR policies and guidelines available vis a vis the effects of social norms, culture and religion in their implementation to promote adolescents access to SRH information and services.
- To facilitate and strengthen the emerging positive social and cultural practices that promote ASRH rights to prevent teenage pregnancies and child marriages.

Expected Outcomes

- Rapid assessment report to inform and provide guidance to the development of by-laws on ending child marriages and promoting Adolescents Sexual and Reproductive Health Rights.
- Consensus on recommendations for action for improved access to ASRH information and services in institutions and community at large.
- Identified positive social and cultural norms and practices that can be promoted and up-scaled in programming to promote ASRHR to prevent teenage pregnancies and child marriages.

Limitations of the Study

The study had limitations in that there were some financial constraints faced during the process of conducting the assessment. In this regard, the size of the population sample involved in the rapid assessment was limited as it was financially impossible to involve the whole population under study. Relatedly, facts or data that could be quantified and summarised were those gathered from the sample, therefore reliability and validity could have been compromised. However, to mitigate such posibilities some follow ups to Focus Group discussions, by way of in-depth interviews were made. Furthermore, the whole rapid assessment was conducted without exploring issues on disability undermining the critical issue of inclusivity, an issue which could be another window for future studies.

Research Design and Methodology

i. Trochin (2008) posits that in applied social research there is value in consciously combining both qualitative and quantitative methods to come up with the mixed methods approach which greatly influenced the approach to this rapid assessment. Thus, this study followed the quali-quanti research design that sought to utilize both aspects of the positivist and phenomenological approaches to research for the reason that both qualitative and quantitative data are simultaneously collected, analyzed and interpreted. In this article the main research instruments (focus group disussions, interviews and observation of the proceedings at the chief's court and case studies) usually used in the mixed method designs are presented and elaborated on. It is believed that using different types of procedures for collecting data and obtaining that information through different sources can augment the validity and reliability of the data and their interpretation. In this regard the positivism paradigm component was used as the study, in many instances, sought to come up with universal and context free generalisations for what is happening in Shamva as well as in Murewa from given samples. Another rationale was the researcher's belief that human behavior and social phenomenon can be objectively measured through statistics (McNeill and Chapman 2006, Cresswell 2009). Patton (2002) also avers that use of qualitative approach in research allows direct quotations and excerpts from interviews and focus group discussions which can be used to present the participants' perceptions. Denzin & Lincoln (2005) posit that qualitative research is basically the interpretive study of a specified phenomenon or problem hence the researchers herein were central to the analysis of data from Shamva and Murewa Districts.

Both studys (Murewa and Shamva) made use of Focus Group Discussions but the difference was that Shamva used 7 groups comprising the following:

a)15 Traditional Leaders (comprised of Chief Nyamaropa and Village Heads)
b) 15 Religious Leaders from different church denominations,
c) 15 Adolescent Boys and Girls,
d)15 Parents and Guardians,
e) 15 Women,
f) 15 Stakeholders drawn from various Service Providers in the Community,
g) 15 College Lecturers from different provinces of Zimbabwe (used as control group only)

In Murewa, Focus Group Discussions were also used with slight variations involving 5 Focus group discussions were done in 5 different wards firstly focusing on the rural wards 1,4,8,17 and 18. The focus group discussions also focused on resettlement wards such as ward 24 in Macheke and, lastly, ward 30 and 16 which are urban wards in Murewa. The focus group discussions included traditional leaders, church leaders, parents and guardians and the adolescent boys and girls. Each FGD had 15 participants however the adolescents had to have their own FGD for more

in-depth discussions as it was realized that the older women and men would dominate the discussion. The use of such an approach helped in attaining a multi view from participants. Also this approach enabled the research team to obtain detailed information about personal and group feelings, perceptions and opinions. It also saved time and money compared to individual interviews whilst getting a broader range of information. However, the research team noted that some individuals dominated the discussion overshadowing others and emotions must be noted in the discussion.

	WARD	**Church leaders**	**Traditional Leaders**	**Adolescents**	**Parents and guardians**
FGD 1	24	2	2	5	7
FGD 2	30,16	2	2	5	6
FGD 3	19,20,21	2	3	6	4
FGD 4	8,17,18	3	2	5	5
FGD 5	1 and 4	2	3	5	5

Interviews with Key Informants from various stakeholders like Government Departments as well as NGOs were used both in Murewa and Shamva. For Shamva the Key Informants comprised the following

a) DDC,

b) Ministry of Primary and Secondary Education,

c) Ministry of Health and Child Care

d) Ministry of Youth,

e) ZAPSO and NAC.

f) A single parent widow who went into child marriage,

g) A traditional aunt, and

h) A Chawa religious aunt.

For Murewa the following stakeholders were used: 12 Key informant interviews were done with the Ministry of Health and Child Care (Department of family health services, Community department), Ministry of primary and Secondary Education, Social Services, Community Care workers, Judicial Services Commission, Ministry of Women Affairs, Gender, Community and Small to Medium Enterprise Development, National Aids Council, Young Peoples Network, Women and Law in Southern Africa, Murewa Rural District council. The key informant

interviews gave the research team an opportunity to have in depth discussions with key policy makers at district level who advocate for ASRH in their work on a day to day basis.

In addition, Field trip to the Chief's traditional Court and observations made during court proceedings and Document analysis of secondary data like ZIMSTAT data was used in Shamva

The Sample and Sampling Procedures

A sample is a set of data drawn from a population or a subset of a population which is the group of subjects on which information is obtained- a portion of elements of a population (McNeill and Chapman 2006). This study regards a sample as a representative selected number for study whose characteristics exemplify the larger group from which it was selected (Patton 2002). Cluster sampling was done in selecting participants in FGDs from different wards in Murewa District as well as in Nyamaropa-Shamva in selecting participants from different villages and wards to come up with a representation of what is happening throughout the districts under study. In addition, purposive sampling was done in selecting segments of the population like adolescent boys and girls, parents and guardians, aunts, traditional and church leaders because of its focus on particular characteristics of a population that were of interest to the researcher to enable him answer the research questions (Patton 2002). Aspects of purposive sampling such as expert sampling was used in this study where the researcher needed to glean knowledge from people who had particular expertise from, professionals who serve in various fields offering services to the communities involved like teachers, nurses, police, youth officers and administrators who were interviewed (expert elicitation) (Trochin 2008)

Definition of key terms

Social Norms

These are informal rules that govern behaviour in groups and societies and these motivate people to act. Some legal scholars have touted social norms as efficient alternatives to legal rules, as they may internalize negative externalities and provide signaling mechanisms at little or no cost (Posner 2000)

Cultural Practices

Frese (2015) alludes that cultural practices are shared perceptions of how people routinely behave in a culture (similar terms used are intersubjective perceptions or descriptive norms) and values are shared ideals of a culture (similar terms are injunctive norms).

Adolescent

The World Health Organization (WHO 2019) says an adolescent as any person between the ages 10 and 19. This age range falls within the WHO's definition of young people, which refers to individuals between ages 10 and 24.

ASRH Services

WHO (2019) regards **Adolescent sexual** and **reproductive health** as the physical and emotional wellbeing of **adolescents** and includes their ability to remain free from unwanted pregnancy, unsafe abortion, STIs (including HIV/AIDS), and all forms of sexual violence and coercion.

Summary

This Chapter has laid down the the introduction and background information to the study by giving an overview of the research problem. It highlighted some insights into the rationale behind the philosophy and practice of focusing on ASRHR. It further sheds light on the situation obtaining in Zimbabwe in general.The subsequent challenges particular to Murewa and Shamva with regards to ASRHR programmes were noted from which the statement of the problem and research objectives were crafted. As the paper draws down to its taper, it also sums how the study will be organised.The next Chapter (2) will feature the **Desk Review of Secondary Data** which involves the review of previous researches by different line Ministries and other development partners. This will also include the review of existing guidelines on ASRHR by Ministry of Health and Child Care and by Ministry of Primary and Secondary Education. Finally, Chapter 3 will focus on **Data compilation, analysis and presentation as well as research findings, conclusions** and **recommendations.**

Chapter 2: Literature Review

Introduction

The entire international community is gradually awakening to the realisation that an effective health education delivery system with robust adolescent sexual and reproductive health services is critical in empowering adolescents overcome challenges they face. Therefore, it is mandatory that, deliberate and collaborative efforts on an international, regional and national level be made to ensure that adolescents have a right to access age appropriate sexual and reproductive health information, education and services that enable them to deal with their sexuality. Nelson Mandela's seminal quote says it all: "There can be no keener revelation of a society's soul than the way in which it treats its children." This implies that a nation's index of commitment to the wellbeing of its adolescents lies in its constitution, laws and policies which must be aligned to protect and guarantee children's rights, freedom, liberties and entitlements. Above all, the laws and policies should inform and direct the arms of society as they interact and conduct day to day transactions without which a nation would be riddled and ruined with social ills like teenage pregnancies, gender based violence, unsafe abortions, sexually transmitted diseases and child marriages. On this note, this paper focuses on the Effects of Social Norms and Cultural Practices in Adolescents Accessing SRH Information and Services to Prevent Teenage Pregnancies and Child Marriage in Murewa and Chief Nyamaropa's area in Shamva District.

Socio-economic status of Shamva and Murewa Districts

A close knit to the above, child marriage and teenage pregnancies are determined by socio-economic factors hence the need have a grounding on Shamva and Murewa districts with regards to their socio-economic statuses. **S**hamva District is one of the eight districts constituting Mashonalaland Central Province with a total population of 123 650 (ZIMSTAT 2012) and located 28 km east of the regional capital, Bindura. Major economic activities predominant in the district are small scale gold mining after the closure of the Madziwa Nickel Mine and Shamva Gold Mine which were the golden goose of the district and the anchor of many livelihoods (giving rise to the, 'makorokoza' (illegal miners) phenomenon). Also, the district was once a hub of commercial farming activities employing many locals but with the advent of the resettlement and land redistribution programmes many workers were left unemployed. At the same time beneficiaries of resettlement and land redistribution have embarked on tobacco production which provides sustenance (www.ZIMSTAT.co.zw). As a result of large scale mining and commercial farming activities once dominant in the district, a large pool of migrant labourers from neighbouring Mozambique, Zambia and Malawi came into the area and have now settled permanently in the district endowing Shamva with cultural diversity. In view of the current volatile economic situation in the country coupled with erratic rainfall pattern the majority of people in Shamva particularly

Nyamaropa area are trapped in the vicious poverty cycle- a situation that jolts life of adolescents resulting in early marriages and teenage pregnancies. A glance at the population statistics would be vital in understanding Shamva in its totality. Below is a table with a summary of Shamva's population structure

Shamva's population structure: (C 2012: ZIMSTAT 2015)

Age range

0--9 yrs.	**10-19yrs**	**20-29yrs**	**30-39yrs**	**40-49yrs**	**50-59yrs**	**60-69yrs**	**70+yrs**	**TOTAL**
36 939	28 938	22 612	15 402	7 747	5 213	3 648	3 089	
Females								**62 290**
Males								**61 360**
Total								**123 650**
Rural								**122 742**
Urban								**908**

Similarly, Murewa District, is located in Mashonaland East Province, and forms part of the Communal Lands Areas of Zimbabwe. In 2012, total population of the District was estimated at 199 607 persons, and the number of active farming households was estimated at 39 000. Figures for the number of male and female headed households were not available, but it has been estimated that 60–70% of the rural population in Zimbabwe are women. In Murewa District, the majority are Shona speaking. It is 98 kilometres northeast from the national capital, Harare, along the Nyamapanda highway, in the main route to Tete in Mozambique. In 2012, the number of inhabitants was 199 607 (males 94 269 and 105 338 females) with 30 wards and 5 traditional wards in total. Its economy is based on agriculture, with quite an active community involved in cross border trade. It has a high population of women and young people. Its HIV prevalence is 12.3%and rate of child marriage is 36%.

Below is a summary of Murewa's population structure:

Murewa District population structure (C 2012: ZIMSTAT 2015)

Age range

0-9 yrs	**10-19 yrs**	**20-29 yrs**	**30-39yrs**	**40-49yrs**	**50-59yrs**	**60-69yrs**	**70yrs+**	**TOTAL**
56 397	49 688	30 028	22 265	13 459	11 374	8 OO5	7 969	
Females								**105 338**
Males								**94 269**
Total								**199 607**
Rural								**182 941**
Urban								**16 666**

Agriculture is the main economic activity in the district. Maize, the staple crop, occupies the bulk of the cultivated land of all households and is the main source of on-farm income. Other crops cultivated include groundnuts, sunflower and a variety of vegetables. As well as being an important source of food, these crops are also an important supplement to on-farm incomes.
Most households attempt to grow these vegetables throughout the year, often using water from irrigation ponds during the dry season. At this juncture, it is prudent to provide a snapshot of the Health Service and Educational facilities and infrastructure available in Murewa district as well as Chief Nyamaropa Area- the focal point of this Rapid Assessment in Shamva.

Health Service and Educational Facilities in Murewa and Shamva (Nyamaropa)
Chief Nyamaropa Area, where Ward 16 is located, has 5 primary schools which are Batsiranai, Mukwari, Madziwa Mine, Mudzinge and Muringamombe. These 5 primary schools feed one Madziwa Mine Secondary (Forms 1 to 4). Those adolescents who proceed to A level seek services elsewhere outside the ward, the nearest facilities being Chindunduma 2 High or Jiti High Schools. In health services, the Ward has two Health Service Centres which are Madziwa Mine Clinic and Takawira Clinic which are all Council facilities. These two clinics use Shamva District Hospital as their Referral Centre.

