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Legislators promoting access to adolescent's sexual reproductive health rights: Case of portfolio committee on health and child care in Zimbabwe

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Abstract
Adolescents in Mbare, Zimbabwe are facing numerous challenges in assessing sexual and reproductive health services. The government has failed to support policies that permit access to sexual reproductive health services by adolescents. The research objectives were to explore the role of the Parliamentary Portfolio Committee on Health and Child Care in promoting access to adolescent's sexual reproductive health rights. The researcher used qualitative research methodology. The data was collected from forty-three respondence using key informative interviews and in-depth interviews from the Parliamentary Committee on Health and Child Care, Parliament of Zimbabwe researchers, and adolescents in Mbare. Thematic analysis of information obtained revealed that the existing legal and policy guidelines and negative attitudes from health services providers towards sexually active adolescents have made it difficult for adolescents to visit health centers to seek information and services, especially on their sexual and reproductive health. Henceforth this has promoted a high death rate, early child marriages, unsafe abortion, and transmission of Sexual Transmitted Infections (STIs) among adolescents in Mbare. The study also found out that the Parliamentary Health Committee has been advocating for reviews to laws that are viewed as retrogressive towards the realization of adolescents sexual reproductive health rights and this will make a leeway to any adolescent in accessing reproductive health services whenever they need it. The study has shown that a need to be done in terms of policy implementation to include adolescents on universal access to health services.

Keywords: Adolescents, Parliamentarians, Reproductive, Sexual, Public Health

Introduction

Globally, adolescent's access to sexual reproductive health services has been ignored regardless of the high risks that countries face for their ignorance. The realization of the right to Sexual Reproductive Health and the availability of comprehensive universal access to SRHR in many countries is still a challenge. Engaging in early sexual activities by adolescents is now common and adolescents do not have a limited understanding of how to prevent reproductive health problems. Lack of adequate information on SRHR has led adolescents into risky sexual behaviors resulting in a high prevalence of sexually transmitted infections (STIs) and HIV prevalence, early unintended pregnancy, and vulnerability to delivery complications resulting in high rates of deaths and disability. Trying to curb this problem, various legal instruments were put in place such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Maputo Declaration, Sustainable Development Goal (SDG) number 3, which aims to eradicate HIV infections and provide universal access to sexual and reproductive health services as well as incorporating such services into national strategies (United Nations 2015).

A critical analysis was done by different authors on the causes of poor sexual reproductive health among adolescents in accessing sexual reproductive health services (Ngwenya 2016; Landa & Fushai, 2018; Mutanana, & Gasva, 2020; Rugowo & Maphosa, 2017) [6]. In a ministerial statement given in Parliament on the 4th of March 2021, the Minister of Women Affairs Minister Sithembiso Nyoni reviewed that in Zimbabwe, at least 4 959 teenagers fell pregnant while there were 1 774 child marriages recorded between January and February 2021.

The Health Belief Model (HBM) was used because it was one of the first models to predict and explain variations in contraceptive behavior among women in the 1970s and 1980s (Hall 2012). The model views humans as rational beings who use a multi-dimensional approach to decision-making regarding whether to perform a health behavior. Moreover, the young people's health-seeking behaviors are based on perceived benefits and costs, enabling or modifying factors that affect access and utilization of services, influencing their decisions to seek SRH services.

Access to SRHR can be universal only if it applies equally to all people. Equity in access to sexual reproductive health services is therefore central to the process of prioritizing interventions. The Agenda 2030 principle of leaving no one behind guides countries to put people first, in particular those who currently are underserved, marginalized, or discriminated against, including adolescents, people with disabilities, and LGBTI individuals. SRHR interventions should target the needs of all individuals, which requires countries to work more deeply on applying a rights-based approach. (NEAPACOH, 2019).

