

Simba Utano

Baseline Evaluation Report

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Acronyms

AGYW	Adolescent Girls and Young Women
AYP	Adolescent and Young People
CAP	Computer-assisted personal interviewing
CCW	Child Case Care Workers
CPC	Child Protection Committee
FGD	Focus group Discussions
FP	Family Planning
GBV	Gender Based Violence
ICAD	Interagency Coalition on AIDS and Development
ICASO	International Council of AIDS Service Organizations
KAPB	Knowledge Attitude Practice and Behaviour
PrEP	Pre-Exposure Prophylaxis
SAT	Southern African AIDS Trust
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infections
VAWG	Violence Against Women and Girls
VMMC	Voluntary Medical Male Circumcision

Definition of Key Terms

Term	Definition
GBV	Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially-ascribed (i.e., gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty. These acts can occur in public or in private. (IASC GBV Guidelines 2018).
Gender	Gender refers to the socially-constructed differences between females and males — and the relationships between and among them — throughout their life cycle. They are context- and time-specific and change over time, within and across cultures. Gender, together with age group, sexual orientation and gender identity, determines roles, responsibilities, power and access to resources. (IASC Gender Handbook in Humanitarian Action 2018). Gender is an important concept in basic gender analysis that helps deepen understanding about social relations as an entry point to sustainable change through development.
Gender Norms	Social norms that relate specifically to gender differences, informal rules and shared social expectations that distinguish expected behaviour on the basis of Gender
Harmful Practices	Harmful Practices are forms of violence against women and girls which are defended on the basis of tradition, culture, religion or superstition by some communities. They are often known as 'harmful traditional practices.' (OHCHR)
Sexual violence	Sexual violence is defined as: any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. Sexual violence includes rape. (IASC Gender Handbook in Humanitarian Action 2018)
SRH	It is a state of complete physical, mental, and social wellbeing in all matters relating to reproductive system. (IASC Gender Handbook in Humanitarian Action 2018)
SRHR	Sexual rights result from the application of existing human rights to sexuality and sexual health. These include the right to receive the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health-care services. Sexual rights protect all people's rights to fulfil and express their sexuality with due regard for the rights of others and within a framework of protection against discrimination. Reproductive rights are rights of all persons "to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to the highest attainable standard of sexual and reproductive health." (IASC Gender Handbook in Humanitarian Action 2018)
VAWG	It is any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women and girls including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. (UN)

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Executive summary

Introduction

Zimbabwe has a youthful population, with two thirds of the total 14 million population below the age of 25 and young people (15-24 years) comprising approximately half of all new HIV infections in Zimbabwe. Adolescent girls and young women (AGYW) have been identified as a group at disproportional risk of HIV infection. Despite similar HIV prevalence rates between ages 10 to 14 (2.8%), HIV prevalence among young women (ages 20-24) is 8.1% – almost three times higher than HIV prevalence among young men (2.7%), indicating that AGYW are at extreme risk of contracting HIV. AGYW experience converging social, cultural, economic, and political factors that undermine their sexual and reproductive health and rights (SRHR), which makes them vulnerable to HIV infection. AGYW remains a very high global priority and an important target group for HIV and SRH programming.

The overall objective of the evaluation was to establish the status quo of HIV/SRHR knowledge and utilization of services in the four districts and to inform the PMF with baseline values.

Methodology

The evaluation team used a four-pronged methodology (mixed method) in its data collection exercise. It carried out literature and documentary analysis, structured interviews, focus group discussions and key informant interviews in order to capture more complete, valid and reliable data. The Knowledge, Attitudes, Behaviour and Practices (KABP) participants were randomly selected while Focus Group Discussion (FGD) participants were purposively selected in the four districts. Data collection was conducted over eight days (28 February 6 March 2020). Quantitative analysis was done using STATA 14.2. while qualitative data analysis was conducting using thematic analysis.

Findings

A total of 354 AGYW, boys and young men were recruited in the four districts: 37% (n=131) were recruited from Goromonzi, 35% (n=126) were recruited from Mazowe, 15% (n=54) were recruited from Umguza and 13% (n=42) were recruited from Seke. Of the 354; 62%, (n=220) were females while 38% were males. Overall, 34% (n=119) were 10-14 years old, 38% (n=133) were 15-19 years old, and 29% (n=102) were 20-24 years old.

A total of 16 focus group discussions were conducted with 172 parents/carers, young people, community cadres and traditional and religious leaders. Of the 172 participants, 59% were females and 41% were males; 31% were single, 64% were married and 2% were either divorced or separated and 3% were widowed. Twenty-five (25%) were aged 24 years and below, while 14% were aged

between 25-45 years, 26% were aged between 36-45 years and 16% were between 46-55 years and 19% were above 56 years. Fifty-one (51%) had attained ordinary level (high school) while 14% had attended but not completed high school; 13% had reached tertiary education; 16% had only primary level education and 6% have never been to school. All those who reported never having been to school were females.

Data shows that knowledge of HIV transmission and prevention was high across the four districts. Umguza had the lowest number (43%) of young people who knew that having sex with one uninfected partner reduces the risk of HIV transmission. Condoms were considered an effective HIV prevention method; 72% (n=220) reported that using condoms every time during sex prevented an HIV negative person from getting HIV. About 81% (n=287) knew that a person cannot get HIV from mosquito bites and 78% (n=275) were aware of PMTCT services. New biomedical prevention methods were not well known as only 27%, (n=95) knew about PrEP. Just above three quarters of these young people had never married and did not have a current sexual partner with the exception of Mazowe which was the outlier with the highest number of sexually active young people (66%) and 80% reporting have a current sexual partner. Among those never married, the majority were married between the age of sixteen- and eighteen-years indicating prevalence of early/child marriages.

Early sexual debut, transactional sex, sex work and drug abuse were some of the high-risk behaviours that put young people at risk of contracting HIV infection. Age disparity partnerships and transactional sex was more commonly cited in Mazowe compared to other districts. Poverty, economic hardship and artisanal miner were mentioned as driving AGYW into either transactional sex or into selling sex which puts them at higher risks of HIV and sexual and gender-based violence.

Although young people were aware of GBV and its different forms, there was a gap in accessing GBV information. Very few young people, 19% (n=65) reported that they had heard or received some information on GBV in the past three months. This was similar across all four districts. The patriarchal nature of the Zimbabwean society showed up strongly in FGDs with men across all districts saying women and girls were responsible for the GBV and violence that happens to them as they provoke men with their manner of dress or by failing to submit to their husbands. Harmful practises such as forced and child marriages, virginity testing and girl pledging were cited as key drivers of GBV in the four districts. The harmful practises were exacerbated by poverty which often drives young people out of school and parents marrying off their daughters, before the age of 18, in exchange for food or money. Although GBV was rampant in the communities it was noted that awareness of local safe spaces or shelters where GBV survivors get protection was sub-optimal.

Overall, the majority of young people (69%, n=232) reported having heard about sexual health and that they knew where to access SRHR services. The exception was Umguza who had relatively low number of young people (51%) who reported that they know where to access SRHR services. Clinics and hospitals were cited as places where young people can access SRHR services. A number of individual level, household level and community level factors were raised as impeding young people's access to SRHR service.

Conclusion

The findings highlighted a number of risk factors that put young people at risk of contracting HIV and of GBV. Knowledge and access to HIV/GBV and SRHR is uneven across the four selected districts. The different levels of knowledge will call for a nuanced approach and awareness raising programmes must take into account these differences.