According to Craig, (2014), the health services in Murewa district are organized along two tiers; a network of rural health centres and a referral Murewa Hospital. There are two rural mission hospitals (Musami and Nhowe hospital) in the district. There are now more than 20 functional rural health centres in Murewa. Murewa is attractive with its business centres, markets and the easily accessible offices of social Welfare Services where certificates for free health care are obtained (Craig 2014). Whilst there are about 26 clinics in Murewa District, it is vital to note that there are also 3 hospitals; Musami hospital, Nhowe hospital and Murewa District General Hospital. Musami hospital is located about 21km away from Murewa, Nhowe hospital is located 39km away along Macheke road whereas Murewa general hospital is located 800m away from the growth point (Table 6). Murewa hospital was established during the colonial era. It has a mortuary, theatre, maternity and out-patient departments, wards, laboratory, intensive care unit and houses for nurses, doctor and pharmacist. In November 2017, the X-ray machine was introduced and people living near the center no longer have to travel to Musami hospital for x-rays.

Concept and Principles of Adolescents Sexual Reproductive Health (ASRH)

Related to the above, it is prudent that there be a common understanding of the key term (ASRH). In this regard, MOHCC (2016) defines (ASRH) as implying Adolescent Sexual and Reproductive Health described as services that should be safe, effective, and affordable to meet the individual needs of young people (males and females) who return when they need to and recommend these services to friends. By the same token, WHO (2016) observes that Adolescents have a right to health services that can meet their particular needs including the right to information on sexual and reproductive health, family planning, contraception, risks associated with early pregnancy and the prevention and treatment of sexually transmitted infections. WHO (2016) further posits the term adolescence as the period between the ages of 10-19 years and young people as those between the ages of 10-24 years.

Hinged to the above, MOHCC (2016) alludes that adolescents and youth often lack knowledge, and comprehensive information about their emerging sexuality and development and tend to remain poorly informed about such critical matters. Information that they need to deal with problems associated with this period of rapid change, brought on by their changing bodies and needs constitutes Comprehensive Sexuality Education. On this note, UNESCO (2016) points out that adolescents' sexual reproductive health services, should be user friendly, age appropriate, relevant as well as confidential.

SRH Challenges faced by adolescents in Zimbabwe

The Ministry of Health and Child Care (2016) confirms that adolescents face many sexual and reproductive health problems like high rates of unplanned pregnancies, early child bearing and the transmission of sexually transmitted infections including HIV. In this regard, this vulnerable group

falls victim to other related challenges like child marriage, gender based violence as well as maternal mortality. UNICEF (2005) defines child marriage as a union between two people in which one or both parties are younger than 18 years of age, and further reveals appalling world Child marriage rates of 4% by the age of 15 and 32% by the age of 18. UNESCO (2016) avers that in Sub-Saharan Africa, 40% of women are married as children. Also, it has emerged that some girls as young as 8-9 are forced to marry adult men by their families. In this regard, child marriage and teen pregnancies is a transcending challenge which subsequently forks into a myriad problems requiring multi-sectoral and multi-disciplinary approaches which warrant international collaborative effort and commitment. MOHCW (2018) statistics reflect that 40% girls and 30% boys have had sex before the age of 18 years and that 24% of maternal deaths in the country occur among young women. Statistical data further reveal that knowledge of Family Planning is 41% in young people and that there is high prevalence (9%) of STI among adolescents and a significant number of new HIV infections among those aged 15-19 years. (ZIMSTAT 2015), further gives statistics of child marriages are as follows: Mashonaland Central 50%, Mashonaland West 42%, Masvingo 39%, Mashonaland East 36%, Midlands 31%, Manicaland 30%, Matabeleland North 27%, Harare 19%, Matabeleland South 18%, and Bulawayo 10%. These statistics clearly show that the problem of child marriage is entrenched and rife in Mashonaland Central especially Shamva as well as in Murewa hence the need to study the phenomena to uncover the underlying factors.

Key Drivers of Child Marriage and Teenage Pregnancies in Shamva and Murewa

It is ironic that Zimbabwe with its high literacy rate still suffers from an outdated practice where the girl child was viewed with disdain and reduced to be a sexual toy. Previous research carried out in Shamva by REPSSI Child Protection and Safeguarding Policy of November (2014) confirmed that Child marriage is increasing in Shamva District as evidenced by the rise of cases of very young mothers that come to the hospital for ANC or for various medical conditions. The study highlighted that district social welfare services were reported to be receiving 8 cases of child marriage every month at their offices alone. The same study also established that school drop- out rate in the district was high among both boys and girls a situation which leaves them with little to do and as a result, they get into marriages. From the study, it emerged that Child Marriage is driven up by peer pressure, and failure by some parents to play their parental roles effectively in giving advice to their children. In addition, tobacco production and artisanal gold mining the economic mainstay of communities around Chief Nyamaropa area has created a situation where money earned or generated from these activities is used as bait to lure adolescent girls especially from poor families into casual sexual activity and child marriage. Child marriage is also considered as a result from early sexual debut in adolescents and teenagers (Muzhingi 2016). In addition, The Human Rights Watch (2016) notes Shamva and Murewa Districts have the highest child marriage prevalence rates of 51% and 31% respectively. Girls as young as 8, 11 or 16 are given away in marriage and sometimes forced into marriages, resulting in them dropping out of school. Studies reveal that even though boys can be victims of child marriage, the consequences are less severe. Poverty, religious and cultural beliefs and lack of uniformity in marriage laws have been identified

as the main drivers of child marriages. Experts in the field have stressed the need for policy reform and alignment of marriage laws to the Constitution in order to mitigate the issue of child marriages. A study by Zizhou (2017) revealed that traditional conflict resolution mechanisms based on the customary law that still exist in rural communities and the traditional institutions that implement them can contribute significantly to the maintenance of social order in Murewa. Social scientists believe that social justice and human dignity is at the heart of ending child marriage, teenage pregnancies, gender based violence, gender inequality and extreme poverty and can bring health to communities and deal with all these global challenges that these communities face. In this regard, failure to eradicate child marriage through sustained community involvement is denying liberty and empowerment to women as they are relegated to nonentity as they are like round pegs in square holes.

Consequences of Child Marriages and Teenage Pregnancies

UNICEF (2005) posits that adolescent pregnancy is associated with health risks for the mother that subsumes maternal death. UNESCO and UNFPA (2016) assert that adolescent pregnancy has a direct impact on the Maternal and child mortality, and triggers the vicious cycle of ill health and poverty. Medical practitioners concur, that child marriage and teenage pregnancies often result in complications during pregnancy and delivery, including operative virginal deliveries, caesarean sections and maternal mortality. The national adolescents' fertility study (2016) observes that unsafe abortions are also experienced as the teenage girls try to end pregnancy, and the resultant adverse outcomes witnessed are largely because the adolescents are not physiologically mature enough to produce babies. Available literature indicates that offspring of adolescent mothers are at a higher risk of morbidity and mortality, low birth weight, still births and pre- term births. In addition, there are heightened chances of experiencing gender based violence. Not much research work premised on adolescent pregnancy has been to determine the extent of adolescent pregnancy and its associated cause and consequences of adolescent pregnancy among the 10 – 19 year adolescents.

This paper holds that adolescents' sexual encounters are unplanned and the resultant 'marriages' collapse early and easily. Inferences based on statistics about Mashonaland Central and Mashonaland East, inherently spell doom for Murewa and Shamva districts. www.GIRLSNOTBRIDES.org points out that adolescents are most likely to get pressure from the family and their peers and that the family may either promote early pregnancy or oppose girls' accessing sexuality education and other information about pregnancy prevention. It is this lack of access to sex education which exposes adolescent females to pregnancies. In Zimbabwean culture, it has been the role of aunts to educate girls on sexuality, a tradition besieged and laid to waste by modernity. To this effect, parents are expected to educate their children on such matters, which most mothers do not feel comfortable enough to talk about sex with their daughters. In the absence of sex education and parental guidance, young women fall prey to adolescent pregnancy (UNESCO 2016). It is imperative that interventions be put in place to improve knowledge, through

revisiting and interrogating national legal and policy frameworks, societal values, norms attitudes and cultural and religious practices for long lasting sustainable solutions to this crisis.
In addition, given the high child marriage rate and teenage pregnancies (50%) for Mashonaland central where Shamva is located as well as 36% (Mashonaland East) at the backdrop of the high estimated national HIV prevalence rate shown below there is no doubt that adolescents are under a serious threat. Young adults are under a two pronged problem of child marriage and teenage pregnancies as well as the scourge of HIV and AIDS putting their lives at risk. This demands urgent early intervention measures hence the rationale of the rapid assessment by RMT in a bid to inform policy and strengthen implementation on ARSH provisions.