Literature review

Inadequate SRH Information

According to the Zimbabwe National Adolescent Sexual and Reproductive Health Strategy (2010–2015), young people lack comprehensive knowledge on SRH issues and services, with little knowledge more skewed towards child abuse and HIV and AIDS. A study conducted by Muchabaiwa & Mbonigaba, (2019) on the impact of the adolescent and youth sexual and reproductive health strategy in Zimbabwe, shows that inadequate access to health information and services, inequitable gender norms, contributes to a lack of knowledge and awareness about puberty, sexuality, and basic human rights among adolescence. Additionally, the Center for Reproductive Rights (2018) argues that there is generally a lack of comprehensive material with information around sexual and reproductive health for all target groups including adolescents with disabilities and those in conflict settings. Article 13 of the Convention on the Right of Child (CRC) provides for the right to information including the right to sexual and reproductive health information. Seeking and accessing sexual and reproductive health information is essential to the enjoyment of sexual and reproductive health and rights by adolescents. In an African society, it is taboo for parents to discuss sexual issues with their children even though these adolescents are practicing unsafe sex. Henceforth, many parents, do not impart knowledge to their children on SRHR issues. According to Muzadzi (2018) traditional and religious leaders promote abstinence as an exclusive intervention for unmarried young people to prevent STIs and pregnancy, however, other studies proved that abstinence can be difficult to practice. Macdonald (2017) postulates that culture and stereotypes intersect constantly within the SRH work and education since it is the root of people's identities, values, pride, biases, and behaviors. Most people in African societies still shy away from an open discussion about women's sexuality and sexual choices because many Reproductive Health and gender issues are sensitive or controversial because they are subject to different interpretations, some of which are considered divine or sacrosanct and hence cannot be subject to change, (Jumo, 2011). In the Zimbabwean culture, it was the role of aunts and uncles to educate young boys and girls as they grew into puberty. However, this practice has been eroded by modern practices such as formal schooling, urban migration, collapsing of the family unit, and also access to alternative sources of information like television, radio, and print media. The studies in the reviewed literature were done some years before and in different cultural settings. Times have changed now and so is the way adolescents behave henceforth this research seeks to address some of these gaps.

Level of Awareness on the existing Sexual Reproductive Health Rights

According to Morris & Rushwan (2015), young people lack comprehensive knowledge of SRH issues and services, with little knowledge more skewed towards child abuse and HIV and AIDS. Adolescents have little-to-no information on legal and policy provisions in place to protect their sexual and reproductive health rights. World Health Organization (2018) [9] propounds that the majority of people become sexually active during adolescence and that the use of protection and contraceptives is very low among the same. The WHO (2011) report states that over 100 million cases of sexually transmitted infections (STIs) were recorded among young people, as well as more than 2.5 million unsafe abortions which were recorded for adolescents worldwide. A study carried by Landa & Fushai (2018) shows that adolescents in Mupandawana are particularly affected by a lack of information and they do not have knowledge of policies that relate to their SRH. Muzadzi (2013) points out that the Zimbabwe National Adolescent Sexual and Reproductive health strategy 2010-2015 indicates that ASRH is offered through three models which are as follows: Health facility approach (integrated approach) which is a model where SRH services are provided to young people as part of the general public; Community approach which is a situation where SRH services are strictly designed for young people through community youth centers; and School-based approach which is the provision of life skills education and counseling by teachers/lecturers and peer educators in schools (both public and private) and tertiary and vocational institutes. Despite all these efforts adolescents, especially those in marginalized communities have little to no information about legal policy provisions in place to protect their SRHR.

The SRHR role of the Parliamentary Committee on Health and Child Care

According to McCafferty (2009), political will and leadership are fundamental to improving women's access to sexual and reproductive health services. Parliamentarians are well placed to promote gender-sensitive health and SRHR policies through legislation and societal status as role models or opinion leaders. According to Musuka and Chingombe (2017) as 'watchdogs' parliamentary portfolio committees, have the role of monitoring national budget performances and ensuring that the national budgets address key health issues affecting everybody in the country. The parliamentary portfolio on Health and Child Welfare in Zimbabwe, for example, engages consultants to assist in analysing the budget bids and estimates of expenditure, and also in other issues such as legislation and policy analysis.

