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FACULTY OF SOCIAL SCIENCES AND HUMANITIES

DEPARTMENT OF SOCIAL WORK.

ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR ADOLESCENT GIRLS ENGAGED IN SEX WORK: A CASE OF KOMBONIYATSVA COMMUNITY EPWORTH, ZIMBABWE.

BY

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A DISSERTATION SUBMITTED TO THE DEPARTMENT OF SOCIAL WORK, BINDURA UNIVERSITY OF SCIENCE EDUCATION IN PARTIAL FULLFILLMENT OF REQUIREMENTS FOR **THE BACHELOR OF SOCIAL WORK HONOURS DEGREE.**

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APPROVAL FORM

Supervisor, I certify that I have supervised **GARAI STACEY for the research entitled, "ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR ADOLESCENT GIRLS ENGAGED IN SEX WORK: A CASE OF KOMBONIYATSVA COMMUNITY EPWORTH, ZIMBABWE."** in partial fulfilment of the requirements of the Bachelor of Social Work Honours Degree (HBScSW) and recommend that it proceeds for examination.

SUPERVISOR

NAME……SIGNATURE……..DATE……...The Department Board of Examiners is satisfied that this dissertation report meets the examination requirement and therefore recommend Bindura University to accept a research project by **GARAI STACEY titled, "ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR ADOLESCENT GIRLS ENGAGED IN SEX WORK: A CASE OF KOMBONIYATSVA COMMUNITY EPWORTH, ZIMBABWE."** in partial fulfilment of the requirements of the Bachelor of Social Work Honours Degree.

CHAIRPERSON NAME……SIGNATURE……..DATE……

DECLARATION

I _____ declare that the work submitted is my own and that appropriate credit has been given where reference has been made to the work of others

DEDICATION

To my parents and siblings for their steadfast love and unwavering support throughout the study.

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I am grateful to the Lord God who has given me so much determination, strength, and wisdom to carry out this research. I would like to express my deepest gratitude to the following people: My supervisor, Mr Chineka, for his guidance, support, patience and encouragement throughout the course of the study. My parents who taught that education is psychological liberation. Research participants; thank you for your time, your patience, and your willingness to answer my questions and share your opinion on life with me. Your cooperation was essential to the success of the study. My colleagues and friends who always supported and encouraged me to keep going when I feel like I'm losing the battle. Thank you very much.

ABSTRACT

The research study examined access to SRH services for young girls engaged in sex work in Epworth Komboniyatsva Community. The main thrust of the study was to examine factors which ensure accessibility of services, barriers and how they can be curbed and approaches to which comprehensive access to SRH services can be enhanced. The study employed a case study research design and it was qualitative in nature. It employed in-depth and key informant interviews for the purposes of data collection. A sample size of fifteen (15) participants and five (5) key informants was utilised to collect pertinent information for the study. The research study employed the human rights based approach. It revealed that access to SRH services is intricacy and involve a myriad of factors. Majority of the participants revealed that SRH services are an important aspect in their lives but a huge gap was noticeable between their needs for services and their right to access services. Basing on the findings it was apparent that participants rights to be treated with dignity and access to SRH services is often overshadowed by social isolation, discrimination and other stereotypical assumptions. Criminalisation, socio-cultural factors like stigma and discrimination and segregated care, negative attitudes from service providers hinders access to SRH services. Also factors such as the availability of youth friendly services, peer educators, community led interventions leads to accessibility of services. The study recommends that policy makers should regard access to available SRH services for adolescent girls engaged in sex work within governmental and NGO facilities as a public health concern. Thus without discriminatory stances as stipulated within human rights based approach. Anti-discrimination laws and regulations should guarantee adolescent girls engaged in sex work right to access comprehensive SRH services.

LIST OF ABBREVIATIONS

AIDS	ACQUIRED IMMUNO DEFICIENCY SYNDROME
CeSHHAR	CENTRE FOR SEXUAL HEALTH AND HIV AIDS RESEARCH
HIV	HUMAN IMMUNODEFICIENCY VIRUS
HRBA	HUMAN RIGHTS BASED APPROACH
MOHCC	MINISTRY OF HEALTH AND CHILD CARE
MSF	MEDICANES SANS FRONTIERS
NGO's	NON-GOVERNMENTAL ORGANISATIONS
NSWP	GLOBAL NETWORK OF SEX WORK PROJECTS
STI	SEXUALLY TRANSMITTED INFECTION
SRH	SEXUAL AND REPRODUCTIVE HEALTH
SRHR	SEXUAL AND REPRODUCTIVE HEALTH RIGHTS
UNCRC	UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD
UNAIDS	THE JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
WHO	WORLD HEALTH ORGANISATION
ZNFPC	ZIMBABWE NATIONAL FAMILY PLANNING COUNCIL

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CHAPTER ONE
INTRODUCTION AND BACKGROUND

1.0 INTRODUCTION

This chapter presents the research study by way of providing a delineation on access to sexual and reproductive health services for young girls engaged in sex work. The thrust of the study is to examine access to sexual and reproductive health services for young girls engaged in sex work in Epworth Komboniyatsva Community. The background in which the study is situated is discussed. It provides the statement of the problem associated with the study. Research aim and objectives are highlighted in the chapter. It bestows a detailed insight to the justification of the study, definition of key terms and structure of the dissertation.

1.1 BACKGROUND TO THE STUDY

Consequential progress has been made in recent decades toward the realisation of Sexual and Reproductive Health Rights around the world. Following the ICPD Programme of Action in Cairo in 1994 and the Beijing Declaration and Platform for Action in 1995, the International Conference on Population and Development (ICPD) was convened (Brown 1994). Several governments throughout the world have pledged to, and have made significant actions toward, achieving SRHR at the state and global levels, and Zimbabwe is no different (Newsday 2019). Despite the progress made, ensuring universal access to comprehensive access to SRH for adolescent females involved in sex work remains a difficulty (UNICEF 2021). These conventions establish admirable global objectives, but they can make it more difficult to give services to adolescents or collect data from them (Busza et al., 2017). Adolescents account for one-quarter of the world's populace, Branje (2021), and they are among the people who are most affected by the global HIV/AIDS epidemic.

Women and girls are extremely affected in a variety of situations around the world and face multiple SRH challenges, primarily in sub-Saharan Africa and Asia. Access to goods and services related to SHR is a fundamental element of sexual and reproductive rights (SRHR) (WHO 2016). It is very important to involve women, adolescents, young girls involved in sex work, and older sex workers. Adolescent girls who have sex on the move or in hard-to-access areas are not well serviced compared to adolescent girls in more stable locations (UNICEF 2010). Studies in China show that adolescent girls engaged in sex work in high-risk areas are significantly less likely to

undergo peer education, outreach services, free condoms, or HIV testing (Zhang, Temmerman, & Li 2012). A study in China recommends that existing services for adult sex workers, such as drop-in centres, are relevant to young people and need to be significantly redesigned for accessibility (Mavedzenge, Luecke & Ross 2013).

A human rights-based framework must include access to complete sexual and reproductive health services that range from STI prevention to post-natal care. Other populations' sexual and reproductive health concerns have rarely been addressed by public health programs (UNAIDS 2017). SRH assistance for adolescent females involved in sex work are frequently hampered by abolitionist attitudes and common conflations of sex work (NWSP 2016). Even though young girls who work in the sex industry are not specifically prohibited from using SRH services. Their access to sexual reproductive health care and rights is hampered by structural hurdles such as criminalization, stigma, and discrimination (NWSP 2016). The portrayal of sex workers as "vectors of disease" in the public health paradigm has promoted stigma while prioritising limited HIV and STI interventions to the detriment of their overall SRH requirements.

Insufficient funding in the NGO sector has forced youth engaged in sex work to rely on public health care, which is often inaccessible, opaque and discriminatory. Age consent is a major problem hindering access to public health care (NWSP 2016). As a result, there are few comprehensive and compassionate SRH services available to young girls engaged in sex work. Everyone has the right to sexual and reproductive health care. However, adolescents in the sex industry exemplify widespread inequalities in SRH coverage and treatment leading to violations of their sexual and reproductive rights (Busza et. al., 2019). The main population at risk of HIV infection include sex workers of all genders, with young girls being the main affected population (WHO 2016). In Epworth, adolescent girls engaged in sex work are particularly vulnerable when accessing SRH services. This is due to widespread stigma and discrimination, combined with the particular vulnerability of young people, who are sometimes shunned by family and friends.

Adolescent girls engaged in sex work has recently increased in the African region due to socio-economic and political factors that negatively affect the lives and health of African children. Sex workers of all genders, including those living with HIV, are entitled to SRH services like everyone else. However, adolescent girls' participation in sex work demonstrates widespread deficiencies in SRH coverage and treatment, leading to violations of their human rights (Branje 2021). As a result,

adolescent girls engaged in sex work are vulnerable and are at significantly higher risk of HIV infection than their peers. Prostitution in most African countries is illegal, leading to social stigma. Social stigma against young girls working as sex workers has limited their access to relevant SRH information (Day & Ward 1997). In African countries, adolescent sex work is largely driven by widespread poverty, especially in Sub-Saharan African countries. Thus this is considered to be one of the factors that increase the prevalence of AIDS in Africa.

Adolescent girls engaged in sex work are often prevented from seeking health services due to stigma related to their work and in some cases, hostile regulatory environments or provider's hostile medical service providers. Other system-based reasons, including legal and policy barriers to accessing SRH services; increased exposure to uniformed services leads to harassment and lack of information on youth-friendly HIV and SRH treatment (Dhana et al., 2014). Such community response discourages them from accessing SRH/STI services, thereby increasing the risk of infection and re-infection from untreated STIs (Lafort et al. 2010). However, in most African countries where prostitution is illegal, adolescents engaged in sex work continue to be significantly affected. Adolescent girls engaged in sex work need a legal environment that ensures respect for SRHR through access to comprehensive SRH services.

1.2 STATEMENT OF THE PROBLEM

Young girls engaged in sex work face obstacles when accessing SRH services across multiple settings in Zimbabwe specifically in Epworth were sex work is rife. Adolescent girls engaging in sex work continue to face challenges resulting in spread of sexually transmitted diseases and untimely maternal deaths. Despite escalation in governmental efforts, development partners and other stakeholders through policies and targeted interventions to enhance access to SRH services for the youth. Existing studies provides loopholes on access to conventional SRH services for adolescent girls indulging in sex work (Nawanse and Jjuuko 2017). Empirical data to deliver efficient interventions in a way that is acceptable and accessible to this population remain sparse. Hence multiple intricacy SRH issues are emanated within young girls in the sex work industry. It is against this background that this study aims to establish access to SRH services for adolescent girls within the sex work industry.

1.3 JUSTIFICATION OF THE STUDY

Komboniyatsva Community in Epworth provided a fair representation of a hot spot area for the purpose of this study. It is an improvised settlement made up of people from many cultures. Young girls who engage in sex work face prejudice and stigma as a result of societal and harmful practices, making it difficult for them to seek comprehensive SRH assistance. Zimbabwe's restrictive rules also play a role. By looking into the experiences of SRH services in Epworth, this study ensured that under aged girls engaging in sex work have access to SRH services that are acceptable to them and the community. It adds to the body of knowledge about how to improve access to SRH services for this vulnerable group. Stakeholders will benefit from the findings of the study. Also, young girls engaged in sex work, university students, non-governmental organizations, and the government are all impacted. The information generated is also important in developing strategies and policies which enables access to sexual and reproductive health services.

1.4 AIM

The aim of this study is to examine access to sexual and reproductive health services for young girls engaged in sex work within Epworth Community.

1.5 OBJECTIVES

1. To identify the range of sexual and reproductive health services available in the Epworth Community.
2. To determine how these services are accessible to young girls engaged in sex work in the Epworth Community.
3. To examine strategies to improve access to sexual and reproductive health services for young girls engaged in sex work in Zimbabwe.

1.6 DEFINITION OF KEY TERMS

Adolescents

World Health Organization (2018) defines adolescents as individuals between 10 and 19 years of age. Therefore for the purposes of this study the terms “adolescent girls and young girls” will be used interchangeably. Thus adolescents also refers to a young person at puberty stage between childhood and adulthood.

Child Prostitution

According to the United Nations (2015), child prostitution refers to the act of engaging or offering the services of a child to perform sexual acts for money or other considerations with that person or any other person. Therefore child prostitution is the engagement by young persons in promiscuous sexual activities for pay.

Sex-worker

According to The Worst Forms of Child Labour Convention (1999), sex worker is a person who performs sexual acts for any form of reward or compensation. Thus a sex worker is a person who engages in sexual activities for payment.