Figure 5: Estimated HIV Prevalence in Adults by Province 2017

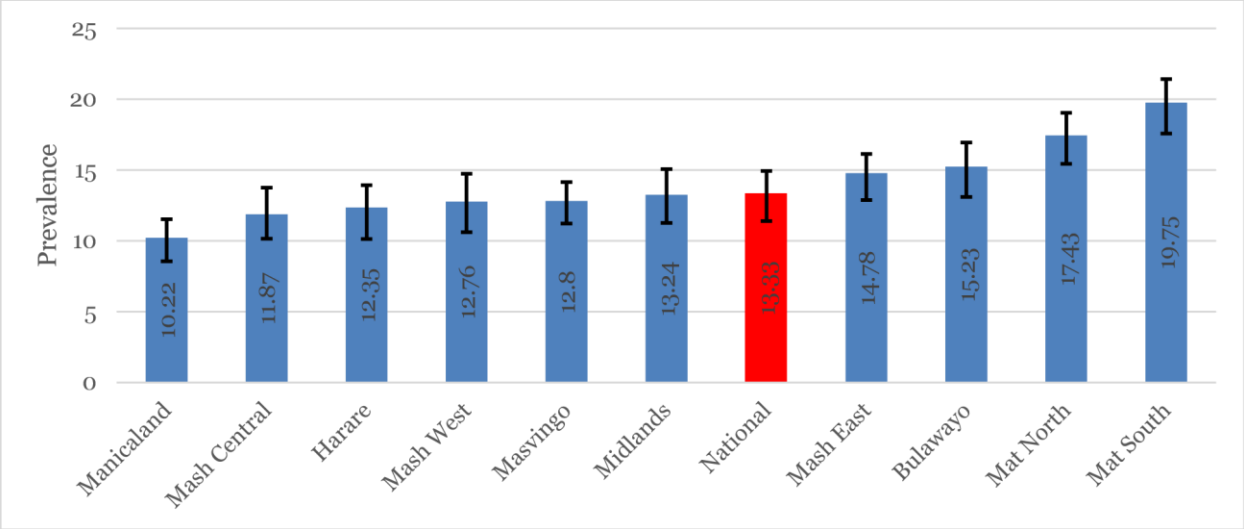


Figure 7: Estimated Prevalence by District

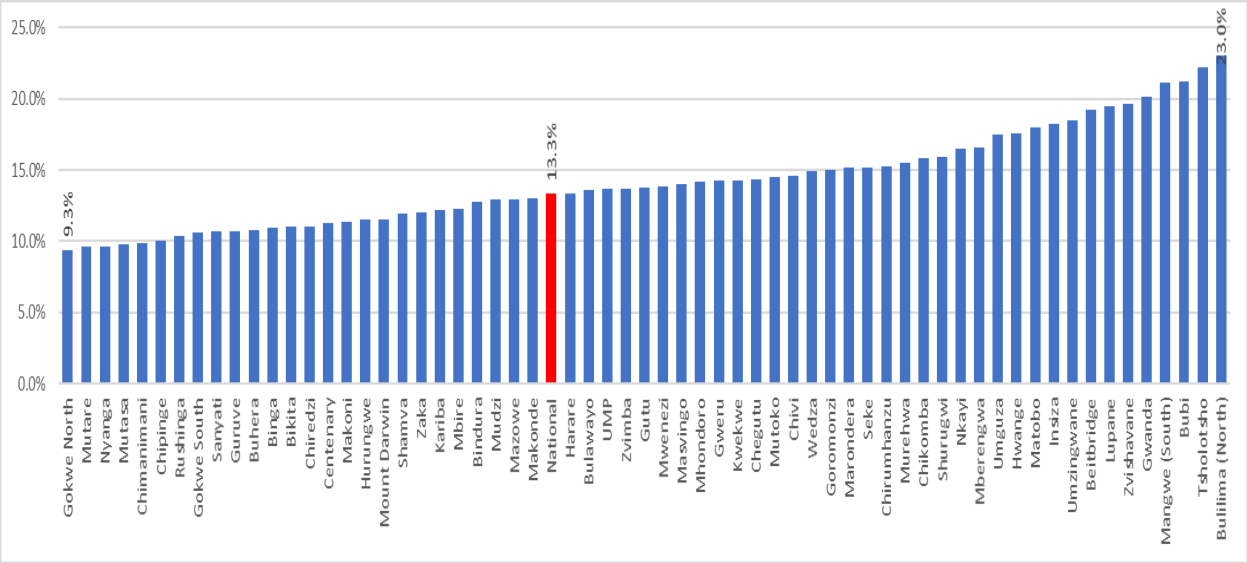
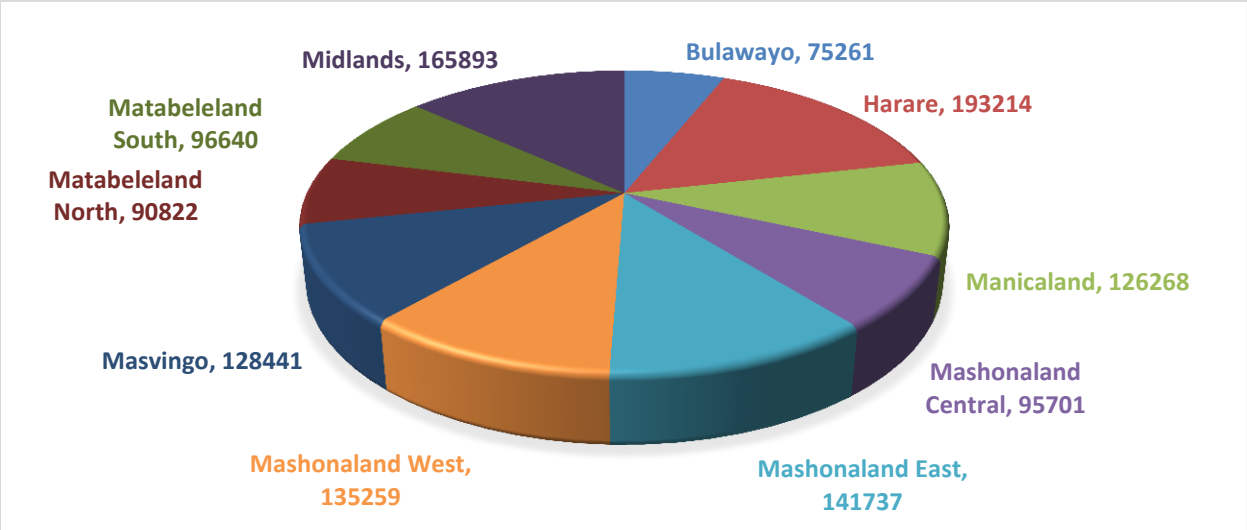
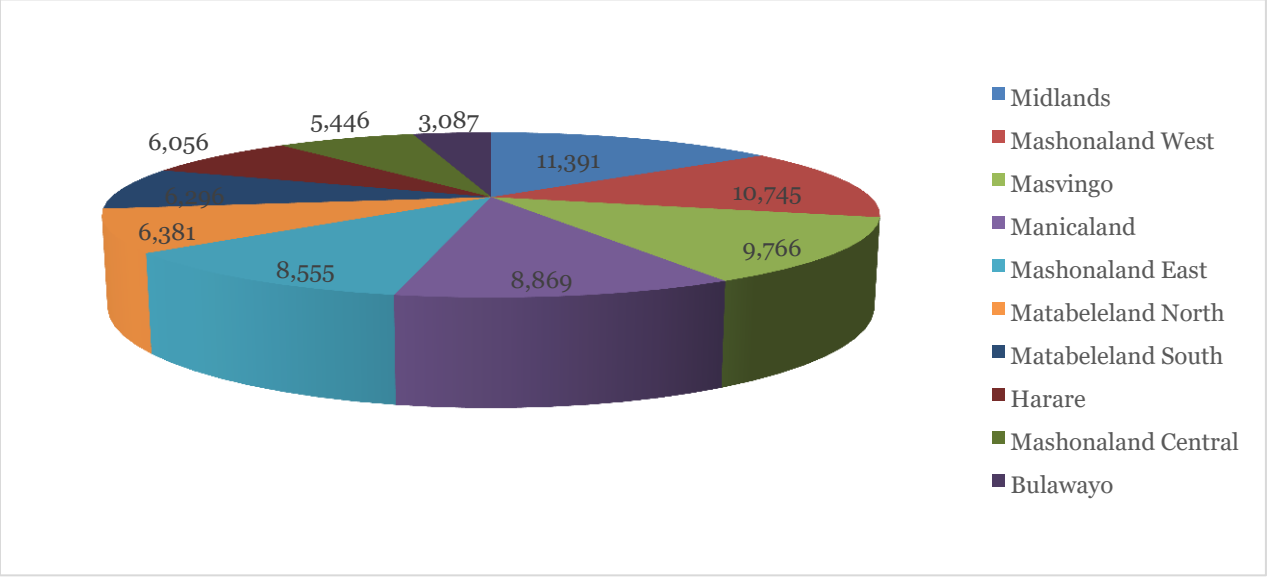


Figure 9: Estimated Number of Adults (15+ years) living with HIV & AIDS by Province



The number of adults living with HIV ranges from 75,261 in Bulawayo to 193,214 in Harare.

Figure 10: Estimated number of children living with HIV/AIDS by Province



Policy and Legal Frameworks on ASRH in Zimbabwe

The International Conference on Population and Development (1994), to which Zimbabwe is signatory observed and endorsed the right of adolescent and young people to obtain the highest level of care. Zimbabwe further demonstrated its political will and commitment to eliminate child, early and forced marriage by 2030 in line with target 5.3 of the Sustainable Development Goals. As noted in its Voluntary National Review at the 2017 High Level Political Forum, the government reaffirmed commitment to this target, highlighting that the Constitutional Court outlawed the marriage of people under 18 in 2016. Zimbabwe further co-sponsored the 2017 Human Rights Council resolution recognizing the need to address child, early and forced marriage in humanitarian contexts. In 2014, the country signed a joint statement at the Human Rights Council calling for a resolution on child marriage. Also, it ratified the Convention on the Rights of the Child in 1990, which sets a minimum age of marriage of 18, and acceded to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1991, which exhorts states to ensure free and full consent to marriage. In 2015, Zimbabwe rallied behind the African Union Campaign to End Child Marriage in Africa_from which a National Action Plan and Communication Strategy is now being developed. In addition, Zimbabwe ratified the African Charter on the Rights and Welfare of the Child, including Article 21 regarding the prohibition of child marriage in 1995. In 2008 Zimbabwe ratified the African Charter on Human and People's Rights on the Rights of Women in Africa, including Article 6 which sets the minimum age for marriage as 18. It is pleasing to note that Zimbabwe is one of the 20 countries which has committed to ending child marriage by the end of 2020 under the Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern Africa. During its 2016 Universal Periodic Review, Zimbabwe supported recommendations to address the exclusion of women in the economic, social and political sphere, with specific attention to child marriage. In 2016 the UN Child Rights Committee urged Zimbabwe to establish an effective monitoring system to assess progress towards ending child marriage. It also recommended the government provide survivors with compensation and rehabilitation and conduct an investigation into the alleged involvement of members of religious sects in facilitating child marriage.

Efforts to address Child marriages and teen pregnancies

Zimbabwe has taken some steps towards addressing child marriages through its National Gender Policy which was revised in 2017 to incorporate components that address child marriage. To this effect, a draft National Action Plan to End Child Marriage is being developed. In 2016 Zimbabwe's Constitutional Court outlawed child marriage, so that no one may enter into any marriage before the age of 18. The ruling includes marriages under the Customary Marriages Act which had previously not had a minimum age requirement. In pursuance of the above, Zimbabwe crafted a

number of laws in tandem with the noble goal of protecting sexual and reproductive rights for young people among which include:

- Termination of Pregnancy Act, 1977
- Sexual Offences Act,2003
- Domestic Violence Act, 2006
- Legal Age of Majority Act, 1982
- The Children's Act, 2001.

In order to facilitate effective operationalization of these conventions and laws, a number of policies, Guidelines and strategies that address ASRH were put into place some of which are:

- National Reproductive Health Policy and National Reproductive Health Services Guidelines.
- Zimbabwe National HIV and Aids Strategic Plan (ZNASP):2015-2020
- Zimbabwe Maternal and Neo natal Health Road Map:2007-2015
- National HIV and Aids Behaviour Change Strategy:2011-2015
- National Health Strategy:2008-2013
- Educational Policy with respect teenage pregnancy, HIV, AIDS, and life skills programmes
- National Guidelines on HIV Testing and Counselling for minors
- National Youth Policy

Dr Gumbo (2011) remarked that Laws, policies and facilities are only as good as women access and use them which implies that concerted effort must be made to reduce barriers in accessing services by adolescents. Despite the presence of such wonderful blue-prints, Zimbabwe continues to be bedevilled with problems of child marriages and teenage pregnancies. This suggests that the laws are not being implemented or that there are some underlying causes of child marriage and teenage pregnancies which are embedded in the socio-economic and cultural as well as religious practices which need to be investigated and interrogated.

Lack of Legal Protection

This paper believes that, a vibrant Comprehensive Sexuality Education and Sexual Reproductive Health Education specifically designed for adolescents would bail nations from the above vice. However, given the long-standing stigma toward young people's sexual activity and childbearing outside of marriage in Zimbabwe, it is important to consider the context in which adolescents first become sexually active. It is a fact that Zimbabwe has a declining, but still very high, HIV prevalence (15% of 15–49-year-olds were HIV positive in 2011, sexual activity without consistent condom use can expose adolescents to the risk of HIV infection. The reproductive health needs of adolescents as a group have been largely ignored by existing reproductive health services, information and services should be made available for them to understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of

infertility. This paper observes that Zimbabwe's judiciary arm strongly condemns childbirth outside of marriage and many unmarried adolescents' pregnancies are likely to be unintended. Such unwanted pregnancies can lead to child marriage and therefore likely unsafe abortions, since Zimbabwe's penal code legally restricts all abortions, except those needed to save the woman's life or physical health. But because of legal restrictions and the resulting clandestine nature of abortion, information about how often adolescents with unintended pregnancies resort to abortion is lacking. However, among births to all women (of any marital status) who were adolescents when they delivered, 33% are unplanned (ICPD Programme of Action paragraph 7:41).

A critical analysis of some current laws in Zimbabwe reveals some disparities and inconsistencies emanating from the definition of critical terms such as: a child, the age of consent to sex and age of consent to marriage (The Human Rights Watch 2015). It is from the variations in the interpretation of the laws that continue to pose problems which calls for urgent attention to harmonize laws with the new constitution. Gaps in Zimbabwe's child protection system result in lack of protection for survivors of child marriage and significant obstacles to girls seeking redress. For example, girls who have limited information about their rights, often do not have the money to travel to where they can seek protection from the authorities, and when they do, the authorities often dismiss their concerns as "a family matter." Zimbabwe has conflicting legal provisions on the minimum age for marriage. Zimbabwe's constitution does not expressly prohibit child marriage, and a number of laws effectively condone it. In this regard, Section 78 of the constitution says that anyone who has attained the age of 18 has the right to found a family and that no one should be compelled to marry against their will. The government has said, however, that Section 78 does not set 18 as the minimum age for marriage, but simply confers a right on those above 18 to found a family. However, The Zimbabwe Constitutional Court, in the case of Mudzuri and Anor v Ministry of Justice, Legal and Parliamentary Affairs and Ors,(2016) affirmed that child marriage is ultra vires the constitution and therefore cannot stand in Zimbabwean law

Dove-tailed, to the above, Programming for young people is guided by International and Regional frameworks and commitments. Lessons have been drawn from Eastern & Southern African (ESA) - Ministerial Commitment on Comprehensive Sexuality Education (CSE) and Sexual Reproductive Health (SRH) services for adolescents and young people, Laws and policies for protection of Sexual and Reproductive Health & Rights (SRHR) of young people at local level. Analysts concur that the National ASRH Strategy (2016-2020) has clearly crafted goals intended to reduce morbidity and mortality associated with sexual and reproductive health among adolescents and young people .The special key Strategy Impact is espoused with "improved sexual and reproductive health of adolescents and young people in Zimbabwe" with three pronged major outcomes premised on safe sexual, reproductive health and HIV practices among adolescents and young people; increased uptake of quality youth friendly integrated SRH and HIV services; and strengthened protective environment for adolescents and young people.

Against the backdrop of such well thought after strategy, the country continues to be dogged with child marriages and teenage pregnancies which are indicative of serious ARSH challenges. Zimbabwe's conflicting legal provisions on the minimum age for marriage are considered chief culprits (Muzhingi 2016). He further alludes that, the national constitution does not expressly

prohibit child marriage, and a number of laws effectively condone it. This implies that the gaps in the law, extreme poverty, poor access to education, and harmful religious beliefs and social norms are chief culprits in fuelling child marriage in Zimbabwe, Human Rights Watch found. (Human Rights Watch 2015)

Context and rationale for the Rapid Assessment

In view of the shocking statistics obtaining in Mashonaland East and Mashonaland Central where the highest rates of child marriages were registered, it infers that the girl child is under siege which warrants intervention strategies. In this regard, Shamva District - one of the districts hardest hit, a study of 70 Households and 177 young people aged 15-24-year-old who were in current and previous child marriages was conducted. The majority, (87%) of the young married people survey participants were female suggesting that more girls than boys are in child marriages. Head of households interviewed said they would prefer to offer the girl-child to early marriage at a younger age than a boy-child. Thirty-one percent (31%) were subsistence farmers, 20% artisanal workers and 26% unemployed. The unemployment rate among 15-19 and married young people is 54% with 31% occupied as subsistence farmers. The majority, (75%) survive on an income of less than US$100.00 per month indicating a low socio-economic environment. A high prevalence of child marriage has been associated with the Apostolic Sect in Zimbabwe and 44% of the study population are affiliated to the religion. In this regard, Dr Murwira (2018) posits that the major drivers of ASRH problems are socio-cultural and socio-economic issues are the root causes of the challenges affecting young people in Zimbabwe. Despite the existence of policies and guidelines in place, the problem of child marriages persists unabated. It is on this basis that, that this study subjects the phenomenon to scrutiny focusing on social norms and cultural practises. It is the assumption herein, that previous researches mainly focused on different aspects of ASRH and accessibility of information and services without a special focus on social and cultural norms, therefore the rapid assessment is going to focus on socio-cultural norms as a hindrance to access to ASRH.