Even when support for budget analysis is provided, improvements inequitable allocation may be difficult to ensure due to the falling real incomes across most of the East and Southern African regions and the hyperinflationary environment in the case of contemporary Zimbabwe.

Parliament, as the arm of the state institution that oversees the work of the executive arm, has a key role to play in ensuring efficiency, effectiveness, and accountability at all levels. According to Martin Chungong cited in Inter-Parliamentary Union (2017) [5] argues that Parliamentarians leverage their powers as the representatives of the people to voice the needs and concerns of the most vulnerable. Without Parliament ensuring adequate budget appropriation, conducive legislative environment, and thorough oversight over government health policies and program interventions, most of the targets under SDG 3, including universal health coverage, will not be met. Parliaments, therefore, have a very important role to play in creating an enabling environment for health-related policy implementation, which is a critical precondition for ensuring universal access to SRHR.

Government of Zimbabwe Initiatives to Improve the Sexual Reproductive Health of Adolescents.

Domestically, Zimbabwe has a long list of instruments that speak to adolescent health and facilitate the effective operationalisation of several conventions, laws, and strategies that address ASH. Starting with the principle law, the Constitution of the Republic of Zimbabwe Amendment Number 20 of 2013; guarantees the right to health, including reproductive health to all citizens. It contains a Declaration of Rights that seeks to protect "the fundamental rights of the individual". Section 78(1) of the Constitution sets out 18 years as the minimum age of marriage in Zimbabwe. Section 26 of the Constitution provides that no marriage must be entered into without the free and full consent of the intending spouses (Zimbabwean Constitution, 2013). This means that forced marriages and child marriages are prohibited under the Constitution and children must not be pledged into marriage. However, it is important to note that "the fundamental rights of the individual" are not specifically for adolescents.

The Zimbabwean government adopted the National Adolescent and Youth Sexual and Reproductive Health Strategy, National (ASRH) Strategy (2016-2020) which covers adolescents and young people between the ages of 10 – 24. It aims to provide sector-wide governance to government ministries and all none state actors including the civil society and development partners in the provision of sexual and reproductive health services for adolescents and young people in the 10-24 years age group, (National Adolescent and Youth Sexual and Reproductive Health Strategy II: 2016-2020). The National Population Policy of 1988 recognizes women's right to control their fertility and exercise their reproductive rights. The Population Policy specifies that "individual rights to choose freely and responsibly the number, spacing, and timing of children they want will be fully respected"; and that it is essential to recognize the aspirations of women and youth, in particular, the policy also specifically states the need to address adolescent health, with particular emphasis on reproductive health, UNFPA (2016). However, according to UNFPA (2016), the Population Policy has never been implemented, though the policy that was revised in 2009 was shelved up to the present. This is very alarming and a cause of concern, revealing the idea that most policies are just there for show but they lack practicality and are not implemented. In many countries sound national ASRH strategies exist, however, they are not implemented or are only weakly implemented because of a lack of comfort in dealing with sensitive issues. Biases emanating from attitudes and values that are either personally held or grounded in religion or tradition act as potent barriers in preventing evidence-based recommendations from shaping policies, and in translating sound policies and strategies into action on the ground (World Health Organization, 2018) [9]. According to Boateng (2017) [1] when national ASRH strategies are not implemented effectively, adolescents and young people are unable to obtain the SRH education they need in their schools and communities, and also from health facilities in their communities. This result is unwanted pregnancies, unsafe abortions, and high STIs incidences including HIV infection.