Sexual Reproductive Health

World Health Organisation (2016) states that sexual reproductive health is an umbrella for various issues affecting men, women, boys and girls alike. It represents four separate areas: sexual health, sexual rights, reproductive health and reproductive rights. These are integral elements of the right to enjoyment of the highest attainable standard of physical and mental health.

1.7 STRUCTURE OF THE DISSERTATION

CHAPTER ONE- INTRODUCTION & BACKGROUND.

The thrust of the study is to examine access to sexual and reproductive health services for young girls engaged in sex work in Epworth Komboniyatsva Community. This chapter gives a background on access to SRH services for adolescent girls engaging in sex work. It provides the statement of the problem associated with the study. Research aim and objectives are highlighted in the chapter. It bestows a detailed insight to the justification of the study and definition of key terms.

CHAPTER TWO-LITERATURE REVIEW.

The purpose of this chapter is to introduce the literature reviewed on adolescents' girls engaging in sex work access to SRH services from a global, regional and national (local) perspective. According to Nerderir (2010) literature review refers to the course of interpreting, scrutinizing, and assessing and summarising theoretical information related to a certain topic. This is done so as to place it in context and to indicate opinions of other researchers and authors. The literature review brings out the gaps of the area under study as well as recommendations in solving the

problem. The subject matter sheds more light through the use of theoretical framework in turn this demystifies more on the research.

CHAPTER THREE-RESEARCH METHODOLOGY.

This chapter gives an outline of research methods that were used in the study. It provides information on the participants, that is, the criteria for inclusion in the study, who the participants, were and how they were be sampled. The research design is qualitative which explores data on access to SRH services for adolescents engaging in sex work within the Epworth community. The research study also describes the study setting and the target population. The instruments that were used for data collection are also outlined. The researcher also discusses the methods used to analyse data. The ethical issues for the researcher and participants that followed in the process are discussed. Lastly the limitations of the study are also outlined.

CHAPTER FOUR-PRESENTATION OF DATA & DISCUSSION OF FINDINGS.

This chapter focuses on data presentation, analysis and discussion of findings of the research on access to SRH services for young girls engaged in sex work in Epworth Komboniyatsva Community. The study utilised the qualitative approach. Demographic data was presented using tables whilst with data it was through thematic analysis. In-depth interview guide and key informant interview guide were used for data collection, hence an analysis and interpretation was provided for each instrument. The research was guided by the following objectives: to identify the range of SRH services available in the Epworth Community, to determine how these services are accessible to young girls engaged in sex work in the Epworth community. Also to examine strategies to improve access to SRH services for young girls engaged in sex work in Zimbabwe. The chapter did make an inclusive discussion on access to SRH services reinforced by relevant publications.

CHAPTER FIVE-CONCLUSIONS AND RECOMMENDATIONS.

This chapter concludes the study by recapitulating the major findings of the study on access to sexual reproductive health services of adolescent girls engaged in sex work, a case of Epworth Komboniyatsva Community. The chapter also provide conclusions basing on the research findings namely available sexual and reproductive health services within Epworth Community, how these services are accessible to young girls engaged in sex work in Epworth Community and the

strategies to improve access to sexual and reproductive health services for adolescent girls engaged in sex work in Zimbabwe. Thus the various conclusions and recommendations that emerged from the study were discussed.

1.8 CHAPTER SUMMARY

In this chapter the researcher managed to introduce and give a brief background of the research topic. The chapter gave an insight on the statement of the problem, research aim as well as objectives of the research study. The significance of the study was also highlighted as well as definition of key terms.

CHAPTER TWO
LITERATURE REVIEW

2.0 INTRODUCTION

The purpose of this chapter is to present the literature that has been assessed on the access of adolescent girls in sex work to SRH services from a global, regional and national (local) perspective. According to Nerderir (2010), literature review refers to the process of interpreting, examining, evaluating, and synthesizing theoretical information related to a given topic. This is done to put it in context and to indicate the opinions of other researchers and authors. The literature review highlights the shortcomings of the field under study as well as recommendations for addressing the problem. The topic is further elucidated through the use of a theoretical framework, which further demystifies more on the research.

2.1 THEORETICAL FRAMEWORK

Human Rights Based Approach.

The study examined access to SRH services for adolescent females involved in sex work using a human rights-based approach. The human rights based approach is founded on the Universal Declaration of Human Rights and other international human rights treaties' universal ideals and standards (Griffin 2006). The HRBA establishes a legal foundation and principles that guide all countries around the world, ensuring the availability of services to all segments of the population. HBRA is a normative working methodology that is based on globally recognized human rights. It aims to examine obligations, disparities and susceptibility and discriminatory practices that obstruct and undermine human rights (UNHRC 2018). As a result, it aspires to promote, preserve and implement human rights in all sectors and modalities including health. Under this approach programs and policies are anchored in a system of rights and obligations set by international law. This contributes to sustainability by empowering rights holders, particularly the marginalized.

People in the most marginalized situations, who experience the greatest challenges to realising their rights and obtaining services, should be given priority, according to a human rights-based approach. The HRBA aims to redesign adolescent sex worker programs in order to embrace international standards and increase access to SRH services through program implementation (Griffin 2006). All of the rights and services outlined in the Universal Declaration of Human Rights are available to everyone. Human rights are essential, according to the HRBA, and depriving

someone of their rights is a grave affront to justice. It also recognizes that fundamental social, cultural, and political drivers of SRH need to be addressed in order to enable equal access to SRH services. Individuals have equal rights and entitlements to SRH education and services, according to the human rights perspective. As a result of this contemplation, the study illustrates the necessity for young girls engaged in sex work to have access to complete SRH as a human right.

2.2 SRH SERVICES AVAILABLE IN EPWORTH

2.2.1 Abortion Services.

Induced abortion is typically unlawful in Saudi Arabia, according to the non-codified principles of Islamic law, and is only permitted in certain circumstances. For example, if a woman is pregnant for less than four months and a professional determines that continuing the pregnancy would be detrimental to her health, the pregnancy can be terminated to save the mother's life (UN 2011). This is in accordance with Ministerial Resolution No. 218/17/L of June 26, 1989, which contains article 24 of the Rules of Implementation of the Regulations of Medical and Dental Practice. However, such legally sanctioned abortions can only be performed in government hospitals, and there are two additional requirements: the patient and her husband or male guardian must both sign a standard government-approved form of written consent, as well as a recommendation signed by a panel of three specialists and the hospital director (UN, 2011).

Nepal's experience is instructive for a successful rollout of safe legal abortion based on public health evidence-based policy. The passage of abortion-related legislation in 2002 resulted in a significant decrease in severe abortion complications and maternal mortality (Ying et.al. 2013; Nepal Ministry of Health, 2002; WHO, 2015). In cases of rape, incest, or foetal abnormality, or if the pregnancy poses a danger to the woman's life or physical/mental health, the Safe Motherhood and Reproductive Health Rights Act of 2018 allows abortion up to 12 weeks' gestation on request and up to 28 weeks' gestation if the pregnancy poses a danger to the woman's life or physical/mental health. In 2014, there were approximately 1,100 government-approved health facilities in towns that provided legal abortion or post-abortion treatment (Puri et. al, 2016). According to Sadaawi (2007), abortion services are only provided in Egypt, Algeria and Morocco for the aim of preserving the mother's life, whereas permitted in Sudan and Iraq in situations of rape and incest. Abortion is legal in Tunisia throughout any trimester and on demand.

Coverage for safe abortion services is only accessible in Thailand. Based on indications that it is legal throughout the country, including in Saraburi and Trang (NWSP 2016). Absent in Cambodia, India, and Vietnam, all of which have highly liberal abortion legislation. One of the leading causes of maternal death is the poor management of high-risk unwanted pregnancies, particularly unwanted pregnancies among unmarried young girls and women (WHO 2016). Safe abortion services should be available to all women who choose to terminate a pregnancy in Sub-Saharan Africa, where it accounts for 10% of all maternal fatalities (WHO 2017). In nations like Zimbabwe, restrictive abortion laws contribute significantly to increased inaccessibility, which has resulted in an increase in maternal mortality. Failure to meet the SRH needs of adolescents results in STI infections and an increase in HIV infection rates. As a result, access to accessible SRH services is required to ensure that the entire community benefits.

2.2.2 Post natal and Antenatal Care

Saudi Arabia is a signatory to the Convention on the Elimination of All Forms of Discrimination against Women. It grants women access to all healthcare services in the country under Article 12 (UN, 2006). Saudi Arabian women are entitled to appropriate prenatal and post-natal services, including free services where necessary, as well as suitable nourishment during lactation (UN, 2006). Mongolia has made significant success in reducing maternal mortality and increasing both prenatal care coverage and skilled attendance at delivery, both of which are high at over 90% and 98 percent, respectively. Mongolia's strong commitment to provide access to sexual and reproductive health services for all populations is shown in these recent advancements.

In Rwanda, both state and non-governmental institutions provide SRH services. Echography is used to treat pregnant women, as well as antenatal and postnatal care and partial health interventions. Fertility awareness, prenatal counselling, and postnatal care are accessible in 45-52% of government and non-governmental facilities (Ndayishimiye et al. 2020). Contraception, STI screening and treatment, postnatal and prenatal care for both adults and adolescents are among the SRHs services available in communities. According to Mongkolchati (2018), maternal health services, including emergency obstetric care, were offered in government facilities without user fees within local communities across the Asian Pacific. Premarital, prenatal, obstetric, and postpartum health care are among the SRH services accessible in Saudi Arabian communities, according to WHO (2016). Contraception is available upon request for married couples only.

2.2.3 Diagnosis, treatment of HIV and other STI's.

According to a report published by the Guttmatcher Institute in 2019, health insurance policies in the United States cover the full range of available SRHs, STI testing and prevention, counselling, had related treatments with no out-of-pocket expenditures. Some young individuals, on the other hand, may not use insurance to receive reproductive health treatments because they are unaware that they are covered or because of worries about confidentiality (Fuentes e.t al.2018). In Rwanda, SRH services are provided by both public and private organisations. Ndayishimiye et al. (2020) found that SRH services are available to the general public in both governmental and private organisations in Rwanda's Kigali and Huye. Adult male circumcision, as well as tests and treatment for STIs such as syphilis and candidiasis, are available at these facilities.

A study published in 2016 by Partnering to Inspire, Transform, and Connect the HIV Response in Zimbabwe (Partnering to Inspire, Transform, and Connect the HIV Response in Zimbabwe) looks at the available SRH services in communities. STl testing and treatment, HIV testing, counselling and therapy, and adherence support are among them. According to a report by MoHCC (2016), Zimbabwe's Reproductive Health Policy establishes a framework for providing integrated maternal health, family planning, STI, and AIDS care. The government of Zimbabwe is the primary provider of SRHs, either through its own facilities such as health centres and hospitals, or through subsidies to other providers such as non-governmental organisations and community-based organisations (NGO's and CBO's) inside communities. PSI Zimbabwe conducted an integrated programme for SRH services under the (ISP) throughout communities in collaboration with the Zimbabwe Ministry of Health and Child Care (MoHCC). Epworth and Mabvuku satellites are a visible example is Epworth and Mabvuku satellite clinics. This includes integration of HIV services (HIV counselling and testing, treatment and prevention) and other services.

A study conducted in Enugu State, SRHs are available, but not particularly for adolescents and other key populations. Contraception, HIV/AIDS testing and counselling, and maternity and prenatal care are among the services provided to the general public (Odo, Samuel, Nwagu, and Nnamani & Atama 2018). Sexuality education, STI prevention and treatment, and HIV/AIDS counselling were among the services accessible to adolescents from schools and churches. Mayhew & Adjei (2004) published a report that included information on the priority-setting processes for developing Ghana's health system. In Accra, priority-setting was done based on

disease ranking by DALYs. As a result, only a limited range of SRH services pertaining to HIV, maternal health, and contraception were included, leaving the majority of SRH services out.

WHO, CEDAW, and ICPD for Action policies have influenced the availability of SRH services in Zimbabwe's communities. According to a UNAIDS research published in 2017, updated policies in Zimbabwe, such as the National Adolescent Sexual and Reproductive Health Strategy 2010-2015 and the National Policy on HIV/AIDS, have boosted the provision of SRH services. Viral load monitoring, adherence support, STI screening and treatment, postnatal and prenatal care for both adults and adolescents are among the SRHs services available in communities. NGO's like as CeSHHAR, MSF, and KP Friendly locations, according to NAC (2017), provide a comprehensive spectrum of SRH services for critical populations in Harare, Chirundu, and Beitbridge. Although SRH services are available, they are not available to some populations, resulting in STI infections and an increase in HIV infection rates. Thus need for access to available SRH services to ensure that the community benefits as a whole.

