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INVESTIGATING THE KNOWLEDGE, ATTITUDES, AND PRACTICES TOWARD ADOLESCENT GIRLS' ACCESS TO SRHS. A CASE STUDY OF DOMBOTOMBO CLINIC

By

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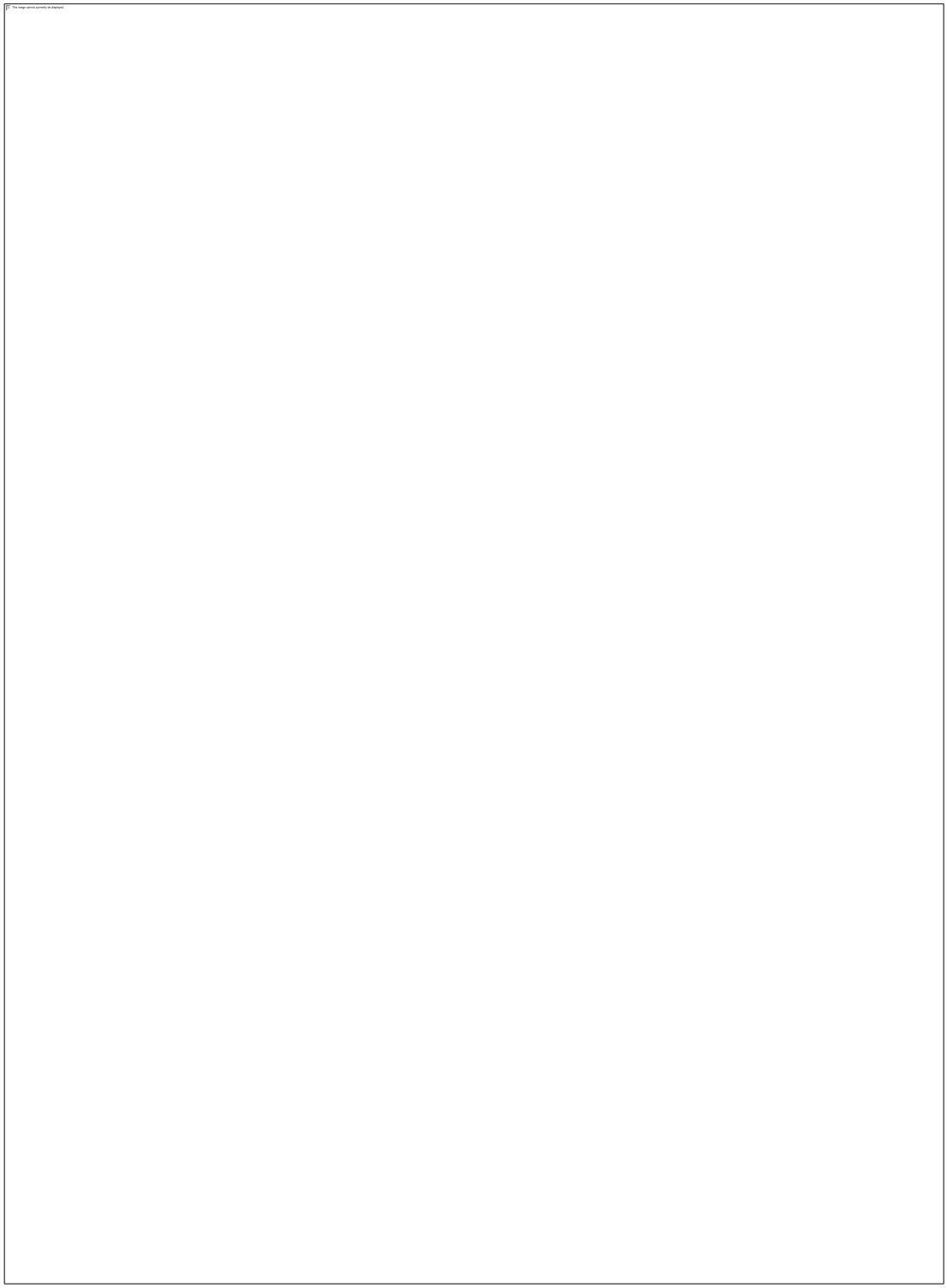
ABSTRACT

The study investigated the knowledge, attitudes, and practices influencing adolescent girls' access to SRHS in Marondera Urban. A case study approach focused on Dombotombo Clinic and the surrounding community. Data was collected through questionnaires, focus groups, and key informant interviews. Thematic analysis was used to analyze qualitative data and identify key patterns. Key findings of the study, adolescent girls have inadequate knowledge about available SRHS options and their sexual health needs. Negative attitudes on the part of the adolescent girls, while health workers showed a positive attitude. SRHS. Service delivery challenges, a lack of privacy because of inadequate infrastructure. The low SRHS utilization among adolescent girls at Dombotombo Clinic is a result of a complex interplay between limited knowledge, negative community attitudes, and unfriendly service delivery practices. The study recommends implementing comprehensive sexuality education programs in schools. Conducting community awareness campaigns to challenge stigma and promote open communication about sexual health. Addressing these knowledge gaps, negative attitudes, and service delivery issues, this research aims to contribute to improved access to SRHS for adolescent girls in Marondera. This can empower them to make informed choices about their sexual and reproductive health, leading to better health outcomes and a brighter future.



APPROVAL FORM

TITLE OF DISSERTATION: INVESTIGATING THE KNOWLEDGE, ATTITUDES, AND PRACTICES TOWARD ADOLESCENT GIRLS' ACCESS TO SRHS. A CASE STUDY OF DOMBOTOMBO CLINIC

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DECLARATION

I, B200463A hereby declare that this project is my original work and that it has not been copied or lifted from any other source without acknowledgment.

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DEDICATION

To my parents, for believing in me.

ACKNOWLEDGEMENTS

I am grateful to God for taking me this far. I would like to express my sincere gratitude to my dissertation advisor E. Chigondo, for invaluable guidance and encouragement. I am also deeply grateful to the participants in this study, particularly the adolescent girls who shared their experiences and perspectives with honesty and courage. I would like to acknowledge the staff at Dombotombo Clinic for their cooperation and assistance in facilitating data collection. A special thanks to Gloria Nyamaropa. Finally, I am grateful to my family and friends for their unwavering love and support throughout this process.

LIST OF ABBREVIATIONS

SRHS - Sexual and Reproductive Health Services

WHO - World Health Organization

STI - Sexually Transmitted Infection

PHIA - Zimbabwe Population Based HIV Impact Assessment

CSE - Comprehensive Sexuality Education

TA - Thematic Analysis

NGO - Non-Governmental Organization

UNFPA - United Nations Population Fund

HIV - Human Immunodeficiency Virus

MoHCC - Ministry of Health and Child Care

YFSRHS - Youth-Friendly Sexual Reproductive Health Services

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CHAPTER 1

1.1.Introduction

This chapter lays the groundwork for a study on a critical global issue, underutilization of Sexual and Reproductive Health Services (SRHS) among adolescent girls, particularly in developing countries. SRHS plays a vital role in the well-being of young women. These services, encompassing contraception, STI prevention/treatment, and comprehensive sex education, empower girls to make informed decisions about their sexual and reproductive health. Unfortunately, many girls face barriers that limit their access to SRHS, leading to negative health consequences and hindering their overall development. The World Health Organization (WHO) defines SRHS as the right of everyone to have control over their sexual and reproductive health, including access to high-quality, gender-sensitive services. However, various factors like societal norms, cultural beliefs, gender inequality, and weak healthcare systems create a complex web of obstacles hindering access to SRHS, particularly for adolescent girls. The consequences of limited access are dire. A report by the United Nations Population Fund (UNFPA) reveals that millions of adolescent girls give birth annually, and complications from pregnancy are a leading cause of death in this age group globally. Negative attitudes and stigma surrounding adolescent sexuality create shame and fear, further discouraging girls from seeking SRHS. Additionally, structural barriers like limited clinic hours or lack of transportation further restrict access. Given the urgency of this issue, this research aims to investigate the knowledge, attitudes, and practices concerning adolescent girls' access to SRHS in Marondera, Zimbabwe. By understanding the specific barriers they face, we can develop solutions to improve their access to these crucial services and ultimately improve their health outcomes

1.2.Background of the study

Adolescent girls in Zimbabwe face significant hurdles in accessing Sexual and Reproductive Health Services (SRHS), despite their critical role in promoting overall well-being. The World Health Organization (WHO) defines SRH as "a state of complete physical, mental and social well-being in all matters relating to the reproductive system" (WHO, 2018). SRHS for adolescents encompasses a variety of services, including contraception, STI prevention and treatment, and counseling. The importance of SRH for adolescent health has gained increasing recognition in recent years, leading to more research on access barriers. Studies highlight numerous challenges faced by girls, including lack of awareness about available services, negative societal attitudes towards SRH, and limitations on their decision-making power (WHO, 2018). Dombotombo Clinic, a primary healthcare facility in Marondera serving a low-income population, offers free SRH services like contraception, STI testing/treatment, and counseling. However, despite these services being readily available, adolescent girls in the area have the lowest utilization rate. This case provides a valuable opportunity to explore the specific reasons behind this low uptake within the context of Dombotombo Clinic and the surrounding community.

1.3.Aim

To explore the knowledge, attitudes, and practices toward adolescent girls' access to SRHS.

1.4.Statement of the Problem

Marondera Urban faces a concerning trend: high rates of teenage pregnancy and STIs among adolescent girls. According to the 2022 Zimbabwe PHIA, STI prevalence among adolescent girls

(14-19) in urban areas is a troubling 15.4%, exceeding the national average of 13.7%. Despite government efforts to make SRHS services accessible to women and girls, adolescent girls have the lowest uptake. These free services at Dombotombo Clinic remain underutilized by this high-risk population. This lack of access has severe consequences for their sexual health, increasing their vulnerability to STIs. This study aims to delve into the reasons behind this low utilization, and assess adolescent girls' understanding of SRHS and their sexual health needs. Investigating these aspects, will lead to an understanding of the the current state of SRHS access for adolescent girls at Dombotombo Clinic.

1.5.Objectives

- To assess the current level of awareness among adolescent girls regarding sexual and reproductive health services available to them.
- To evaluate the attitudes of both the service providers and the recipients towards adolescent sexual and reproductive health.
- To explore the effectiveness of the current practices at Dombotombo Clinic in providing sexual and reproductive health services to adolescent girls and recommend possible interventions to improve access.

1.6.Research questions

2. What are the prevailing knowledge levels and attitudes among adolescent girls in Marondera Urban regarding sexual and reproductive health?
3. What are the attitudes of health workers toward providing SRHS to adolescent girls?

4. What are practices surrounding SRHS among adolescent girls and practices at Dombotombo Clinic to ensure the privacy and comfort of adolescent girls seeking services?
5. What measures can be put in place to improve adolescent girls' uptake of SRHS?

1.7. Assumptions

This research study will be based on the following assumptions;

- Adolescent girls lack knowledge of sexual reproductive health services
- There is a disconnect between health service providers and adolescent female clients.

1.8. Significance of the study

This study also has the potential to contribute to the broader body of knowledge regarding adolescent health services. It can add to the understanding of how socio-demographic characteristics intersect with knowledge and attitudes to shape health outcomes. This is particularly relevant in the case of Dombotombo Clinic, which could serve as a microcosm for similar settings across the region. The findings could be instrumental in guiding policy recommendations and programmatic interventions aimed at enhancing the accessibility and quality of SRHS for adolescents.

1.9. Delimitations

This study will narrow itself to the Marondera urban district using adolescent girls who live in those areas and health workers at Dombotombo clinic who are responsible for providing SRHS. The targeted populations for this study are adolescent girls and health workers.