1.0 Contextual Background

Zimbabwe has a youthful population, with two thirds of the total 14 million population below the age of 25 [1, 2] and young people (15-24 years) comprising approximately half of all new HIV infections in Zimbabwe [3]. Adolescent girls and young women (AGYW) have been identified as a group at disproportional risk of HIV infection. Despite similar HIV prevalence rates between ages 10 to 14 (2.8%), HIV prevalence among young women (ages 20-24) is 8.1% – almost three times higher than HIV prevalence among young men (2.7%) [4], indicating that AGYW are at extreme risk of contracting HIV. Converging social, cultural, economic, and political factors that undermine AGYW sexual and reproductive health and rights (SRHR) makes them very vulnerable to HIV infection [5]. The AGYW population remains a very high global priority and an important target group for HIV and SRH programming.

The national data shows that there are still considerable gaps in knowledge of basic HIV prevention methods among AGYW [6]. In Zimbabwe, only 51% of adolescent girls aged 15-19-years-old have comprehensive and correct knowledge of HIV. Knowledge of specific risk factors (such as transmission in sexual networks or the risk of age-disparate sex and anal sex), of newer biomedical prevention methods (such as Pre-Exposure Prophylaxis (PrEP)), or of links between HIV and gender-based violence, remain low [6]. It is well documented that young people report finding it difficult to access support and clinically informed information about how to negotiate safer sex [7]. In a few instances where AGYW have accessed services, the services are often not age-appropriate, are unfriendly and/or accompanied by stigma and judgmental attitudes from service providers, family members and their communities [7, 8], suggesting the limitations of current services to meet the evolving needs of AGYW.

Generally, their risk of HIV infection is exacerbated by their low risk perception and limited access to prevention methods as well as high peer pressure [8]. Despite 40% of girls having had sex before the age of 18 and 21% having begun child bearing before the age of 20, HIV testing coverage and counselling remains low (58%) among sexually active adolescent girls (15- 19-years-old). Therefore, it is crucial to employ a “business as unusual” approach that seeks to refine our focus and target approaches to reduce risky behaviours around issues such as transactional sex, lack of and inconsistent condom use, early sexual debut and unintended pregnancies. AGYWs risk is further compounded by gender norms, Intergenerational relationships, multiple concurrent partners, transactional sex lack of economic empowerment, gender based violence and child marriages [5]. Additionally, the HIV programme is not reaching AGYW with appropriate youth-friendly services, nor does the programme use innovative and interactive ways of communicating about prevention and the importance of medication adherence.

It is well documented that constrained access to HIV/SRH services has negative effects on health outcomes for AGYW. Therefore, tailored strategies are needed. Ensuring access to HIV prevention and SRH services becomes critical for this population.

Project Background

SIMBA UTANO: Enhancing gender equality & human dignity for vulnerable AGYW

It is against this background that the Simba Utano collaborative project will be implemented. The project has a duration of four years and seeks to achieve the following three objectives:

- Increase utilization of equitable SRHR and HIV services by vulnerable AGYW in four districts of Zimbabwe;
- Improve delivery of quality, gender responsive, inclusive care and support to address priority SRHR needs of adolescents and young people particularly AGYW;
- Improve effectiveness of young people, particularly AGYW, and community organizations to advocate for evidence based, equitable, accountable and quality SRHR services and policies.

The project seeks to address the demand side of health service delivery by working in priority districts to address the systemic barriers to accessing health which includes the socio-cultural norms and traditional community beliefs that impede access and utilization of services especially for AGYW and other vulnerable populations. From the supply side, the project will address the structural barriers to equitable access to SRHR services. From a structural perspective, the project will strengthen health and governance systems to support the delivery of quality and responsive SRHR and HIV services for AGYW.

This project will support the strengthening of community health systems through twinning linkages for South to South organizations, such as the Southern African AIDS Trust (SAT) and SafAIDS, to share best practices and evidence-based programming with the two Zimbabwean partners in order to enhance project outcomes. Best practices and technical support will also be provided from the ICAD membership in Canada and the ICASO network, including its regional consultant, to support the work of the Zimbabwean organizations.

The project will build upon several proven approaches that will be integrated into the implementation of the “Pachoto groups” (peer groups) initiative that Katswe Sistahood has developed to provide adolescents girls with the opportunity to discuss sexual health issues in an open and safe environment. The initiative uses a story-telling/narration approach to discuss important issues related to adolescent sexual and reproductive health including issues such as SRHR education and menstrual health. In addition, Community Score Cards like the one developed in the

Coalition for Effective Community Health and HIV Response, Leadership and Accountability measures will be put in place to support governance and accountability. The purpose of the score rating is to monitor whether service provision is improving, remaining static or getting worse during the project period. The challenges identified will be resolved jointly between the health centre staff and community.

The project will focus on four districts: Mazowe, Goromonzi, Seke and Umguza. All four districts were identified as HIV hotspots by the Ministry of Health. The direct beneficiaries targeted by the project are primarily AGYW (ages 10-24) but also include young men (ages 10-24), men who have sex with men (MSM) and sex workers. It will also provide some support to all women of reproductive age (15-49 years). The project will also work with Village Health Workers, Peer Educators, Behaviour Change Communicators, Community Leaders, Health Workers and Administrators. The project will indirectly benefit a population of over 300,000 (51% F) in the four districts and will influence policies at the district and national level, with lessons learned and best practices shared from Zimbabwe to the larger ICASO and ICAD networks.

2.0 Aims and Objectives of the Evaluation

The purpose of the evaluation is to ascertain the current utilization of SRHR and HIV services and to provide a snapshot of the situation pre-operation in the four districts. The baseline is meant to set benchmarks and help establish baseline values and inform the setting of targets for actual implementation.

3.0 Methodology and approach

The Consultants conducted a mixed method (qualitative and quantitative) cross sectional evaluation. The mixed methods were mutually reinforcing and complemented each other and thus allowed for validation of data from different sources (triangulation).

3.1 Component A: Quantitative research

Randomly selected AGYW, boys and young men completed a structured questionnaire administered through Computer-Assisted Personal Interviewing (CAPI). The quantitative tool was to solicit information on Knowledge, Awareness, Behaviour and Practices (KABP). Domains included: socio-demographic characteristics, sexual behaviour, knowledge of GBV/VAWG and HIV/SRHR.

3.1.1 Sample size calculation

The sample size was calculated with reference to the total number of AGYW, boys and young men aged 15-24 living in Seke, Mazowe, Umguza and Goromonzi (according to the 2012 Zimbabwe National Census Report) where the Simba Utano programme will be implemented. Sample size was calculated using a margin of error of 5%; confidence interval of 95% and response distribution of 50% (<http://www.raosoft.com/samplesize.html>).

Sampling

We employed a three-stage sampling strategy. The first stage was basically selecting all the 4 baseline districts (purposive sampling). The second stage was a random selection of 2 wards within these districts. The final stage was a random selection of a proportionate number of young people in each ward. To ensure that the sample was representative, efforts were made to maintain balance in age and level of education of young people. We aimed to recruit 384 participants, equally split among the districts using Probability Proportionate to Size (PPS) sampling (Table 1), but 354 were recruited.