Methodology

The study was informed by pragmatism. This allows for both qualitative and quantitative data. The study used primary data that was collected from a sample of 43. The study selected 37 adolescents using simple random sampling. The participants were drawn from a high-density suburb in Harare, Zimbabwe. Key informants were selected from members of the Parliamentary Portfolio Committee on Health and Child Care based on their knowledge on ASRHR, semi-structured questionnaires were used to gather data through face to face interviews The population of 43 participates was large enough to draw a sample size that enables generalizability of results of the effectiveness of the Parliamentary Portfolio Committee on Health and Child Care in promoting Adolescence Sexual Reproductive Health Rights (ASRHR). The population was a critical part of the research because it involves information that is being sought from the documents as well as the direct interviews that were held before the research topic (Cresswell, 2014). Ethical considerations such as consent, voluntary participation, rights to withdraw from the study, confidentiality, and not causing harm were adhered to**.** The Clerk of Parliament approved and gave consent for the research to be conducted at their institution.

Objectives

1. To assess the role of the Parliamentary Portfolio Committee on Health and Child Care in advocating for Adolescents Sexual Reproductive Health Rights.
2. To examine the level of awareness among adolescents on the existing Sexual Reproductive Health Rights.
3. To investigate challenges encountered by adolescents in accessing Sexual Reproductive Services.

Data Analysis

The researcher used bar graphs, and pie charts to analyses the knowledge of adolescents on SRHR related issues from the field. According to Cresswell (2014), data presentation refers to the organization of data into tables, graphs, or charts so that logical and statistical conclusions can be derived from the collected measures. Data analysis involves review, cleansing, and altering data to get useful information suggesting conclusions and support decision making. This method is suitable for qualitative methodology as it thoroughly inspects the data only to get the important information. The researcher used bar graphs to analyses the knowledge of adolescents on SRHR related issues.

Results and discussions

Key issues emerging from the research finding are that adolescents are facing many challenges when accessing health services, despite existing Zimbabwean Government policies. Parliament of Zimbabwe has not been very much

involved in SRHR issues and this resulted in a lack of universal access to SRHR to women and girls. The involvement of Parliamentarians in SRHR advocacy gives a platform for them to work up together with civil societies to reduce the spread of HIV and AIDS, STIs, and adolescent pregnancies. The Parliamentary Portfolio Committee on Health and Child Care is playing a crucial role in advocating for universal access to ASRHR. The committee has managed to influence legislative and policy changes such as the Marriages Bill of 2019 which aims to protect and promote the rights of adolescents. Despite the cultural and religious beliefs in the country, the Committee has gone an extra mile to push for a review of the current age of consent to accessing sexual health services, and a review of the Termination of Pregnancy Act. Despite all these efforts played by the Committee, they are not attaining quick successes, especially on substantial movement like on legislation due to the negative attitude of the society about ASRH issues.

Lack of Sexual Reproductive Health Information

The research shows that the availability of sexual reproductive health services and information could make a huge difference in the lives of many of these young people and help them manage their reproductive lives. The changes in adolescents have health consequences not only in adolescents but also over the life-course hence Parliamentarians are playing an important role in representing in government the needs and aspirations of the people including young people creating a conducive legislative environment for the realization of adolescent health and well-being. Participant B. highlighted that.

> *Young people need to be heard they got special issues of adolescence and there are many health issues affecting adolescence. Parliament of Zimbabwe is a people's parliament hence we must show leadership in engaging with adolescents so the Health Committee needs to actively and pro-actively support adolescents especially on issues around their sexuality where there is a lot of cultural issues. Hence by creating youth-friendly services, it will make adolescence able to access SRH services. The committee has been encouraging the Ministry of Health and Child Care to provide youth-friendly services for adolescents and strengthening the awareness creation strategies among the youth to increase the utilization of the services ……*

However, some studies have found that youth-friendly spaces may not be effective in increasing service use as young people may realistically fear the stigma associated with seeking SRH care, given negative views and societal values about the sexuality of young people. There is therefore a growing trajectory towards having integrated and comprehensive SRH service provision at every health care institution.