1.9.1 Key definitions

Sexual reproductive health (SRH): A state of physical, mental, and social well-being in all matters relating to the reproductive system and its functions and processes. This includes the ability to have a satisfying and safe sexual life, the capability to reproduce, and the freedom to make decisions about reproduction without coercion, discrimination, or violence.

Adolescent girls: Girls aged 10-19 years.

Sexually transmitted infections (STIs): Infections that can be transmitted through sexual contact, including vaginal, anal, and oral sex.

Access: the ability of adolescent girls to obtain necessary health services, which can be influenced by factors such as availability, affordability, and acceptability.

Knowledge: encompasses the information that girls have about SRHS, including understanding of their own health and rights.

Attitudes: involve the perceptions and beliefs held by girls and their communities about using these services, which can be shaped by cultural, social, and religious norms

Practice: are the actual behaviors and actions taken by girls to their sexual and reproductive health, which can include seeking care, using contraception, and engaging in safe sex.

1.10 Dissertation Outline

Chapter 1: Introduction and Background of the study. The chapter introduces the topic under study, highlighting the background of the study, significance, study objectives, research questions, aim, and the conclusion of the chapter.

Chapter 2: Reviews relevant literature on the importance of SRHS for adolescent girls' health and well-being. Discusses common barriers faced by adolescent girls in accessing SRHS services globally and nationally in Zimbabwe. Explores the role of knowledge, attitudes (individual and community level), and practices (service delivery, social norms) in influencing access to SRHS. Include relevant research on factors contributing to low service utilization among adolescents despite availability.

Chapter 3: Research methodology, states the use of a case study approach focusing on Dombotombo Clinic and the surrounding community. Describes the methods used to collect data, which are structured questionnaires, focus group discussions, and key informant interviews. Explains how the collected data will be analyzed thematically to identify key patterns and insights.

Chapter 4: Present the key findings from the study, organized by the research themes, which are knowledge, attitudes, and practice. The chapter presents data based on the findings in the form of tables, charts, and descriptions

Chapter 5: Summary, conclusions, and recommendations, the final chapter, summarizes the study, derives conclusions, and offers recommendations.

1.11. Chapter Summary

This chapter covered various issues that form the basis of this study. The background of the study, statement of the problem, study objectives, research questions, significance, and delimitation of the study were covered. The next chapter will review related literature**.**

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

This section delves into the perspectives of various researchers regarding adolescent girls' access to sexual and reproductive healthcare (SRH). It focuses on understanding their level of knowledge, attitudes, and actual practices related to SRH. The review will also explore how these factors are interconnected, drawing insights from existing research. It will examine the effectiveness of previous studies on this topic and identify any potential barriers that might be hindering girls from utilizing SRH services. Building on Arlene's (2015) definition, this section functions as a comprehensive analysis of existing research on adolescent girls' access to SRH. It will specifically explore how access to these services is perceived on a global scale, with a particular focus on Southern Africa and Zimbabwe. Additionally, the conceptual framework that will guide this study will be presented.

2.2. Theoretical Framework

Access to sexual and reproductive health services (SRHS) is a cornerstone of adolescent girls' well-being. SRHS empowers them to navigate their bodies and futures with knowledge and confidence (UNFPA, 2020). However, their ability to access and utilize these services is intricately woven into the fabric of their environment. Bronfenbrenner's ecological systems theory (1979) provides a powerful lens to examine these environmental influences. This theory proposes that individuals exist within a series of nested systems, each playing a role in shaping their development and behavior. These systems interact and influence each other, creating a complex yet interconnected landscape, and microsystem, this encompasses the immediate surroundings an

adolescent girl interacts with daily. Family dynamics, particularly parental support and open communication, significantly impact her knowledge and attitudes toward SRHS Aggleton et al., (2019). Schools, another crucial microsystem component, can equip girls with essential SRHS information and skills through comprehensive sexuality education (CSE) programs (UNESCO, 2018). Furthermore, fostering a strong home-school connection, where parents and educators collaborate, reinforces SRHS messages and encourages healthy practices (Kirby et al., 2011). The macrosystem, represents the broader cultural and societal context. Cultural beliefs and social norms within this system can significantly shape how girls access and perceive SRHS (World Health Organization, 2019). Gender inequality presents a particularly challenging aspect of the macrosystem. Unequal power dynamics often limit girls' access to SRHS and control over their bodies (UNFPA, 2017). Mesosystem and Exosystem: While not explicitly mentioned earlier, these additional systems contribute to the complexity of the environment. The mesosystem refers to the interactions between microsystems, such as the connection between home and school environments. The exosystem focuses on indirect influences, like a parent's workplace environment or community norms that can indirectly impact an adolescent girl's SRHS experiences. Understanding these interconnected ecological systems is not just about awareness; it's about creating positive change. By recognizing the multi-layered factors at play, we can design interventions and policies that target these various levels. For instance, programs could focus on fostering open communication within families, advocating for comprehensive sexuality education in schools, and addressing broader societal norms that perpetuate gender inequality. Ecological systems theory offers a valuable framework for navigating the complexities that influence adolescent girls' access to SRHS. By acknowledging these interconnected systems, we can move beyond a fragmented approach. This holistic understanding allows us to design comprehensive

interventions that empower girls to make informed choices about their sexual and reproductive health, ultimately leading to a healthier and brighter future for them.

2.3. Literature review

2.3.1. Knowledge of SRHS

Studies consistently paint a complex picture of sexual and reproductive health (SRH) knowledge among adolescents and university students. Research reveals a spectrum of understanding, with concerning gaps in knowledge, attitudes, and actual behaviors related to SRH (Tchokossa, 2018; Chola, 2020; World Fertility and Family Planning Highlights, 2020. Adolescent girls, in particular, often face significant knowledge gaps. Research by Chola (2020) suggests a limited understanding of specific topics like female and male sterilization methods, with HIV/AIDS being the only widely recognized sexually transmitted infection (STI) among this demographic. Furthermore, broader studies (World Fertility and Family Planning Highlights, 2020) reveal a concerning lack of understanding among adolescents regarding core SRH concepts like reproductive physiology, menstrual cycles, fertility, and STIs in general. These knowledge gaps can have serious consequences, limiting their ability to make informed choices and navigate their sexual and reproductive health with confidence. These findings underscore the critical role of comprehensive sexuality education (CSE) in addressing these knowledge gaps and promoting healthy SRH behaviors. CSE goes beyond basic biological facts; it equips young people with the knowledge, attitudes, and skills they need to make informed choices about their bodies, relationships, and sexuality. Adolescence is a developmental stage characterized by increased risk-taking behaviors Jaun, (2019).). A Malaysian study by Tchokossa (2018) exemplifies this variation. While science

students demonstrated stronger SRH knowledge and a more positive outlook on sexuality education, they surprisingly reported higher engagement with pornography. This highlights a potential disconnect between knowledge and behavior, suggesting a need for educational approaches that go beyond rote memorization and foster critical thinking and decision-making skills. Young people may engage in sensation seeking and rely more heavily on peers than parental guidance, potentially increasing vulnerability to risky sexual practices. CSE can help mitigate these risks by fostering open communication, promoting healthy relationships, and encouraging responsible decision-making.

Adolescence presents a unique opportunity to positively influence health behaviors due to the brain's remarkable plasticity during this period Melese et al., (2020). This heightened adaptability allows the brain to be shaped by environmental influences. Two key environments that significantly impact adolescent behavior are family and school Kinaro et al., (2015). Research consistently shows that supportive family dynamics and positive school environments are crucial for optimal development. However, a paradox exists in some regions. Studies like Paquette et al. (2020) highlight that open communication about sexual and reproductive health (SRH) within families is often taboo in Eastern Africa. This silence ironically coincides with the region's high rates of unintended pregnancies among adolescents. Overall, the quality of parent-child relationships, parental supervision, and the values instilled within families are consistently linked to adolescents' sexual risk-taking behaviors and the age at which they initiate sexual activity (Blackstone et al., 2019). Furthermore, adolescents in Sub-Saharan Africa specifically face a double challenge. Research by Melese et al. (2020) and Paquette et al. (2020) suggests a lack of adequate knowledge about sexually transmitted infections (STIs) among this population. Additionally, these adolescents often encounter significant barriers when trying to access available

SRH services and health products. These barriers can be due to limited availability of youth-friendly services or a lack of accurate and sufficient information about SRH topics.

Eritrea, a nation in East Africa, has a concerning demographic trend. Young people, particularly those under 19, make up a significant portion of the population, with nearly half (47.7%) falling into this category. Almost a third (28%) are between 10 and 19 years old. Asmara, the capital city, reflects this trend, with over a quarter (28%) of secondary school students being 14 to 18 years old Sserwenya et al.,(2021). Similar to adolescents globally, Eritrean youth navigate a critical period in their lives during their teenage years. This transitional phase exposes them to numerous risks and vulnerabilities that can have lasting consequences Ahinkra et al., (2021). Research by Mwaisak et al. (2021) conducted in the country's southern region revealed a concerning lack of comprehensive knowledge about reproductive health among female students, even after a pre- and post-intervention study. National surveys further highlight this issue, with comprehensive knowledge about HIV, sexually transmitted infections (STIs), and related prevention methods falling below 10% Jonas et al, (2020).

Adolescent reproductive health (SRH) has generally not received sufficient attention in Eritrea. Early sexual activity without proper information or access to services is on the rise, affecting 15% and 21% of adolescent women and men, respectively (Mbadu et al., 2015). These rates vary significantly across regions. This lack of knowledge and access to services puts this age group at significant risk. Adolescence is a critical period where young people navigate significant transitions, including those related to sexuality and relationships. However, a lack of comprehensive knowledge about sexual and reproductive health (SRH) can leave them vulnerable Onasasoga et al.,(2018). Equipping adolescents with evidence-based, confidential, and age-

appropriate SRH information and services is crucial to empower them to make informed choices and avoid health risks Cusey et al., (2020). The WHO's KAP model highlights the connection between knowledge and behavior. It suggests that increased knowledge can lead to positive behavioral changes, and vice versa Bekele et al., (2020). Ideally, knowledge of SRH should increase with age, potentially due to higher education levels and broader life experiences. This study supports this notion, with grade eleven students demonstrating the highest knowledge scores.

Unfortunately, peer pressure and traditional societal norms can lead adolescents to unreliable sources of information about sexuality, potentially encouraging risky behaviors (Ezenwaka, 2020). Supportive family relationships and positive environments in schools, workplaces, and neighborhoods are essential for adolescents to make healthy choices regarding sexuality, career paths, and overall well-being Kara et al., 2023).

The text then explores the complex relationship between knowledge of contraception and its actual use. While some studies haven't found a direct link for example, Bekele et al.,(2020)in Zambia, others suggest a connection between education level and contraceptive use, particularly long-acting reversible methods (Paquette et al., 2020 in Kenya). Understanding the specific methods used is also important. Studies by Blackstone et al. (2017) and Iyanda et al. (2020) point out that knowledge gaps around ovulation can limit the effectiveness of the calendar method, potentially increasing unintended pregnancy rates among adolescents compared to older women. Education appears to play a role here as well, with Chola et al. (2020) finding a link between education and contraceptive use among adolescents. Interestingly, Tchokossa (2018) observed that older adolescent girls with higher education were more likely to use contraception than younger girls with the same education level.