For Murewa, The National ASRH Strategy, (2016-2020) established that despite the presence of a clear strategy in place in Zimbabwe, there still remain ASRH challenges. In this regard, statistics show that 40% girls and 30% boys have had sex before the age of 18 years and 24% of maternal deaths in the country occur among young women. More so, knowledge of Family Planning is 41% in young people and there continues to be high prevalence of teenage pregnancies and child marriages. STI prevalence among adolescents is 9% and a significant number of new HIV infections are occurring in those aged 15-19yrs. Lastly, gender based violence among young women is high (MOHCW 2018).

Basic tenets of a good ARSH service delivery system is mandated by WHO guidelines to adopt national values as well as observing gender and cultural sensitivity to ensure equal access and acceptability of services by adolescents and young people. (National Adolescents and Reproductive Health Strategy 2010-2015) Similarly, the Rapid Assessment is premised on the objectives and intervention strategies such as to increase availability, access and utilisation of friendly ASRH services, to adopt and promote safer sexual and reproductive health practices by young people, to put in place a conducive, safe, friendly and supportive environment for addressing

ASRH issues. Major thrust will also be to revamp and strengthen coordination through collaborative equal partnerships for evidence based ASRH programming through key interventions that include social and positive behaviour modification change processes, communication, service delivery, policy and advocacy and networking and co-ordination. (National Adolescents Sexual and reproductive Health Strategy 2010-2015)

It is Rozaria Memorial Trust's strong conviction that the Rapid Assessment will unveil the hidden cultural, social and religious practices that are a hindrance to adolescents in accessing ASRH services. Rozaria Memorial Trust thought it prudent and imperative to carry out a rapid assessment on the social norms and cultural practices in order to fill up intervention gaps creating hick-ups in adolescents' access to comprehensive ASRH services. The rapid assessment will be handy in identifying the positive and negative social norms and cultural practices like, "chisahwira and chiramu" that influence adolescents into early marriages. The outcome of the rapid assessment will inherently help to build on positive social norms and cultural practices like the "gota" and "nhanga" concepts to stamp out teenage pregnancies and child marriage. Findings will also revitalise RMT's programming with regards to advocacy for the abolition of negative social norms and cultural practices. The rapid assessment also advances guiding principles in the provision of ASHR services to adolescents and young people in tandem with the human rights and developmental approaches thereby enabling adolescent girls to realise their full potential. The rapid assessment seeks to adopt an evidence based participation and active involvement of multi sectorial partners to identify factors that make girls vulnerable to child marriage and also vulnerable in marriages with the intent to end this excruciating phenomenon.

Conclusion

RMT through the Rapid Assessment acknowledges that child marriage is an entrenched practice and that there are no one-size fits all solutions to ending it. It is on this basis that we realise and value other emerging cross cutting issues that ensure effective service delivery through meaningful participation of adolescents and young people, gender mainstreaming and parent and community participation. In doing so the rapid assessment takes a leaf from the Male circumcision exercise. Cultural, social and religious barriers were encountered but successfully warded off through use of different intervention strategies to spur success in programming. This paper also acknowledges that existing mechanisms already in place for HIV testing and counselling are also entry points to ASRH services. It sees strength and relevance in the enabling mechanism created by the Zimbabwe National guidelines for HIV testing in and counselling for children and adolescents (2014) both above and below 18, as a contribution to spur programming success. It is RMT's cherished vision to create opportunities for survivors of child marriages through opening avenues of increased psychological support at all levels in the community (within families, local leadership (chiefs and village heads), religious leaders, local authorities and amongst health practitioners.) We yearn to empower child brides to emerge as community champions and role models. It is a fact that child marriage batters girls' dreams when they drop out of school without productive skills, weighed down by low self-esteem and emotionally tormented. Survivors, if afforded access to education, and comprehensive sexuality education and reproductive health rights, will scale greater heights and make inroads into unexplored avenues in avoidance of child marriage. There

is need for community support groups for those in child marriages to encourage the adoption of positive rights-based ideas and thinking with encouragement and support from a group with similar experiences Through encouragement of community dialogues on child marriage, Advocacy to harmonise and enforce the laws that govern the legal age for marriage and the age of consent we can curb incidences of abuse and violence and ensure that offenders are given stiff penalties

Chapter 3

Data Analysis and Interpretation

Introduction

This segment presents the Shamva and the Murewa Rapid Assessment Reports concurrently. In this regard, both research studies exploited aspects of qualitative research design in which primary data was sourced using Focus Group Discussions, In-Depth Interviews as well as desk reviews of secondary data. In addition, effort was made to quantify phenomena hence quantitative attributes were fused to constitute a mixed methods design. And in analysing the data, the Shamva research study used the Glaser & Straus's (1967) Constant Comparative Grounded Theory in which there was use of open coding - where data was grouped into themes and categories. Where data categories had similarities, they were combined together. It is from these categories and themes that matrices and diagrams can be drawn and used to aid identification and comparison of themes and patterns as verbal and textual data were studied (Costley et al 2011). In Murewa, the study used the thematic approach in its data analysis.

Both the Murewa and Shamva studies solicited data through Focus Group Discussions with Traditional Leaders, Religious Leaders, Adolescent Girls and Boys, Parents and Guardians, Women and various Stakeholders and Service Providers within the community. In addition, the studies used in-depth interviews with key informants including, DDCs, Ministry of Youth, Ministry of Primary and Secondary Education, NAC, and Ministry of Health and Child Care, a Moslem traditional aunt, a church adolescents' advisor, Field trip to the Chief's traditional Court, Document analysis of secondary data as follow- ups to validate responses from the Focus Group Discussions. (for Shamva District) ZAPSO

Involved in the Shamva study were 7 Focus Group Discussions of 15 Traditional Leaders (comprised of Chief Nyamaropa and Village Heads), 15 Religious Leaders from different church denominations, 15 Adolescent Boys and Girls, 15 Parents and Guardians, 15 Women, 15 Stakeholders drawn from various Service Providers in the Community and 15 College Lecturers from different provinces of Zimbabwe who were used as a pilot study and control group in this research. This was found necessary to assess the suitability of as well as the basis for moderating and refining the research instruments before their actual use. Furthermore, the Study carried out interviews with key informants such as DDC, Ministry of Primary and Secondary Education, Ministry of Health and Child Care, ZAPSO, NAC, a Chawa traditional aunt, a church adolescents' advisor, Field trip to the Chief's traditional Court, Document analysis of secondary data as follow-ups to validate responses from the Focus Group Discussions.

For Murewa, 12 Key informant interviews were done with the Ministry of Health and Child Care (Department of family health services, Community department), Ministry of primary and Secondary Education, Social Services, Community Care workers, Judicial Services Commission, Ministry of Women Affairs, Gender, Community and Small to Medium Enterprise Development,

National Aids Council, Young Peoples Network, Women and Law in Southern Africa, Murewa Rural District council. The key informant interviews gave the research team an opportunity to have in depth discussions with key policy makers at district level who advocate for ASRH in their work on a day to day basis.

The Murewa rapid assessment also used the **focus group discussions** as a methodology for data collection. 5 Focus group discussions were done in 5 different wards firstly focusing on the rural wards 1,4,8,17 and 18. The focus group discussions were also conducted with participants from resettlement wards such as ward 24 in Macheke and lastly ward 30 and 16 which are in urban areas of Murewa. The focus group discussions included traditional leaders, church leaders, parents and guardians and the adolescent boys and girls. Each FGD had 15 participants. However, the adolescents had to have their own FGD for more in-depth discussions as it was realized that the older women and men would dominate the discussion. The use of such an approach helped in attaining a multi view from participants. This approach also enabled the research team to obtain detailed information about personal and group feelings, perceptions and opinions. It also saved time and money compared to individual interviews whilst getting broader range of information. However, the research team noted that some individuals dominated the discussion overshadowing others and emotions were noted during the discussions.

	WARD	**Church leaders**	**Traditional Leaders**	**Adolescents**	**Parents and guardians**
FGD 1	24	2	2	5	7
FGD 2	30,16	2	2	5	6
FGD 3	19,20,21	2	3	6	4
FGD 4	8,17,18	3	2	5	5
FGD 5	1 and 4	2	3	5	5

Findings and Discussions from the Focus Group Discussions with Traditional Leaders.

Although Focus Group Discussions were used in both Shamva and Murewa studies, there were some differences in the manner they were conducted. In Shamva, it was thought prudent to hold separate group discussions with different stakeholders as well as different age groups whereas in Murewa the stakeholders were bunched together. For Shamva, it was felt that some age groups and sexes would be dominated by others and that adolescents would not be free to express their views if elders were present. From responses to Item 1 of the Focus Group Discussion with Traditional Leaders (see Appendix 1) in both districts it emerged that the right to education, freedom, food and clothing were known to most traditional leaders. They however remained silent on other range of child rights to health, information on Adolescent Sexual Reproductive Health Rights (ASRHR) which is suggestive to the fact that most boy and girl adolescents are marginalised with regards to their essential entitlements and rights. This is contrary in view of the Traditional Leaders Act (29:17) where traditional leaders are obliged to protect children from traditional harmful practices and further mandates them to channel criminal cases of sexual

violence and abuse to the criminal justice system. This provision mandates traditional leaders to ensure timely reports of cases of child marriages in their communities which will not happen if leaders are not aware of the rights they need to safeguard.

Responses to item 2 revealed that all stakeholders Focus Group Discussions lamented that cultural and traditional institutions have crumbled and were in shambles, a situation which paves way for churches and schools to take over roles once played by aunts and uncles in the past. They blame this scenario for the upsurge of child marriage and teenage pregnancies in the district. In this regard the traditional leaders, parents and guardians yearned for the revival of lost traditional institutions like the" Gota" and" Nhanga" These positive aspects of culture were also a theme identified in Murewa as Cultural initiatives highlighted as spaces that were used culturally to advise and mentor adolescents and reduce teenage pregnancy and child marriage. The discussions focused on reintroducing these spaces for discussions in the community with adolescents especially girls who are mostly affected as they end up dropping out of school taking multiple roles of becoming a mother, wives and daughters in law at an early age.

There was consensus among all participants from the two studies that improved connectivity with the outside world with the advent of cell phones and internet, coupled with alcohol and drug abuse were chief culprits in cultural erosion they held responsible for child marriage and teenage pregnancies. There was 100% concurrence that there is mothers' take- over control of all children where fathers feel relegated to nonentities in the home and children no-longer listen to them as witnessed by adolescents dressing styles "marembe" (Scruffy dressing where young men wear their trousers hanging low) and miniskirts. The traditional leaders also lambasted current laws which they claimed spares the rod thus turning adolescents into renegades. Particular for Murewa was the observation that *"Vana vamazuvano vanonetsa kutsiura havachanzwe kana kurova mwana ukamuona achiita musikanzwa haukwanise nekuti anokuudzai kuti hamusi mai vangu* (Young people of today are difficult to correct, they do not listen. You cannot beat them or censure them if they are misbehaving. They will tell you that you are not their parent.) This is also a call for collective and collaborative efforts in raising children by all stakeholders in communities. In Shamva, the discussions tended to take a blame game between men, women and teachers over the upsurge in indiscipline and the related ills such as school dropouts, child marriages and teenage pregnancies

From the Traditional Leaders, it emerged that divorce rates in Nyamaropa area were high among the newly married couples who were said to be underage. They revealed that some husbands were under immense pressure from wives who regarded their daughters as sources of revenue which was contributory to prostitution and that some mothers were secretly betrothing their underage daughters to men of their choice so as to enjoy groceries. These leaders expressed support for RMT's effort to stamp out child marriage and yearned that wider outreach moves be made into their communities to educate everyone. Village heads expressed their readiness to work with Chief Nyamaropa to monitor the conduct of adolescents to desist from engaging in child marriage. It was pointed out that it was mainly dressing by young girls that enticed men and adolescents to violate girls sexually. In both Districts two more issues cropped up here which were that even elder men were dating young girls and having sex with them. The other issue was the traditional allusion that

once pregnant a girl must be married, which has serious implications. The girl is still under age and her body is not prepared for motherhood thereby compromising her health and her capacity to withstand demands and challenges of a marriage leading to failed marriages.

On Item 3, all respondents in Shamva urged village heads to reinforce laws against child marriage. In this regard, participants urged law enforcement agents to observe the context of traditional settings when dealing with child marriage as they required the complainant only to report to the police for prosecution to be made hence some cases remain unreported. Parents were also blamed for failing to act as role models for adolescents to emulate. Again, village heads in resettlements were regarded with contempt and were rendered powerless to effectively enforce chief's laws.

In Murewa, responses to Item 4 indicated that 75% of the traditional leaders preferred that ASRH education start as early as Grade Three citing that children have been observed engaging in sexual activities at this age. 10% of the respondents hinted that children be taught ASRH issues as from the age of10 whereas 15% preferred children to be introduced to ASRH as from ECD emphasising the importance of age appropriateness of the content delivered. On this note, it emerged that girls were more vulnerable than boys as girls as young as 8 years old have been sexually abused. The leaders also reiterated that it was the crucial role of mothers to impart ASRH knowledge to girls to shape and direct the behaviours as they grow. It was also alarming to traditional leaders that due to cultural erosion adolescents were illicitly getting ASRH information through the internet and from pornography which encouraged them to experiment with sex contributing to child marriage and teenage pregnancies.