2.2.4 Cancer Screening

Across a number of studies conducted across a wide range of low- and middle-income countries, HPV vaccination in adolescent girls within communities has been shown to be cost-effective in the prevention of cervical cancer (Campos et al, 2012). Visual cervical inspection with acetic acid has been shown to be cost-efficient in developing countries when used as part of a screening and treatment strategy (Campos et al, 2015a; Denny et. al, 2016). Screening programmes based on cytology can also be found in the community. In Uruguay, the SRHR package includes screening for and treatment of reproductive health malignancies, as well as counselling. North Macedonia has established a national SRH action plan (2018–2020). It accelerates SRHR integration, which includes breast and cervical cancer prevention and early detection. Vulnerable populations have been protected, and universal access to sexual and reproductive health care has been ensured. Failure to give young girls aged 9–13 years the cost-effective HPV vaccine has ramifications of cervical cancer morbidity and mortality.

2.2.5 Contraception

Uruguay has taken consequential steps in developing and executing a SRHR public policy as part of a health-system reform initiative aimed at ensuring universal access to SRH treatments. Modern contraception (quality contraception provision, ensuring the availability of a wide range of

contraceptive methods, including long-acting reversible contraceptives, free or at low cost), safe abortion, antenatal, perinatal, and postnatal care, including new-born care, screening and management of reproductive health cancers, CSE, and information and counselling are all part of the SRHR package of interventions (WHO 2016). It's worth noting that holistic adolescent health interventions, such as SRHR, mental health, and nutrition, are all heavily emphasised. A national intersectoral strategy was launched to expedite progress in the reduction of adolescent unwanted pregnancies. This strategy was launched and is under full implementation within communities. In Saudi Arabia contraception is required upon request and to married couples only (Sadaawi 2012).

Contraceptive services are accessible at public facilities in the Lao Peoples Democratic Republic, however they are only utilised by married adult women who already have children. Unmarried teenagers without children do not have access to these services, increasing their risk of unintended pregnancies and sexually transmitted infections (STIs) (Lim et al, 2015). All populations in Chile have access to contraceptive services. Chile passed the Law on Fertility Control Information, Orientation, and Provision (Republic of Chile 2010). The law protects everyone's right to choose the contraceptive method of their choice in a free and responsible manner (CEDAW 2013). Contraception is available in Pakistan through community-based distribution. Women are visited in their homes by lady health workers who provide contraceptive information, supplies, and referrals to permanent control techniques.

In Sub-Saharan Africa, family planning services are delivered through three methods: health care facilities, commercial outlets, and community-based systems. IUDs, injectables, condoms, and pills are among the contraceptive services provided in Zimbabwe's communities (Busza 2017). Despite all of the advancements and resources available in most developing and industrialised nations, over 120 million women still have unmet contraceptive needs each year; 80 million women have unwanted pregnancies, and 45 000 die as a result of unsafe abortions. Unmet need is disproportionately high among all women aged 15-19 (43%) compared to all women aged 15-49 among women who desire to avoid pregnancy (24%). Many SRHs are already scarce, and the spectrum of services provided in many nations within local communities excludes them. As a result, African communities must have equitable access to available SRHs.

The Ghanaian government, school leaders, and community members all express great support for sexual and reproductive health (SRH) education in the community and schools. However,

according to a recent study, Ghanaian programmes do not provide all of the information that adolescents require (Guttmacher Institute 2017). While SRH education in Ghana is advanced in comparison to other nations in the region, material is sometimes delivered in a reactionary manner, emphasising the significance of abstinence and the consequences of sexual engagement. As a result, teachers all around the world face difficulties when it comes to teaching sexuality education (UNESCO, 2014). In Zimbabwe, for example, sexuality education is taught as a stand-alone subject in the HIV and AIDS curriculum, despite the International Technical Guidance on SRH Education's recommendation that it be incorporated into the other mainline subjects (UNAIDS, 2014). As a result, the responsibility for teaching sexuality education falls solely on the shoulders of guidance and counselling teachers, and school dropouts are disregarded within the community.

2.3 Accessible SRH services for young girls engaged in sex work.

Everyone has the right to use SRH services offered by the government and non-governmental organisations. In India, Indonesia, Papua New Guinea, and Thailand, programmes have been formed to ensure that law enforcement does not obstruct HIV treatment and prevention among teenagers involved in sex work (UNAIDS 2017). In Indonesia, the National Policy and Strategy on Adolescent Health (2004-2009) states that the government and the community must support and foster adolescent SRH. This policy guarantees that teenage girls involved in sex work have access to SRHs and that services are given without discrimination. Persons under the age of 18 are explicitly protected from prosecution by New Zealand's Prostitution Reform Act, 2003. As a result, SRH services are provided to young people in all settings, including at school and outside of school, as well as on the streets and among sex workers.

Several Asian Pacific countries have established criteria for health service delivery that are "confidential, do not require parental agreement, are affordable or free of charge, and accessible in a variety of settings." These have implications for adolescent sex workers because they support the idea of a state obligation to provide certain services to all people without discrimination while protecting their privacy rights (Asia Pacific Regional Issues Brief 2011). These factors have a major impact on these teens' health-seeking behaviour. National HIV regulations in PNG and Fiji, according to the HIV/AIDS Management and Prevention Act (2004), make it illegal to refuse anyone access to HIV prevention methods such as condoms, lubricant and syringes.

In Zimbabwe, adolescent sex workers have access to SRH services provided by non-governmental organisations (NGOs) in their areas. According to a CeSHHAR research from 2009, at least 26 090 persons have been treated for sexually transmitted diseases and 20% have tested HIV positive out of 52 214 people who visited the organization's clinics since 2009. It may be seen in Harare, Chirundu. According to the Ministry of Health and Child Care of Zimbabwe (MoHCC), the number of sex workers contacted by HIV prevention programmes in Zimbabwe has more than doubled, from 7 300 in 2014 to 16 900 in 2015. Young girls involved in sex work who are shy and require solitude frequently complain of discrimination at health facilities, but through CeSHHAR, health and other concerns impacting them have been addressed on their own platform. As a result, such measures must be adopted in order to provide comprehensive access to SRH services for young girls engaging in sex work in local communities.

In Sub-Saharan Africa and Asia, there have been relatively few sex worker programmes for both adolescents and adults. Adolescent and adult sex workers in Durban, Mombasa, Tete, and Kilindi, according to Dhana et al. (2014), attested to the availability of SRH services. NGO's and CBO's are the primary providers of these services. HIV prevention and care are primarily available to adolescent sex workers, but other SRH services, such as contraception, treatment for unwanted pregnancies, cervical cancer screening, and sexual gender-based violence, are rarely available. Condoms are the most common type of contraception used by adolescent sex workers, although condoms have a significant failure rate among sex workers (Benoit et al., 2018). Cervical cancer is common as a result of human papillomavirus infection, but little is known about the extent to which screening programmes reach those who work in the sex industry.

2.3.1 Barriers faced when accessing SRH services.

2.3.1.1 Criminalisation.

Adolescent criminalization, both direct and indirect, is still one of the most significant impediments to SRH access, as well as a structural determinant of severe violence. According to Scorgie (2011), sex work is illegal in several African countries, and sex workers who are found will suffer the full fury of the law; they are considered as a nuisance, and they endure a great deal of shame and discrimination. Constitutional laws and practices can further discourage sex workers from obtaining needed SRH care for fear of legal retaliation. Many law enforcement agents assaulted adolescent sex workers in Zimbabwe during the Covid 19 lockdowns, according to recent

studies. Due to the size and mucosal characteristics that are unique to the less developed reproductive tracts of adolescents, adolescent girls engaged in sex work who are raped are more susceptible to genital injury following rape. Other consequences of criminalisation, such as the confiscation of condoms by the Zimbabwean police and army as evidence of sex workers, reduce the use of SRH services.

Adolescents who work in the sex industry may not have access to condoms or are unaware of their significance. Condoms found in the possession of sex workers are frequently confiscated or destroyed by authorities. In a 2012 survey conducted by Open Society in Kenya, Russia, South Africa, the United States of America, and Zimbabwe, police physically and sexually abused condom-carrying citizens in all six nations. Threats of arrest for condom possession have sometimes been used to blackmail and exploit people (Benoit et al., 2018). Condom use among adolescents engaged in sex work was low in countries with large HIV epidemics. Despite capacity development operations for a specialised police unit, the researchers observe in a 2011 ECPAT study on Singapore. Instead of providing proper care and protection, the unit criminalised and deported adolescents engaging in sex work, only recognising the child as a victim in four out of 89 cases in 2009 (ECPAT 2011).

2.3.2.2 Socio-cultural barriers.

Social attitudes towards sexuality, family planning and access to sexual and reproductive health services are largely stigmatized and can expose young people to discrimination. The embarrassment and fear of social stigma discourages many young people from seeking information about SRH and seeking services for fear of being seen or shared with their families (Ralph & Brindis 2010). Significant discrimination has been reported in public SRH settings around the world where most healthcare professionals are unaware of awareness training related to health issues in youth sex work (NSWP 2016). In Africa, socio-cultural barriers are most commonly related with restrictive social standards surrounding young sexuality (Dhana et al., 2014). They prevent teenage sex workers from accessing SRH information and services for fear of stigma, social pressure and discrimination.

2.3.2.3 Negative attitude by service providers

Adolescents involved in sex work have obstacles to accessing and using services, such as dread of being served by known healthcare personnel and sharing facilities with adults (UNDP, 2012).

Adolescents and youth's access to and use of accessible reproductive health care is influenced by how the services are delivered to them and how user-friendly they are (Nduba, Morris & Anke 2011). Because of provider biases, adolescent sex workers may be hesitant to seek SRH treatment for fear of being judged or mistreated by clinicians and health facility staff (Prohmo et al., 2009). Young people who engage in sex work may face stigma at the health clinic, disapproval in some social settings, and disgrace in their families (NCAPD 2010).

Furthermore, a lack of provider training on the specific SRH needs of young people may make providers hesitant to provide services to them, limiting their ability to deliver high-quality, confidential, and comprehensive SRH treatment (Creel and Perry, 2003). According to Mturi (2001), it is ironic that the healthcare institution that should serve as a beacon of hope for adolescents has instead turned out to be a source of disillusionment for them, partly due to healthcare providers' judgmental attitudes and the unfriendly nature of the services themselves. While studies have identified the healthcare facility as a possible source of sexual health information and services for adolescents, many adolescents are avoiding it, (Mturi 2001). Many adolescents are avoiding the use of the health care institution for this purpose.

2.3.2.4 Segregated Services.

According to WHO guidelines and community research, combining health services in one location (health services integration) improves acceptability, accessibility, and uptake of care for critical populations (WHO 2016). SRH services are rarely provided in a single area, forcing sex workers to travel to many locations to meet their various health needs. The segregated nature of SRH care can lead to issues with uptake and adherence, as well as a loss of income. Separated services not only make it more difficult to get specific services, but they also keep significant issues from being addressed. Because SRH and STI services are provided in various locations, issues such as consultation and family planning, such as the use of condoms with long-term relationships, are not addressed. There is also stigma when abortion clinics operate independently rather than as part of a wider family planning or general health clinics is a major risk (Singh et al., 2017).

Lack of SRH and HIV care integration might be extremely hazardous for pregnant adolescent sex workers. Young female sex workers may not have access to HIV testing and antiretroviral therapy during pregnancy if SRH services are not accessible in the same location, which increases mother-to-child transmission (NWSP 2016). Lack of integration of SRH and HIV services also adds to

lower prevention awareness, as evidenced by a study of female sex workers in Karnataka, India, which found that only 24.7 percent of female sex workers knew about MTCT prevention measures (Singh et al., 2017). In places like Sub-Saharan Africa, high maternal and child mortality rates are worsened by a lack of integrated maternity and child health services. Lack of integration not only obstructs the achievement of Sustainable Development Goals, but also further marginalises sex workers and their children.

2.3.2.5 Cost of SRH services.

Many African countries, including Uganda, Nigeria, and Botswana, have reported low-quality SRH services for adolescents, citing inconvenient hours of operation and high fees. Access to programmes for adolescents engaging in sex work may be limited due to structural difficulties such as cost, location, transportation, and limited scheduling (Carroll et al, 2012). In metropolitan places such as Kigali, this has resulted in a rise in undesired teen pregnancies, hazardous sexual behaviours, a lack of comprehensive awareness about SRH, and increased HIV infection (Blake et al, 2015). SRH issues are one of the leading causes of high morbidity and mortality rates among young people around the world (Mokdad 2013). Apart from contextual factors, the disproportionate burden of SRH concerns experienced by young people is frequently exacerbated by a lack of SRH knowledge and/or insufficient availability and/or accessibility of SRH services (Chandra-Mouli 2015).