Awareness among adolescents on the existing Sexual Reproductive Health Rights

The researcher investigates the level of adolescent's awareness of the existing SRHR. The study revealed that in as much as many adolescents in Mbare are engaging in premarital sexual intercourse, adolescents have little-to-no information on legal and policy provisions in place and this has contributed to low uptake of sexual and reproductive health services among adolescents. The bar graph below shows that 36% of the respondents highlighted that they know SRHR legal frameworks and policies that are in place. In contrast, 64% of adolescents respondents reviews that they have no information regarding SRHR legal frameworks.

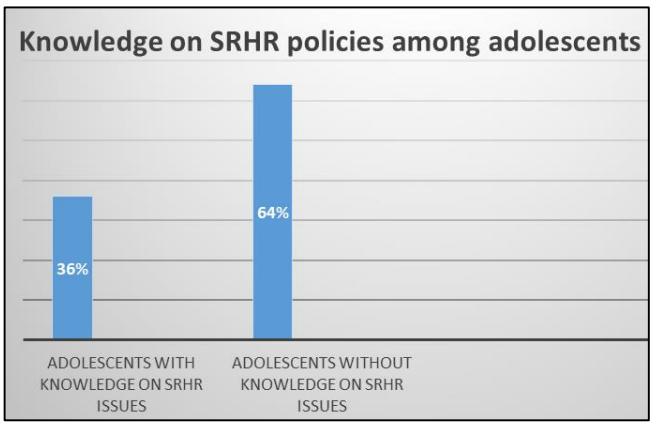

Fig 1: shows knowledge of adolescents on SRHR issues

From the above finding participant D commented that;

> *The committee is working with different stakeholders and ministries to increase access to comprehensive sexuality education. This is because children between 12 and 16 years can among themselves have consensual sexual intercourse without offending any penal provision. That legal position aside and most children are not aware of that legal position it is fact that children are engaging in sexual activity among themselves at an early age. Such children require access to sexual and reproductive health services as an intervention.*

According to Center for Reproductive Rights (2017) seeking and accessing sexual and reproductive health information is essential to the enjoyment of sexual and reproductive health and rights by adolescents. Comprehensive sexuality education is critical for informing adolescents about sexual and reproductive health services, their right to access such services and the right to make decisions about their sexuality and reproduction free from violence, undue influence, or coercion. However, sex talk in a typical Zimbabwe family and public discussion is a taboo and is rarely spoken about. Under such circumstances, it therefore not easy for the committee to convince society to educate adolescents on sexuality matters. To bridge this information gap ministers in the Eastern and Southern Africa (ESA) region adopted 2013-2020 ESA Comprehensive Sexuality Education commitments upon which the Health Committee hinges its implementation follow-up oversight. An informed young person is more empowered and has the courage to stand and defend their reproductive rights.

Restrictive laws in Zimbabwe

Adolescent respondent states that restrictive laws in Zimbabwe on abortion have made many adolescents not able to seek medical abortion at a local clinic. Regardless of Zimbabwe being a signatory to the Maputo Plan of Action which calls for allowing abortion in state states parties, Zimbabwe's law does not allow free abortion services to every woman who wants one. According to Chiweshe and

Masiyiwa (2018) [3], the law that is currently in effect on abortion in Zimbabwe is the Termination of Pregnancy Act of 1977 which only allows abortion when the continuation of the pregnancy endangered the life of the woman or poses a serious threat of permanent impairment to her physical health, and in cases where the fetus was conceived as a result of unlawful intercourse, including rape, incest or intercourse with a mentally handicapped woman. According to Ushie (cited in NEAPACOH 2019), abortion is a key SRH issue affecting Africa and highlighted that much as abortion is high in developed counties, most unsafe abortions take place in Africa (76 percent). In Zimbabwe, one in every four unintended pregnancies ends in abortion.