However, education isn't the only factor. A Ugandan study among the Somali community showed that access to healthcare professionals played a significant role, with participants obtaining contraceptive information from health workers (Nsubuga et al., 2020). This highlights the importance of readily available and culturally sensitive SRH service. In another Ugandan study by Nsubuga et al. (2020) demonstrated a high level of knowledge about contraception, with nearly half reporting current use. Condoms were the most popular method, with usage increasing among students in higher academic years. Deitch et al, (2019) also found condoms to be the most widely known and used method, with withdrawal and safe days being less common. Limited knowledge about contraceptive options can be attributed to various factors, including lack of awareness, restricted access, poor communication with parents, and fear of side effects (Moyo & Rusinga, 2017). World Family Planning Highlights (2020) identifies irregular menstrual cycles and weight changes as potential side effects that may deter adolescents.

2.3.2. Attitude.

Adolescents' attitudes towards sexual and reproductive health (SRH) are a complex tapestry woven from various threads (Semachel et al., 2018). Factors like their existing knowledge, cultural beliefs, and access to accurate information all play a role in shaping these attitudes. Research suggests that comprehensive sexuality education (CSE) can be a powerful tool for positive change Deitch, (2019). By increasing awareness, correcting misconceptions, and fostering informed decision-making, CSE can empower adolescents to navigate SRH with confidence. However, challenges persist. Negative perceptions surrounding modern contraception, often fueled by concerns about side effects and misinformation, can create barriers to its use Kinaro et al., (2015). Cultural and societal influences also play a significant role, shaping attitudes towards SRH services and contraceptive use in general.

Furthermore, parental attitudes exert a strong influence on adolescent girls' contraceptive use Deitch et al, 2015). This highlights the importance of family dynamics in shaping attitudes towards SRH. Positive and open communication within families can create a supportive environment where adolescents feel comfortable discussing SRH concerns. Addressing these complex factors through culturally sensitive interventions and comprehensive sexuality education is crucial. By promoting positive attitudes towards SRH, we empower adolescents to make informed choices that safeguard their health and well-being.

Adolescents face a complex landscape when it comes to their attitudes towards contraception. Their social and demographic backgrounds play a significant role, with many lacking access to sexual and reproductive health (SRH) services throughout their reproductive years (Paquette et al., 2020). Studies haven't extensively documented adolescent attitudes, but some insights emerge. A recurring theme is the negative perception surrounding modern contraception due to fear of side effects and misinformation (Kinaro et al., 2015). Shame, stigma, and judgmental attitudes from healthcare providers further compound the issue. Interestingly, a Nigerian study by Melese et al. (2020) found that while a majority of participants viewed emergency contraception positively (51%), some young women associated it with promiscuity and deemed it inappropriate for married women. This highlights the influence of religious beliefs on attitudes. Parental attitudes significantly impact adolescent girls' contraceptive use Deitch et al, (2015). Studies by Onasoga (2018) and Ahinkra et al. (2020) illustrate contrasting views. While Onasoga's research suggests adolescents may not see contraception as suitable for married women, another study in Kenya (KEEA Municipality) found the perception that contraception is solely for married adults and could lead to infertility. Furthermore, Ahinkra et al. (2020) established a link between attitudes towards contraception, contraceptive use, and adolescent pregnancy. Non-pregnant adolescents

often held negative views, associating contraception use with being a "bad character." This same study revealed discomfort among adolescents regarding receiving and sharing SRH information with parents (Ezenwaka et al., 2020).

Apathy towards SRH issues can also contribute to missed opportunities for accurate information and services (Ezenwaka et al., 2020). Factors like parental attitudes, communication patterns on sexuality, and views on sex education all influence adolescent behavior. Additionally, judgmental healthcare workers and societal shaming discourage adolescents from seeking contraception at clinics Jonas et al, (2020). Studies suggest that negative provider attitudes and perceptions are major barriers to contraception use at healthcare facilities. Religious beliefs can further restrict access for young women perceived to be sexually active Sserwanya et al., (2019). Negative peer influence, tabloids, inadequate sexuality education, and lack of supportive social networks all contribute to the challenges surrounding contraceptive use. Community perspectives, as evidenced by a Kenyan study (Iyanda, 2020), may also limit access. This study emphasized the importance of open communication with parents, peer support, and integrating comprehensive sexuality education into youth programs and curricula.

Parental unapproachability can hinder adolescents from seeking SRH advice Blackstone et al., (2021). Cultural norms can also influence behavior. A study by Mwasaika, et al. (2021) suggests that Community Health Volunteers (CHVs) in Kenya prioritize promoting condom use due to its dual protection against pregnancy and sexually transmitted infections (STIs). They also attributed their focus on condoms to cultural inappropriateness around parents discussing contraception with young daughters. Religion further shapes attitudes, as evidenced by a Kenyan study, Tchokosaa, & Adeyemi, (2018) where maternal approval was linked to higher contraceptive use among

adolescents. While many studies report negative attitudes, Kimoro et al. (2015) highlight a South African study where 98.4% of adolescents expressed positive views on contraception. Similarly, a study in Ethiopia found favorable attitudes towards contraception (Melese et al., 2020). Those who disapproved often cited religious grounds.

This influence of religious beliefs is further supported by studies in Uganda (Mbadu et al., 2015) and South Africa (Melese et al., 2020). Strict religious views can frame contraception as inappropriate behavior for young women. Additionally, the societal disapproval of premarital sex and the lack of comprehensive sexuality education contribute to low contraceptive use Moyo & Rusinga, (2017). Therefore adolescents navigate a complex web of social, cultural, and religious influences that shape their attitudes towards contraception. Addressing these challenges through open communication, comprehensive sexuality education, and culturally sensitive interventions is crucial to empower adolescents to make informed choices about their sexual and reproductive health.

2.3.3. Practices

Adolescent girls, in particular, face numerous challenges related to SRHR (Sexual and Reproductive Health and Rights). Limited knowledge, unhealthy practices, and societal taboos often create significant barriers. Studies by Tchokossa (2018) emphasize the importance of SRH education in schools, alongside parental communication and NGO involvement, in addressing these issues. The school environment plays a role in shaping SRHP. Research by Onasoga, (2018) suggests that girls in single-sex schools might demonstrate better knowledge compared to co-educational settings, though practices may be similar. Studies reveal significant knowledge gaps regarding SRH among adolescents, like those identified in Malaysia by Iyanda et al. (2021). This

underscores the critical role of comprehensive sex education. Furthermore, research in Saudi Arabia and Africa (Ahinkra et al., 2021) points out how societal norms and misinformation surrounding contraception can deter adolescents from seeking reproductive health services. Addressing these knowledge gaps and misconceptions is crucial for promoting positive SRHP.

Furthermore, cultural norms surrounding menstruation significantly impact girls' self-esteem and SRH practices, particularly in rural areas (Kara, 2019). Mothers play a crucial role in educating daughters about SRH, but many lack the skills and confidence for effective communication (Kara, 2019). Therefore, enhancing SRH education, breaking taboos, and improving parent-adolescent communication are essential for promoting healthy SRHP among girls. Cultural influences significantly impact adolescent girls' access to SRHS (Sexual and Reproductive Health Services) (Ezenwaka, 2020). These norms often lead to early marriage, limited SRH information, and misconceptions about contraception, as seen in Uganda, South Africa, Nigeria, and Kenya (Chola, 2020). Understanding and addressing these cultural influences are crucial for providing effective SRHS, particularly in traditional and marginalized settings (Iyanda et al., 2020). Deeply ingrained traditional beliefs can hinder access to essential SRHR information and services for adolescent girls (Kinaro et al., 2015). These beliefs often discourage open discussions about sex education, contraception, and abortion. Additionally, myths and misconceptions surrounding menstruation can lead to inadequate knowledge and poor menstrual hygiene practices among girls (Chola, 2020). Combating the stigma associated with menstruation and addressing these traditional beliefs are crucial for promoting safe and hygienic SRHR practices among adolescent girls (Tedesse et al., 2020).

Studies have explored healthcare provider attitudes and the clinical environment as barriers to adolescent access to care. Research from South Africa and Ethiopia (Crawford et al., 2020) suggests inconsistencies in perceptions of provider attitudes towards adolescents. A Ugandan study by Bekele, et. al (2020) highlights how negative provider attitudes can discourage adolescents from utilizing SRHS. For effective utilization, services need to be delivered in youth-friendly environments with welcoming and supportive healthcare workers Gebreyesus et al., (2019). However, a shortage of trained healthcare professionals to offer these services remains a challenge, as identified in studies from South Africa, Ethiopia, and Uganda Kene et al., (2023). Studies by Abdurahman (2023) and Mekib & Demissei (2023) point to staff shortages with training on youth-friendly services and lack of dedicated spaces for young people within facilities as significant barriers. Data from Tanzania, Semachew, Tarekegn, & Embiale, (2021) reveals a concerningly low percentage (37.2%) of service providers trained in adolescent sexual and reproductive health information and counseling. This lack of trained providers creates missed opportunities for adolescents to access critical healthcare services.

Healthcare institutions play a vital role in ensuring adolescents' SRHR through SRHS. The review explores successful models implemented in West Africa and Malaysia. These models create welcoming and comfortable environments for adolescents through dedicated waiting areas, staff trained in adolescent communication, and age-appropriate educational materials (Bongongo & Govender, (2019). Confidentiality and privacy are crucial. Clinics should have clear policies and private consultation spaces to encourage adolescents to seek services (Atuhaire et al., 2021)

2.4. Chapter Summary

This review of literature painted a complex picture of the factors influencing adolescent girls' sexual and reproductive health practices (SRHP). Knowledge gaps, societal attitudes, cultural norms, and limited access to services create significant challenges. The studies highlighted the importance of comprehensive sex education in schools to equip adolescents with accurate information. Furthermore, fostering open communication between parents and daughters is crucial for navigating SRH concerns. Breaking down cultural taboos and addressing traditional beliefs that restrict access to SRHS is essential for positive behavior change. Collaboration with schools, community leaders, and youth organizations can expand access to SRH information and encourage help-seeking behavior. Additionally, innovative approaches like peer education programs and telehealth services hold promise for reaching marginalized populations. Promoting healthy SRHP among adolescent girls requires a multifaceted approach. By addressing knowledge gaps, challenging social stigmas, and ensuring access to youth-friendly healthcare services, we can empower girls to make informed choices about their sexual and reproductive health. Further research is needed to explore the effectiveness of various interventions and identify culturally sensitive approaches to improve SRH outcomes for adolescent girls globally.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter is going to give details of the research methodology that was employed by the researcher in conducting their study. The chapter will also outline the resign design, sampling, data collection techniques. The methodology comprises of the research design, ethical issues, and possible limitations, research instruments, sampling technique, sample size, target population and data analysis. The mixed method approach using a cross sectional design was conducted in Marondera urban. Focus group discussions and a questionnaires were used to gather information on the knowledge, attitudes and practices towards adolescent girls' access to SHRS. In-depth interviews were used to collect data from key informants.

3.2 Research Approach

This study used a qualitative research approach. According to Crewell (2012), a mixed method is a procedure for collecting, analyzing, and mixing both qualitative and quantitative research methods in a single study to understand the research problem. Quantitative research is the process of collecting and analyzing numerical data to find patterns and averages, test causal relationships, and generalize results to the wider population, Bhandari (2020). Moser & Korstjens (2018) highlighted that qualitative research was designed to produce a low inference description of a phenomenon. Interviews and focus groups provided the researcher with raw data from horse-mouth and has its roots in social science with further enlightenment on why people act as they do,

their knowledge, attitudes, way of life, and suspicions among others. The research used a mixed method research approach because it is effective in obtaining detailed, contextualized insights of qualitative data and the generalizable externally valid insights of quantitative insights of quantitative data as supported by Family Health International (2005). The approach was also chosen because it provides a better understanding of the research problem.