Discussions on Item 5 revealed that 100% of the respondents agreed that in view of the heart rending challenge of child marriage and teenage pregnancies, now was the time for parents to engage their adolescent boys and girls on ASRH issues as aunts and uncles are no-longer as effective as they used to be in the past. In this regard, it was seen prudent for parents to establish parent- child relationships which would enable adolescents to feel free to present their problems relating to their growth and development as far as ASRH issues were concerned. In addition, traditional leaders, parents and guardians suggested that local radio broadcasting services and TV programmes focusing on educational ASRH programmes would pay dividends in confronting child marriage and teenage pregnancies. Of particular concern to participants were the legal age of consent to sex which is 16 years and the legal age to marriage which is 18 years which is controversial as those aged 16 are school going adolescents and minors at law who risk falling pregnant and dropping out school. Also, in Shamva and Murewa, it was considered that health facilities available in the community were not adolescent user-friendly as they lack privacy and confidentiality when offering services to adolescents.

Analysis of Data from Focus Group Discussions with Religious Leaders

Responses to Group Discussion item 1 (see Appendix 2) reflected that Religious Leaders had knowledge of child rights. It was noted that most religious denominations claimed that they conduct some sessions where sexuality education is taught and have child only conferences where adolescents access age appropriate knowledge about their growing up. But these were not comprehensive ASRH programmes but were based on abstinence a theme that also emerged in the

Murewa study. There was 100% consensus that poverty was the main contributory factor forcing girls into child marriage.

Church leaders contributed that society had negative attitudes towards adolescent girls who are survivors of rape and teenage pregnancies as they are stigmatised. It is because of the stigma that girls resent to rush into marriage or carry out unsafe abortions. Also, for fear of stigma young girls commit suicide or subject themselves to emotional torture and stress as they do not seek counselling (ASRH) services. It also emerged that the main focus in different churches is to direct parents to guide and control their children. On this note, they conduct home visits and hinted that some punishment by expulsion or demotion were instruments meant to deter mischief and effect compliance. In view of the above, 65% of the respondents revealed that there were no ASRH aspects taught to adolescents as such but focus was on the bible teaching which outlaws use of condoms and contraceptives- a religious and cultural issue that also emerged in Murewa.

Further to the above, it was revealed that in some Apostolic sects, girl children as young as 8-13 year olds were getting married in church which was a gross violation of child rights which also endangered the health and lives of these children. Furthermore, it emerged that once these children were married, the young mothers were not allowed access to pre-natal health services as well as immunisation, which renders statistics unreliable as some cases remain unrecorded. This FGD also indicated that there are rampant practices of "kuzvarira" meaning betrothal within the Masowe and Marange sects as it is the parents who choose who will be their son-in-law and not the girl child- a situation which deprives children of their rights. It was also pointed out that in the Marange sect there is heavy reliance on prophecy where the holy spirit has a role to sniff out prostitutes and ill-doers among the adolescents who are punished by expulsion from the church as a deterrent to mischief. However, it is these expulsions which were instrumental in the formation of splinter groups within the various sects which further made it difficult for churches in reporting cases of child marriages to the police. Church leaders further indicated that, generally, people in the community were reluctant to report cases of child marriage to the police because they prioritised the need to maintain good relations with their neighbours within the community

All participants in the two districts revealed that there were traditional and cultural practices like "chiramu" and "chisahwira" which violated body zones of space leading to sexual abuse of sister in-laws and subsequent child marriage. Respondents in Shamva further expressed fears in that nowadays children are socialised into abusive language and sexually suggestive lexical items adolescents such as; "anegumbo," "mazakwatira," "anodonhedza musika "or" magate." Some language aspects used in the local community perpetuate abuse and violation of women and girls like the proverb, "muzukuru mugunde wepwa waasekuru" giving impetus to the phenomenon of child marriage. On a similar note, there were some identifiable positive language items which could be exploited and used as a rallying point to discourage child marriage in the community. This is where the proverb, "Regai dzive shiri mazai haana muto." Similarly, there is a wise Korekore adage which says, Regai dzive hunde tsotso hadzina mavhunze." These are powerful and influential cultural tools used to inhibit practices of proposing love to adolescent girls who are not yet mature. In addition, there are some strong messages of counsel to adolescents embedded in the proverbs "Mandikurumidze akazvara mandinonoka," and "Takabvako kumhunga hakuna

ipwa." These all serve to warn young boys and girls against early indulgence in sex before completing their school. Furthermore, the church and cultural practices of virginity testing (chinamwari/ makumkuro/kuenda kurukova) were identified as amounting to abuse and violation of girls' rights.

Analysis of Data from Focus Group Discussions with Adolescent Boys and Girls

In Murewa and Shamva findings were that adolescents of both sexes knew their rights which was indicative of an effective health and life skills in Guidance and Counselling currently taught in schools. On Item 2, adolescents further revealed that they were shy and felt ashamed to access ASRH services from local centres. The majority of the adolescents disclosed that they were uncomfortable and dissatisfied with the nurses' lack of confidentiality as reflected by utterances like, "Vanoswera vaparidzira munharaunda yose zvandafambira pachipatara kana nezveurwere hwangu hwose ndopedzisira ndosekwa nenyika yose sebenzi." (They will spread my health issues all over the community and I will be a laughing stock) (particular to Shamva) This was attributed to the reason why adolescents would prefer to seek services from the private service providers. This also implies that adolescents are prepared to obtain provisions like condoms from vendors which compromises the quality of services, makes tracking of services difficult and has subsequent health risks involved.

In addition, the adolescents indicated that they also seek information and services from peers which is a dangerous inertia as misinformation cannot be ruled out, which possess a health challenge. Adolescent girls hinted that they were prepared to consult traditional herbalists for abortion than taking the medical route because abortion is considered illegal and that nurses cannot facilitate it without first reporting to the police which attracts strict legal punishment (specific to Shamva). Other factors contributing to the preference of herbalists are that churches and the traditional religion consider abortion as a taboo and public knowledge that a girl had an abortion attracts social stigma, curses and condemnation that one can never be considered suitable for marriage.

Adolescent girls in both districts further highlighted that if they got pregnant they would elope to the man responsible. This fuels early marriages. If the man responsible for the pregnancy refuses to take the girl as a wife that is when one feels unworthy to live and suicide is a possibility. Quite a number of adolescents were into hiding their pregnancies in which they abuse their bodies as well as the unborn babies and most often, some adolescent girls end up dumping their unwanted babies. In Shamva it emerged that unwanted teenage pregnancies were a serious issue affecting most adolescent girls who resent seeking services from local clinics on the basis that the centres were not youth friendly. This is because the adults and the adolescents are bunched together when receiving services, a situation which compromises privacy. In addition, it was pointed that, nurses were openly unfriendly as they were abusive to adolescents as reflected by the following statements, "Regai titange kurapa varikurwara chaivo kwete imi munomhanyira zvebonde muchine mukaka pamhuno" (Let us treat those who are ill first not you, who rush into sex while you are still young). To make matters worse, parents were reported to be unwelcoming to pregnant girls who are often chased from home to their boyfriends thus triggering child marriage.

The Shamva Study also found that traditional dances like jiti and zvigure (nyau) where popular obscene dance "zunza mazakwatira" feature are viewed to be sexually suggestive and enticing to adolescents to engage in sexual activities. These are instrumental to child marriages as they offered opportunities ideal for the seduction and abuse of girls. By the same token, adolescent boys acknowledged that skin tights and miniskirts were sexually suggestive and were a leading cause for rape and the resultant child marriages. Adolescent boys further indicated that some married women often proposed them especially if they were successful in their gold panning activities because they wanted money. Victims of such women are likely to engage in sexual activities with girls and they often regard adolescent girls with disrespect. In addition, adolescents admitted that they view pornography and this is considered to influence child marriage as they are driven by the urge to experiment with sex. It was also revealed that some phrases like "Akabatana (she is tight(sexy), ane gumbo (she has good legs), anodonhedza musika (She will bring the market down) and simbi" stirred girls' emotions and sexual feelings and at the same time infuriated and dehumanised them- a violation of their rights

Analysis of Data from Focus Group Discussions with Parents and Guardians (Males and Females)

Whereas parents and guardians had knowledge of the basic rights of children like food, shelter, love and protection they exhibited some information gaps with regards to the growing up and sexuality of adolescents. It emerged that parents are not giving ASRH services to adolescent boys and girls. This study observed that parents in Shamva confuse the concept the discipline enforcement as corporal punishment which is not the case. On item 2, 100% of the respondents indicated that they have very little discussions with adolescents about their sexuality, a role they believe has been wrestled from them by modern institutions like education, church and the health sector. The parents and guardians further remarked that, "Children now know better as they consider themselves more educated." 50% of the participants attributed this problem to colonialism and modern laws which seem to have relegated local traditions.

All Parents and guardians in both districts pointed out that ASRH services are limited as some adolescents are out of school hence cannot benefit from guidance and counselling as well as health and life skills offered in schools. Similarly, services offered at health centres are only available to those who visit the clinics when they are sick. It was suggested that ASRH be introduced to children as from Grade 6 (10 – 13 year olds). Both studies noted that male parents and guardians had higher expectations about abstinence, virginity, purity and marriage on adolescent girls than on adolescent boys. In this regard, sex before marriage by boys was tolerated by parents whereas it was not tolerated for girls. This reflects that girls were regarded as a source of wealth through lobola when they are married. It is for this reason that young girls are forced to marry whenever they engage in sexual activities, a phenomenon that fuels child marriage.

In Shamva, it emerged that parents and guardians consider abortion unacceptable and a taboo. Participants alluded that teenage pregnancies were unacceptable and advocated for stiffer penalties for those responsible for making the girls pregnant. However, parents admitted their reluctance to report cases of abuse and child marriages to the police for the sake of maintaining good relations in the community. The male parents considered themselves at risk from the young

girls who enticed them through various means like mini-skirts and sexually suggestive advances difficult to resist. On a similar note, some cultural language items and proverbs such as,'kuroorana vematongo,' sometime legitimises violation of child rights and precipitates child marriage. There was a 100% acknowledgement among parents and guardians who indicated that the Marange sect did very little to uphold child rights as adolescent boys and girls did not have the privilege and right to access education, health and ASRH services. In addition, mining activities like "chikorokoza" as well as tobacco growing and curing had negative impact on the provision of ASRH services which encouraged child marriage and teenage pregnancies (which was subtle in the Murewa study). Tobacco is a cash crop and the cash revenue attracts women who are then married as a source of labour.

Analysis of Data from Focus Group Discussion with Stakeholders

Primary and secondary school teachers, expressed their reservations over the age of consent to sex (16) which virtually meant that school going adolescents of this were entitled to have sex when they are yet to complete school (a theme also raised in Murewa). This meant that their chances to achieve anything in life were bleak due to child marriage and teenage pregnancies. It was also raised that there were high chances that STIs can spread among school going population since they are shy to access medication from local clinics where services were not adolescent friendly. In view of high teenage pregnancies, the implications were that adolescent girls are likely experience health risks as their bodies are not yet ready and prepared for child bearing. Teachers remarked that, "Kudzivirira kurinani pane kurapa, "which implied that parents should ensure access to family planning information to their adolescent boys and girls.

There was 100% consensus among teachers that comprehensive sexuality education was mandatory as from ECD as it has been noted that children as in Grade One and Grade Two were being sexually abused. It also emerged that there are 3-4 cases of girl school drop-outs at the local primary schools, a situation which compels parents to take keen interest in the welfare and safety of their children to ensure that they complete their education and marry out of their choice. Teachers were also bitter over parents who remained silent when their children were sexually abused for the sake of protecting relations and the need to benefit from "roora semombe yechimanda" paid by the one who would have taken away the girl's virginity which would not be forthcoming in the event that the culprit is arrested and imprisoned. The other reason why parents were not reporting cases of sexual abuse of their girl adolescents was that culture highly values girls' virginity and once a girl is known to have lost it, she is stigmatised and men are reluctant to marry her. The FDG pointed out that the local secondary school, was losing as many as 40 (7% of the school enrolment) adolescent girls every year due to teenage pregnancies and child marriage. This exceeds by far the district rate of 2% implying that child marriage and teenage pregnancies are a greater challenge in Nyamaropa area than elsewhere in Shamva- a development which warrants arresting through multi-sectoral collaborative efforts.

It was noted that school locations favoured sexual abuse of girl children as the area is bushy and that some schools were far from homes. Poverty was also considered as a contributory factor to child marriage and teenage pregnancies. Adolescent girls, think that by marrying early they would

enjoy life and escape the vicious cycle of poverty. “Makorokozas” who ply their trade in the surroundings, use cash to bait the young girls into having sex potentially leading to child marriage and teenage pregnancies and dropping out of school. It was also noted that the local community regarded and valued marriage more than education. Teachers in the FGD indicated that books with relevant teaching content for G&C were not available in schools for effective delivery of ASRH. They further alluded that there was adequate space to use as counselling rooms to observe confidentiality. In addition, teachers indicated that they were not trained counsellors hence would need skilling through workshops, and that pupils would take the learning area seriously if it were made an examinable subject.