Adolescent respondent states that restrictive laws in Zimbabwe on abortion have made many adolescents not able to seek medical abortion at a local clinic. The study shows that adolescents their main source of accessing SRH services were from local traditional healer Miss C. an adolescent respondent states that;

Vasikana vazhinji munomu muMbare vakunoenda kunobviswa nhumbu naGogo X vanoshandisa hen'a kuibvisa nhumbu yacho. Ini ndine shamwari yangu yakaita nhumbu ane 13 years akaenda kunobviswa nhumbu nagogo ivavo haana kumbogara 3days akabva ashaya. Dai mitemo yemuZimbabwe ichitendera kuti munhu anobviswa nhumbu pachena dai vana vazhinji kusanganisirara shamwari yangu isina kumbofa (Most of the adolescents here in Mbare are practicing backyard abortions with a local traditional healer who uses clothes hanger to terminate that pregnant. I have one of my friends who fell pregnant at 13 and went on to practice unsafe abortion with that local traditional healer and she died after three days. If Zimbabwe law permitted termination of pregnancy to everyone who wants it we would not lose many adolescences including my friend to unsafe abortion)

In support of the above statement, Participant A. highlighted that.

> *In South Africa, after the 1994 reforms, parliament passed the Choice on Termination of Pregnancy Act which was gazetted in 1997. This Act provides for abortion on request up to twelve weeks, and under a broad set of circumstances, in consultation with a health worker, up to twenty weeks. Under this law, trained midwives can do abortions. Henceforth, the new Act replaced the Abortion and Sterilization Act of 1975 which allowed abortion in very limited circumstances leaving a large number of women and girls carrying out illegal abortions every in South Africa. The Termination of Pregnancy Act of 1997 has therefore broadened the number of women and girls who can access legal and safe abortion and some great number of young people in Zimbabwe who have money they even went to S.A to terminate their pregnancies. Hence the Committee aims to make this facility being affordable for everyone in Zimbabwe regardless of their economic status by doing that this will prevent loss of lives due to backyard abortion.*

In addition to the above Participant, C highlighted that in our country they are several undocumented cases of unsafe abortions or deaths that are associated with unsafe abortions.

> *Due to the economic crisis we are facing in the country younger and younger people are involved in sexual activities and abortion in this country is being used as a contraceptive method by adolescents. So as someone reached the age of twenty-one she had already had multiple abortions and this will affect her long run. So as Parliament we need to balance our approach we are not saying we are promoting our young people to be sexually active but at the same time, we must accept that most of them are active so we must respond to health care and needs. Instead of making the moral issue let it be a public health issue.*

About 60% of adolescent respondents in Mbare highlighted that they are not able to access Sexual Reproductive Health services at a local clinic because of the current age of consent to accessing sexual health. In Zimbabwe, an adolescent under the age of sixteen old cannot access sexual and reproductive health services and treatment without parental consent. Hence by the study conducted shows that existing legal and policy guidelines have restricted many adolescents in accessing SRH services at a local clinic although Section 76 (1) of the Constitution of Zimbabwe states that: "Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services" Hence the committee is working on the amendment of the Termination of Pregnancy Act of 1977 and this will give adolescents the freedom to abort pregnancies other than in the specified circumstances. Doing so would expand access to safe abortion and prevents high death rates due to unsafe abortions among adolescents.

Youth Friendly Services

The availability of youth-friendly services and information could make a huge difference in the lives of many of these young people and help them manage their reproductive lives, according to research. This shows that the changes in adolescents have health consequences not only in adolescents but also over the life-course hence Parliamentarians are playing an important role in representing in government the needs and aspirations of the people including young people creating a conducive legislative environment for the realization of adolescent health and well-being.