3.3 Research Design

Akhtar (2016) noted that a research design is the arrangement of conditions for the collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy and procedure. Adam, Pierre, and Roulstone (2009), defines research design as a plan or a blue print of how the researcher intend to conduct the research. The research was carried out using a case study research design which is in-depth study of a particular research problem rather than a far-reaching statistical examination or survey, (Anastas & Jeane, 1999). The researcher used case study design because it serves best in exploring present-day, realistic situations and provide the foundation for implementation of ideas, policies and response initiatives in the whole development trajectory.

3.4 Data Collection Methods

3.4.1 Focus group discussions

The use of focus group discussions benefited both the researcher and the participants. Nyumba et al (2018) stated that focus group discussions are frequently used as a qualitative approach to gain an in-depth understanding of social issues and the method aims to obtain data from a purposely

selected group of individuals rather than from a statistically representative sample of a broader population. The participants got the chance to express their views on access to SRHS, measure their knowledge, and determine attitudes and the availability of youth-friendly services in Marondera Urban.

3.4.2 Questionnaire

It is a list of all questions, which seeks to source data from the people to answer certain laid down research objectives. It's an instrument for raw data collection. The design of questionnaire is critical to ensure that the correct research questions are addressed and that accurate and appropriate data for statistical analysis is collected. Structured questionnaire, can be used to collect data on a large number of participants in a relatively short amount of time. They can be used to collect data on a variety of topics, including demographics, determine attitude, and explore practices related to SRHS

3.4.3. Key informant Interviews

In interviews, the researcher used key informants to get objective information on the area under study. Key informant interviews were conducted with purposively selected participants so that their perspectives could be explored. The structured interview used was similar to a questionnaire-type approach yielding a fairly superficial level of response.

3.5 Target Population

Honegr et al (2020) defined target population as a group of people or individuals from which a distinct sample can be drawn. Marondera Urban is divided into 12 wards where adolescents can be found. Marondera Urban has 6, 620(10.2%) girls between the ages of 15 and 19 out of a

population of 66,700. There are 300 girls that had the probability of taking part in the study. Dombotombo clinic has 40 health workers on rotation and 4 had the probability of being interviewed

3.6 Sample

A sample is defined as a set of elements which are ideally representative of the population. A total of 100 girls participated in the survey out of a general population of 6620. Individuals (15) were randomly selected to be part of the focus group discussion. Two health workers were interviewed, the Sister in charge and another registered general nurse. The total number of participants was 117 for the study.

3.7 Sampling Technique

Sampling is the process of data collection for generating theory whereby the researcher jointly collects, data and analyses the data and decides what data to collect next and where to find them (McCrae & Pursell, 2017). The study implored probability sampling, using a stratified sampling technique. The sample for this study was to be representative of the population of adolescent girls in Marondera urban. This was achieved by dividing the target population into strata using age, residence, and socioeconomic status) and a random sample was selected from each stratum. The researcher selected private (Herentals College) and public schools (Rakodzi High School, vocational training centers (Marondera Vocational Center), and community organizations (Heartfelt Church) across the 12 wards. The rationale for choosing this technique was to gather data representative of adolescent girls across the district. Purposive sampling was implored in this research to select health workers. Purposive sampling means selecting a sample on the basis of one's knowledge, its elements, and the nature of the study necessary in-depth and data from the

perspectives of the researched population (Shamoo & Resnik, 2015). The sister in charge oversees and reports operations to the district and the general nurse is a direct service provider.

3.8 Ethical Considerations

Punch (2011) defines ethical issues as a set of beliefs and values that guide a research approach.

3.8.1 Consent

It is important to obtain informed consent from all participants, including parents or guardians for minors. Participants should be fully informed of the purpose of the study, the risks and benefits of participation, and their right to withdraw at any time.

3.8.2 Confidentiality

All participant data should be kept confidential and secure. This means that data should only be accessed by authorized personnel and should not be shared with third parties without the participant's consent.

3.8.3 Vulnerability

Adolescent girls are a vulnerable population, so it is important to take steps to minimize any potential harm to participants. This includes using sensitive and respectful language, avoiding questions that could be triggering or traumatic, and providing support to participants who may need it.

3.8.4 Neutrality

The researcher respected the opinions of the respondents without deliberately seeking to influence them in any manner possible. The researcher ensured neutrality by avoiding a judgmental approach during the interviews.

3.9 Validity and reliability of research instruments

Research instruments are measurement tools designed to acquire information on a topic of interest. The researcher is going to use questionnaires, a pen, a recorder as well as a notepad as research instruments to carry out the research study. Middleton (2019) stated that reliability and validity are concepts used to evaluate the quality of research which indicates how reliability is about the consistency of a measure and validity is about the accuracy of a measure. Validity in research is important to see whether the research instruments are practically measuring the variables that the research is focusing on. Legitimacy can be measured through content and develop validity. Content validity concentrates on determining whether examination instruments sufficiently contained inquiries to cover the aim of the study. The researcher guaranteed content legitimacy by taking into consideration the aim of the study amongst the outlining of research questions.

3.10 Chapter Summary

This chapter is discussed the details of the research methodology that was employed by the researcher in conducting their study. The chapter also outlined the design, sampling, and data collection techniques. The methodology comprises of the research design, ethical issues, possible limitations, research instruments, sampling technique, sample size, target population, and data analysis.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1. Introduction

This chapter examines and discusses data collected through questionnaires, interviews, and focus group discussions (FGDs). The research explores the perspectives of adolescent girls and health service providers regarding their comprehension of sexual and reproductive health services, as well as their associated attitudes and practices. The research findings will be outlined and presented under the following themes, which align with the study's objectives:

- Assess the knowledge levels of SRHS among adolescent girls.
- Evaluating attitudes of service providers and recipients towards SRHS.
- Explore current practices at Dombotombo regarding providing SRHS to adolescent girls.

4.2. Response Rate

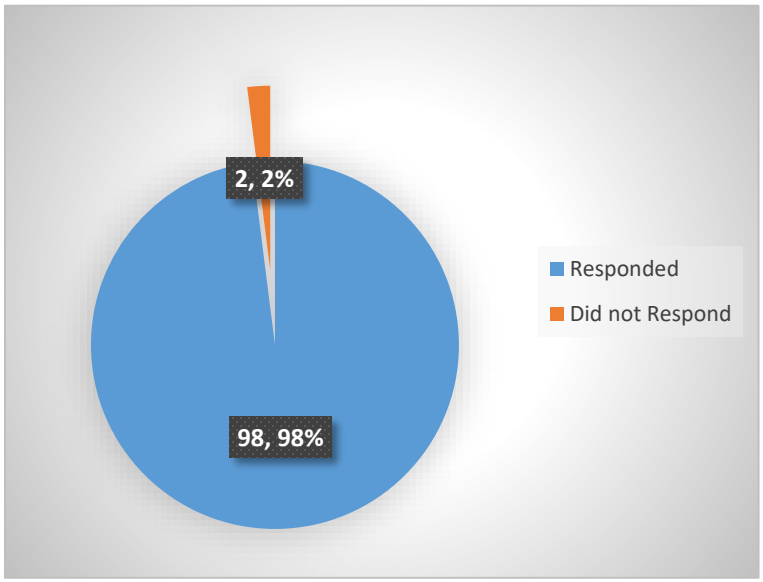
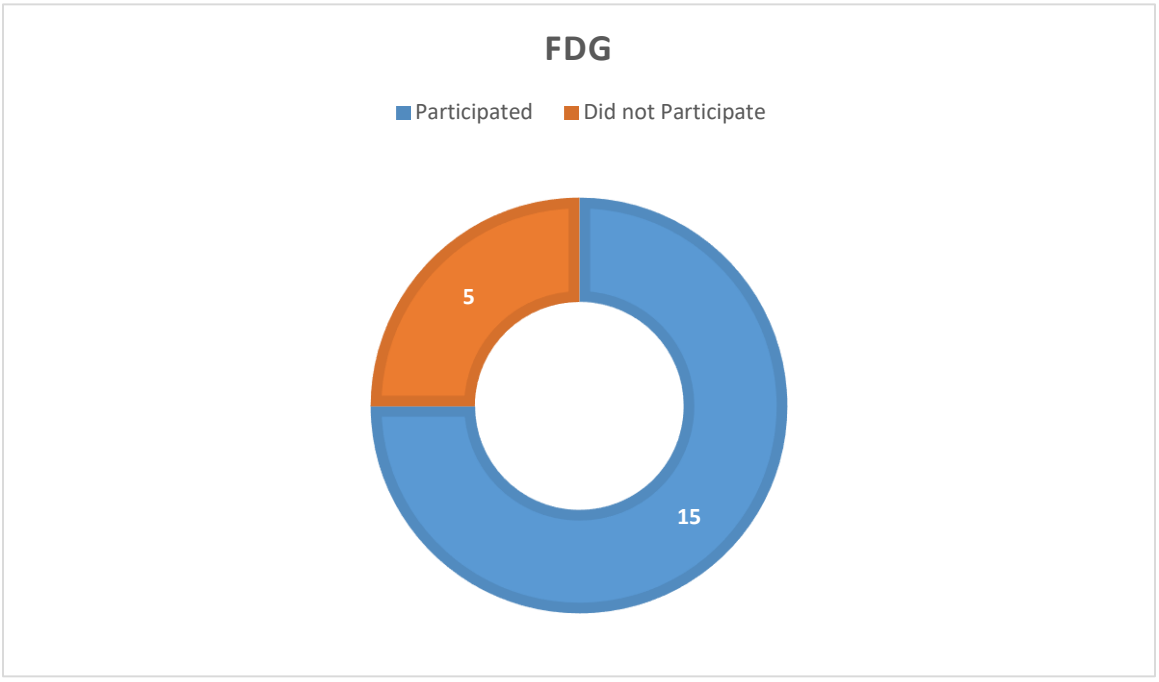


Fig 4.1. Questionnaire

n=(100)

Fig 4.2. Focus Group Discussion Response Rate



n= (20)

Table 4.1 Key Informants Response Rate

No of Informants Targeted(*n1*)	**Number of informants reached (***n2*)	**Response rate**
2	2	**100%**

n= (2)

4.3. Demographic Data

4.3.1. Questionnaire

Table. 4.2

Age: 15-16	17-19
50	48

Living with: Parents	66	Marital Status: Married	28
Alone	12	Single	41
Friends	0	Divorced	0
In school	20	Separated	13

Education: Primary	5	Religion: Christianity	88
Secondary	75	Islam	10
Tertiary	18	ATR	0
None	0	None	0

Income: $30	43	Children: 1-2	24
$40-60	20	3-4	3
$70-90	20	Above 4	0
Above $100	15	None	1

n=98

The average age of 16.8 years. A significant portion of the girls fell under the age of 16, highlighting a focus on this specific age demographic. In terms of education, secondary education dominated, with a commendable 76.5% of participants having completed it. However, a small segment (5%) only had primary education, suggesting a potential area for further investigation. The living situation data leaned towards a family-oriented environment. Nearly two-thirds (67.3%) of the girls reported residing with their parents, offering insights into their support system. The average income of $54.9 provides a snapshot of the girls' financial circumstances. This information can be valuable for understanding their economic background and potential challenges. The marital status data presented an interesting finding. A noteworthy portion (28.5%) of the girls were already married, which may be a unique characteristic of this particular population compared to broader trends. Additionally, a smaller number (13.2%) reported separation, suggesting a potential

area for further exploration. Looking at family structures, roughly a quarter (24.4%) of participants indicated having between 1 and 3 children, offering a glimpse into their family dynamics

4.3.2. Focus Group Discussion

The researcher successfully conducted Focus Group Discussions (FGDs) with a high participation rate. Out of the 20 targeted participants, 15 joined the discussions (75% success rate). Encouragingly, 90% of those who participated actively contributed throughout the sessions. This positive outcome can likely be attributed to the researcher's clear communication style. By tailoring the language to the participants' understanding, the researcher ensured everyone felt comfortable sharing their thoughts and experiences. The discussions yielded valuable insights into the girls' knowledge, attitudes, and practices regarding reproductive health services.