A complex combination of factors influences the accessibility of SRH services, including youth's SRH knowledge and awareness of services, costs of using the services, and the quality of the services they provide. Seventy-seven percent of females polled in China said they needed more health information, and 50.8 percent said they wanted free condoms (Zhang et al., 2012). They also expressed a need for low-cost STI diagnosis and treatment (53.7%), with only 25.5 percent of the 148 people who reported STI symptoms in the previous year seeking treatment at public health facilities (UNDP 2016). According to the findings, interventions do not adequately address the reality of the various social and contextual factors that affect female adolescents who engage in sex work access to SRH services (Zhang et al., 2012).

2.4 Approaches to improve access to SRH services.

2.4.1 Community Empowerment Models

To improve access to SRH services and encourage prevention behaviours, community empowerment models such as awareness raising, community-led drop-in centres, outreach, and advocacy should be adopted. Community empowerment, according to the World Health Organization (WHO), is an "extremely vital" tool for improving access to SRH services for sex workers, mostly adolescents, and redressing human rights violations (WHO 2016). Participants in Toronto, Texas, agreed that sex worker-led interventions are critical as part of the SRH response, citing several examples from their own communities. Adolescents involved in sex work can play a variety of roles in community-based SRH initiatives, including peer educators and counselors. Trainings are also developed and implemented, as well as referral networks to enhance access to comprehensive SRH services.

Access to SRH services for young girls engaged in sex work has been implemented in Zimbabwe through NGO programmes. According to the NAC (2016), Sisters with a Voice is a national sex worker programme sponsored by CeSHHAR and Mavambo in Zimbabwe on behalf of the Zimbabwean National AIDS Council. Sisters with a Voice has reached over 50,000 young and adolescent female sex workers in 36 locations across Zimbabwe, providing a mix of health education and clinical services, including HIV testing and treatment, as well as peer education and participatory activities aimed at fostering social cohesion. IMBC has been significant in providing antenatal care services for teen moms, including adolescent girls engaged in sex industry, through the Mavambo Trust (NAC 2016). As a result, similar strategies must be implemented by governments to ensure access to SRH services for young girls engaged in sex work.

2.4.2 Youth Friendly Services.

The Red Stiletto Shoe campaign was developed and launched in 2017 by the German sex work organisation Berufsverband erotische and Sexuelle Dienstleistungen in collaboration with gynecologists. This was done in order to raise youth understanding of and access to congruent services within the sex work sector (NSWP 2017). Sex workers of all ages were provided with comprehensive, nonjudgmental gynecological services. Youth-friendly services are critical in addressing SRH services for young girls involved in sex work in communities in a number of worldwide situations. Youth Friendly Services (YFS) has been shown to help teenagers in the sex work sector by increasing the availability, acceptability, accessibility, and equity of health services (NSWP 2016).

In Thailand, more user-friendly health services have been introduced, allowing young girls involved in sex industry to obtain SRH care. In Thailand, the Ministry of Public Health has established 350 Health Promoting Hospitals dedicated to health promotion and the improvement of health services (Rushwan 2015). Friend Corners were created to meet the SRH requirements of critical populations in community housing areas with specialised SRH workers. Adolescent peer counsellors are the first point of contact. Music, fashion, and health advice were all mixed on the Friend Corner website. It has been commended for making information more appealing to users (Rushwan 2015).

According to the ICESCR, youth-friendly health care is essential because it delivers adequate sexual and reproductive health treatments while maintaining confidentiality for crucial populations. The National Guidelines for the Provision of Youth-Friendly Services in Kenya (2005) lays out the fundamental reproductive health services package for young people, with the goal of increasing their well-being and quality of life. In addition, the National Youth Policy (2007) lists concerns that must be addressed in order for young people to transition to adulthood in good health. Unsafe abortions, STIs, HIV/AIDS, and a lack of youth-friendly services are among them. In Kenya, the Bar Hostess Empowerment and Support Programme holds regular programmes for adolescent girls interested in sex work and offers free HIV and STI testing at wellness centres. The positive outcome can be seen through this work.

2.4.3 Peer educators.

Zimbabwe has a peer education initiative as well. Peer educators, aged 18 to 24, and are available in community-based facilities, according to MoHCC (2016). According to studies, skilled peer educators are a more reliable source of information than adults when it comes to sexual and reproductive health for teenagers who work in the sex industry (Angwersen, 2001, Mason, 2003; WHO 2007). As a result, both the government and non-state entities must actively engage peer educators. As a result, young people are more inclined to seek advice from their peers on sexuality concerns. Peers can impact young people's good or bad behaviour in general. Participants in Nepal's focus groups attributed access to SRH information to the presence of local peer educators working through CBOs (NSWP 2016). According to a systematic review published by UNICEF in 2016, community-based condom distribution strategies thus street outreach and peer distribution

to increase access to condoms among adolescents, as well as provision of opioid substitution therapy to those who inject drugs.

2.4.4 Integration of SRH services.

Comprehensive SRH services, as described by the SWIT, should be made available to sex workers of all ages, taking into account the disparities in objectives and goals between job and personal life. Programs that are only focused on HIV and STIs support sex workers' pathologisation while diverting attention away from their overall health needs. Integration of SRH and other health services could also help to expand coverage; integration would mean that an adolescent's varied health needs could be met at a single location. Despite the programmatic conflict, numerous recent studies emphasise the need to improve health system integration within and across the child welfare and protection system. Especially when it comes to the connections between SRH and HIV programming. A recent study on integrating HIV and AIDS issues for children into child protection systems discovered a large gap in terms of SRH, HIV, and protective measures (Long 2013). In fact, from a rights-based approach, where all rights are equal, service integration is critical.

2.4.5 Establishing stand-alone/night clinics.

Night clinics make SRH services more accessible to adolescent sex workers. During the evenings in the Tete-Moatize area, a small stand-alone clinic on the outskirts of Moatize provides condoms, STI care, and HTS (Lafort et al., 2010). Two-thirds of the population seeking SRH assistance are young Zimbabwean women engaged in sex work. These SRH services are used by a large number of adult and adolescent sex workers. Initially, the clinic provides STI care and information, as well as HIV education, contraception, and volunteer HIV and syphilis counselling. A group of peer educators was taught how to communicate about behaviour change and how to distribute condoms. According to Lafort et al. (2010), stand-alone clinics, night clinics, and DICs can provide assistance suited to people who engage in sex work in a non-stigmatising environment and during appropriate hours. This have highlighted to have a positive effect on health seeking behaviours in several settings.

2.5 CHAPTER SUMMARY

This chapter presented the literature related to access to sexual reproductive services of adolescent girls engaged in sex work. It explored the existing literature which gives backing and relevance to

this study. The Human Right Based Approach was assigned to the chapter to give credit to the phenomena under study. All three objectives were examined through the lenses of globally, regionally and locally scholars.

CHAPTER THREE
METHODOLOGY

3.0 INTRODUCTION

This chapter consists of the research methods employed in the study. It contains information about the participants, such as the study's eligibility requirements, who the participants were, and how they were sampled. The study uses a qualitative research methodology to look into information on SRH services for adolescents involved in sex work in the Epworth community. The study location and target population are also described in this chapter. The instruments that were utilised to acquire the data are also highlighted. The researcher also describes the data analysis methodologies employed. The ethical implications for the researcher and those who participated in the procedure are examined. Finally, the study's limitations are discussed.

3.1 RESEARCH APPROACH

The research study is qualitative in nature. Qualitative research enables the researcher to come up with an in-depth understanding on access to SRH services for adolescent girls engaged in sex work in Epworth Komboniyatsva Community. Qualitative research explores attitudes, behaviour and experiences through methods such as interviews (Dawson, 2002). It is a means for exploring and understanding the meaning of individuals or groups ascribe to a human problem (Saunders 2016). Qualitative research methodology is empirical, thus, it seeks to explore a vivid understanding of the social vulnerabilities encountered by young girls engaging in sex work pertaining access to SRH services and the coping strategies. The researcher employed the qualitative approach in an effort to achieve the objectives of the study. Due to the approaches' flexibility the research was interesting since interactions were less formal.

3.2 RESEARCH DESIGN

The researcher employed a case study as a research design. Cooper (2003) defines a research design as a plan or structure and approach to exploration adopted so as to get answers to research questions or problems. Creswell (2013) defines a case study as a method of investigation used in qualitative research whereby the researcher develops an in depth analysis of a case, often a project, event, process, activity, an individual or a group. Therefore a case study research design was appropriate in the research study. As it provides an in-depth description, exploration and

explanation of access to SRH services for adolescent's girls engaged in sex working Epworth Komboniyatsva Community through qualitative data collection and analysis methods.

3.3 STUDY SETTING

The research study is focused in Epworth Komboniyatsva Community which is an informal settlement. A study setting is a physical, social and cultural site in which the researcher conducts the study. A research site is a place where the researcher conducts a research (Bird, 2016). Epworth is a dormitory town in South-Eastern Harare Province, Zimbabwe. The people in the district are mainly poor and a mere mention of Epworth often evokes images of crime, drug abuse and sex work. Komboniyatsva is disreputable for being a hub of prostitution, drug abuse and where women's dignity is not respected. In the sprawling settlements adolescent girls engaging in sex work has become a new normal within Epworth Community. Access to SRH services is often hindered due to discriminatory practices posed by the community and ignorance by young girls indulging in sex work.

3.4 TARGET POPULATION

The targeted population were the adolescents engaged in sex work, nurses and NGO officials, community health workers as they have knowledge to the topic under study. This enriches the study since relevant information comes from the very people who have knowledge relating to access to SRH services for adolescent girls engaged in sex work. The target population refers to the group of participants who have pertinent information needed by the researcher about the topic under study and belongs to the area the researcher is conducting the study. Bhattacherjee (2012) articulates that population refers to the people or unit of investigation with the features that the researcher wishes to study. The identification of targeted population is vital as it ensures the involvement of people who have relevant information sought by the researcher (Lincoln & Guba 1995). In this regard, the information relates to access to SRH services for adolescent girls engaged in sex work, referring to the case of Epworth Komboniyatsva Community.

3.5 SAMPLE SIZE

Sample size refers to the act of selecting the number of observations or replicates in a statistical sample. A sample size is the number of people who participate in the study (Polit & Beck 2012).

The authors further state that there are no fixed rules for sample size in qualitative studies. The guiding principle in sample size is determined by the data saturation that is, sampling to a point at which no new information is obtained and redundancy is achieved. Therefore, the sample size for this study was determined by the necessity to keep the investigation feasible and practical. Therefore for the purposes of this study the researcher mobilized 15 adolescents engaged in sex work sustenance by 5 key informants from various organisations.

3.6 SAMPLING TECHNIQUES

3.6.1 Purposive sampling

The researcher used purposive sampling to conduct the research study. According to Creswell (2016), purposive sampling is used to intentionally select individuals or sites to learn or understand a central phenomenon. The researcher established standards for key informants within the research study. These emphasised on knowledge delivery within access to SRHs of young girls engaged in sex work within Epworth Community. The researcher focused on key informants with vast knowledge, basing on the fact that they were knowledgeable on issues surrounding access to SRHs of adolescent girls engaged in sex work. They also have interactions with the young girls engaged in sex work at their institutions. Thus the main thrust of purposive sampling is to focus on particular characteristics of a population that are of interest which enabled the researcher to attain research objectives.

3.6.2 Snowball Sampling

Selection of adolescent girls engaging in sex work was done using snowball sampling .Exponential non-discriminative snowball sampling was utilised by the study in which the first subject engaged provides multiple referrals. Snowball sampling according to Rubin and Babbie (2013) is whereby each person with desired attributes is asked to suggest additional people with the same attributes. Snowball sampling is extensively used for qualitative research with a population hard to locate. It is actually difficult to find young girls selling sex due to fear of criminalisation and discrimination hence snowball sampling was utilised. To create a snowball sample the researcher used two steps which include help from Mavambo facilitators of the Sisters with a Voice program. Also from other adolescents girls engaging in sex work attending the program to discover more participants until the desired sample size was attained.

3.7 DATA COLLECTION

Data collection refers to the accumulation of information to address a research problem. It is one of the crucial aspects of any research study (Du Plooy-Cilliers, Davis & Bezuidenhout 2012). Athanasou et al (2012), stresses that the research question and objectives guides the data collection method. The research study was on examining access to SRHs for young girls engaged in sex work in Epworth Komboniyatsva Community and the researcher employed in-depth interviews and key informant interviews.