From the FGD, it was revealed that VFU services were not available at the local police base but at district level. It was further pointed that, some officers have received training in VFU issues and that there were standard procedures followed when dealing with child marriages and victims of abuse. It emerged that child marriage cases are not openly reported which suggests that child marriages are clandestinely done as the families concerned would do everything to hide and pretend as if nothing has happened to preserve family relations. It was also revealed that deliveries by child mothers are not done at local clinics but are referred to district hospitals hence are not reported to the police and even when reported it will be too late and difficult to investigate as documents often go missing to authenticate the age of the mother. The FDG further blamed lack of coordination of ASRH service providers- the health sector, police teachers and village heads. It was observed that the various stakeholders at ward level were not operating on the same wave-length as child marriage issues were riddled with rampant corruption and bribery as evidenced by silence over these cases. All concerned parties acknowledged that child marriages were happening yet no reports were made. Teachers revealed that they sometimes face problems with the community in protecting children leaving the teachers to appear as if they were interfering with issues of the community. They further indicated that it is the case of child abuse they were forced to act in the interest of the child as directed by the Education laws.

The police added that it was possible for any member of the community to act as informant to the police on child marriage. The police officers acknowledged that it was only in cases where a girl child was impregnated and the boy or man responsible refuses to take responsibility that most reports are made to the police as a retributive measure to punish the offender.

The Health personnel highlighted quite a number of services on offer at their clinics which range from family planning services, counselling, HIV and AIDS related services and ART as well as youth friendly services. It emerged that the health care workers did not render their services to adolescents well as it was observed that they would only want to intervene when the youths were already in problems. It was suggested that health care workers made regular outreach programmes to the adolescents- arming them with information, knowledge and life skills for their survival in stormy adolescent development. The nurses further acknowledged that it was common in the past that nurses used to have negative attitudes towards adolescents seeking ASRH services but they have now been trained to observe and respect client privacy.

The various stakeholders involved recommended that child marriage and teenage pregnancies required a multi-sectoral approach and response to solve. It also noted that the procedures for

reporting to the police required the consent of the parent which was a set back to the referral and reporting system. The police were encouraged to work with schools, village heads and the health workers on issues of child marriage and teenage pregnancies. There is need for the police constabulary to work with CCWs to stop chid marriages. In view of the current challenge of child marriage village heads and parents were considered as accomplices to child marriage as no marriage transaction can take place without the knowledge of the village head and if the parent is unwilling.

Analysis of Data from In-depth Interviews

Unlike in Murewa where both data from Focus Group Discussions and In-depth interviews were compounded and analysed simultaneously, in Shamva In-depth Interviews were analysed separately. This was done to determine if the same categories of data and themes obtained from group discussions replicated using the interviews to enhance validity and reliability of the study as well as the research instruments. In this regard, respondent (KI) indicated that there were field officers in wards trained in ASRH whose role is to cascade information to community members. It further highlighted that the ministry was working with the Junior Council whose members also trained in ASRH to target in and out of school youths. However, it was revealed that members still needed more information. Religion was identified as the major hindrance in stamping out child marriages especially in Chemhondoro area. Cultural practices like “chiramu” were predominant especially in ward 14 (issues identified in Murewa).

Respondent 3 indicated that the district hospital handled about 10 cases per week of survivors of abuse and child mothers who are referred to this facility from various health service centres in the district for monitoring during delivery. It was revealed that child mothers contribute significantly to the total district maternal mortality rate and that Shamva district’s maternal mortality rate is high for its population size. In this regard, regional statistics of maternal mortality rate by district are as follows:

A Table showing maternal mortality for Mashonaland Central by district.

District	**Maternal Mortality Rate**
Bindura district	394
Mt Darwin	727
Mazoe	513
Guruve	556
Mbire	475
Muzarabani	556
Rushinga	424
Shamva	694

Statistics above are alarming in that the national maternal mortality rate is **458.0** and for Shamva with a tiny population **694** is really high. Furthermore, teenage pregnancies are mostly hidden till they are several months which implies that child mothers are likely to avoid the requisite medication and risk developing complications and their lives during delivery. Some religious

sects resist medical care and are steeped in child marriage practices which conspire to raise maternal mortality rates, a practice which needs a multi-disciplinary approach that RMT seeks to promote and advance.

In relation to the above, the International Journal of Maternal and Child Health (2014) reveals the following Maternal Mortality for Mashonaland East Province based on maternal death notifications:

District	Maternal Mortality notification rate (per 1000 live births)
Sadza District Hospital	**339**
Marondera & Chihota Hospitals	**337**
Murewa/Nhowe Hospital	**300**
Mutoko District Hospital	**396**
Makumbe Hospital	**326**
Hwedza Hospital	**337**
Epworth Clinic	**340**

From the study, education level and married pregnant women contributed most to maternal deaths notifications. The frequency of notifications ranged from 70 % to 100%. Those who were not married were more likely (odds ratio 1.24, p value 0.559) to deliver at home than those who were married. In addition, unbooked women and those booked at gestation more than 28 weeks contributed more towards maternal mortality notifications. In the same vein, Apostolic women were found contributing more to notifications. This implies that a lack of knowledge on ARSH emanating from religious background leads fuels child marriage which also prejudices adolescent girls of their education subsequently condemning them to ill-health and pregnancy related risks resulting in high mortality rate. The fact that the figures above are below the national mortality rate could mean that there are more child mothers dying unreported.

For Shamva, respondent (KIV) alluded that teachers had the mandate to offer ASRH services in G&C, as a learning area and a programme where they collaborate with other service providers and stakeholders in the district like MOHCC, NAC and others. Interviewees (KV) and (KVI) indicated that they ran various community based programmes including Young Peoples Network, youths in schools, youth in business, OVCs in addition to working collaboratively with other organizations like NAC on ASRH, child abuse and gender based violence.

On Item (b) respondent (KI) indicated that their role was to reinforce government policy on contraceptives, abortion and family planning. However, we must uphold traditional practices, laws, culture, and medicines. Abortion is discouraged in Christian religion and is legally accepted in limited circumstances which are protected under the Termination of Pregnancy Laws. "As directed by the Traditional Leaders Act {29:17} we have an obligation to protect children from

harmful traditional practices" In this regard, the DDC's office works with chiefs and village heads to direct criminal cases of child abuse and sexual violence to the police for prosecution. For that to happen it was imperative for collaboration with this office if RMT's efforts to end child marriages and teenage pregnancies are to be successful.

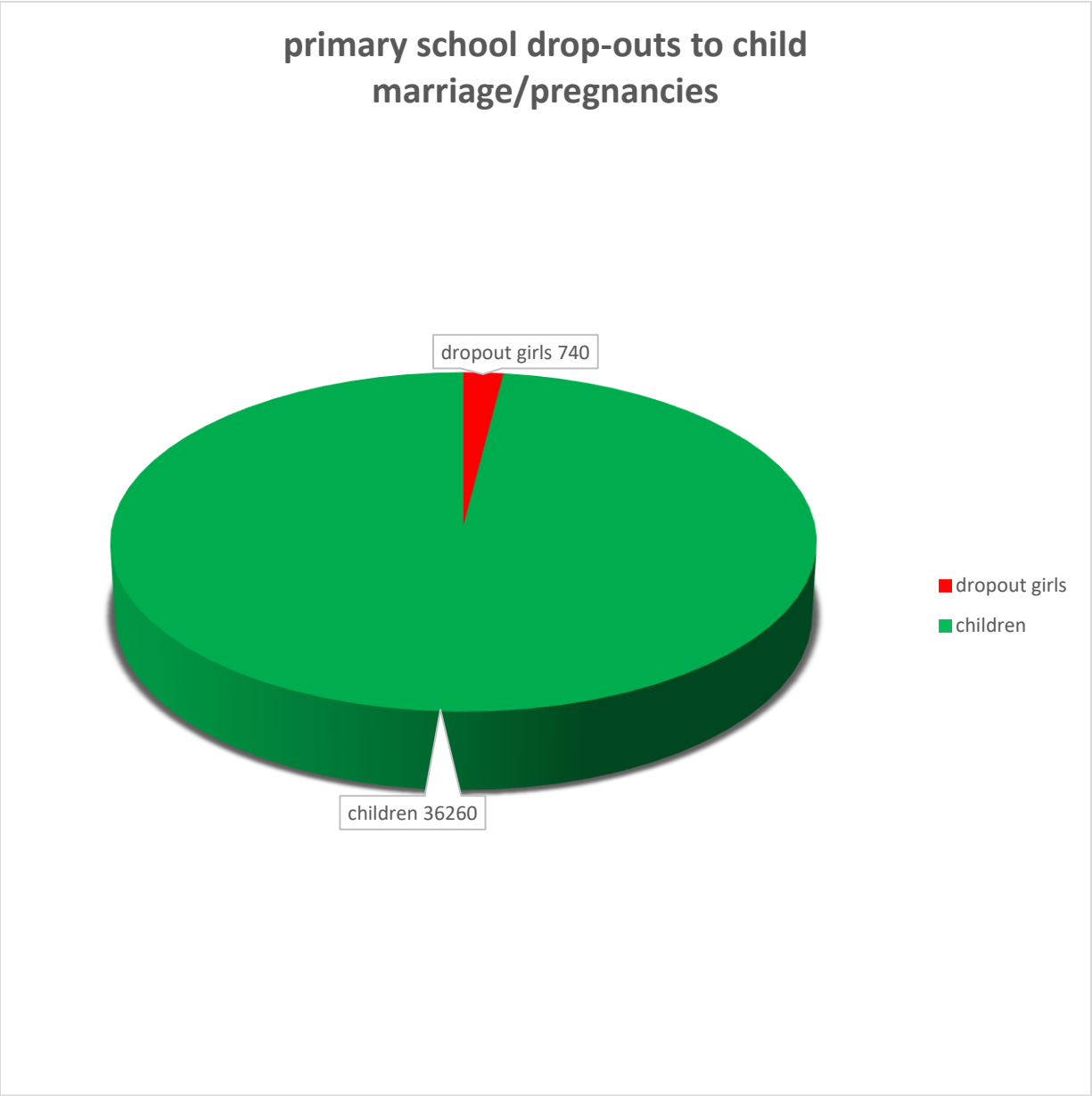
Respondent (KI) revealed that they were working with the Zimbabwe National Family Planning Council in an endeavour to establish Youth Friendly units and resource centres to offer ASRH related programmes which could also be the spring board for coordinated and collaborative efforts towards ending child marriage. The same proposals were also mooted by the Ministry of Health, ZAPSO and NAC which would be a welcome development towards a united front which could partner schools in confronting the problem. By the same token, respondent (KIV) acknowledged that his Ministry has the infrastructural network in all parts of the country and manpower but teachers would need capacity building by way of workshops and material resources to deliver information to the community. Respondent (KIV) further indicated that the positive aspects of our culture could be harnessed with greater parent participation in instilling good morals as has been witnessed by Indian TV programs on television channels such as Zee world.

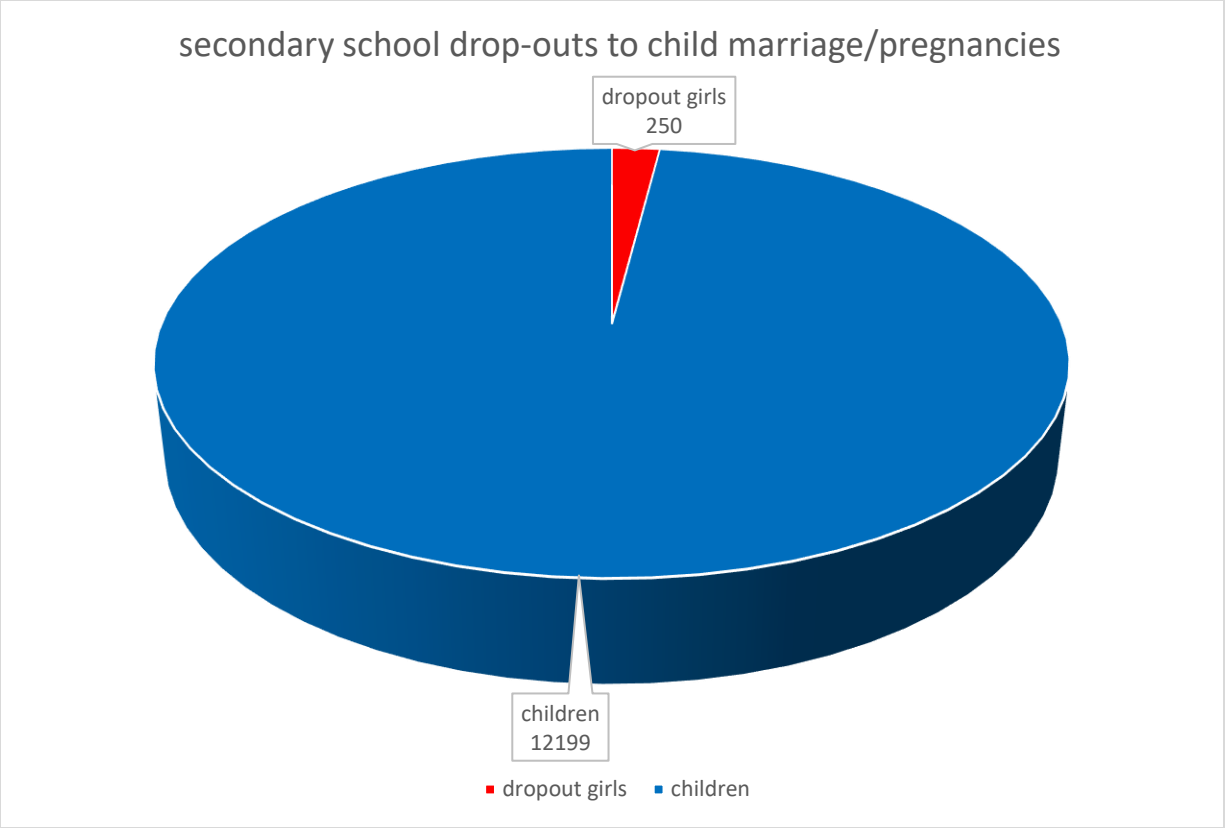
All participants highlighted the dangers associated with adolescents obtaining contraceptives from vendors but blamed this on the attitude of our nurses who were not sensitive to the adolescents. (This issue that was a problem in both districts). Policies and legal procedures were considered prohibitive for adolescents to seek abortion and family planning services insisting they be accompanied by parents. All participants further noted that cultural and religious factors were responsible for child marriages and teenage pregnancies as well as illegal abortions for it is a taboo for a girl or woman to be pregnant outside marriage.