Table 1: Sample distribution by district

District	Ward	Ward name	Number of people
Goromonzi	Ward 2	Mawanga	68
	Ward 12	Mwanza	68
Mazowe	Ward 16	Somerset	64
	Ward 22	Mazowe mine	64
Seke	Ward 1	Nemasanga	28
	Ward 13	Beatrice	28
Umguza	Ward 7	Fairbridge	32

	Ward 16	Stanhope	32
Total			384

3.1.2 Quantitative data collection

All participants completed a structured KABP questionnaire and a client satisfaction form. Quantitative data was collected using KoBoCollect, a remote data collection method based on the Open Data Kit (ODK) – a suite of tools that allow data collection using mobile devices and data submission to an online server. After data collection, the data were migrated from the tablets to the laptop for backup purposes in addition to being synchronised to the KoboCollect online server where it was downloaded for analysis.

3.2 Component B: Qualitative research

3.2.1 Qualitative data collection

The qualitative component used focus group discussions (FGDs) and key informant interviews. Qualitative methods were used to explore sexual behaviour, HIV and SRHR knowledge, and GBV/VAWG knowledge. We adopted a purposive maximum variation sampling approach in recruiting participants who participated in the qualitative interviews. Efforts were made to ensure an equal representation of male and female participants in all interviews.

Focus Group Discussions

Focus group discussions were conducted in the selected wards of all 4 districts. Focus Groups were broken down into same-sex groups to ensure that women, girls, men and boys participated freely. FGDs stimulated debate on key issues such as knowledge of HIV and HIV prevention methods among young people, knowledge of GBV/VAWG and utilization of SRHR services. Purposive maximum variation sampling was used to recruit FGD participants. FGDs included drawing ‘a before and after diagram’. The resulting diagram is a participatory tool which depicts status quo and the desired change. With permission from participants, detailed notes were taken by a trained notetaker.

Key Informant Interviews

Key informant interviews were conducted with healthcare workers in the selected four districts. The questions were open and framed in such ways as to ensure that interviewees participate in more dialogue and provide as much information as possible. As with other qualitative methods, key informant interviews were conducted using semi-structured interview guides. The purpose of the interviews was to establish from the supply side the availability and uptake and quality of SRHR and HIV services by young people and to understand the main barriers that young people face in

accessing services from service providers and establish how these are either similar or different from those raised in the young people FGDs/KABP interviews.

3.3 Data management and analysis procedures

All quantitative data were collected remotely and kept in password protected files. FGDs and key informant interviews were also kept secure and confidential. Quantitative analysis was done using STATA 14.2. Verifiable syntax records (do-files) will be provided upon request. Analysis started by giving descriptive statistics of the key indicators of the performance measurement framework (PMF). We then explored any associations between the sociodemographic characteristics including age, sex and geography of young people and key indicators of PMF using Chi-squared tests.

Detailed notes were taken by a trained note taker for all the FGDs, in-depth interviews and key informant interviews. These were then typed verbatim and translated into English. The consultants conducted an inductive thematic analysis of the transcripts independently and compared results to come up with a provisional coding framework. Discrepancies were resolved by discussion. Once the consultants were satisfied that coding was consistent, the remaining transcripts were coded. Additional codes identified through the line by line coding were added to the coding framework. All qualitative data were uploaded, coded and summarized using a qualitative software package (NVivo 11.0, QSR International). Names and other individual identifiers were removed from transcripts, before transcripts are entered verbatim into NVivo 11.0, software. Qualitative data was analysed using thematic analysis. The data was subsequently arranged into themes and subthemes and illustrated with quotes.

3.4 Ethical considerations

Permission from the relevant authorities to conduct this activity as well as obtaining entry and co-operation from the various organizations participating in the evaluation was granted. Written consent to participate in the interviews as well as for audio recording of the interviews were sought from all participants before the interviews. Parental consent was sought for all young people below the age of 18 years. All information collected was treated in the strictest confidence and was only used for the purpose of this evaluation.

4.0 Evaluation findings

4.1 Demographic characteristics of KABP participants

Of the 354 participants who completed the KABP survey, the majority 62% (n=220) were female. Overall, 34% were 10-14 years old, 38% were 15-19 years old, and 29% were 20-24 years old (Table 2). Just above three quarters of these young people were never married, with almost all those recruited in Goromonzi, Seke and Umguza reported having never been married. Among those who reported to be married, the majority got married between the age of sixteen and eighteen years.

Virtually all of the young people reported that they had attended school. Twenty-eight (28%) did not complete primary school. Of the 72% that did, 18% reported that they only completed primary school; 23% reported that they had some secondary school and 31% indicated that they had completed secondary school or higher. More girls (19.5%) completed primary school than boys (15.7%). However, this levelled out at the high school level where the percentage of girls (31.4% completing secondary school was almost identical to that of boys (30.6%).

Participants in this baseline survey were religious, with the highest proportion (28% of males and 42% of females) belonging to the Apostolic sect.

Table 2: Socio-demographic characteristics of survey participants

	Goromonzi (N=131)		Mazowe (N=127)		Seke (N=42)		Umguza (N=54)		Total (N=354)	
	Males (N=61) n/N (%)	Females (N=70) n/N (%)	Males (N=27) n/N (%)	Females (N=100) n/N (%)	Males (N=23) n/N (%)	Females (N=19) n/N (%)	Males (N=23) n/N (%)	Females (N=31) n/N (%)	Males (N=134) n/N (%)	Females (N=220) n/N (%)
Age										
10-14	22/61 (36.1)	36/70 (51.4)	4/27 (14.8)	4/100 (4.0)	7/23 (30.4)	7/19 (36.8)	15/23 (65.2)	24/31 (77.4)	48/134 (35.8)	71/220 (32.3)
15-19	28/61 (45.9)	24/70 (34.3)	12/27 (44.4)	41/100 (41.0)	10/23 (43.5)	6/19 (31.6)	7/23 (30.4)	5/31 (16.1)	57/134 (42.5)	76/220 (34.5)
20-24	11/61 (18.0)	10/70 (14.3)	11/27 (40.7)	55/100 (55.0)	6/23 (26.1)	6/19 (31.6)	1/23 (4.3)	2/31 (6.5)	29/134 (21.6)	73/220 (33.2)
Marital status										
Never married	61/61 (100.0)	64/70 (91.4)	24/27 (88.9)	40/100 (40.0)	22/23 (95.7)	16/19 (84.2)	23/23 (100.0)	29/31 (93.5)	130/134 (97.0)	149/220 (67.7)
Married	0/61 (0.0)	5/70 (7.1)	3/27 (11.1)	55/100 (55.0)	1/23 (4.3)	2/19 (10.5)	0/23 (0.0)	1/31 (3.2)	4/134 (3.0)	63/220 (28.6)
Divorced/Separated	0/61 (0.0)	1/70 (1.4)	0/27 (0.0)	5/100 (5.0)	0/23 (0.0)	1/19 (5.3)	0/23 (0.0)	1/31 (3.2)	0/134 (0.0)	8/220 (3.6)
Age at marriage										
<16	-	0/5 (0.0)	0/3 (0.0)	4/55 (7.3)	0/1 (0.0)	0/2 (0.0)	-	0/1 (0.0)	0/4 (0.0)	4/63 (6.3)
16-18	-	3/5 (60.0)	0/3 (0.0)	30/55 (54.5)	0/1 (0.0)	0/2 (0.0)	-	1/1 (100.0)	0/4 (0.0)	34/63 (54.0)
>18	-	2/5 (40.0)	3/3 (100.0)	21/55 (38.2)	1/1 (100.0)	2/2 (100.0)	-	0/1 (0.0)	4/4 (100.0)	25/63 (39.7)
Level of education										
None	0/61 (0.0)	0/70 (0.0)	0/27 (0.0)	1/100 (1.0)	0/23 (0.0)	0/19 (0.0)	0/23 (0.0)	0/31 (0.0)	0/134 (0.0)	1/220 (0.5)
Incomplete primary	25/61 (41.0)	25/70 (35.7)	4/27 (14.8)	5/100 (5.0)	7/23 (30.4)	6/19 (31.6)	9/23 (39.1)	17/31 (54.8)	45/134 (33.6)	53/220 (24.1)