4.3.3. Key Informant Interviews

The researcher successfully conducted interviews with all the targeted key informants, achieving a 100% response rate. The key informant interviews enabled the researcher to meet the research objectives, which were to assess the knowledge levels of adolescents regarding sexual and reproductive health services, understand the attitudes of health workers towards providing these services, and gain insights into the practices related to sexual and reproductive health services for adolescent girls at the Dombotombo Clinic.

4.4. Knowledge Levels

A study gauged adolescent girls' knowledge of sexual and reproductive health through a 6-question test. While the overall score yielded a moderate understanding (43 %), a significant knowledge gap emerged regarding rights and services associated with sexual and reproductive health. This

gap was particularly evident in parental consent, where a mere 11% of participants answered correctly. These findings stand in stark contrast to a separate study conducted in Eastern Ethiopia, where knowledge levels were considerably higher at 68%, Mohammed, (2020). However other studies that were done the region by Ahinkra, (2020) and Melese et al (2020) showed that knowledge levels concerning SRHS was low.

Table 4.3

Item	**True**	**Not sure**	**False**	**%Correct**
Only physical change and not mind and behavioral changes occur during adolescence	18	8	72	81.16%
The menstrual cycle more than once within a month is not a problem	27	19	52	27.55%
The carrier of the STIs may unintentionally transmit the virus to its partner	73	17	8	74.49%
You are required to pay for family planning services at the Dombotombo clinic	43	33	22	43.8%
HIV does not spread the virus from an infected person's coughing and sneezing	92	4	2	93.88%
you require parental consent to access sexual reproductive health services	11	48	39	11.22%

n=98

The table above shows the results for the first section of the questionnaire designed to measure knowledge levels. For each item, the table shows the answer choices (True, Not sure, False) for whether the statement is true and the percentage (%) of people who chose each option. An additional column, 'Correct Answers', has been added to indicate whether the correct answer rate is 70% or higher. The results show that teenagers have a good understanding of HIV transmission and the importance of mind and behavioral changes during adolescence. However, there are some areas where knowledge could be improved, such as the menstrual cycle and access to sexual reproductive health services. Only 27 % of teenagers knew that a menstrual cycle more than once within a month was not a problem. This suggests that there may be a need for educational programs to teach teenagers about normal menstrual cycle. Only 43 % of teenagers knew that family planning services at the Dombotombo clinic were free. This suggests that there may be a need for increased awareness of the availability of free sexual reproductive health services. Only 11 % of teenagers knew that parental consent is not required to access sexual reproductive health services. This suggests that there may be a need for educational programs to teach teenagers about their rights regarding sexual reproductive health. The inaccessibility of information was further confirmed by the responses from the FDG, in response to the question on where they access their information adolescents regarding sexual health, one respondent said

"The majority of what I know I have seen from television, at school we rushed through the topic, I watch a lot of teen shows" – (F.15)

Mirroring findings from Kolkata (Dasgupta et al., 2019) and Tirupati (Reddy et al., 2019), this study reveals a similar trend in how adolescent girls access information about sexual and reproductive health. Mothers, relatives, and media sources like TV and the internet all play a role

in their learning. However, a crucial disconnect seems to exist. While mothers emerge as the primary source of information on sensitive topics like menstruation (as found by Reddy et al., 2019 with 61.2% citing mothers), the low knowledge scores on rights and services associated with sexual and reproductive health suggest a communication gap between mothers and daughters. This highlights a potential need for improved communication strategies within families to ensure girls have access to comprehensive and accurate information on all aspects of sexual and reproductive health.

Another response said *"I ask my friends it's less embarrassing to ask each other"* – (F.17)

The study reveals a troubling disconnect: sexually active adolescents seem to rely on peers for contraception, with only 25% reporting consistent contraceptive use. This mirrors findings from Eritrea (Andemeskel et al., 2021) where most adolescents were reluctant to discuss sexual and reproductive health with their parents. Similarly, an Ethiopian study (Ayalew et al., 2020) underscored the challenges teenagers face in having open conversations about sex with their parents. These disparities in communication between parents and adolescents regarding sexual health likely stem from a complex interplay of factors. The studies may have involved different populations in terms of age, socioeconomic background, or cultural norms. This reflects that cultural attitudes towards sexuality can also significantly influence communication patterns within families.

'There's no one to ask we can't approach our mothers because they have never brought it up'-.

(F.15)

‘*Lessons about contraceptive use among adolescents are a taboo in our community. Parents believe that if they teach their girls about contraception, that‘s a green light to practice pre-marital sex and prostitution. So there is a large gap in terms of knowledge, and it is unfortunate because we see more than three pregnant 14-year-olds every month.*- RGN

According to Moyo and Rusinga (2018), there is a prevailing social silence surrounding the topic of sexuality in Zimbabwe. As a result, adolescent sexuality remains a taboo subject. While parents are seen as the logical source of information, they often refrain from discussing sexuality issues with their children, as cultural norms dictate that sexual education is the exclusive domain of aunts and uncles. Furthermore, traditional mechanisms of sex education have weakened in recent decades and are primarily focused on gendered sexual socialization rather than the promotion of sexual health. Many traditional programs prioritize abstinence-only approaches, emphasizing delaying sexual activity until marriage [Gleichsman & Bergdahl, 2018]. However, this ignores the reality of teenagers' sexual behavior. Research by Lindberg et al. (2020) shows these programs are ineffective in delaying sexual debut or reducing teen pregnancy rates. A more comprehensive approach that acknowledges teenagers' curiosity and potential for sexual activity is needed. This suggests that adolescent girls lack a reliable and trusted source of information regarding sexual and reproductive health services. The key informant interviews conducted in the study corroborated this finding, with a health worker confirming this observation.

‘*Parents who come in with pregnant teenagers often say, I've told her to leave boys alone, parents don’t understand that saying don’t talk to buys isn’t sex education.’* RGN

The levels of knowledge are generally low and there are no sources of information in regards to sexual reproductive health that adolescent girls are confident in. Traditional sex education often reinforces harmful gender stereotypes. It focuses on girls' "purity" and boys' "sex drive" Sears & Sanders, (2019). This not only creates unrealistic expectations but also hinders discussions about healthy relationships, consent, and sexual pleasure for both genders. As Jensen & Lindberg (2019) argue, a shift towards pleasure-positive, gender-inclusive pedagogy is crucial for fostering healthy sexual development. parental anxieties, and limited access to healthcare services (exosystem) can indirectly hinder comprehensive sex education. These external factors can create a climate of silence and shame around sexuality, making teenagers less receptive to open discussions. Sweeney & Desai, 2020. Broad cultural values and societal norms (macrosystem) regarding sex and sexuality significantly impact how sex education is delivered. Stigma, religious beliefs, and gender roles can influence curriculum content and teacher comfort levels, limiting the scope of sex education Parker et al., 2019. Teenagers are undergoing rapid physical, emotional, and social development (chronosystem). Traditional programs often fail to adapt to these changes, offering generic information that may not address their evolving needs and interests at different stages of adolescence Sundberg et al., 2019. By acknowledging the interconnectedness of these systems, we can create a more holistic approach to sex education, empowering teenagers to make informed choices about their sexual health and well-being.

4.5. Attitude

The analysis of the data collected reveals that adolescent girls possess a diverse range of perspectives concerning sexual and reproductive health services. Specifically, 40% of the girls surveyed expressed apprehension that receiving sexual education may result in increased sexual activity. Moreover, 23% of the girls expressed their dissatisfaction with the current school

curriculum, stating that textbooks do not provide adequate information regarding sexual and reproductive health. On the other hand, a significant proportion of the girls, 90%, demonstrated a positive attitude towards menstrual health by rejecting the common misconception that menstrual cycles indicate poor health. However, there remains a considerable number of girls, 40%, who believe in the myth that contraceptives can lead to infertility. Additionally, 50% of the girls are under the impression that healthcare providers may scold or reprimand them for asking about condoms or other contraceptive methods. Interestingly, these beliefs and attitudes held by adolescent girls differ greatly from the perspectives of health workers who advocate for comprehensive sexual and reproductive health education, access to contraceptives, and positive attitudes toward menstrual health.

' condoms are free here no one has to ask, we put them on windows, bathrooms, and outside benches so that clients do not have to as some find it embarrassing' .- RGN.

This gap is alarming as it indicates the divide that exists between the healthcare provider and the female adolescent client.

Table 4.4

	True	Not sure	False	%Correct
15. Sexual education leads to more sex	40	6	52	53 %
16. school's textbook lacks sufficient knowledge concerning SRH	23	41	34	34 %

17.A teenage girl does not go into the kitchen during her menstrual cycle	3	5	90	91 %
18. Anyone who receives STIs should cover it up	40	26	32	32 %
19. taking contraceptives before marriage will cause infertility	60	23	15	36 %
20. Nurses will scold you for asking for condoms	44	18	36	17 %

n=98

The table above shows the results from the attitude section of the questionnaire, this is a positive result. Most teenagers understand that sex education doesn't encourage more sex, but a significant portion is unsure. This highlights the need for educational programs to clarify this misconception. A concerning number (65%) of teenagers feel their textbooks lack SRH information. This suggests a need to review and update school curriculums to ensure they provide comprehensive and accurate information. There is a very positive result concerning menstruation, 90% of the adolescents understand that menstruation is a normal bodily function and doesn't restrict daily activities. Over half (76%) of teenagers are unsure or believe STIs need to be hidden. This highlights the need for education about STI prevention, transmission, and seeking treatment without stigma. A significant majority (93%) hold a misconception about contraceptives causing infertility. Educational programs should address this myth and provide accurate information about different contraceptive methods. 62% of teenagers are unsure or believe they'll be judged for seeking condoms. This

indicates a need to address stigma around accessing sexual health services and promote open communication with healthcare providers.

Adolescent girls' attitudes towards sexual reproductive health services (SRHS) are heavily influenced by societal factors. Point-biserial correlation was used to determine the relationship between knowledge and attitude, with a coefficient of 4.08 which indicates a positive correlation between knowledge scores and attitude answers. This means that participants with higher knowledge scores answered correctly on the attitude questions, suggesting a positive association between knowledge of SRHS and attitudes towards SRHS. Fear of judgment and stigmatization, as well as individual perceptions, shape their perspectives. This can have detrimental consequences on their health and well-being. Stigma and fear surrounding SRHS prevent many youths from accessing these essential services. Young people who perceive SRHS as shameful or embarrassing are less likely to seek help, even if they recognize its potential benefits, Mulugeta et al (2019). This fear stems from the negative attitudes and misconceptions prevalent in society. Social and cultural norms play a significant role in shaping adolescents' access to and utilization of SRH services. In many communities, premarital sexual activity is frowned upon, and young people who engage in it are often judged or condemned. This creates a barrier to accessing SRHS, as adolescents may fear being discovered or punished. The lack of access to SRHS among youth who experience stigma and fear has negative implications for their health. They are more likely to experience unintended pregnancy, sexually transmitted infections (STIs), and other health problems. To improve youth access to SRHS, it is crucial to address the stigma and fear surrounding these services Francis & Gabriel, (2019). Community-based sensitization programs and educational campaigns can help to change perceptions and promote a more supportive environment. Parents, teachers, and healthcare providers should also be equipped with the

knowledge and skills to provide comprehensive and unbiased information to young people Onukwugha, Hayter &Magadi, (2019). By creating a safe and supportive environment where adolescents can access SRHS without fear or judgment, we can empower them to make informed decisions about their sexual and reproductive health. This, in turn, will lead to improved health outcomes and a brighter future for young people.