Respondents 2,3,4,5,6 indicated that there were some action plans in their organisations to arrest child marriage, and teenage pregnancies which were premised on empowering the adolescent girls by affording them opportunities to pursue education, thereby arming them with requisite information about contraceptives. Peer educators and mentorship programmes were considered of importance to achieve this. The idea of keeping the girl child in school by even allowing those who would have dropped out of school and those young mothers who have an interest in education to be given the chance to do through various support programmes was welcomed. There are notable examples at Jiti High School- where adolescent girls who went into child marriage but decided to go back to school with the assistance of an NGO are doing A Level (as directed by policy circular 36). It emerged that all schools were teaching G&C at various levels by giving children adequate age appropriate information to catch them young for greater impact in their lives.

Respondent (KIV) indicated that the whole Shamva District was losing at least 2% of its school girl children as from Grade 6 up to secondary school to child marriage and teenage pregnancies. In this regard, given that there are 37 000 primary school children and 2% equals 740 girls. With the 12 449 secondary school going adolescents, 2% of them it means close to 250 girls getting married or dropping out due to teenage pregnancies in one single year. These statistics are presented on the two pie-charts below:

Pie – Charts showing the numbers of primary and secondary adolescents dropping from school due to child marriage and teenage pregnancies



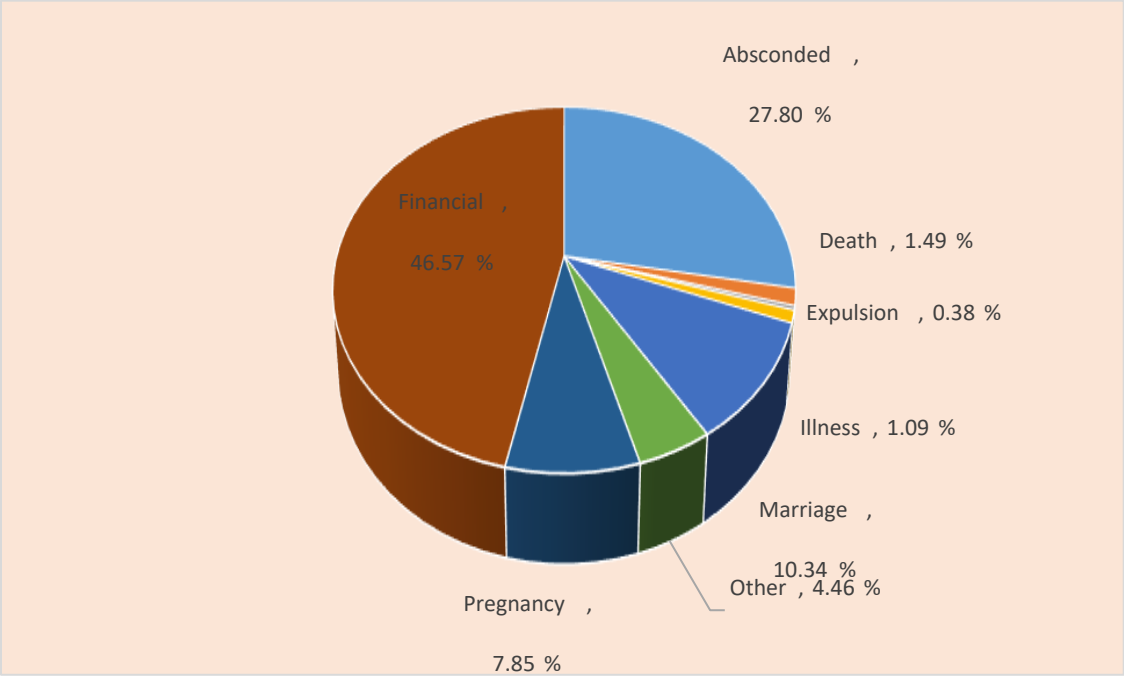


National statistical data on school dropouts shown below reflects that as early as Grade Six (around 10 to 12 years), Zimbabwe loses about 1.2 % of young adolescent girl children indicated below as national school dropout rate in 2017. In the case of Shamva, the dropout rate was 2% which is higher than the national, reflective of the severity of the problem. At Form Three, the national total dropout rate is 1.46 whereas Shamva has a school dropout rate of 2% again which higher than the national average. It was revealed during the interview that child marriage, teenage pregnancies and poverty account for most school dropouts among female adolescents.

Table 8.10: Promotion, Repetition and Dropout Rates by Grade, Zimbabwe 2017 and 2018

	Promotion 2017 to 2018			Repetition 2017			Dropout 2017		
	M	F	T	M	F	T	M	F	T
To Grade 2	93.9	95.0	94.41	1.4	1.0	1.20	4.7	4.0	4.39
To Grade 3	96.9	98.0	97.46	1.2	0.9	1.04	1.9	1.1	1.50
To Grade 4	95.5	97.3	96.39	0.9	0.7	0.83	3.6	2.0	2.78
To Grade 5	97.7	98.4	98.04	0.8	0.6	0.73	1.5	1.0	1.23
To Grade 6	96.8	98.0	97.43	0.9	0.7	0.79	2.3	1.2	1.78
To Grade 7	92.4	93.8	93.09	0.8	0.6	0.72	6.8	5.6	6.19
To Form 1	78.9	81.0	79.92	0.5	0.3	0.40	20.7	18.7	19.68
To Form 2	96.8	96.6	96.71	0.3	0.2	0.24	2.9	3.2	3.05
To Form 3	100.3	96.3	98.26	0.3	0.3	0.29	-0.6	3.4	1.46
To Form 4	82.2	80.3	81.26	2.8	2.7	2.75	15.0	17.0	15.99
To Form 5	24.3	22.6	23.44	2.1	2.0	2.03	73.7	75.4	74.52
To Form 6	95.7	95.9	77.21	0.2	0.1	1.27	4.1	4.0	21.52

Figure 8.6: Secondary Level Percentage Dropout by Reason, Zimbabwe 2018



An analysis of the major contributory factors to school dropouts have been documented and presented on the pie chart above. It is apparent that the young adolescents as from Grade Six up to Form Four are still children and yet their childhood is cut short due to child marriage and teenage pregnancies. These children become child mothers and fathers constituting a recipe of disaster, pain and sorrow in their entire lives unless concrete and sustainable solutions are adopted to eradicate deep rooted socio-cultural factors and traditional practices that stifle the future of adolescents, mostly girls, who are always on the receiving end of male orchestrated initiatives.

All interviewees highlighted that the provision of ASRH was under the of the guidelines of the United Nations and that children had the right to age-appropriate information on ASRH but pointed out the need to strike a balance between culture, religion and national policy and law. From all respondents it emerged that there were some negative cultural and traditional as well as religious practices that were contributory in fuelling child marriage and teenage pregnancies ranging from family arranged marriages, betrothal, traditional practices like “chisahwira,” “chiramu” and wife inheritance like “chimutsamapfihwa” where adolescent girls were forced to take-over dead aunts children and husband as culture demands. Generally, it was observed that socio-economic activities upon which Shamva hinges were “chikorokoza,” tobacco farming coupled with poverty

and the value the locals place on marriage instead of education were behind high incidence of child marriage and teenage pregnancies.

In- depth interview with a young widow

The young widow (KVII) revealed that she was a survivor of child marriage. She was married at 16 and was widowed at 24; a mother of 2 daughters aged 7 and 4 respectively. She further indicated that she single-handedly fended for the two children and saw them through primary and secondary school as well as guiding them through their turbulent adolescence. She highlighted that she had to take the two responsibilities of a mother and father to see to it that the two kids were disciplined as well as informing them of ARSH issues with the intent that they would not make the same mistakes that she made of engaging in early sexual activities and dropping from school. The respondent was very open in that there were many options of getting money through the seemingly easy way like selling her body but "I thought it was not a sustaining, fulfilling and dignified mode of life and vowed that hard work was the only way out" She added, "Now I am into business which has seen me send my first girl to university and the second one has passed her O- level and awaits to go to college" The secret of her success was her openness when discussing life issues with her children in which she uses her own life as an example that the girls should avoid by all means.

Respondent (KVII) further indicated that she often goes to the Makorokoza mining sites where she cooks and sells sadza and does not hide that the men out there are loose with their cash which attracts young adolescent girls and young mothers into prostitution- selling their bodies for cash. This phenomenon is not a health practice as schoolgirls because of the Covid 19 have nothing to do are attracted by these cash flashing boys and may not go back to school due to pregnancies. Furthermore, young married mothers are tempted into multiple sexual partnerships with the miners, potentially ruining their marriages and risking HIV and STIs infection. "The area is not a safe place for young girls as they risk being raped as gender based violence is rife" (KVII)

In-depth interview with a church aunt (KVIII)

Respondent (KVIII) conceded that child marriage was really a challenge of the modern day society citing that our adolescents do not listen as they think they know it all. She also indicated that most adolescent girls and boys engage in early sex on their way to and from school and that they are heavily influenced by the internet. She also revealed that as a church they feel morally obliged to teach adolescents about growing up and the importance of following acceptable codes of conduct as directed by God. Firstly, she stated that as a church aunt her candidates for counsel are those about to get into marriage. She teaches the women how to conduct herself before the husband and how to take care of her children. "My role as tete is to teach our girls to follow proper channels when they proposed by a man until when the man pays lobola in a lawful manner- which is not different from our culture as a society."

Respondent (KVIII) further highlighted that for the church to discipline an adolescent, he or she must have received proper orientation from the parents, who are very important. "This does happen overnight and demands that parents give themselves time with their young adolescents." She went on to acknowledge that despite the church teachings adolescents were into sex and suggested that school children be taught ARSH as early as ECD where content should be age-appropriate. She

went on to advocate for the provision of family planning contraceptives from the age of 12 dispelling fears that they would turn into prostitutes.

In-depth interview with a Chawa religious aunt (KIX)

Considering Shamva's cultural diversity, (unlike in Murewa) the study had an interview with a Chawa religious aunt who acknowledged that lives of girl children were under siege and more vulnerable gender based violence, dropping from school due to teenage pregnancies as well as child marriage. She narrated her experience as a parent whose girl child was impregnated when she was in Form Three a situation which forced the girl into prostitution and cross border trading at a young age. These experiences led her daughter to reconsider going back to school. With the mother's support the young woman became so determined in her studies that she graduated as a teacher setting herself as a role model for adolescents in similar circumstances.

The respondent acknowledged that she was from a Chawa religious traditional culture with its origins in Malawi. As a religious aunt she chronicled that in their culture were taught respect and strict cultural adherence in that girl are not allowed to mingle with men and in church worship separately. In addition, girls and women wear a head cover called **Cover Satan** which extends to cover the face so that no young woman's can be seen by the public to avoid temptations from the opposite sex. As part of ARSH all Chawa girls go into initiation for three weeks once they start menstruation. In the initiation camp the adolescents are taught good neighbourliness and sexual and reproductive health issues. They are also taken into initiation camp when they are about to marry during pregnancy as well as after their first birth where are tutored on how to take care of the baby. In the initiation camps the young ladies were under the mentorship of traditional or cultural gurus called **nakangas**

The initiation sessions were called the **Chinamwari sessions** and in these, good behaviour befitting of a woman were taught and that those who transgressed were punished by the community. Dressing is prescribed and that a girl's thighs and elbows are not to be exposed. Virginity tests are conducted by elderly women but girls now detest this practice as it denigrates women when their status is made public. Family planning contraceptives are unwelcome by the Chawa culture and that the culture is facing resistance from young generation due effects of modern media. The respondent revealed that with the current cultural mingling Chawa religious practice is under threat and that young girls and boys now engage in sex which fuels child marriages and teenage pregnancies. (KIX) laments that girls abused and forced into child marriage cannot access justice because corruption in the courts and police is rampant.

A Visit to the Chief's Traditional Court and Observations made during Court proceedings.

As a point of departure from Murewa, the Shamva research team had a visit to the Traditional Chief's Court Session. The purpose of the visit was for the research team to acquaint themselves with the traditional justice delivery system and assess how its structures could be used in combating and eradication of child marriages and teenage pregnancies which would empower young girls and women in general. The visit was also premised on finding out from the court's structures how women were represented as well as establishing how issues child marriage and gender based violence were dealt with by the traditional court.

From the observations made, it dawned to the research team that the traditional court is democratic in its conduct and delivery of social justice. Decisions made and the final verdict over cases tried were democratic for there was no one individual dominating during court proceedings. It also emerged that the Chief is highly regarded and honoured but nevertheless took into consideration decisions made by members of the Council and also welcomed contributions from the public before passing a final verdict. Interesting to note were that all village headmen meet and brief the Chief on issues threatening their communities like those individuals violating agreed codes of conduct which could prove handy if by-laws communally developed on child marriages were taken aboard.