Complete primary	7/61 (11.5)	12/70 (17.1)	6/27 (22.2)	17/100 (17.0)	1/23 (4.3)	5/19 (26.3)	7/23 (30.4)	9/31 (29.0)	21/134 (15.7)	43/220 (19.5)
Some secondary	11/61 (18.0)	17/70 (24.3)	2/27 (7.4)	31/100 (31.0)	7/23 (30.4)	2/19 (10.5)	7/23 (30.4)	4/31 (12.9)	27/134 (20.1)	54/220 (24.5)
Complete secondary or higher	18/61 (29.5)	16/70 (22.9)	15/27 (55.6)	46/100 (46.0)	8/23 (34.8)	6/19 (31.6)	0/23 (0.0)	1/31 (3.2)	41/134 (30.6)	69/220 (31.4)
Religion										
None	1/61 (1.6)	0/69 (0.0)	7/27 (25.9)	8/99 (8.1)	2/23 (8.7)	1/19 (5.3)	1/23 (4.3)	2/31 (6.5)	11/134 (8.2)	11/218 (5.0)
Apostolic	14/61 (23.0)	35/69 (50.7)	9/27 (33.3)	42/99 (42.4)	8/23 (34.8)	6/19 (31.6)	7/23 (30.4)	8/31 (25.8)	38/134 (28.4)	91/218 (41.7)
Catholic	6/61 (9.8)	2/69 (2.9)	1/27 (3.7)	3/99 (3.0)	3/23 (13.0)	2/19 (10.5)	2/23 (8.7)	0/31 (0.0)	12/134 (9.0)	7/218 (3.2)
Pentecostal	21/61 (34.4)	13/69 (18.8)	7/27 (25.9)	28/99 (28.3)	6/23 (26.1)	5/19 (26.3)	1/23 (4.3)	12/31 (38.7)	35/134 (26.1)	58/218 (26.6)
Protestant	18/61 (29.5)	10/69 (14.5)	2/27 (7.4)	15/99 (15.2)	4/23 (17.4)	4/19 (21.1)	3/23 (13.0)	7/31 (22.6)	27/134 (20.1)	36/218 (16.5)
Muslim	1/61 (1.6)	7/69 (10.1)	0/27 (0.0)	0/99 (0.0)	0/23 (0.0)	0/19 (0.0)	0/23 (0.0)	0/31 (0.0)	1/134 (0.7)	7/218 (3.2)
Other	0/61 (0.0)	2/69 (2.9)	1/27 (3.7)	3/99 (3.0)	0/23 (0.0)	1/19 (5.3)	9/23 (39.1)	2/31 (6.5)	10/134 (7.5)	8/218 (3.7)
Living with disability										
No	60/61 (98.4)	70/70 (100.0)	25/26 (96.2)	97/100 (97.0)	22/23 (95.7)	19/19 (100.0)	22/22 (100.0)	30/31 (96.8)	129/132 (97.7)	216/220 (98.2)
Yes	1/61 (1.6)	0/70 (0.0)	1/26 (3.8)	3/100 (3.0)	1/23 (4.3)	0/19 (0.0)	0/22 (0.0)	1/31 (3.2)	3/132 (2.3)	4/220 (1.8)

4.2 Demographic characteristics of FGD participants

A total of 172 participants took part in one of the four FGD categories. Of the 172 participants, 59% were female and 41% were male; 31% were single, 64% were married, 2% were either divorced or separated and 3% were widowed. Twenty-five (25%) were aged 24 years and below; 14% were aged between 25-45 years; 26% were aged between 36-45 years; 16% were between 46-55 years; and 19% were above 56 years. Thirteen (13%) had some tertiary education, 51% had attained their O (ordinary) levels; 14% had not completed ordinary level; 16% had primary level education only; and 6% had never been to school (Table 3). Of the 13% who had tertiary education; 61% were male; 39% were female. Of the 51% who attained O levels, 51% were female and 49% were male. All those who reported never having attended school were female making them more economically dependent on their spouses because they lack the necessarily education qualification and skills to find employment.

Table 3: Participant breakdown by type of FGD

FGD type	Number of FGD	Number Participants		Total
		Female	Males	
Young people age 15-24	4	20	18	38
Parents/carers	4	30	21	51

Community and Religious leaders	4	14	20	34
Community cadres	4	38	11	49
Total	16	102	70	172

Of the 172 participants, 11% reported that they were students, 69% were unemployed and 20% were employed (Table 4). Out of the 102 females who took part in the FGDs; 73% were unemployed, 16% were employed and 12% were students. Out of the 70 males who took part; 64% were unemployed, 26% were employed and 10% were students.

Table 4: Demographic characteristics of FGD participants

	N=172		
	Females (N=102)	Males (N=70)	Total
Age			
≤24	25	18	43
25-35 years	15	10	25
36-45 years	29	16	45
46-55	16	11	27
>55	17	15	32
Highest level of education			
Never been to school	11	0	11
Primary	19	7	26
Form 1-3	18	6	24
Form 4-6	45	43	88
College	9	14	23
Marital status			
Single	34	20	54
Married	61	48	109
Divorce/Separated	3	1	4
Widowed	4	1	5
Occupation			
Student	12	7	19
Unemployed	74	45	119
Employed	16	18	34

4.3 Knowledge and awareness of HIV

Knowledge of HIV transmission and prevention was relatively high across the four districts (Table 5). Almost two thirds, (64% of males and 61% of females) of the young people reported that having sex with only one, faithful, uninfected partner reduces the risk of HIV transmission. Compared to other districts, Umguza had the lowest number (41% of males and 45% females) of young people who knew that having sex with one uninfected partner reduces the risk of HIV transmission. Condoms were considered an effective HIV prevention method, and 75% of males and 70% of females reported that using condoms every time during sex prevent an HIV negative person from getting

HIV. About 80% of males and 82% of females thought that a person cannot get HIV from mosquito bites. The majority of young people (91% of males and 92% females) reported that a person cannot get HIV by sharing a meal with someone who is infected. Finally, a high proportion (80% of males and 82% of females) were aware of PMTCT when they reported that a woman who is HIV positive can do something before, during or after pregnancy to not infect her baby.

We explored young people's knowledge on newer biomedical HIV prevention methods. Although the majority of young people (78% of males and 54% of females) reported to know the link between VMMC and partial HIV protection, only a few (23% of males and 30% of females) knew about PrEP.