'The local clinic has nurses that we go to church with, we can't ask for contraceptives or information about sex, imagine your mother being told you were treated for STIs at the clinic, that would create problems'- Respondent 6 (F.16)

Everyone here knows everyone around here, coming to the HIV testing section is scary because if you meet someone you know then you owe them an explanation and we don't want to create trouble at home.- (F.19)

Adolescents are deterred from utilizing sexual and reproductive health (SRH) services due to the fear of stigma associated with them in their communities. These communities often view using SRH services as inappropriate, leading teens to believe they'll be judged or ostracized for seeking help. This fear isn't unfounded. Research supports this connection between societal attitudes and adolescent behavior. A study by Conteh (2020) in Sierra Leone found a direct link between social norms and adolescents' willingness to use SRH services. Similarly, a separate study in Tanzania revealed that young people there avoid seeking professional help for reproductive health issues due to shame and fear of being judged by their community Ninsiima, Chiumia &, Ndejjo,(2021). The research suggests that healthcare providers generally support adolescents using SRH services. This highlights a gap between the attitudes of medical professionals and the prevailing social norms within some communities.

'It used to be awkward, very uncomfortable conversations, but with time and the crisis that our community is in we have adjusted and we have found ways to have these conversations through training .' –RGN

Young girls must get this information, it is vital to acknowledge that they are sexually active, which is a big issue with parents that come in with their adolescent children, with pregnancy or an STI, the disbelief. So we work with the acknowledgment that young women are sexually active.- Sister in Charge.

A concerning gap exists between healthcare workers' attitudes and adolescent girls' perceptions regarding SRH services. While healthcare providers appear welcoming towards girls seeking these services, a perception issue lingers on the girls' side. Adolescents might perceive healthcare workers as unfriendly or judgmental, creating a barrier to them accessing essential healthcare. Research by Motuma et al. (2019) supports this notion, highlighting how adolescents' perception of healthcare workers directly influences their utilization of SRH services. Intriguingly, research on healthcare worker attitudes toward adolescent SRH use paints a complex picture. Some studies, like Onukwugha et al. (2019) in Ethiopia, reveal negative attitudes among healthcare workers towards young people seeking SRH services. This negativity could potentially stem from a lack of proper training, as evidenced in Tanzania by Ninsiima et al. (2021). Their study found that only 37% of service providers had received relevant training in adolescent sexual and reproductive health (ASRH). These might be influenced by the quality of sex education delivered in schools. Traditional programs often focus on abstinence-only approaches and lack information about contraception Gleichsman & Bergdahl, 2018. This could stem from experiences within the healthcare system or negative portrayals in the media. The gap between school education and

discussions at home might contribute to this, which is a significant interaction between the micro and meso systems within which the girls exist. Parents might feel uncomfortable discussing sexual health, leaving teenagers with limited information Sears & Sanders, 2016. The combined influence of school culture, peer pressure, and societal attitudes can create a stigma around seeking SRHS, leading to misinformation and fear of judgment. Clinics with trained counselors, like Dombotombo, serve as a potential model for bridging this gap. These counselors possess the necessary skills to create a safe and welcoming space for adolescents, fostering trust and encouraging them to utilize SRH services effectively. Ultimately, creating a positive and supportive environment specifically tailored to adolescents is crucial for ensuring positive health outcomes in this age group.

4.6. Practice

The survey results paint a complex picture of adolescent girls' behaviors regarding sexual and reproductive health (SRH) in Dombotombo. While a significant majority (62%) expressed interest in learning more about SRH, only a relatively small proportion (22%) actively sought out such information. This suggests a general curiosity but a potential hesitation to pursue knowledge proactively. There seems to be some level of openness within families regarding menstruation, with over two-thirds (72%) of girls reporting occasional updates to mothers or sisters, Paquette et al, (2020) confirm this and attribute this openness to financial dependency. However, comfort levels regarding sexual health discussions are significantly lower. Only 10% of the girls felt comfortable discussing these issues, and nearly half (46%) reported never feeling at ease. This discomfort might explain why almost half (45%) of the girls always try to keep their sexual health concerns private. Point biserial correlation was used to establish the relationship between attitude and practice, coefficient of 4.08, a positive correlation coefficient indicates that participants with

higher knowledge scores to answered "always" on the practice question. The secrecy surrounding sexual health could be due to the stigma associated with the topic or a lack of trust in healthcare providers.

Despite the expressed interest in learning more about SRH, the data reveals a low utilization of available services. Only a fifth (20%) of the girls reported always using the local clinic's SRH services, and another third (32%) reported using them occasionally. This highlights a clear lack of awareness about the services offered at the Dombotombo clinic. The survey found that adolescents who are married or already have children are more likely to access SRH services this is similar to the results, from a study done in Ghana, Ezenwaka, (2020) this suggests a potential link between life experiences and healthcare utilization. Focus group discussions revealed that HIV testing and counseling (HTS) is the most frequently accessed service. This may indicate a primary concern for HIV prevention, but it also underscores the need for a broader range of SRH services to be promoted and readily available to all adolescents in Dombotombo.

I've been to Dombotombo for HIV testing, I did not trust my boyfriend so I got tested after an unprotected sexual encounter. (F.17)

'I have done HIV testing because it is compulsory when you're pregnant and when you're breastfeeding' (F.16)

The high HIV testing rates observed among pregnant and lactating mothers likely stem from a government-driven initiative. The Provider-Initiated Testing and Counseling (PITC) program mandates HIV testing and counseling for all pregnant women and lactating mothers as part of their standard healthcare. This program ensures comprehensive prenatal and postnatal care while

promoting public health by encouraging early detection and management of HIV, Ahinkra et al (2021) who states that SRHS is suddenly demystified when an adolescent becomes pregnant. Similarly, women seeking access to family planning pills are required to undergo this testing and counseling process, potentially contributing to the observed testing rates.

The study also sheds light on contraceptive preferences among the girls in Dombotombo. Male condoms emerged as the most commonly used method, likely due to factors beyond simple effectiveness. Convenience appears to be a major consideration for the girls, suggesting a potential need for increased education and access to a wider range of contraceptive options. Further exploration of these preferences through focus groups or in-depth interviews could provide valuable insights for tailoring future family planning programs to better meet the specific needs and priorities of adolescent girls in the community.

We buy condoms, they are cheap and you can buy them in town where there are fewer chances of being recognized. (F.18)

You don't have to keep condoms like keeping pills, if my mother finds family planning pills in my things I would be in big trouble. (F.16)

Among adolescents who use contraception, condoms reign supreme. This preference is supported by research from Moyo & Rusinga (2018). Their study aligns with the findings of this, highlighting the widespread availability and affordability of male condoms for adolescents in Dombotombo. The survey revealed that a pack of three condoms costs just a dollar, making them a readily accessible option. However, a crucial barrier emerges when considering female contraceptives. While clinics offer a variety of free female methods like implants, pills, IUDs, and injectables,

these services remain underutilized. The study suggests that adolescents, who are primarily school-going, are hesitant to access these free services at the local clinic. This hesitancy might be due to concerns about privacy or simply a preference for a non-clinical setting. Unfortunately, this reluctance often translates to a lack of access to these free options, pushing them towards purchasing condoms at private establishments where privacy might be perceived as greater.

It's important to note that the Dombotombo clinic offers all SRH services free of charge, eliminating consultation fees as a potential barrier. Highlighting this fact alongside educational campaigns promoting the benefits and accessibility of various female contraceptive methods could be crucial in encouraging adolescents to explore these options beyond condoms

'We provide, all forms of contraception, HIV testing and counseling, PEP (Post Exposure Prophylaxis), PreP (Pre Exposure Prophylaxis), sex education, and general counseling for free.'
–Sister in Charge (F.49)

While the Dombotombo clinic being municipal eliminates direct financial barriers through free SRH services is a commendable step, it only addresses one piece of the puzzle for adolescents. Research suggests that confidentiality remains a paramount concern for this age group. A study by Ninsiima et al. (2021) emphasizes the crucial role of standardized indicators when evaluating youth-friendly SRH services (YFSRHS). These indicators should prioritize factors that directly impact adolescents' willingness to utilize these services. Specifically, accessibility, staff characteristics, and competency, and most importantly, confidentiality and privacy practices tailored to young people's needs are all crucial aspects for evaluation.

The Ninsiima et al. study sheds light on broader challenges faced during the expansion of YFSRHS programs in Tanzania and South Africa. These challenges expose a gap between current practices and established global quality standards for adolescent healthcare. Many facilities fail to meet these standards due to inadequate infrastructure, resulting in a lack of privacy and confidentiality for adolescents seeking SRH services. Frequent stock outs of essential contraceptives further disrupt service quality and discourage potential users. These issues underscore the importance of a multifaceted approach to improving YFSRHS programs. Investing in infrastructure upgrades, staff training on youth-specific communication and confidentiality protocols, and robust supply chains to ensure consistent availability of contraceptives are all essential for creating YFSRHS programs that are truly effective and meet the holistic needs of adolescents. By addressing these accessibility and confidentiality concerns alongside financial barriers, the Dombotombo clinic and similar facilities can create a more welcoming and trustworthy environment for adolescents seeking SRH services. This, in turn, can lead to increased service utilization and improved health outcomes for young people in the community.

'There is one consultation room, one room for antennal care, another for post-natal care, and another one for outpatients and our labor ward, so our usual area for family planning is an open area, HIV testing, and counseling are is a separate area, but we only have two counseling offices and they are inadequate for our catchment area' –Sister in Charge

*'We simply do not have space that provides confidentiality in the way that would be ideal, we try but everyone waits in the same open area and our community is small there is a chance someone will recognize you in the family planning que'-(*RGN)

The limited availability of infrastructure at healthcare facilities that cater to adolescents' specific needs creates a significant structural barrier to SRH service utilization. This highlights the urgent need to expand healthcare service facilities to ensure adherence to standardized protocols. Furthermore, the absence of clear policies and guidelines specifically geared towards youth-friendly SRH services presents a major challenge. While existing frameworks like the Zimbabwe National Family Planning Council (ZNFPC) guidelines, National Health Policy, and the Public Health Act (Chapter 15:17) provide a legal foundation for healthcare workers, they lack the necessary focus on creating services that cater specifically to the needs and sensitivities of adolescents.

This lack of youth-specific policies hinders information dissemination about available services, further limiting adolescents' access and knowledge. To improve health outcomes for young people in Dombotombo and similar communities, developing clear and comprehensive adolescent-specific SRH service guidelines is crucial. These guidelines should address concerns around infrastructure expansion, youth-friendly communication protocols for healthcare workers, and ensuring consistent availability of essential services and contraceptives. By implementing such targeted policies, healthcare providers can create a more welcoming and accessible environment that removes structural barriers and empowers adolescents to make informed choices about their sexual and reproductive health.