3.7.1 Data collection techniques

3.7.1.1 In-depth Interviews.

The researcher utilised in-depth interviews to accumulate information within the research study. In-depth interviews were used to interview adolescents girls engaged in sex work on access to SRHs. In-depth interview is rationally purposive, and it allows for individual responses, (Annum 2014). According to Leedy (2005), in-depth interviews allows a more comprehensive understanding of the participants' opinions that would be likely using a mailed questionnaire. "Semi-structured in-depth interviews consist of several key questions that not only help to define areas to be exposed, but also allow the interviewer and interviewee to diverge in order to pursue an idea or response in more detail" (Gill et al., 2014). In this method, the researcher and participants become more flexible (De Vos et al., 2014). Thus the researcher found in-depth interview generally to be most suitable in citizen associated research, and adopted it as a major tool for this study since it is autonomous.

3.7.1.2 Key informant interviews.

Key informant interviews were also used to gather data for the study. Key informant interviews have additional benefits as they provide an opportunity to collect contextual information about the community (Hennink 2007).Thus the researcher engaged experts to secure unique knowledge on access of SRHs of adolescents girls engaged in sex work. The experts included 2 nurses, 2 NGO officials from MSF, CESHHAR and a community health worker. The researcher was taking notes verbatim thus word for word noting down non-verbal responses. Also where necessary, questions were explained. A voice recorder was also used to record the interviews.

3.7.2 Data Collection Tools.

3.7.2.1 In-depth interview guide.

The researcher made use of an in-depth interview guide to collect information through the use of in-depth interviews to gather data from the chosen participants. The researcher found in-depth interview guide to be pertinent as it allow the participants to elucidate in detail factors surrounding access to SRH services for adolescent girls engaged in sex work.

3.7.2.2 Key informant interview guide.

Key informant interview guide was utilised by the researcher to collect information from nurses, NGO officials and Community Health Workers within the community. Thus the researcher made use of key informant interviews .The key informant interview guide was congruent because it enabled the key informants to illustrate in detail factors surrounding access to SRH services for adolescents engaged in sex work.

3.8 DATA ANALYSIS TECHNIQUES

The data acquired from the research study through in-depth and key informant interviews was audio-recorded and notes were taken to ensure verbatim accuracy. The data analysis in this study was adapted from Colaizzi (1978), who stressed the need of matching the proper data source with the suitable data gathering method. In qualitative research, this happens at the same time (Shosha 2012). Shosha (2012) used Colaizzi's seven-step framework, citing Sanders (2016) as saying that Colaizzi's data analysis process entails reading and re-reading each transcript to get a general sense of the content, as well as extracting significant statements from the transcripts that relate to the phenomenon under investigation.

Also, organizing created meanings into categories and clusters of themes, as well as forming meanings from significant utterances. Including topics in a comprehensive account of the statements made by the participants. In this research study, Colaizzi's (1978) thematic analysis entailed the search for and identification of similar sequences that run across the interviews, and the themes are usually abstract (Shosha 2012). The researcher reviewed the transcripts numerous times while listening to the voice notes in order to find reoccurring themes or remarks. The researcher used these "theme clusters" to provide a detailed account of how the participants felt about access to SRH services for young girls involved in sex work. In addition, comments in

indigenous languages were translated into English, and demographic data was presented in tables and graphs.

3.9 FEASIBILITY OF THE STUDY

A feasibility study determines if a proposed plan or project is feasible. According to Rubin & Babbie (2013), a feasibility study evaluates a project's viability to assess whether it is likely to succeed. Following data analysis, the researcher delivered a letter from the university as well as a letter from the councilor who represents the ward were Epworth Komboniyatsva Community is located. Also a letter from the provincial medical director was issued through email. This served as proof that the researcher had been granted authorization to conduct the research. In addition, no Covid 19 regulations were broken because the researcher was bound by them. The consent documents were significant because the student's willingness to engage was guaranteed by the consent forms. As a result, the research became possible.

3.10 ETHICAL CONSIDERATIONS

The researcher made certain that ethical issues were addressed in order to reduce the likelihood of an ethical breach occurring throughout the research procedure, especially since the study participants are adolescent sex workers, a marginalised population. According to Willman (2009), the concept of ethics is a complex construct characterised by particular attitudes and ideas that influence research methodology. As a result, he sees research ethics as principles of doing the right thing at the right time and in the right place. The ethical considerations established trust among the informants as well as respect for sound study conclusions.

3.10.1 Confidentiality.

Even if the research participants did not perceive any danger from data publication, the principle of confidentiality was maintained to the extent practicable to protect the interests and identities of the participants. Confidentiality is an ethical factor in research that protects the researcher's sharing of information with third parties without the respondents' knowledge (Zina, 2012). As a result, the respondents' identities were not linked to the information they provided, and it was not made public or disclosed without their consent. Confidentiality was maintained throughout the study by storing raw data in a secure location, not putting names on raw data, and conducting interviews with important informants in private. The researcher identified participants by data numbers not by

name. The researcher did make sure that the collected information was kept on unidentified place by other parties.

3.10.2 Informed Consent.

The participants were informed about the research study so as to have a full understanding of the requested involvement, time, the topic to be covered and the risks associated. Zina (2012) views informed consent as a process of three main issues which are the provision of the information by the researcher, the understanding of the information by the potential participant and making a response to information. In a different view, Engel and Schutt (2013) view informed consent from four core principles which are explicit act of verbal or written agreement. Therefore, a consent form was prepared showing the requirements of the study. Participants were told about the general nature of the study and the consent forms describing the study, participants did not encounter any risk and they delivered what was expected from them. The researcher used both written and oral consent to participants. Also English and Shona was used to ensure that each and every one of the respondents had a clear understanding.

3.10.3 Anonymity and Privacy.

Anonymity and privacy was upheld during research. Engel and Schutt (2013) concurs anonymity as the principle that guide the researcher not to identify the respondents by their names in research output whilst privacy refers to safe, conducive, private and physical location to conduct the research and ensuring anonymity and confidentiality. To assure this the researcher employed pseudonym and removed the information that identifies the respondents by their names. Thus the real names of the respondents were not used to identify the data.

3.10.4 Honesty

The findings from the study were not distorted by the researcher's personal pressures since this ethic requires the researcher to be honest and open in both presenting findings and disclosing methods. The researcher disclosed results as they are. According to Creswell (2014), when reporting, sharing and storing data, the researcher must avoid plagiarism, falsifying authorship and disclose information that would harm participants. This was achieved through analysing and presenting data as it was provided by study participants.

3.10.5 Protection from harm

Participants must be protected from possible harm. Willman (2009) claims that the ethical principles of beneficence and non-malfeasance emphasize the importance of researchers balancing the desire to protect the respondents from psychological harm. The issue of accessibility of SRH to adolescent sex workers is sensitive to some of the children involved in it hence the researcher did take measures to avoid harm through informed consent. The respondents were told briefly about the research and its impact to those who were not comfortable to participate so as to avoid psychological harm.

3.11 LIMITATIONS OF THE STUDY

The study is actually a sensitive issue suspicious of their involvement especially considering that sex work in Zimbabwe is a criminalized trade and they are adolescents. Also sex work is a phenomenon which is shameful and girls involved are discriminated and stigmatised in our culture. The researcher assured the research participants that the findings of the study were not to be reported on the basis of individual identities but rather on the overall reports of respondents. Another limitation was interviewee's at first only revealed socially acceptable views. To overcome this problem, the researcher assured that the data was to be treated with confidentially and that anonymity was guaranteed through the use of pseudonyms (Creswell, 2016).This enhanced the responses from the participants.

3.12 CHAPTER SUMMARY

This chapter dealt with the research methodology. An explanation of qualitative research as a method for data collection and analysis was given. It described the population and sampling techniques as well as explaining the data collection methods procedures followed. The information about the sample was provided and ethical considerations were also spelt out which were vital within the research process.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.0 INTRODUCTION

This chapter focuses on data presentation, analysis and discussion of findings of the research on access to SRH services for young girls engaged in sex work in Epworth Komboniyatsva Community. The study utilised the qualitative approach. Demographic data was presented using tables whilst with data it was through thematic analysis. In-depth interview guide and key informant interview guide were used for data collection, hence an analysis and interpretation was provided for each instrument. The research was guided by the following objectives: to identify the range of SRH services available in the Epworth Community, to determine how these services are accessible to young girls engaged in sex work in the Epworth community. Also to examine strategies to improve access to SRH services for young girls engaged in sex work in Zimbabwe. The chapter did make an inclusive discussion on access to SRH services reinforced by relevant publications.

4.1 PRESENTATION OF FINDINGS

4.1.1 Background Information of participants.

Table 4.1 Age range of participants.

Age Range	Number of participants
10-12	0
13-15	0
16-17	7
18-19	8
Total	15

Table 4.2 shows the age range of participants' that is adolescent girls engaged in sex work within the research study. It indicates that seven (7) adolescents were between the ranges of 16-17 years and eight (8) adolescents were between 18-19 years in the research study.

Table 4.2 Level of education of participants.

Primary Level	Ordinary Level	Advanced Level
10	5	0
Total		

Table 4.2 illustrates that ten (10) participants attained primary education whereas 5 participants advanced to ordinary level. Also out of the fifteen (15) participants no one exceeded to advanced level.

Table 4.3 Age Range of Key Informants.

Age Range	Number of Participants	Occupation	Total
24-30	1	Nurse	1
31-35	1	Nurse	1
36-40	1	Ceshhr Staff (NGO)	1
41-45	1	MSF Staff (NGO)	1
46-50	1	Community Health Worker	1
Total	5		

Table 4.3 represents the age range of key informants who participated in the research study. It shows that one (1) key informant was between the age range of 24-30 years and the other key informant was also between the ages of 31-35. Also one (1) key informant was between 36-40, one (1) key informant was between 41-45. The other key informant was between the age ranges of 46-50.

Table 4.4 Professional Qualifications of key informants.

Participant	Occupation	Years in service
1	Nurse	6
2	Nurse	8
3	MSF Staff(NGO)	5
4	CESHHR Staff (NGO)	6
5	Community Health Worker	11

Table 4.3 shows the professional qualifications and years in service of the key informants that participated in the research study. It indicates that two (2) key informants were nurses and one (1) had 6 years' experience whilst the other one had 8 years' experience. It also shows that one (1) key informant was an NGO official from MSF who had 5 years' experience. It also indicates that the other key informant was an NGO official from CeSHHAR who had 6 years of experience. Also it indicates the Community Health Worker who had 11 years in service.

4.2 Presentation of Qualitative Data.

Qualitative data was presented according to the research objectives which were: to identify the range of sexual and reproductive health services available in the Epworth Community. Also to determine how these services are accessible to young girls engaged in sex work in the Epworth community. To examine strategies to improve access to sexual and reproductive health services for young girls engaged in sex work in Zimbabwe. Qualitative data was attained using in-depth interviews and key informant interviews. Based on the objectives above, findings have been discussed under the following themes contraception and family planning, antenatal services, delivery services, accessibility of services, ignorance, stigma and discrimination, youth friendly services, community led interventions.

4.2.1 Sexual and reproductive health services available in the Epworth.

4.2.1.1 Knowledge about SRH services

Adolescent girls engaged in sex work were interviewed using in-depth interviews on what they knew and understand about Sexual and Reproductive Health services. The question was intended

to source information from adolescent girls engaged in sex work on the prevention, diagnosis and treatment as related to STIs, HIV/AIDS, contraceptive service and counselling, pre and postnatal care. Also delivery care, treatment of STIs, abortion services, cancer screening and access to information and education.

Fifteen participant's where interviewed through in-depth interviews about what Sexual Reproductive Health services are and one (1) participant said

"Ndinonzwisisa kuti masevhisi anoona nezveutano zvepabonde zvinosanganisira kurapwa zvirwere zvepabonde zvakaita se syphilis, gonorrea uye kutarisira une pamuviri, kubvisa pamuviri nekutestwa utachiona hweHIV". (Meaning SRH services are services which relates to sexuality which include treatment of STI's, pre natal care, abortion services and HIV/AIDS testing)

Another participant interviewed added

*"SRH services masevhisi anoona nezveutano hwepabonde zvinoti kurapwa kwezvirwere zvepabonde, kuongororwa utachiona hweHIV."(*Meaning SRH services are services relating to sexuality which include STI diagnosis and treatment and HIV testing and treatment)

It was actually visible that participants lacked knowledge on issues to do with cancer screening and abortion services.