Table 5: Knowledge and awareness of HIV by district and sex

	Goromonzi (N=131)		Mazowe (N=127)		Seke (N=42)		Umguza (N=54)		Total (N=354)	
	Males (N=61) n/N (%)	Females (N=70) n/N (%)	Males (N=27) n/N (%)	Females (N=100) n/N (%)	Males (N=23) n/N (%)	Females (N=19) n/N (%)	Males (N=23) n/N (%)	Females (N=31) n/N (%)	Males (N=134) n/N (%)	Females (N=220) n/N (%)
Can having sex with only one, faithful, uninfected partner reduce the risk of HIV transmission?										
No	22/61 (36.1)	22/70 (31.4)	7/27 (25.9)	28/100 (28.0)	5/23 (21.7)	8/19 (42.1)	5/22 (22.7)	14/31 (45.2)	39/133 (29.3)	72/220 (32.7)
Yes	39/61 (63.9)	41/70 (58.6)	19/27 (70.4)	70/100 (70.0)	18/23 (78.3)	10/19 (52.6)	9/22 (40.9)	14/31 (45.2)	85/133 (63.9)	135/220 (61.4)
Don't know	0/61 (0.0)	7/70 (10.0)	1/27 (3.7)	2/100 (2.0)	0/23 (0.0)	1/19 (5.3)	8/22 (36.4)	3/31 (9.7)	9/133 (6.8)	13/220 (5.9)
Can using condoms every time during sex prevent an HIV negative person from getting HIV?										
No	12/61 (19.7)	14/70 (20.0)	4/27 (14.8)	18/100 (18.0)	4/23 (17.4)	9/19 (47.4)	7/22 (31.8)	7/31 (22.6)	27/133 (20.3)	48/220 (21.8)
Yes	49/61 (80.3)	45/70 (64.3)	22/27 (81.5)	78/100 (78.0)	18/23 (78.3)	10/19 (52.6)	11/22 (50.0)	21/31 (67.7)	100/133 (75.2)	154/220 (70.0)
Don't know	0/61 (0.0)	11/70 (15.7)	1/27 (3.7)	4/100 (4.0)	1/23 (4.3)	0/19 (0.0)	4/22 (18.2)	3/31 (9.7)	6/133 (4.5)	18/220 (8.2)
Can a person get HIV from mosquito bites?										
No	52/61 (85.2)	52/70 (74.3)	19/27 (70.4)	86/100 (86.0)	20/23 (87.0)	17/19 (89.5)	15/22 (68.2)	26/31 (83.9)	106/133 (79.7)	181/220 (82.3)
Yes	7/61 (11.5)	11/70 (15.7)	7/27 (25.9)	9/100 (9.0)	2/23 (8.7)	2/19 (10.5)	5/22 (22.7)	4/31 (12.9)	21/133 (15.8)	26/220 (11.8)
Don't know	2/61 (3.3)	7/70 (10.0)	1/27 (3.7)	5/100 (5.0)	1/23 (4.3)	0/19 (0.0)	2/22 (9.1)	1/31 (3.2)	6/133 (4.5)	13/220 (5.9)
Can a person get HIV by sharing a meal with someone who is infected?										
No	55/61 (90.2)	62/70 (88.6)	25/27 (92.6)	99/100 (99.0)	22/23 (95.7)	17/19 (89.5)	19/22 (86.4)	25/31 (80.6)	121/133 (91.0)	203/220 (92.3)
Yes	5/61 (8.2)	8/70 (11.4)	1/27 (3.7)	1/100 (1.0)	1/23 (4.3)	2/19 (10.5)	3/22 (13.6)	4/31 (12.9)	10/133 (7.5)	15/220 (6.8)
Don't know	1/61 (1.6)	0/70 (0.0)	1/27 (3.7)	0/100 (0.0)	0/23 (0.0)	0/19 (0.0)	0/22 (0.0)	2/31 (6.5)	2/133 (1.5)	2/220 (0.9)
Are there tablets that people who do not have HIV can take to reduce their chance of getting HIV?										
No	29/61 (47.5)	41/70 (58.6)	14/27 (51.9)	37/100 (37.0)	15/23 (65.2)	9/18 (50.0)	6/22 (27.3)	17/31 (54.8)	64/133 (48.1)	104/219 (47.5)
Yes	13/61 (21.3)	9/70 (12.9)	5/27 (18.5)	46/100 (46.0)	4/23 (17.4)	2/18 (11.1)	8/22 (36.4)	8/31 (25.8)	30/133 (22.6)	65/219 (29.7)
Don't know	19/61 (31.1)	20/70 (28.6)	8/27 (29.6)	17/100 (17.0)	4/23 (17.4)	7/18 (38.9)	8/22 (36.4)	6/31 (19.4)	39/133 (29.3)	50/219 (22.8)
Can a woman who is HIV positive do anything before, during or after pregnancy to not infect her baby?										
No	8/61 (13.1)	10/69 (14.5)	5/27 (18.5)	4/100 (4.0)	4/23 (17.4)	1/19 (5.3)	4/23 (17.4)	4/31 (12.9)	21/134 (15.7)	19/219 (8.7)
Yes	46/61 (75.4)	47/69 (68.1)	16/27 (59.3)	92/100 (92.0)	19/23 (82.6)	17/19 (89.5)	14/23 (60.9)	24/31 (77.4)	95/134 (70.9)	180/219 (82.2)

Don't know	7/61 (11.5)	12/69 (17.4)	6/27 (22.2)	4/100 (4.0)	0/23 (0.0)	1/19 (5.3)	5/23 (21.7)	3/31 (9.7)	18/134 (13.4)	20/219 (9.1)
Can an HIV negative man reduce his chances of getting HIV by going for voluntary medical male circumcision?										
No	11/61 (18.0)	22/70 (31.4)	4/27 (14.8)	24/100 (24.0)	4/23 (17.4)	3/19 (15.8)	4/23 (17.4)	10/31 (32.3)	23/134 (17.2)	59/220 (26.8)
Yes	49/61 (80.3)	30/70 (42.9)	22/27 (81.5)	61/100 (61.0)	19/23 (82.6)	12/19 (63.2)	15/23 (65.2)	15/31 (48.4)	105/134 (78.4)	118/220 (53.6)
Don't know	1/61 (1.6)	18/70 (25.7)	1/27 (3.7)	15/100 (15.0)	0/23 (0.0)	4/19 (21.1)	4/23 (17.4)	6/31 (19.4)	6/134 (4.5)	43/220 (19.5)

4.4 Sexual Behaviour

Overall, 19% of males and 41% of females recruited into the survey reported having had sex at least once (Table 6). Highest levels of having had sex at least once were reported in Mazowe (37% of males and 74% females). Females regardless of age were more likely to report having a current sexual partner compared to males (81% vs 32%). With respect to age discrepancy among young people who reported to having a current sexual partner, 72% of males and 51% of females reported that their partner/spouse age difference was 1-4 years; 12% of males and 38% of females reported that their partner/spouse difference was 5-10 years, and 10% of females reported to having a current sexual partners/spouse who was 10 or more years older.