However, some studies have found that youth-friendly spaces may not be effective in increasing service use as young people may realistically fear the stigma associated with seeking SRH care, given negative views and societal values about the sexuality of young people. There is therefore a growing trajectory towards having integrated and comprehensive SRH service provision at every health care institution. In Zimbabwe, an adolescent under the age of sixteen old cannot access sexual and reproductive health services and treatment without parental consent. Hence by the study conducted shows that existing legal and policy guidelines have restricted many adolescents in accessing SRH services at a local clinic although Section 76 (1) of the Constitution of Zimbabwe states that: "Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services"

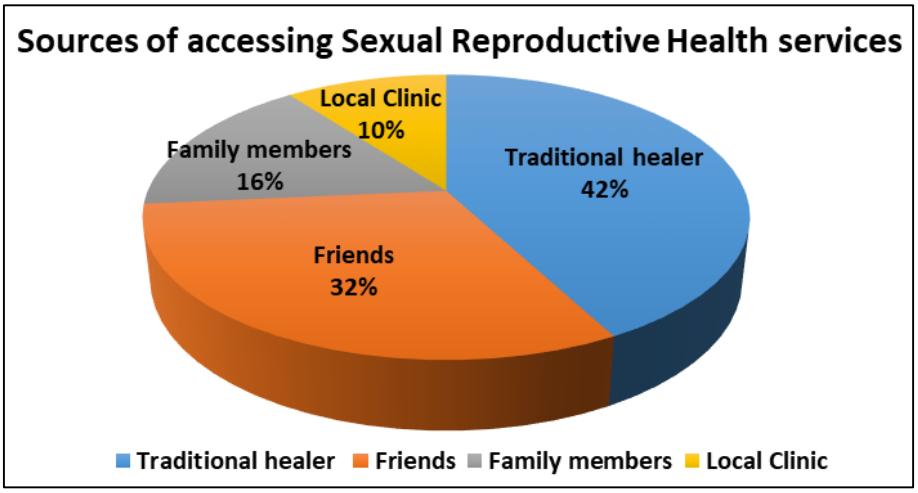

Fig 2: Sources of accessing SRH services

The above pie chart review shows that the majority of participants (47%) source SRH services from a local traditional healer, followed by 37% who access them from friends, 16% from family members, and 6% from a local clinic. One of the adolescent's respondents highlighted that; *Pandakamborwara neSick ndaitodawo kuenda kuClinic kunorapwa asi nenyaya yekuti kuClinic manurse havarape mwana anouya ega asina mubereki ari pasi pemakore sixteen zvakaita kuti ndiende kunopihwa mushonga wechibhoi kuna ambuya vanorapa* (When I was affected by Sexual Transmitted Disease I was willing to go and get treatment at a local clinic but with the fact that the health workers do not help adolescents below the age of sixteen without the consent from the adult made me go and seek assistance from local traditional healer).

Mr. K. a Parliament researcher highlighted that the committee is advocating to review the age of consent to accessing health services to give adolescents full rights to access reproductive health services regardless of their age without parental consent.

The attainment of universal health coverage has given the Health Committee more opportunity to bring awareness to other Parliamentarians on challenges that are being faced by most adolescents in accessing SRH services in the country mainly from a poor background. This had impacted a huge push for an increase of adolescents accessing SRH services and information for example in 2018 where Members of Parliament fought harder to ensure that duty on sanitary ware is suspended to make it affordable to all citizens. This gives a positive result in the country because sanitary ware was accessed by the majority who need it at lower prices. For the 2030 agenda to be achieved we must not leave anyone behind hence the well-being of adolescence must be respected.

Conclusion and recommendations

Parliament of Zimbabwe has not been very much involved in SRHR issues and this resulted in a lack of universal access to SRHR to women and girls. The involvement of Parliamentarians in SRHR advocacy gives a platform for them to work up together with civil societies to reduce the spread of HIV and AIDS, STIs, and adolescent pregnancies. The Portfolio Committee on Health Committee needs to engage with religious and traditional leaders to raise awareness on the risks of deficient SRHR services among sexually active adolescents and the negative impacts of child marriages. When the leaders in society are educated on SRHR related issues they will bring together and modernize policies, practice, and socio-cultural issues to ensure that a safe and supportive environment is provided for adolescents seeking SRH services. The Portfolio Committee on Health and Child care must engage adolescents more in decision making, planning about ASRHR this will ensure relevance, the effectiveness of policies, and a conducive environment for sexually active adolescents.

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