4.7. Chapter Summary

This chapter delves into the analysis and presentation of research findings gathered from the field. Data collection methods included self-administered questionnaires, focus group discussions, and interviews with key informants. The researcher used pie charts, tables, and descriptive text to

present the information. The findings generally aligned with existing research on adolescent girls' knowledge of SRHS. While knowledge levels were found to be relatively high, negative perceptions regarding healthcare workers' attitudes towards them persisted. However, some findings deviated from previous studies, such as the positive attitude of healthcare workers observed in this research. Interestingly, the study revealed that adolescents often seek information about sexual health from their peers rather than healthcare providers. Key informants highlighted the lack of adequate infrastructure as a major barrier. Current facilities lack the necessary features to ensure complete confidentiality and a comfortable environment for adolescents seeking SRH services**.**

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

This section combines the key findings from the preceding chapters, revisiting the research questions and objectives outlined in the introduction, and evaluating the extent to which the study has addressed them. The chapter then presents the main conclusions drawn from the analysis of the data collected during the research process. These conclusions highlight the complex picture surrounding adolescent girls' sexual and reproductive health (SRH) behaviors in Marondera Urban. Following the conclusions, the chapter offers a set of recommendations for future action. These recommendations are informed by the study's findings and are designed to improve access to SRH services and knowledge for adolescent girls in Marondera. The recommendations target various stakeholders, including social workers, healthcare providers, policymakers, and community organizations. Finally, the chapter concludes by reiterating the significance of this research and its potential contribution to improving the sexual and reproductive health outcomes of adolescent girls in Marondera and similar communities.

5.2. Summary

The introductory chapter of this study set the stage for an investigation into adolescent girls' access to Sexual and Reproductive Health Services (SRHS) in Marondera, Zimbabwe. It emphasized the significance of SRHS for young women's overall health and well-being while acknowledging the roadblocks they encounter in obtaining these services. Even though the local clinic offers no-cost SRHS, adolescent girls in Marondera have a surprisingly low rate of service utilization. This study aimed to comprehensively examine the knowledge, attitudes, and practices that surround adolescent girls' access to SRHS, along with how these elements connect to their social and demographic characteristics. The research questions delved deeper into specific areas such as the girls' existing knowledge levels, the influence of cultural attitudes, the practices currently in place at the clinic to deliver SRHS, and potential interventions to enhance service uptake. To ensure focused research, the study targeted adolescent girls residing in Marondera urban and healthcare workers at the Dombotombo Clinic. Key terms were clearly defined to avoid ambiguity, including SRH, adolescent girls, sexually transmitted infections (STIs), access, knowledge, attitudes, and practices. In essence, this chapter laid the groundwork for research. The findings from this study, particularly regarding the Dombotombo Clinic, could serve as a valuable microcosm for comparable settings throughout the region. Ultimately, this knowledge can guide policymakers and program developers in crafting interventions and recommendations to improve the accessibility and quality of SRHS for adolescent girls.

The second chapter delved into existing research on adolescent girls' access to Sexual and Reproductive Health Services (SRHS). It emphasized the importance of understanding their knowledge, attitudes, and practices concerning SRH. The chapter reviewed how these factors are

interrelated and explored potential barriers that prevent girls from utilizing SRHS. Bronfenbrenner's ecological systems theory provides a framework for examining the environmental influences that shape adolescent girls' access to SRHS. This theory highlights the interconnectedness of various systems, including family dynamics, schools, cultural norms, and broader societal contexts. A significant body of research points to concerning knowledge gaps among adolescents regarding SRH topics. Studies revealed a particular need for comprehensive sexuality education (CSE) to address these gaps and equip young people with the knowledge and skills to make informed choices. Adolescents' attitudes towards SRH are also complex and influenced by various factors. Negative perceptions surrounding contraception, cultural beliefs, and parental disapproval can create significant barriers. Research suggests that CSE can play a positive role in shaping positive attitudes towards SRH. The chapter then explores the practices related to SRH among adolescent girls. Cultural norms and misinformation can significantly impact these practices. Studies highlight the importance of addressing taboos surrounding menstruation and traditional beliefs that hinder access to SRHS. Finally, the review examined healthcare provider attitudes and the clinical environment as barriers to adolescent access to SRHS

The research methodology chapter detailed the strategies employed by the researcher to investigate adolescent girls' access to Sexual and Reproductive Health Services (SRHS) in Marondera Urban, Zimbabwe. Recognizing the limitations of a singular approach, the study adopted a mixed-method design, incorporating both qualitative and quantitative methods. This combined approach allowed for a more in-depth understanding of the phenomenon under study by gathering both numerical data and capturing the lived experiences of participants. Data collection techniques encompassed focus group discussions, questionnaires, and key informant interviews. Focus group discussions provided a platform for adolescents to share their perspectives on access to SRHS, knowledge

levels, attitudes, and the availability of youth-friendly services in Marondera Urban. Questionnaires, a standardized data collection tool, enabled the researcher to gather quantitative data from a larger sample of participants on demographics, attitudes, and practices related to SRHS. Finally, key informant interviews with healthcare workers, purposively selected for their knowledge and expertise, yielded valuable insights into the healthcare system's role in ensuring adolescent access to SRHS. The chapter meticulously detailed the target population, which included all adolescent girls between the ages of 15 and 19 in Marondera Urban. To ensure the sample represented the demographics of this population, the researcher employed stratified random sampling. This technique involved dividing the target population into subgroups based on age, residence, and socioeconomic status, and then randomly selecting participants from each subgroup. Additionally, the chapter underscores the importance of using sensitive and respectful language during data collection to minimize any potential harm or emotional distress to participants. Neutrality is another crucial ethical principle highlighted in the chapter. Measures were taken to establish content validity by ensuring the research questions and instruments comprehensively addressed the study's objectives.

5.3. Key Findings

The data showed that there is a general curiosity about SRH among adolescent girls in Marondera urban, but a hesitation to pursue knowledge proactively. This suggests that there is a need for educational campaigns that are tailored to the needs of adolescents. The study also found that comfort levels regarding sexual health discussions are significantly lower than those regarding menstruation. This suggests that there is a stigma surrounding sexual health that needs to be addressed. The secrecy surrounding sexual health could be due to the stigma associated with the

topic or a lack of trust in healthcare providers. Despite the expressed interest in learning more about SRH, the data revealed a low utilization of available services. This highlights a clear lack of awareness about the services offered at the Dombotombo clinic. The study also sheds light on contraceptive preferences among the girls. Male condoms emerged as the most commonly used method, likely due to factors beyond simple effectiveness. Convenience appeared to be a major consideration for the girls. Among adolescents who use contraception, condoms reign supreme. The survey revealed that a pack of three condoms costs just a dollar, making them a readily accessible option. However, a crucial barrier emerges when considering female contraceptives. While clinics offer a variety of free female methods like implants, pills, IUDs, and injectables, these services remain underutilized. The study suggests that adolescents are hesitant to access these free services at the local clinic. This hesitancy might be due to concerns about privacy or simply a preference for a non-clinical setting. It is important to note that the Dombotombo clinic offers all SRH services completely free of charge. Highlighting this fact alongside educational campaigns promoting the benefits and accessibility of various female contraceptive methods could be crucial in encouraging adolescents to explore these options beyond condoms.

5.4. Conclusion

The study found that there is a general curiosity about SRH among adolescent girls in Dombotombo, but a hesitation to pursue knowledge proactively. This suggests that there is a need for educational campaigns that are tailored to the needs of adolescents. The study also found that comfort levels regarding sexual health discussions are significantly lower than those regarding menstruation. This suggests that there is a stigma surrounding sexual health that needs to be addressed. Another conclusion that can be drawn from the study is that there is a low utilization

of available SRH services despite expressed interest in learning more. This could be due to a lack of awareness of the services that are available, or it could be due to concerns about privacy or confidentiality. The study also found that adolescents who are married or already have children are more likely to access SRH services. This suggests that there is a need for outreach programs to target unmarried adolescents and those who do not have children. The study also found that male condoms are the most commonly used contraceptive method, likely due to convenience and affordability. However, clinic services for female contraceptives are underutilized due to privacy concerns or preference for non-clinical settings. This suggests that there is a need to make female contraceptives more accessible and to promote their use. Finally, one can conclude that improving access to confidential SRH services and promoting awareness of available female contraceptive methods is crucial. Standardized indicators for youth-friendly SRH services should prioritize confidentiality, accessibility, and staff characteristics. Infrastructure upgrades, staff training, and robust contraceptive supply chains are essential for effective YFSRHS programs. Clear and comprehensive adolescent-specific SRH service guidelines are needed to improve health outcomes. In conclusion, the study found several challenges that need to be addressed to improve access to SRH services for adolescent girls in Marondera Urban. These challenges include the stigma surrounding sexual health, the lack of awareness of available services, and the privacy concerns that adolescents have about accessing these services. By addressing these challenges, we can help to improve the sexual and reproductive health of adolescent girls.

5.5. Implications for Social Work Practice

The study reveals key areas where social workers can play a vital role in improving sexual and reproductive health (SRH) outcomes. Social workers can address the stigma surrounding sexual

health through educational campaigns and workshops tailored to young people. They can also collaborate with healthcare providers to ensure clinics are confidential and youth-friendly. Furthermore, social workers can be key in raising awareness about available SRH services. Outreach programs targeting unmarried adolescents and those without children can bridge the gap between expressed interest and service utilization. Social workers can also advocate for increased access to female contraceptives and educate young people about these options beyond condoms. Finally, social workers can contribute to the development of clear and comprehensive SRH service guidelines specifically designed for adolescents. These guidelines should prioritize confidentiality, privacy, and accessibility. By working towards these goals, social workers can empower adolescent girls in Marondera to make informed choices about their sexual and reproductive health.

5.6.Recommendations

The improvement of health outcomes of adolescent girls by increasing the utilization of SRHS in Marondera urban, interventions have to target all the parts of the adolescent girls' ecosystem. Acknowledging the intricate interplay of factors at various levels of influence, extending beyond individual behavior to encompass the broader social context. Interventions would need to be implemented at the following levels.

Individual Level: This level focuses on the knowledge, attitudes, beliefs, and personal skills of adolescents regarding SRHS. The study highlights a gap between curiosity and proactive knowledge seeking. Interventions here could involve workshops led by social workers that address accurate sexual health information, challenge misconceptions, and promote positive attitudes

towards SRHS. Social workers can utilize interactive modules and age-appropriate language to ensure effective knowledge dissemination.

Relationship Level: This level emphasizes the influence of interpersonal relationships, particularly family dynamics. The study suggests a hesitancy to discuss sexual health with family members. Social workers can facilitate workshops involving parents and families to create open communication channels within households regarding SRHS. These workshops can address parental anxieties and equip them with effective communication skills to discuss sensitive topics with their children.

Community Level: This level considers the social norms, attitudes, and resources available within the community. The study suggests a potential stigma surrounding sexual health in Marondera urban. Social workers can collaborate with local leaders, NGOs, and community health workers to organize outreach programs that normalize SRHS discussions, address community-based stigma, and promote service utilization. These outreach programs can utilize peer educators from the community to connect with adolescents on a familiar level and address local concerns effectively.

Institutional Level: This level focuses on healthcare institutions' policies, practices, and resources. The study reveals privacy concerns as a barrier to clinic use. Social workers can advocate for improvements in clinic infrastructure to ensure confidentiality and a youth-friendly environment. This may involve separate adolescent waiting areas, designated SRHS consultation rooms, and gender-neutral bathrooms. Collaboration with healthcare providers can also ensure standardized protocols for youth-centered communication and service delivery, including training on youth-specific sexual health issues and confidentiality practices.

Societal Level: This level considers the broader social, cultural, and economic factors that impact SRHS access, national policies, and resource allocation can influence service availability. Social workers can advocate for policies that prioritize adolescent sexual health education integrated into the school curriculum and ensure adequate funding for SRHS programs. This may involve lobbying policymakers and collaborating with educational institutions to develop age-appropriate and comprehensive sexual health curricula

The strength of a multi-level approach lies in its emphasis on a multifaceted approach. By implementing interventions at various levels, social workers can create a more supportive environment for adolescent girls in Marondera. This can empower them to make informed choices about their sexual and reproductive health, ultimately leading to increased knowledge levels and SRHS service utilization.. This collaborative approach can lead to sustainable changes in policies, resource allocation, and service delivery models. For instance, social workers can collaborate with the Ministry of Health to develop and implement national guidelines for youth-friendly SRHS clinics, ensuring consistent quality standards across healthcare facilities. This collaborative effort across different levels can provide long-term improvements in SRHS accessibility and utilization for adolescent girls.