Table 6: Sexual behaviours

	Goromonzi (N=131)		Mazowe (N=127)		Seke (N=42)		Umguza (N=54)		Total (N=354)	
	Males (N=61) n/N (%)	Females (N=70) n/N (%)	Males (N=27) n/N (%)	Females (N=100) n/N (%)	Males (N=23) n/N (%)	Females (N=19) n/N (%)	Males (N=23) n/N (%)	Females (N=31) n/N (%)	Males (N=134) n/N (%)	Females (N=220) n/N (%)
Have you ever had sex?										
No	53/61 (86.9)	60/70 (85.7)	17/27 (63.0)	26/100 (26.0)	18/23 (78.3)	16/19 (84.2)	21/23 (91.3)	27/31 (87.1)	109/134 (81.3)	129/220 (58.6)
Yes	8/61 (13.1)	10/70 (14.3)	10/27 (37.0)	74/100 (74.0)	5/23 (21.7)	3/19 (15.8)	2/23 (8.7)	4/31 (12.9)	25/134 (18.7)	91/220 (41.4)
Do you have a current sexual partner(s)?										
No	7/8 (87.5)	5/10 (50.0)	7/10 (70.0)	10/74 (13.5)	1/5 (20.0)	1/3 (33.3)	2/2 (100.0)	1/4 (25.0)	17/25 (68.0)	17/91 (18.7)
Yes	1/8 (12.5)	5/10 (50.0)	3/10 (30.0)	64/74 (86.5)	4/5 (80.0)	2/3 (66.7)	0/2 (0.0)	3/4 (75.0)	8/25 (32.0)	74/91 (81.3)
Partner/spousal difference										
Same age	2/8 (25.0)	0/10 (0.0)	1/10 (10.0)	0/73 (0.0)	0/5 (0.0)	0/3 (0.0)	0/2 (0.0)	0/3 (0.0)	3/25 (12.0)	0/89 (0.0)
Partner/spouse is 1-4 years older	4/8 (50.0)	4/10 (40.0)	8/10 (80.0)	38/73 (52.1)	4/5 (80.0)	1/3 (33.3)	2/2 (100.0)	2/3 (66.7)	18/25 (72.0)	45/89 (50.6)
Partner/spouse is 5-10 years older	1/8 (12.5)	5/10 (50.0)	1/10 (10.0)	28/73 (38.4)	1/5 (20.0)	1/3 (33.3)	0/2 (0.0)	0/3 (0.0)	3/25 (12.0)	34/89 (38.2)
Partner/spouse is >10 years older	0/8 (0.0)	0/10 (0.0)	0/10 (0.0)	7/73 (9.6)	0/5 (0.0)	1/3 (33.3)	0/2 (0.0)	1/3 (33.3)	0/25 (0.0)	9/89 (10.1)
Don't know	1/8 (12.5)	1/10 (10.0)	0/10 (0.0)	0/73 (0.0)	0/5 (0.0)	0/3 (0.0)	0/2 (0.0)	0/3 (0.0)	1/25 (4.0)	1/89 (1.1)

Interviewed parents/carers in the four districts identified a number of influential HIV risk factors in their respective communities. Early sexual debut, transactional sex, sex work and drug abuse were mentioned as some of the high-risk behaviours that young people engage in that puts them at

greater risk of contracting sexually transmitted diseases including HIV. Age disparity partnerships and transactional sex was cited most frequently in Mazowe where parents/carers lamented that AGYW are engaging in sex 'way before their time'. Two parents stated that;

Poverty and the upsurge of artisanal miners who have money has created a lot of problems for us in this community as young girls are having sex while they are still young and some are into sex work (Parents/carers FGD, Mazowe district).

Social media is the trouble causer. Young people expose themselves to pornography that is leading them to engage in sexual activities at a tender age. Some of the young people are into sex work and some take drugs and when they fall sick, they are shy to visit the clinic to be treated (Parents/carers FGD, Goromonzi district).

In Mazowe and Goromonzi, two phenomena have been highlighted: economic hardship and artisanal miner were mentioned as driving AGYW into either transactional sex or into selling sex which puts them at higher risks of HIV and sexual and gender-based violence. Illegal artisanal gold miners, also known as *makorokoza* in Mazowe, is a new phenomenon that is taking root in many communities where gold mining is being carried out by illegal/informal gold miners. During the FGDs, parents/carers in the affected districts highlighted that artisanal miners either force themselves on AGYW or attract them with money from the gold mining, which makes it difficult for parents to keep their children away. The artisanal miners were also known for resorting to violence when they are rejected, as evidenced by recent reports of machete-wielding miners who have terrorised communities, making it difficult for communities to intervene. This both exposes the girls to violence and results in early marriages, many of which do not last as the miners abandon the girls when they move to a different area. Given the high poverty levels prevailing in the country, communities in the affected areas feel powerless to deal with the artisanal miners who serve as a serious threat to AGYW.

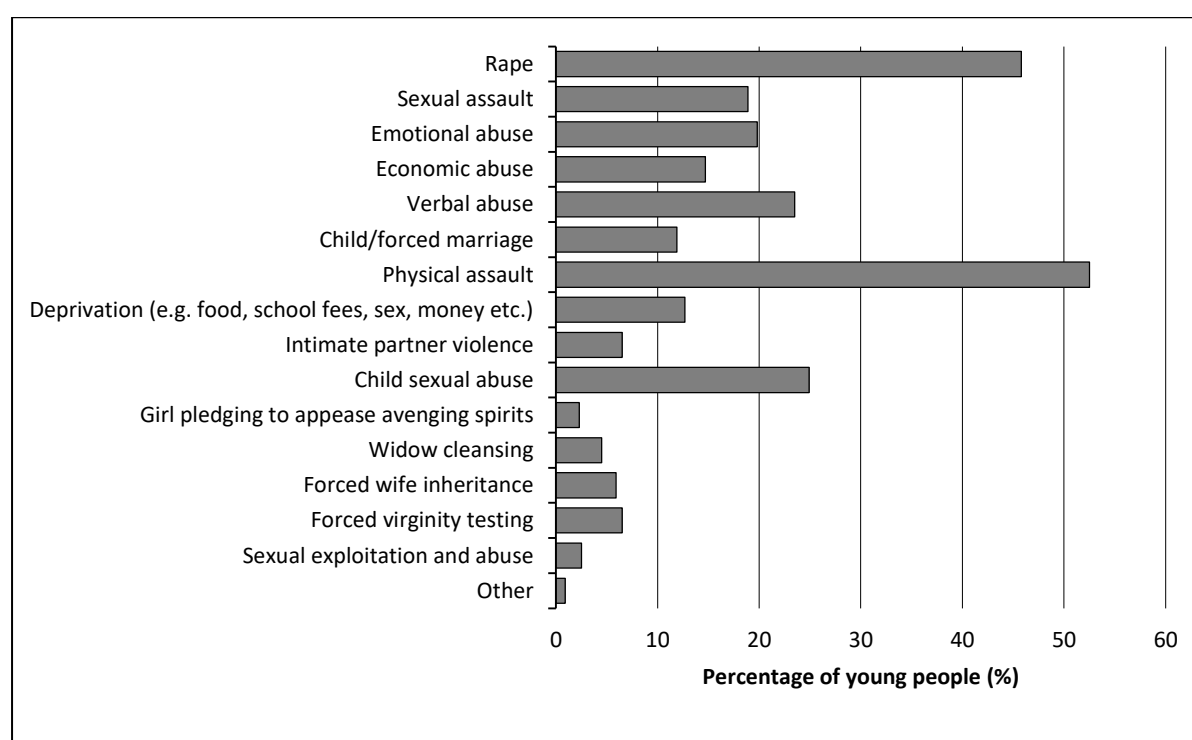
Young people also highlighted peer pressure to indulge in sex, age-disparate partnerships and low condom use as some of the behaviours that puts them at risk of acquiring HIV.