4.2.1.2 Contraception and STI screening and testing.

The research findings were attained using key informant interviews and in-depth interviews. The findings reflects that they are many SRH services available in the Epworth Community. The following are the SRH services available in the Epworth community. Participants were interviewed through in-depth interviews about the range of SRH services available in Epworth Community. The question was intended to source information on the adolescent girls if they are aware of services available in the Epworth Community.

Participants (15) were interviewed and identified range of SRHs available in the Epworth Community.

One (1) participant said

"*Masevhisi arimomu Epworth anoona nezveutano zvepabonde zvinowanikwa mumakiriniki ne mamasangano maviri ,masevhisi aya anoti kurapwa kwezvirwere zvepabonde,kudzivirira pamuviri, kutarisira pamuviri,nekupihwa mazano kune vane utachiona hweHIV "* (meaning *SRHs*

are available in Epworth clinics and organisations which include prevention, diagnosis and treatment as related to STIs and contraceptive service and counselling, pre and postnatal care, delivery care and access to information and education but these are offered at two organisations)

It reflects that adolescent girls had robust knowledge on the available SRH services in the community but many were unaware of abortion services. Also participants actually lacked knowledge on facilities which offered available SRHs services within the community.

4.2.1.3 Abortion, HIV Services, Pre and Post natal Care.

Two key informant's nurses (2) from local clinics were interviewed through key informant interviews about the range of SRH services in Epworth Community at their facilities.

One key informant commented

"Sexual and reproductive health services are available which both adults and adolescents can utilise in Epworth community. The services available include female contraceptives, antenatal and post natal care, HlV counselling and testing, prevention and treatment of STI's. Also abortion services are only offered when the pregnancy pose as harmful to the mother or in the existence of a police report as a result of rape"

The sentiments above actually highlights that they are many available SRHs within the Epworth Community but abortion services are legally binded which leads community members to resort to unsafe abortion practices. Also SRH services at the clinic were designed for the general population without specialisation of SRH providers.

Also the researcher managed to interview another key informant from CESHHR Zimbabwe about the range of services available within their organisation.

The key informant interviewed said

"Our organisation has a strong collaboration with MoHCC and NAC. The organisation provides the YWSS minimum package where they will be educating them on different SRH topics for example gender norms, GBV and HlV prevention using the Girls club manual (primary package).They are also given clinical services (secondary package).These include HIV testing and counselling services, STI screening and treatment, contraception, condoms and lubricants, abortion services, Prep and Pep, ART initiation, viral load monitoring and adherence support".

This actually reflects that a wide array of essential services are offered by the organisation on which the young women engaged in sex work are the first priority. Hence reaching this population increases awareness and access to SRH services which is fundamental in reducing STI and HIV infections.

4.2.2 Accessible SRH services for young girls engaged in sex work.

The study brought about SRH services that are accessible to young girls engaged in sex work in Epworth Community. Participants (adolescent girls engaged in sex work) and key informants were interviewed using in-depth and key informant interviews and the sentiments are discussed below.

4.2.2.1 Accessible SRH services.

It was actually noticeable that many of the SRHs accessible for young girls engaged in sex work were from NGO's who were mobile and others within the Epworth Community.

Fifteen (15) participants were interviewed and one (1) of the participant indicated that *"Zvirinani ndiende hangu kumakiriniki ekuCeshhr kana kuMSF kuMbare nekuti vanamukoti vacho vanoshamwaridzana nesu zvakanaka uye hatishorwi-shorwi nekuda kwebasa redu uye masevhisi ese unomawana"* (Meaning they prefer to go to Ceshhr Mobile clinics and the MSF clinics in Mbare than going to council clinics because the nurses there are friendly ,non-judgmental and all services are available).

Therefore the accessibility of services towards young girls engaged in sex work is largely influenced by the way they are treated. Thus need for upholding the inherent dignity and worth of a person. AIso it is visible that SRH services are rarely offered together, forcing adolescent girls within the sex work industry to travel to multiple locations to address different health needs. The segregated nature of SRH care can subsequently lead to problems hence need for integration of services.

Another participant interviewed added

"Hupenyu hwangu hwashanduka nekuda kwekuti ndinondovhenekwa pandorwara nezvirwere zvepabonde kuCeshhr pasina kana mari yandabvisa pavanoita zvirongwa zvavo kwaChiremba nekuDomboramwari" (Meaning her lifestyle have been improved because she now lives a healthy lifestyle. CESHHR Zimbabwe helped her when she was diagnosed with syphilis free of cost through their community outreach programs at Chiremba and Domboramwari.)

Thus the absence of user fees is also a congruent factor in accessing SRHs within adolescent girls engaged in sex work in the Epworth Community.

Also another participant interviewed articulated that

"Isu tinopihwa package apo patinenge tichidzidziswa zvakasiyana siyana kuSister's with a Voice maringe nezvezvirwere zvepabonde uye tichipihwa masevhisi akasiyana siyana, vanhu vemasangano aya vanouya kumakiriniki aripedyo nekwatinogara" (Meaning they are being given a minimum package were they will be educated on various topics concerning SRH during Sisters with a Voice Sessions. Also they access condoms of good quality which are being offered freely, Pep and Viral load monitoring. The organisation offer SRH services at clinics which are close to our homes)

This actually shows that accessibility of SRHs is also influenced by the proximity on which SRH services are being rendered.

Another participant interviewed said

"Pandakarwara nechirwere chepabonde ndakatanga ndaenda kuMavambo ndikaudza Social worker veko uyo akazondiperekedza kukiriniki yelocal board kunorapwa ndikarapwa zvakanaka" (Meaning when she was suffering from an STI she firstly approached a Social worker from Mavambo and explained her plight she was escorted to the clinic where she was treated nicely and given medication)

Therefore this indicates that the referral system from organisations to facilities and support rendered to adolescents engaged in sex work by organisations improves access to SRHs within communities.

2 NGO officials, thus key informants interviewed actually attested to their SRHs being accessible within the Epworth community.

One key informant interviewed said

"Our services are accessible in the Epworth community through community outreach programs, mobile clinics and one stop shop in all hotspot areas surrounding Epworth. Health providers and community health workers spread awareness about the available youth friendly SRHs .We are also non-judgemental because we know that sex workers engage in sex work due to different reasons and we also know that sex work is work".

Thus information on where adolescents engaging in sex work could access available SRH services was provided through awareness campaigns by organisations. Thus creating a secure and supportive environment for adolescents' health agenda through provision of SRH services within their communities.

4.2.3 Accessibility barriers.

All fifteen (15) participants were interviewed using in-depth interviews and they attested to SRH services being accessible to a lesser extent within council clinics and other organisations owing to the following obstacles from the research findings:

4.2.3.1 Stigma and discrimination

Participants' also indicated that due to stigma and discrimination adolescents girls engaged in sex work lack access to SRHs in Epworth Community.

One participant interviewed articulated that

"Pandakaenda kukiriniki umwe mukoti paakaziva kuti ndinoita zvekutengesa bonde akabva ati ndichazokubatsira kana ndapedza kubatsira vanhu vane zvirwere chaizvo kwete zvekuzvitsvagira akaenderera mberi achiti sei uchirwara nezvirwere zvevakuru iwe."(Meaning when she visited the clinic one of the health worker learnt that she was an adolescent sex worker she said l will assist you after l have assisted those with genuine illness not of their freewill (kuzvitsvagira zvirwere) and she goes on to say why does she get sick with such diseases of adults at such an age and she was not given the attention that a patient would need to the extent that she stopped seeking clinical services.)

Another participant interviewed added

Kiriniki haisi nzvimbo yakanaka iyi tinobatwa zvakashata patinobatsirwa.Pandakaona kuti ndaive ndave nepamwe pamuviri mwana wangu achiri mudiki ndakabatsirwa nambuya kuti ndibvise pamwe pamuviri pacho."(Meaning the clinic is not a good place for them as they are unfavourably judged by health care personnel's so after giving birth they are afraid to visit the clinic .Also when she realized that she was pregnant when her child was only four months "ambuya" helped her to get rid of the unborn child since my child was still young and was failing to provide for her.)

This behaviour from healthcare professionals leads adolescents engaged in sex work within the Epworth Komboniyatsva Community to stigmatise themselves and feel unworthy to access

treatment and services at the health facility. Hence leading to unsafe abortions thus deterioration of heath to the extent of death some of the times.

4.2.3.2 Lack of privacy and confidentiality

All participants, fifteen (15) interviewed through in-depth interviews in this study viewed lack of privacy and confidentiality as limiting factors in accessing SRH services. Adolescents engaging in sex work feared that being seen at the health facilities would actually rise suspicions and questioning about their reasons for seeking SRH services. Also adolescents engaged in sex work were anxious that their parents might know that they had sought SRH services.

Out of the fifteen (15) participants one (1) participant said

"Ini ndinotya kuenda kukiriniki kunowana masevhisi eutano hwepabonde nekuti vanhu vemunharaunda vanozoziva kuti ndinotengesa bonde vozoudza mai vangu vasingatozivi kuti ndavakuita zvepabonde"(Meaning she was afraid to visit the clinic to access SRH services because people from their area might recognize her and tell her mother that she is sexually active since she is unaware.)

Another participant interviewed commented

"Ini handidi zvekuenda kuchipatara ndoda kushandisa piritsi kana ndasangana neclient nekuti kuchipatara unoonekwa nevanhu vakasiyana siyana, piritsi iri rakambotadza kushanda ndikaita pamuviri pandakazobvisa izvi zvakakanganisa utano hwangu." (Meaning she usually used an emergency pill when she had unprotected sex with her clients. She did not want to visit the clinic to get contraception because she was afraid that her mother will know she is indulging in sex work. However, the emergency pill method failed to work for her, she got pregnant' and aborted the child which led to deterioration of her health).

This actually reflects that that privacy and confidentiality must be upheld in order to ensure comprehensive access to SRH services.

4.2.3.4 Ignorance

The research saw ignorance as a barrier in accessing SRH services towards adolescent's girls engaging in sex work through in-depth interviews which were used. Ignorance was further associated with less courage in taking proper care of oneself, need for money and not willing to go

to hospital if sick and it was also associated with societal beliefs. Out of the fifteen participants interviewed,

One participant commented

"Ini handidi kuongororwa zveutachiona nekuti kana uchitengesa bonde unongochiita chirwere chacho, ndinotoita bonde ndisina kudzivirira ndozvinoita kuti ndiwane mari irinani" (Meaning she does not need to be tested and just do not want to seek SRH services because as a sex worker she is bound to be HIV/AIDS positive. She does not use protection and through unprotected sex she can get much more money.)

The mere mentioning of sex workers within the Epworth Komboniyatsva Community as bearers of diseases perpetuates risk behaviours which increase the spread of diseases and untimely deaths within the community.

4.2.3.5 Fear of accessing SRH services.

Participants fifteen (15) thus adolescents engaged in sex work were interviewed through the use of in-depth interviews. It was actually noticeable that when adolescents engaged in sex work were treated, they were afraid to go back to the health facility for treatment soon after or as frequently as they got re-infected especially with STI's.

One participant interviewed said

"Ini ndinotya kuramba ndichangodzokera kukiriniki nekuti vashandi vepakiriki vanotideedza nemazita akawanda-wanda nekuda kwekutengesa bonde, uye vanotaura kuti tirikuvatorera varume vavo nekuvaparadzira dzimba dzavo" (Meaning she is afraid to seek SRH services at the clinic due to fear of being victimised by service providers who claim that they are terrorizing them by having sexual intercourse with their husbands.)

It was actually visible that due to this open rebuke adolescents engaged in sex work were afraid to seek essential SRH services as the community labelled them badly whenever they saw them at the clinic. This was actually very humiliating which led adolescents engaged in sex work to shun the health centres and preferred to stay at home with their diseases and many were marooned in the web of reinfection. This led to self-stigma and stigma from the community.

***4.2.4* Strategies to improve access to SRH services.**

The research study also brought about the ways through which access to SRH services can be improved to young girls engaged in sex work in Zimbabwe. Information was attained through the use of in-depth and key informant interviews and the approaches are discussed below

4.2.4.1 Improved Health Facility Referral System.

From the fifteen (15) participants interviewed through in-depth interviews, six participants mentioned that having an improved health facility referral system at clinics and organisations could promote access to SRH services in Zimbabwe.

One participant interviewed commented

"Kuti masevhisi anowona nezveutano hwepabonde avandudzike, masevhisi aya anofanira ari panzvimbo imwe uye zvakarongeka kuti isu vasikana vanotengesa bonde tiwane ese atikoshera" (Meaning in order to improve access to SRHs for us adolescent girls engaged in sex work the services at clinics must be well coordinated"

The above sentiments indicates that there was a poor reference system within health facilities. Therefore the improved referral system actually motivate adolescents indulging in sex work to go and seek medical help.