By employing interventions at different levels, social workers can play a pivotal role in creating a supportive and empowering environment for adolescent girls in Marondera Urban to make informed choices about their sexual and reproductive health. This comprehensive approach that addresses individual knowledge gaps, fosters open communication within families, tackles community stigma, improves healthcare facilities, and advocates for supportive policies can lead to significant and sustainably improve SRHS outcomes for adolescent girls.

5.7.Chapter Summary

This chapter explored the sexual and reproductive health (SRH) behaviors and service utilization patterns among adolescent girls. The survey results revealed a complex interplay of factors influencing their SRH choices. While a general curiosity about SRH exists, a hesitancy to proactively seek knowledge persists. There is a gap between openness regarding menstruation and comfort levels in discussing sexual health within families. The stigma surrounding sexual health and potential concerns about confidentiality at healthcare facilities contribute to the low utilization of available SRH services. In conclusion, this chapter underscores the need for a multifaceted approach to improve SRH outcomes for adolescent girls in Marondera. Educational campaigns promoting open communication and addressing stigma are crucial. Efforts to improve access to confidential SRH services, particularly female contraceptives, alongside increased awareness of their benefits, are essential. Finally, developing and implementing clear, youth-specific SRH service guidelines, infrastructure upgrades, and staff training can create a more welcoming and effective healthcare environment for adolescents. By addressing these critical areas, stakeholders can empower adolescent girls in Marondera to make informed choices about their sexual and reproductive health.

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APPENDICES

APPROVAL LETTER

APPENDIX 2: PARTICIPANT CONSENT FORM

Research Topic: **INVESTIGATING THE KNOWLEDGE, ATTITUDES AND PRACTICES TOWARDS ADOLESCENT GIRLS' ACCESS TO SRHS. A CASE STUDY OF DOMBOTOMBO CLINIC**

The research shall be conducted by **Anopaishe Mapurisa,** a student at the Bindura University of Science Education currently studying a Bachelor's degree in Social Work. The study is a requirement by the department in order to complete his studies.

I am giving consent to be interviewed by the researcher and the objectives of the study have been clearly explained to me in a language that I understand. By signing this document, I understand that participation in this study is voluntary. I also agree to be audio-taped and I am aware that I am free to withdraw from the study at any given time. I have been given clarification concerning the study. I understand that confidentiality is guaranteed and my identity will not be revealed.

Email address: mapurisaanopaishe@gmail.com

Participant's signature: …… Date: ……

Researcher's signature: ……. Date: …….

APPENDIX 3. Structured Questionnaire

Section A: Demographics

Instruction: Please place a tick (√) against the option that best applies to your response in each item

1. What is your age? ☒ 15-16 ☐ 17-19

2. What is your level of education?

☐a. Primary Education

☐b. Secondary Education

☐c. Tertiary Education

☐d. None Formal Education

3. What is your Religion?

☐a. Christianity

☐b. Islam

☐c. African Traditional Religion

4. Home address (Location)?

5. Who are you living with?

☐a. Parents

☐b. Alone

☐c. Friends

☐d. Live in school

6. What is your Marital Status?

☐a. Married

☐b. Single

☐c. Divorced

☐d. Separated

7. If married, how many children do you have?

☐a. None

☐b. One-three

c. Four-six

☐d. Seven and above

8. What is your estimated Monthly income/pocket money?

a. Below 30$

b.$ 40 - $60

c. $70 - $90

d. $100 - $120

e. Above $150

Section C : Knowledge levels

Item	**True**	**Not sure**	**False**
9.Only physical change and not mind and behavior changes occurs during adolescence			
10.The menstrual cycle more than once within a month is not a problem			
11. The carrier of the STIs may unintentionally transmit the virus to its partner			

12. You are required to pay for family planning services at Dombotombo clinic			
13. HIV does not spread the virus from an infected person's coughing and sneezing			
14. you require parental consent to access sexual reproductive health services			

Section C: Attitudes towards SRHS

	True	**Not sure**	**False**
15.Sexual education leads to more sex			
16. school's textbook lacks sufficient knowledge concerning SRH			
17.A teenage girl does not go into the kitchen during her menstrual cycle			
18.Anyone who receives STIs should cover it up			
19. taking contraceptives before marriage will cause infertility			
20. Nurses will scold you for asking condoms			

Section D: Practice

	Always	**Sometimes**	**Never**
21.I want to learn more new SRH details			
22.I keep my mother or older sister updated when I am menstruating			
23.I feel at ease when talking about Sexual health			

24.I try to keep my sexual reproductive health issues a secret			
25. Do you make use of any sexual health service at the local clinic			

APPENDIX 4. Focus Group Discussion Guide

(40mins)

Note to focus group participants

- Everything shared in this group will be confidential.
- There are no right or wrong answers, just your honest perspectives.
- Respectful communication is important. Everyone gets a chance to speak.

Discussion Topics:

1. Knowledge of SRHS (10 minutes):

- What is SRHS mean to you and what does it encompass?
- Have you heard about different types of SRHS services? (e.g., contraception, STI testing, healthy relationships)
- Where do you get information about SRHS? (e.g., friends, family, school, healthcare providers)
- Are there any terms related to SRHS that you are unsure about?

2. Attitudes towards SRHS (15 minutes):

- How comfortable are you talking about SRHS with friends, family, or healthcare providers?
- Are there any SRHS services you feel are particularly important for young women?
- Are there any myths or misconceptions you have heard about SRHS?
- Do you feel there are any barriers preventing girls from accessing SRHS**?**

3. Practices related to SRHS (10minutes):

- Have you ever accessed any SRHS services? If yes, which ones?
- What factors would influence your decision to use an SRHS service?

- What kind of support would be helpful for young women to make informed decisions about their sexual health?
- Are there any resources or information you feel are missing related to SRHS?

Wrap-Up (5 minutes):

- Is there anything else you would like to share about SRHS?
- What are your hopes for improving access to SRHS information and services for young women?

APPENDIX 5. Interview Guide for Key informants

Part 1-Socio-demographic characteristics:

Socio-demographic characteristics: age, sex, marital status, number of children, socioeconomic stratum, religion.

Part 2-Knowledge

1. In your experience, what are the main challenges adolescent girls face when accessing SRHS?
2. Can you describe some common misconceptions you encounter regarding SRHS among adolescent girls?
3. How confident are you in your own knowledge and ability to provide accurate information about SRHS to adolescent girls? (Explain)
4. What resources do you find most helpful in staying up-to-date on SRHS guidelines and best practices for adolescent care?

Part 3-Attitude

1. How comfortable do you feel discussing sensitive topics like sexual health and contraception with adolescent girls? (Explain)
2. In your opinion, how important is it for adolescent girls to have access to confidential SRHS services? (Explain)
3. Have you ever encountered any personal biases or cultural beliefs that might affect your approach to providing SRHS to girls? (Explain)
4. What are some strategies you use to create a safe and welcoming environment for adolescent girls seeking SRHS?

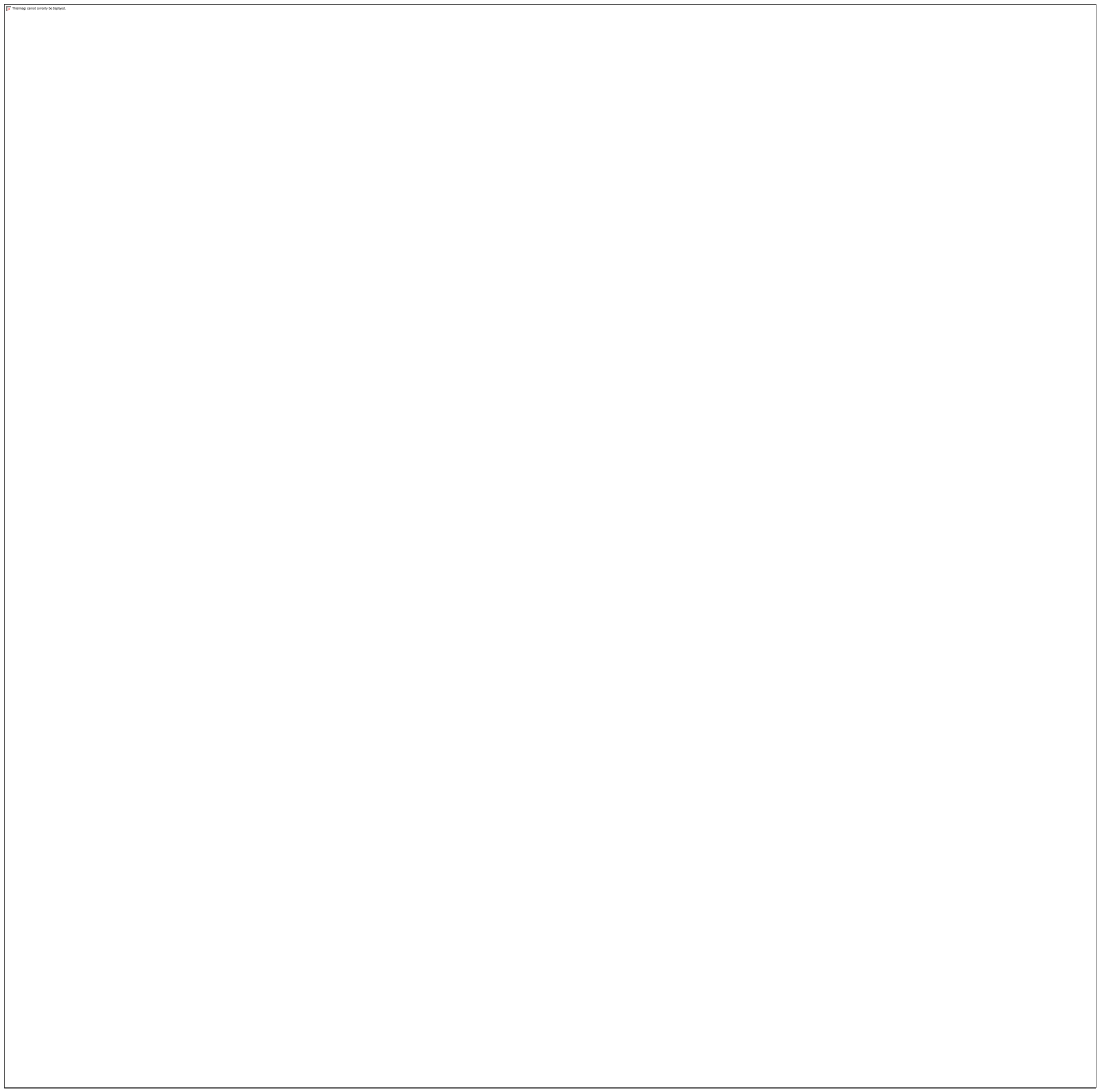
Part 4- Practices

1. Can you describe the typical SRHS services available to adolescent girls in your facility?
2. How do you ensure confidentiality is maintained when providing SRHS to adolescent girls?
3. Do you encounter any logistical challenges in providing SRHS to this age group? (e.g., scheduling, parental involvement)
4. What training or support would be helpful to improve your ability to effectively address the SRHS needs of adolescent girls?

Closing:

1. Is there anything else you would like to share regarding adolescent girls' access to SRHS**?**

Thank you for your time and valuable insight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