Young girls in this community are dating very old men that tend to abuse them and infect them with HIV. Some young people are under pressure from their friends, peer pressure and they start doing sex work because their friends are doing it but they do not know how it is done. For example they tend not to use condoms and contract HIV and STIs and get unwanted pregnancies. They also have no knowledge about abortion and some lost their lives while trying to abort using backyard doctors (Young people FGD, Goromonzi district).

4.5 Knowledge of GBV/VAWG

Overall, the proportion of participants who are aware of GBV/VAWG was 66% among males and 75% among females. In Goromonzi and Umguza, GBV/VAWG awareness was identical between males and females, while in Mazowe and Seke, there was greater awareness amongst females – (86% vs 70%) and (84% vs 70%), respectively. In both the FGDs and in the KAPB survey, there was reasonable knowledge about GBV and the different forms that it takes. Physical assault, rape, child sexual abuse and child pledging were the commonly cited forms of GBV (Figure 1).

Figure 1: Awareness of GBV by Young People



Very few young people (19% of males and 18% of females), reported that they had heard of or received information on GBV in the past three months and this was similar across all four districts (Table 7). Regarding the link between GBV and HIV, the majority (60% of males and 56% of females) reported either that there was no link between GBV and HIV – or did not know if there was a link between HIV and GBV.

Table 7: Knowledge of GBV

	Goromonzi (N=131)		Mazowe (N=127)		Seke (N=42)		Umguza (N=54)		Total (N=354)	
	Males (N=61) n/N (%)	Females (N=70) n/N (%)	Males (N=27) n/N (%)	Females (N=100) n/N (%)	Males (N=23) n/N (%)	Females (N=19) n/N (%)	Males (N=23) n/N (%)	Females (N=31) n/N (%)	Males (N=134) n/N (%)	Females (N=220) n/N (%)
Have you ever heard about GBV/VAWG?										
No	18/61 (29.5)	22/70 (31.4)	7/27 (25.9)	8/100 (8.0)	6/23 (26.1)	3/19 (15.8)	9/23 (39.1)	12/31 (38.7)	40/134 (29.9)	45/220 (20.5)
Yes	40/61 (65.6)	46/70 (65.7)	19/27 (70.4)	86/100 (86.0)	16/23 (69.6)	16/19 (84.2)	13/23 (56.5)	17/31 (54.8)	88/134 (65.7)	165/220 (75.0)
Don't remember	3/61 (4.9)	2/70 (2.9)	1/27 (3.7)	6/100 (6.0)	1/23 (4.3)	0/19 (0.0)	1/23 (4.3)	2/31 (6.5)	6/134 (4.5)	10/220 (4.5)
Heard or received any information on GBV in the past three months?										
No	51/61 (83.6)	55/68 (80.9)	20/27 (74.1)	71/100 (71.0)	16/23 (69.6)	16/19 (84.2)	18/23 (78.3)	26/31 (83.9)	105/134 (78.4)	168/218 (77.1)
Yes	10/61 (16.4)	10/68 (14.7)	6/27 (22.2)	23/100 (23.0)	4/23 (17.4)	3/19 (15.8)	4/23 (17.4)	5/31 (16.1)	24/134 (17.9)	41/218 (18.8)
Don't remember	0/61 (0.0)	3/68 (4.4)	1/27 (3.7)	6/100 (6.0)	3/23 (13.0)	0/19 (0.0)	1/23 (4.3)	0/31 (0.0)	5/134 (3.7)	9/218 (4.1)
Is there a link between GBV and HIV?										
No	21/61 (34.4)	23/69 (33.3)	8/26 (30.8)	30/98 (30.6)	4/23 (17.4)	1/18 (5.6)	8/22 (36.4)	9/29 (31.0)	41/132 (31.1)	63/214 (29.4)
Yes	23/61 (37.7)	22/69 (31.9)	12/26 (46.2)	49/98 (50.0)	10/23 (43.5)	11/18 (61.1)	7/22 (31.8)	13/29 (44.8)	52/132 (39.4)	95/214 (44.4)
Don't know	17/61 (27.9)	24/69 (34.8)	6/26 (23.1)	19/98 (19.4)	9/23 (39.1)	6/18 (33.3)	7/22 (31.8)	7/29 (24.1)	39/132 (29.5)	56/214 (26.2)
If you heard about your neighbour experiencing GBV, a case of GBV occurring in your community, would you report to the police?										
No	11/61 (18.0)	10/70 (14.3)	6/27 (22.2)	24/100 (24.0)	2/23 (8.7)	2/19 (10.5)	6/22 (27.3)	9/31 (29.0)	25/133 (18.8)	45/220 (20.5)
Yes	48/61 (78.7)	57/70 (81.4)	21/27 (77.8)	72/100 (72.0)	21/23 (91.3)	17/19 (89.5)	15/22 (68.2)	21/31 (67.7)	105/133 (78.9)	167/220 (75.9)
Don't know	2/61 (3.3)	3/70 (4.3)	0/27 (0.0)	4/100 (4.0)	0/23 (0.0)	0/19 (0.0)	1/22 (4.5)	1/31 (3.2)	3/133 (2.3)	8/220 (3.6)
Have you ever experienced any forms of GBV/violence?										
No	55/61 (90.2)	64/70 (91.4)	23/27 (85.2)	73/99 (73.7)	20/23 (87.0)	16/19 (84.2)	20/22 (90.9)	30/31 (96.8)	118/133 (88.7)	183/219 (83.6)
Yes	5/61 (8.2)	6/70 (8.6)	4/27 (14.8)	25/99 (25.3)	3/23 (13.0)	3/19 (15.8)	2/22 (9.1)	1/31 (3.2)	14/133 (10.5)	35/219 (16.0)
Don't know	1/61 (1.6)	0/70 (0.0)	0/27 (0.0)	1/99 (1.0)	0/23 (0.0)	0/19 (0.0)	0/22 (0.0)	0/31 (0.0)	1/133 (0.8)	1/219 (0.5)

All the participants who took part in the FGDs acknowledged that GBV was a major problem in their communities. This was well depicted in all 16 of the FGD drawings.

I can say GBV is rampant in this community. People fight in the community or at home over even small disputes. They can fight verbally or physically and we hear of young people and women being raped in the community. There is also child labor where young people are made to work without getting any rest and there is also sexual harassment where by young girls are harassed at the shops with older men and some young men who will be under the influence of drugs and alcohol (Young people FGD, Goromonzi district).

Culture and tradition state that the man is the head of the household. Consequently, decisions starting from financial to family planning are made by men. Women do not have power to make

decisions for the own bodies. Culture also has been used to normalise violence and most women and girls believe that being beaten is a sign of love. In most families, men are the bread winners and when they are perpetrators of violence, they easily get away with it. Normalisation of GBV came out in all the four districts.

People take GBV as something that is a normal thing to do and people no longer report the cases to the police (Parents/carers FGD, Mazowe district).

Women and young girls are the most affected by GBV. The patriarchal nature of the Zimbabwean society showed up strongly in the FGDs with some men across the different districts saying women and girls are responsible for the GBV and violence that happens to them as they provoke men with their manner of dressing or by failing to submit to their husbands. Some women also shared the same view that women and girls were to blame for sexual abuse against them. This shows the extent to which such negative attitudes permeate society and even influence the perceptions of those on the receiving end of the violence.