4.2.4.2 Mass Media

Mass media was one of the way which was suggested by one of the key informant's, a community health worker interviewed using key informant interview. Mass media was insinuated as a way which improves access to sexual and reproductive health services.

The key informant articulated that

"Kuti vasikana vanotengesa bonde vawane masevhisi bazi rinoona nezveutano nemamwe masangano vanofanira kuisa zvirongwa pazvivhitivhiti, maradio, social media"(Meaning in order for adolescents sex workers to access SRHs the Ministry of Health and Child Care together with other partnering organisations must broadcast information on televisions, social media and text messaging on issues regarding to access to SRH services for us.)

This actually postulates that in Zimbabwe, mass media must be widely used to reach the target audience in several programs because of its capability to disseminate information to a larger audience. Hence this should be adopted through programs which cater for adolescent girls engaging in sex in Epworth and Zimbabwe as a whole.

4.2.4.3 Community Empowerment Models.

Outreach programs, drop in centres and sensitisation trainings

Institutional support from service providers was suggested by participants and key informants when interviewed as a way which improves access to SRHS among adolescent girls engaged in sex work in Zimbabwe.

One of the participants when interviewed said,

"Nharaunda, mapurisa, vakoti nevamwe vanoona nezveutano vanofanira kuti supporter kuti tiwane maSRH sevhisi zvakanaka zvisina kutiitira utsinye mukati nekuti tirivanhuwo."(Meaning the police, the health workers and the community at large must support them when accessing SRH services rather than victimizing because they are also human beings and circumstances forced them to engage in sex work.)

Also a key informant added

"Raising community awareness, utilising extensive community based outreach and community based provision of HIV and SRHR services is essential in improving access to SRH services for adolescent girls engaged in sex work."

Hence, it can be argued that ensuring access to SRH services with support from service providers, community actually curbs stigma and discrimination. It also addresses the SRH needs of the general population who are in the community.

4.2.4.4 Peer educators

All fifteen (15) participants also brought about the issue of inclusion of peer educators when offering SRH services to improve access by adolescent engaged in sex work.

One (1) participant said

"Kuti tivandudze kushandiswa kwemasevhisi kune vasikana vechidiki vanotengesa bonde mapeer educator anofanirwa kushandiswa nekuti tiri zera rimwe uye tinonzwisisana"(Meaning in order to improve access to SRH for young girls engaged in sex work peer educators should be utilised in various organisations and healthcare settings within Zimbabwe because peer educators understands us youth best since we all youths.)

This actually highlights that peer educators are of great importance when delivering SRH knowledge to key populations like adolescents within the sex work industry.

4.2.4.5 Youth Friendly Services

Out of the fifteen (15) participants interviewed, ten (10) also brought about the inclusion of youth friendly services within governmental and non-governmental institutions to improve access to SRHs within communities surrounding Zimbabwe.

One participant interviewed articulated that

"Kuti tikwanise kuwana SRH services zvakanaka munzvimbo dzakataukana vanhu vanotipa maservices vanofarira kutaura nesu zvakanaka kunge tinoshamwaridzana" (Meaning in order to access SRHs the service providers must be friendly and they must be youths just like us.)
This actually highlights that services being rendered lack youth friendly services around Zimbabwean communities .Thus they is need to adopt youth friendly services within communities to ensure effective access to SRH services for young girls engaged in sex work.

4.3 Discussion of findings

The aim of this study was to examine access to sexual reproductive health services among adolescents girls engaged in sex work. A case of Epworth Komboniyatsva Community. The researcher managed to interview 5 key informants and 15 adolescent girls engaged in sex work. There were various themes which were drawn from the research study. They include contraception, abortion services, STI screening and treatment, pre and post-natal care, accessibility, stigma and discrimination, lack of privacy and confidentiality. These themes were ascribed to SRH services available in Epworth community and access to these services by adolescent girls engaged in sex work .Themes within strategies to improving SRHs of young girls engaged in sex work include mass media, peer educators, improved health facility referral system.

The first objective of the study was to identify range of SRHs available in the Epworth Community. The study findings show that they are a wide range of available SRHs services within the Epworth Community. These available services were provided by both governmental and non-governmental organisations. Also it is visible that the SRH services available cater for the general populace rather than key populations. According to Rouhi et al (2011) public health centres within Iranian communities that SRHs available include antenatal, postnatal and child health services for the general population. According to Lafort et al (2016) SRH services are available in the areas that we live in but are inaccessible due to various reasons. Hence need for comprehensive access of

SRH services for key populations within communities to curb transmission of diseases and mortality rates as attested by the human rights based approach.

The second objective of the study was to determine how these services are accessible to young girls engaged in sex work in the Epworth Community. The research findings indicated that available SRH services accessible for adolescents engaged in sex work are mainly from NGO's in Epworth. It also reflects that services accessible from NGO's are integrated thus catering for all the needs of adolescent girls engaged in sex work. According to Dhana et al. (2014) both adolescent sex workers and adult sex workers were engaged in Durban, Mombasa, Tete and Kilindi on SRH services accessible. These services are mainly accessible within NGO's and CBO's. Hence articulating that the government within local communities must ensure provision of SRH services to this key population as it a fundamental human right.

Also the study reflects that adolescent girls engaging in sex work have accessed SRH services within the Komboniyatsva Epworth Community for example SRH education ,HIV testing. However, according to the participants the services accessible seems to be inadequate for the SRH needs of adolescents engaged in sex work. Sharma e.t a.l (2017) articulates that adolescent girls and young women engaging in sex work living in the poorest conditions receive fewer essential services during antenatal care and are least likely to have a skilled health professional at their delivery. Thus they is need to uphold the rights of all key populations as according the human rights based approach every human being have the right to access SRH services without possible discrimination.

Also factors which seek to pose as challenges when accessing SRH services were identified within the research study. It is noticeable that the segregated nature of other services as highlighted by participants from Komboniyatsva leads to the inaccessibility of SRH services as adolescent sex workers has to travel to multiple locations. Lack of SRH and HIV service integration also contributes to reduced accessibility of prevention awareness, as noted in a study of young women in sex work in Karnataka, India, in which only 24.7% of young women indulging in sex reported knowledge of MTCT prevention methods (Becker et al 2012). WHO guidelines and community research (2016) agree that offering health services in one location (health services integration) increases the acceptability, accessibility, and uptake of care for key populations. Therefore

integration of SRH services must be adopted practically within Epworth community to ensure effective access of SRH services by adolescents engaged in sex work.

Research findings reflects that stigma and discrimination hinder the access of SRHs within adolescents engaged in sex work within the Komboniyatsva Community in Epworth. In public SRH settings across the globe, where most medical personnel are unaware of sensitisation training regarding adolescent sex work health issues, significant discrimination was reported (NSWP 2016). In Africa socio-cultural barriers generally take the form of restrictive social norms associated with youth sexuality (Dhana et al., 2014).This actually articulates that they is need for sensitisation of communities regarding access to SRHs as a fundamental human right grounded in other human rights. According to the human rights based approach. It is the inherent duty of a nation to make sure that everyone is accessible to these rights without discrimination, easily and on equal basis. Hence the need to ensure access to SRHs within communities is fundamental.

The last objective of the study was to examine strategies to improve access to sexual reproductive health services for young girls engaged in sex work in Zimbabwe. Relating to gathered data by the researcher, most of the strategies that were mentioned by the participants are also being utilized both in developed and developing countries. The way that the participants suggested the strategies articulates that adolescents engaging in sex work face obstacles when it comes to access to SRH services. It also reflects limited knowledge upon regarding sexual reproductive health services as a fundamental human right. One of the strategy suggested was community empowerment models such as awareness raising, community led drop in centre's, outreach and advocacy to improve access to SRH services and encourage prevention behaviours.

It can be noted that community outreach and led in drop centre's are utilized by few organisations in addressing access to SRH services within the communities. However, WHO (2015) has deemed community empowerment an 'absolutely necessary' measure to improve access to SRH services to sex workers mainly adolescents and redress human rights violations. According to NSWP (2016) In Kenya the Bar Hostess Empowerment and Support Programme regularly conducts trainings for health workers and provides free HIV and STI services through wellness centre's and outreach programs. Positive outcome is visible through this work. Also positive parenting sessions are actually vital. Therefore inclusion of such initiatives within communities ensures comprehensive access to SRH services towards adolescents engaged in sex work.

Peer educators is also another strategy that was suggested by participants in Komboniyatsva in improving access to sexual reproductive health services for young girls engaged in sex work in Zimbabwe. Peer education concept is recognized worldwide as an effective program for imparting correct SRH messages to young people whom are sexually active (WHO 2016).Studies found trained peer educators to be more credible source of information than adults in relation to access of sexual and reproductive health (Angwersen, 2001, Mason, 2003; WHO 2007).Thus this can be a more effective strategy to improve access to SRH services within adolescent girls engaged in sex work. Hence need for the government and non –state actors to intensively involve peer educators on issues pertaining access to SRH for adolescents engaging in sex work.

Also another strategy suggested by the participants in ensuring improvement in access to SRH services was integration of SRH services. It is noticeable from this suggestion that adolescents engaging in sex work did not have monetary funds for transport costs to travel to other areas. WHO guidelines and community research (2014) agree that offering SRH services in one location (health services integration) increases the acceptability, accessibility, and uptake of care for key populations. Thus community based facilities in Zimbabwe must ensure integration of SRH services to ensure accessibility by adolescents engaging in sex work.

Youth friendly services was also outlined by participants in Komboniyatsva Community as a way to improve access to SRHR services by adolescent girls engaged in sex work in Zimbabwe. Across a variety of global contexts, it has been demonstrated that Youth Friendly Services (YFS) can address this situation by improving the availability, acceptability, accessibility, and equity of health services for adolescents within the sex work industry (NSWP 2016). The research findings also indicates that accessibility of SRH services linked to youth friendly services was largely attributed to NGO's. Hence there is need to ensure youth friendly services for adolescents engaging in sex work when accessing SRH services as it involves providing appropriate sexual and reproductive health services with respect to confidentiality.

Also, night clinics is another strategy which can be adopted as it improves access to SRH services by adolescents engaging in sex work to curb against stigma and discrimination. According to Lafort et. al (2018) In Tete –Moatize area, a small stand-alone clinic at the outskirts of Moatize offering condoms, STI care and HTS during the evening to young women and adolescent engaging in sex work. Many adult and adolescents sex workers access these SRH services. This actually

portrays that access to SRH services and commodities is often hampered by fear of discrimination and stigma leading to the utilization of night clinics. Hence night clinics can improve the accessibility of SRH services by adolescent girls engaged in sex work. The uniqueness of human rights as portrayed by the human rights based approach includes the right to access SRH services by all populations as human rights are universal and alienable. Thus SRH services must be designed to match the needs of adolescents engaged in sex work.

The participants in Komboniyatsva Community also outlined mass media and well-coordinated referral system within clinics as a way that improves access to SRH services for adolescent girls engaging in sex work around Zimbabwe. According to NAC (2011) mass media widely used to reach the target audience on SRH services accessibility because of its potential to disseminate information to a larger audience. Therefore dissemination information can improve access to SRH services within communities. Also improved referral system within facilities is a vital strategy in improving access to SRH services in Epworth Community. Thus all these strategies should be adopted in order to uphold the human rights of all citizens. According to the human rights based approach while illegal behaviours do not deprive women, adolescents of their human rights and for the purpose of SRH services sex workers are often excluded. These individuals are precluded from seeking as well as accessing services. Thus mass media is a way which can be utilized for advocacy to ensure effective access to SRH services and rights.

4.4 CHAPTER SUMMARY

The chapter examined and procured the research findings on access to sexual reproductive health services for adolescent girls engaged in sex work in Epworth Komboniyatsva Community. The findings of this research study were in line with the objectives of the research which were to identify the range of sexual and reproductive health services available in the Epworth Community. Also to determine how these services are accessible to young girls engaged in sex work in the Epworth Community and to examine strategies to improve access to sexual and reproductive health services for young girls engaged in sex work in Zimbabwe.The next chapter will be on the summary of findings, conclusions and recommendations that were drawn from research findings within this chapter.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0 INTRODUCTION

This chapter concludes the study by recapitulating the major findings of the study on access to sexual reproductive health services of adolescent girls engaged in sex work, a case of Epworth Komboniyatsva Community. The chapter also provide conclusions basing on the research findings namely available sexual and reproductive health services within Epworth Community, how these services are accessible to young girls engaged in sex work in Epworth Community and the strategies to improve access to sexual and reproductive health services for adolescent girls engaged in sex work in Zimbabwe. Thus the various conclusions and recommendations that emerged from the study were discussed.