That the Chief's Council is wholly comprised of men and no woman sits in it reflects underrepresentation of women in the traditional justice delivery system. Drafting in some women could make it more representative and give voice to the marginalised women. On this day no cases on child marriage were heard but issues on elopement and gender based violence in marriage were heard and these were dealt with by the court. The Court showed no mercy for those who battered women. Here physical violence was not tolerated as perpetrators were immediately reported to the police for prosecution after they were punished traditionally.

Chapter 4

Existing Opportunities

Despite all the existing barriers this assessment identified several opportunities and entry points that can be explored for increasing uptake of ASRH services to avert teenage pregnancy and child marriage. These opportunities include:

- RMT has space to advocate for implementation of ASRH, ending child marriage and teenage pregnancy at different global, regional and national spaces
- Support for traditional leaders and stakeholders in the development of bylaws on ending child marriage in Murewa and Shamva districts
- Existing community structures such as CCW, VHW, Child Protection Units as well traditional leaders for information dissemination on ASRH and strong referral support at community level
- Strong civil society organisations if well trained and coordinated offer some opportunities for ASRH uptake and ending child marriage

Research Findings - Emerging Transcending Themes/Issues

From the two studies conducted in Murewa and Shamva, there are some common features which overlap to constitute major findings, of which the highlights are:

ASRH services currently offered in clinics are not adolescent and user friendly. In addition, there is lack of confidentiality and privacy in health service centres. As a result, adolescents are hesitant and unwilling to seek requisite services from the two centres. Furthermore, adolescents are accessing condoms and contraceptives from vendors and private middlemen (backyard services) which puts the adolescents at risk of engaging in unsafe and unprotected sex increasing their chances of HIV and STIs infection as well as teenage pregnancies and child marriages.

The community has become survivalist in that parents have become so engrossed with making ends meet by devoting most of their time to mining and farming operations. As a result, most parents renege on their responsibility of offering guidance and counselling services to their adolescent sons and daughters. There was also lack of parent child communication in which adolescents can open up and feel free to say out their problems in the adolescence period. In addition, parents do not discuss ASRH and issues about growth and development with their children at home because parents feel uncomfortable and that they do not have adequate knowledge and strategies to deal with such issues. Consequently, adolescent boys and girls are getting more information on ASRH from schools, from peers as well as the internet. It was also found that School going adolescents are into sex and often watch pornography from the internet. On this note, it was established that most parents felt that today's adolescents were difficult to control and discipline as they considered themselves more knowledgeable than their parents. There was a blame game between schools, fathers and mothers over whose responsibility it was to impart discipline and guidance to adolescent boys and girls. Older, married men were considered culprits

in child marriages and teenage pregnancies as they date young girls baiting and pampering them with gold and tobacco money, a phenomenon which the current Covid -19 lockdown will impact with severity.

From the study, there are some cultural/traditional and religious practices like “kuzvarira,” arranged marriages and virginity testing fuel child marriages and dehumanise girls as men involved would want to get their wives still virgins thus fuelling child marriages as well as sexual abuse of girls. It was also noted that parents and the local community place more value on marriage than education which funs child marriage and teenage pregnancies. This stems from fact that adolescent girls are regarded as a source of wealth and are under pressure to get married early. Dove-tailed to this, is the need for status by parents through payment of “chimanda “and “lobola” which also provides impetus to child marriage. Hinged on the value placed on marriage it was found that adolescent girls carry out illegal abortions to preserve their dignity and status to avoid being labelled and rejected in marriage which endangers their lives and health. Similarly, some traditional dances like “zunza mazakwatira” were found to be sexually suggestive entice adolescents into wanting to experiment on sex. Closely related to culture, are some language items in use were considered to have an influence on child marriage like “anodonhedzamutaka/musika,” and “akabatana” for they are sexually suggestive comments.

Poverty was found to be a contributory factor to child marriages and teenage pregnancies and that adolescents especially girls are under pressure to get married to escape this abject poverty. Adolescent girls are lured into early sex and child marriages by “makorokozas” and tobacco farmers as they are tempted by the cash that is used as baits. Adolescents boys and girls are also under immense peer pressure from their peers who venture into early marriage getting the illusion that early marriage is rosy.

It was also established that parents are accomplices in their child marriages as they are hesitant to report cases of sexual abuse to the police in order to preserve relations in community (on the pretext of Chigarisani- implying good neighbouriness). On another note, the strict and complicated procedures for reporting child marriages and sexual abuse gives families the option of resolving cases of abuse by marrying the violated girl child as restitution which fuels child marriage. In addition, the laws are contradictory and not harmonised as the age of consent to sex is 16 whereas the age of marriage is 18 which does not offer meaningful protection to adolescents who are entrapped in child marriage.

On a positive note, it was found that Chiefs and traditional leaders command respect and yield influence in communities to address negative social norms cultural, traditional and religious practices that encourage child marriages and teenage pregnancies. On the same note, the no longer visible traditional ways of counselling adolescent boys and girls at the Dare and Nhanga where experienced and trusted uncles and aunts as well as grandmothers could be revitalised to delay their impulsive rush into sex and child marriages. This paper also observes that there are some positive language units like “Regai dzive shiri mazai haana muto” implying let the eggs hatch into chicks and in turn chickens which are beneficial. Also, “Regai dzive hunde tsotso hadzina mavhunze” implying that small tree should be allowed to grow into big ones so as to yield more firewood. These could be the rallying philosophy in the community to inhibit men bent on

destroying the future of adolescent girls by disturbing their education and prospects of a career by marrying them early as children.

Conclusion and Recommendations

In view of the findings, the study considers child marriage as a social vice threatening to tear apart the moral fabric and the very pillars upon which society hinges and needs to be tackled head-on. This study found out that child marriage and teenage pregnancies are rife in Shamva's Chief Nyamaropa Area and Murewa Districts and that the causes mostly stem from social and cultural norms and traditional practices. It is this paper's strong conviction that in tackling problems of this nature solutions must not be dictated from outside the community. Solutions in this regard, must come from within the community itself hence the belief that the community can only be empowered to provide its own solutions through the adoption of community based rehabilitation where the local traditional leadership like the chiefs and the village heads have to be actively engaged to provide sustainable solutions. The chiefs should be on the vanguard, crafting community binding laws premised on ending child marriage and teenage pregnancies. Such an approach gives the wider populace collective responsibility and ownership of the problem and solutions. In this light the study here now presents its recommendations:

- ✓ ASRH services to be introduced and scaled up in primary and secondary schools at all grade levels. Schools have taken up the function of socialization agents on behalf of society and children spend more of their time in schools than with their parents. If this is implemented the adage of catching them young will bear fruits.
- ✓ All ASRH service providers to make collaborative efforts with schools as it is where children spend most of their time. If teachers give age appropriate knowledge and skills it will make a difference.
- ✓ There is need for parents to be educated or trained on ASRH issues as well as basic effective communication skills when dealing with adolescents. Parents confuse disciplining and corporal punishment which will be cleared if knowledge and skills are imparted in them.
- ✓ Teachers need to be capacitated through workshops on guidance and counselling skills. The concept of guidance and counselling is new to some teachers and a skill most teachers unfortunately do not possess.
- ✓ Cases of school drop-outs need follow-ups to establish the cause and be reported to the village head, the police and the chief for further investigation with the desire to assist the dropout as well as establishing the cause.
- ✓ Whenever there is marriage conducted, the ages of those engaged should be established by village heads to prevent child marriages. This could be made easier if it is made mandatory for the consenting partners to produce their birth certificates for verification thus helping to track and check child marriages

- ✓ Adolescents should access ASRH services in youth friendly set ups and that they demand to be attended in privacy and by health personnel they trust would observe confidentiality
- ✓ Parents to report cases of sexual violation of their children to the village head, the chief and the local police for further prosecution as well as deterrence penalty.
- ✓ Laws to be fine-tuned to facilitate arrest and punishment of perpetrators of sexual violence and child marriages.
- ✓ Government to expedite the provision of national identification documents to ease and facilitate arrests a process which could allow such offices to decentralise their operations through outreach visits to schools and clinics.
- ✓ There is need to provide continuous support for those adolescents who are in and out of marriage for them to further their education.
- ✓ The various leaders of Apostolic churches should be engaged in order to create awareness of the problem of child marriages.
- ✓ Adolescents, especially girls, need to be equipped with effective communication and life skills such as being assertive and goal-setting.
- ✓ Adolescents, especially girls, need made aware of body zones of space which need not be violated, like the awareness of body zones of space reserved for friend social interactions, for strangers and for people of the opposite sex.

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APPENDICES

Appendix 1

Focus group discussions Questions with Traditional leaders

1. Do you know any child health rights?

2. Do you have ASHRH programs or platforms for discussions in your community?

3. What is your role as the traditional leader in adolescents accessing SRHR services and information?

4. At what age or stage do you think is important to start discussing ASHR issues with adolescents?

5. Who has a bearing to adolescents to have informed decision to access ASRH?

6. What are the challenges in accessing ASRHR services and information at your health facility and other institutions?

7. What are the recommendations to address these challenges?

Appendix 2

Focus group discussions Questions with Religious leaders

1 Do you know any child health rights?

2 Do you have ASHRH programs or platforms for discussions in your church?

3. What is your role as the church leaders in adolescents accessing SRHR services and information?
4. At what age or stage do you think is important to start discussing ASHR issues with adolescents?
5. Who has a bearing to adolescents to have informed decision to access ASRH?

6. What are the challenges in accessing ASRHR services and information at your health facility and other institutions?

7. What are the recommendations to address these challenges?

Appendix 3

Focus group discussions Questions with Adolescents (girls and boys)

1. Do you know any child health rights?
2. Do you know your general rights?
3. Which ASRHR is being offered at your nearest health facility?
4. Are the services child friendly (accessible, private)?
5. What general comment do you have for the attitude on the health care workers when adolescents walk in for ASHR services?
6. Are ASHR services integrated in school based and outreach programs?
7. To what extent do you agree to the introduction of condoms and family planning services in schools and anywhere where adolescents can access them?
8. Do you have ASRHR programs in your church or community?
9. What are your parents or community attitudes in adolescents accessing ASRHR?
10. In school guidance or counselling what issues or topics are discussed?
11. What comments do your teachers normally give towards adolescents who are in need of SRHR services?
12. How did you learn about ASHR services through radio, tv, parents, peers, health workers?
13. What are the effects of social and cultural norms in accessing ASRHR?
14. What are the challenges in accessing ASRHR services and information at your health facility and other institutions?

15 What are recommendations to dress these challenge highlighted above?

Appendix 4

Focus group discussions Questions with Parents and Guardians

1. What SRHR services are available for adolescents that you know of?

2. Do you discuss SRHR issues with your adolescents?

3. Are services accessible to adolescents at the nearest health facilities or any other service providers?

4. At what age or stage do you think is important to start discussing ASRHR issues with your children?

5. What is your feeling or comments of the introduction of family planning and condoms to adolescents in need?

6. What ASRHR services are being offered at your health facility?

7. Who is responsible for ASRHR issues within family or community level?

8. Who has bearing on adolescents to have informed decision to access ASHR? (church, culture,

parents, health care providers or adolescents).

9. What are the challenges faced by adolescents in accessing SHRH services and information?

10. What do you think can be done or What do you recommend to address the challenges?

APPENDIX 5

Focus Group Discussions with Stakeholders in the Community

Questions directed to the police

1 Do you have a VFU at the post?

2 What is the extent of child marriage in the community?

3 How do you deal with the issue of child marriage?

Questions directed to Secondary School official

1 What is your role in ASRH provision?

2 Do you have any school drop outs related to child marriage and teenage pregnancy?

3 What challenges do you face in ASRH provision?

Questions Directed other stakeholders in the FGD

1 What is your role as Ministry in Adolescents accessing the ASRH?

2 Does your Ministry have any policy or guidelines on ASRH?

3 What are the effects of social norms and cultural norms in Adolescents accessing ASRH services and

information?

4 What are the challenges facing adolescents in accessing SRH services and information?

5 What recommendations do you suggest to address the challenges highlighted above?

APPENDICES (KI……KIV)

Interview Guideline Questions

Key Information Interview Questions

1 What are the ASRH services offered in your health facilities and in the community

Which ASRH services are not offered and Why? What are the positive, negative cultural and policy issues in the delivery of services?

2 How does your facility/facilities offer ASRH services in reference to family planning, condoms and prevention of teenage pregnancy, prevention of unsafe abortions. To what extent do culture/faith positively or negatively impact service delivery?

3 Communities also raised concern over informal accessibility of contraceptives for example from vendors, private pharmacies, adults giving adolescents contraceptives? What danger does this have on adolescents and the community at large? What is facilitating this and what can be done to address this?

4 Does your Ministry have an Action Plan on ending child marriage and teenage pregnancy? If yes what are key cultural, religious, legal issues and interventions being addressed?

5 Community is concerned with the introduction of comprehensive sexuality education to lower grades in schools. What is your comment?

6 What is your organisation's action to cases of teenage pregnancies and child marriages reported to it? What are the social, cultural and religious issues that fuel teenage pregnancy and child marriages?

7 Gender and cultural sensitivity is fundamental in ASRH programmes to ensure equal access and acceptability of social services and opportunities to adolescent and young people. Is there any harmonisation of cultural concerns, practices and ASRH?

8 To what an extent do you think by laws can positively or negatively impact the accessibility of ASRH services? To what extent do you think by laws can facilitate harmonisation?

9 What recommendations do you suggest to address the challenges of accessibility of ASRH?