5.1 SUMMARY OF FINDINGS

The previous chapters discussed the introduction and background of the study that is chapter 1, chapter 2 reviewed the literature, chapter 3 was on methodology that was used for the study in terms of collecting data and chapter 4 was on data presentation, analysis and discussion. The study was directed by three objectives that were to identify available sexual and reproductive health services within Epworth Community, to determine how these services are accessible to young girls engaged in sex work in Epworth Community and the strategies to improve access to SRH services for adolescent girls engaged in sex work in Zimbabwe. The human right based approach was the theoretical framework which guided the study. The study employed qualitative data collection methods. Fifteen (15) adolescents engaged in sex work were used for the sake of the study and were sampled through snowball sampling. Five key informants were sampled using purposive sampling.

5.1.1 To identify range of SRH services available in Epworth Community.

The research study identified range of available SRH services within the Epworth Community. These services included STI screening and testing, contraception, cancer screening, HIV/AIDS testing, treatment, and antenatal and post natal care. According to the research study it is actually visible that SRH services are available within the Epworth Community but they serve the general population .Hence turning a blind eye to key populations for example adolescent girls engaged in sex work which leads to detrimental effects within their sexual reproductive health. Thus SRH

services available must cater for the unique needs of adolescents indulging in sex work. Also it is visible that NGO led facilities have robust available SRH services accessible to all populations than government institutions.

5.1.2 To determine how these services are accessible to young girls engaged in sex work in Epworth Community.

Accessibility of SRH services by adolescent girls engaged in sex work in Epworth Community was brought about by the study. It was noticeable that the accessibility of services was mainly linked to integration of services by NGO facilities which address the unique needs of adolescents' girls engaged in sex work. Also youth friendly facilities, community outreaches and mobile clinics led adolescent girls engaging in sex work to access SRH services. However challenges did impede access to SRH services within Komboniyatsva Community which include stigma, discrimination, poor referral system within facilities and costs. These obstacles' led to the rampant spread of diseases and deaths due to poor access of SRH services within Epworth Komboniyatsva Community.

5.1.3 Strategies to improve access to SRH services for adolescent girls engaged in sex work in Zimbabwe.

Strategies to improve access to SRH services for adolescent girls engaging in sex work were brought in by the research study. The strategies included adopting community empowerment models, improved referral system, night clinics, integration of SRH services within facilities, peer educators, youth friendly services and use of mass media. Integration of services, community empowerment models and youth friendly services were ranked most appropriate by the participants. Hence these strategies need to be adopted to ensure comprehensive access to SRH services within communities around Zimbabwe.

5.2 Conclusions of the Study

The study reached the following conclusions basing on the research findings: Basing on the outlined objectives and the findings of the study, it can be concluded that they are a range of available SRH services within Epworth community. These services are offered by both governmental and NGO based facilities. Also available SRH services like contraception, STI screening and testing, HIV/AIDS, post natal care and antenatal care were mainly for the general

populace. Thus the mentioning of young girls engaged in sex work was limited as they are deemed responsible for their own sexual reproductive problems.

It can also be inferred that accessibility of available SRH services is attributed to SRH service integration mainly through community outreach and mobile clinics and youth friendly services. Also enhanced SRH knowledge through successful programs like Sisters with a Voice and IMBC in Epworth improved access to SRH services within the Epworth Community as a whole. Therefore adopting such ways by service providers within different facilities ensures comprehensive access to SRH services for adolescent girls engaged in sex work.

Also basing on the research findings, it can be concluded that, various challenges impeded access to available SRH services for adolescent girls engaged in sex work. Stigma and discrimination is the order of the day in the community from the community members and service providers as adolescent engaging in sex work are labelled with derogatory names. Thus leading to low self-esteem and inaccessibility to SRH services due to the belief that they are meant for the deserving populace. Monetary funds for transport due to segregated care also play as a hindrance in accessing available services within Epworth community. It can also be concluded that these accessibility obstacles hinder adolescents engaging in sex work to access services which are appropriate and vital for their health leading to spread of STI's and unsafe abortion.

It can also be deduced that adolescents engaging in sex work SRH needs are neglected as it is not considered as genuine illness. Adolescents engaging in sex work are deemed responsible for their fate .Also mere mentioning of sex workers as being vectors of diseases leads to indigent access of SRHs within communities. It can also be concluded that youth friendly services, adoption of peer educators, comprehensive referral system and integration of services improves access to SRH services in Zimbabwe as a whole.

5.3 Implication to social work practice

Social workers have a fundamental role in their ability to uphold social justice through upholding human rights. The social work profession is guided by ethical principles thus to treat each person in a caring and respectful manner, reminiscent of individual differences and cultural and ethnic diversity. Also upholding the rights of the marginalised in a bid to obtain social justice is key. Social workers promote fairness and equity across many aspects within the society for example it promotes equal access to SRH services. Social workers are cognizant of their twofold

responsibility to clients and the broader society. Social work as a profession advocates for upholding all individuals rights, including of adolescent girls indulging in sex work. They are entitled to the full spectrum of SRHR as they are also human. Yet sex workers continue to bear significant SRH inequities and unmet needs for appropriate SRH services at every step along their sexual and reproductive lives. Thus they is need to enhance clients' capacity and opportunity to change and to address their own needs to uphold inherent dignity, worth of a person and social justice.

5.4 RECOMMENDATIONS

The purpose of the research was to examine access to sexual reproductive health services for adolescent girls engaged in sex work. A case of Epworth Komboniyatsva Community. This section provides recommendations basing on the conclusions above and the recommendations are as follows:

5.4.1 Recommendations to the government.

- The study recommends that the government should regard access to available SRH services for adolescent girls engaged in sex work within governmental and NGO facilities. Access to SRH services should be regarded as a public health concern without discriminatory stances as stipulated within human rights based approach. Anti-discriminatory laws and regulations should guarantee adolescent girls engaged in sex work right to access SRH services.
- The government must promote SRH education programming for young girls engaged in sex work and their clients within communities. A lack of SRH knowledge endangers young girls within the sex work industry health and can prevent them from utilising available SRH services. Low SRH literacy among the general population can also burden them with the task of educating their clients on safe sex practices.

5.4.2 Recommendations to NGO's.

- The study recommends that NGO's should prioritise funding for community empowerment models of SRH services. Advantageous community led interventions includes outreach programmes, drop in centres and sensitisation training for medical personnel developed and implemented for adolescents engaged in sex work.

- Also NGO sex work led interventions must partner with health care professionals from the government to form networks of friendly doctors for treatment referrals.

5.4.3 Recommendations to social workers.

- Social workers must increase awareness creation which enables access to SRH through use of the mass media and other large-scale communication to motivate discussions about SRH issues among adolescent girls engaging in sex work is vital. In addition to conducting outreach activities from the health facility into the community, schools, churches and youth peer educators are ways of increasing awareness of available SRH services among young people and community members.
- Also social workers must advocate for access to safe, legal, and affordable abortion services to adolescents engaged in sex work. Restrictive abortion policies may force adolescent girls to employ unsafe, informal pregnancy termination methods at great risk to their health.

5.4.3 Recommendations to service providers (facility based).

- Service providers must adopt a holistic approach to comprehensive SRH services for adolescent girls engaged in sex work which stretches beyond HIV and STI screening and treatment. Inclusive SRH services should be made accessible to adolescent girls engaged in sex work taking into consideration divergent priorities and goals associated with work activities and private life.
- Also service providers should integrate SRH services in line with one stop models. Integrating comprehensive access to SRH services ensures a broad range of care which can be offered in one location, reducing logistical barriers to service uptake. Also the use of peer educators as service providers for SRH for young girls engaged in sex work is perceived to be the viable option to improving access to service utilisation by adolescents' girls engaging in sex work. This suggests the need to train more peer educators to compliment the operational duties of health service providers.

5.4.4 Recommendations to the community.

- The community must adopt anti-discriminatory stances so that adolescent girls engaged in sex work may access services from mainstream SRH services. Comprehensive, long-term

sensitisation and training is required to the community to make SRH services attainable to adolescents engaged in sex work.

- The community is obligated to attend community outreach programs on comprehensive sexuality education and other SRHR initiatives designed for young people mainly those engaged in sex work. This enables them to receive the same information which helps them and their children through extensive SRHR education.

5.5 CHAPTER SUMMARY

This chapter discussed the major findings from the research study. The research findings have been presented by the research objectives. Implications for policy and practice related to access to SRH services for adolescent girls engaged in sex work as well as recommendations for policy and practice and future research were presented.

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APPENDICES

ANNEX 1: Introduction and Informed Consent Form

Dear Participants

My name is Garai Stacey, a fourth-year Bachelor of Science Degree in Social Work student at the Bindura University of Science Education. I am conducting an academic research study on access to sexual reproductive health services for adolescent girls engaged in sex work in Epworth Komboniyatsva Community. This is aimed at gathering information that will be useful in trying to establish the range of SRH services, barriers, and strategies to improve access to SRH services for young girls in the sex work industry in Epworth and Zimbabwe as a whole. Your participation will be inconversant with any risks or benefits but intensely intended for academic research only. All information provided will be solely used for the purposes of research and will be kept confidential. I am kindly requesting for your participation in this research study. Your cooperation will be highly appreciated. If you agree to participate, lam kindly requesting you to sign in the spaces provided below.

Signature of Participant…….. Date…….

Signature of Researcher……..Date……..

ANNEX 2: In-depth Interview guide for participants.

Background Information.

1. What is your sex?
2. What is your age?
3. What is your level of education?

SRH services available in Epworth.

4. What do you understand about sexual and reproductive health services?
5. What are the sexual and reproductive health services available in Epworth Community?
6. What sexual and reproductive health services do you know?
7. Are there any facilities which provide sexual and reproductive health services in Epworth Community?

Accessible SRH services.

8. Have you ever sought any sexual and reproductive health services in Epworth?
9. How are SRH services accessible for adolescent girls indulging in sex work in Epworth Community?
10. Are these services affordable and friendly?
11. Did you face any challenges when accessing sexual reproductive health services in Epworth?

Strategies to improve access to SRH services.

12. In your view, what factors promote access to sexual and reproductive health services for young girls engaging in sex work in Zimbabwe?
13. What should be done to improve access to sexual and reproductive health services for adolescents engaging in sex work in Zimbabwe?

THANK YOU FOR YOUR COOPERATION

ANNEX 3: Key Informant Interview Guide.

1. What is the name of your organisation or clinic?
2. What is your position?
3. What are your years of experience when it comes to dealing with issues relating to SRH?
4. What available SRH services do you offer at your clinic or organisation in Epworth?
5. Are these services accessible to adolescent girls engaging in sex work in Epworth?
6. How often do adolescents engaging in sex work come to access SRH services at your organization or clinic and why?
7. Are they any stumbling blocks towards access to SRH services for adolescent girls within the sex work industry in your community?
8. What are the strategies that should be implemented to improve access to sexual and reproductive health services for adolescent girls engaging in sex work in Zimbabwe?

THANK YOU FOR YOUR COOPERATION.

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BINDURA UNIVERSITY OF SCIENCE EDUCATION

Date 21/04/2022

TO WHOM IT MAY CONCERN

Dear Sir/Madam

REQUEST TO UNDER TAKE RESEARCH PROJECT IN YOUR ORGANISATION

This serves to advise that..... SARAH STACEY ..... Registration No.

B 1850748 ..... is a **BACHELOR OF SCIENCE HONOURS**

DEGREE IN SOCIAL WORK student at Bindura University of Science Education who is conducting a research project.

May you please assist the student to access data relevant to the study and where possible conduct interviews as part of the data collection process.

Yours faithfully

BINDURA UNIVERSITY OF SCIENCE EDUCATION
SOCIAL WORK CHAIRPERSON
10 DEC 2021
FACULTY OF SCIENCE EDUCATION
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26 May 2022

TO WHOM IT MAY CONCERN

RE : REQUEST TO UNDER TAKE RESEARCH PROJECT IN YOUR AREA

This serves to introduce the bearer SARAI STACEY B1850748 who is an HBSc SOCIAL WORK student in the Department of SOCIAL WORK, Bindura University of Science Education and is carrying out a research project in your area.

Your usual co-operation and assistance is therefore being sought.

Thank you for the continued support.

Yours faithfully

BINDURA UNIV. OF SCIENCE EDUCATION
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