Young girls are exposing themselves through the way that they dress. They wear very tight and revealing clothes that tend to attract men who rape them. Mothers should teach their young girls that if they wear provocative clothing such as revealing clothes and miniskirts they will be raped (Traditional leaders FGD, Mazowe).

Some men blamed the excessive knowledge of women and children's rights as perpetuating violence in the families.

Knowledge of rights- women and children are no longer submissive because they always refer to their rights. This forces men to tighten the grip on them thus leading to GBV (Parents/carers FGD, Seke district).

GBV is now serious in the community because women are now very disrespectful, they no longer submit to men as they should and this leads to men 'disciplining' them. This "gender equality" makes women disrespectful as they know that the law is on their side. Unfortunately, this also cascades into young people's relationships as we [parents] are the ones that model the character that our children are supposed to follow (Community leaders FGD, Umguza).

Community members also believe that women are perpetrators of violence. Unfortunately, no statistics exist because men are reluctant to report violence because of the various attitudes that they will encounter. Very few cases of men being beaten or ill-treated by their wives are reported.

4.5.1 Driver of GBV in the communities

Harmful practises such as forced and child marriages, virginity testing and girl pledging were cited as key drivers of GBV in all four districts. The harmful practises are exacerbated by poverty which often drives young people out of school and parents to marry off their girls before the age of 18 in exchange for food or money.

Child marriages are due to poverty and failure to finish school. Most of the women have grade 7 level education which makes them the target for child marriages. Religion is also a challenge especially the Apostolic churches that marry off girls into polygamous unions and most of the girls end up being beaten up by their husbands and the older wives. These churches also treat diseases in a way that violate women. For example, they rape women as a way of curing endometriosis (Community cadres, Goromonzi district).

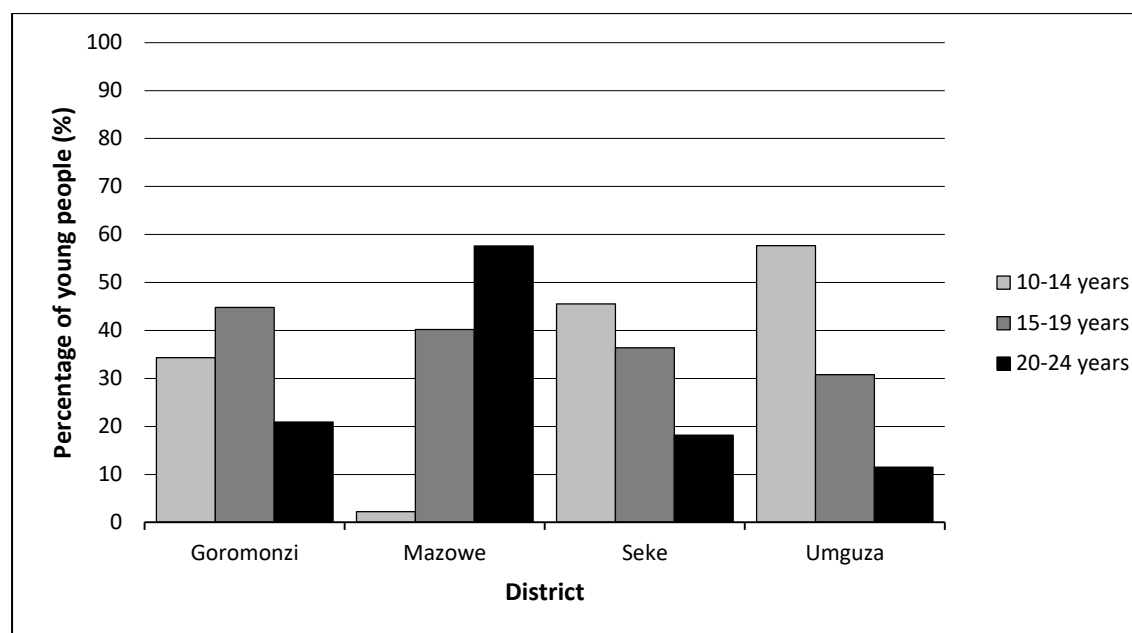
Poverty is the main reason for GBV. Young girls enter into child marriages to escape hunger at home. They tend to face physical, emotional and sexual violence in these kinds of marriages. Again, some girls enter into intergenerational relationships or have transactional sex just so they feed themselves and their families. They do not have a say in these kinds of relationships again (Parents/carers FGD, Seke district).

Dropping out of school has a ripple effect on women's economic empowerment as most of the young women end up economically dependent on their husbands and/or sexual partners for their upkeep. This makes them vulnerable to GBV and HIV as poor education lowers their self-esteem resulting in an inability to negotiate safer sex or report GBV.

4.5.2 Awareness of community-based support networks

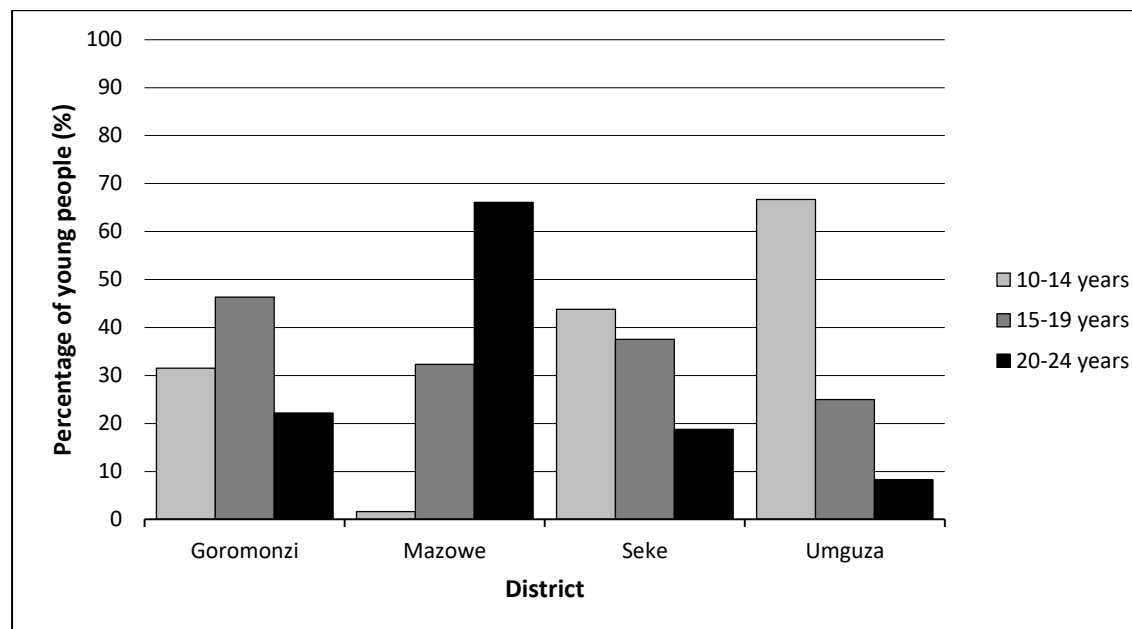
Awareness of local safe spaces or shelters where GBV survivors can get protection was sub-optimal, and rose steeply with age in Mazowe but decreased steeply with age in Seke and Umguza (Figure 2).

Figure 2: Knowledge of local safe spaces or shelters where GBV survivors get protection by district and age



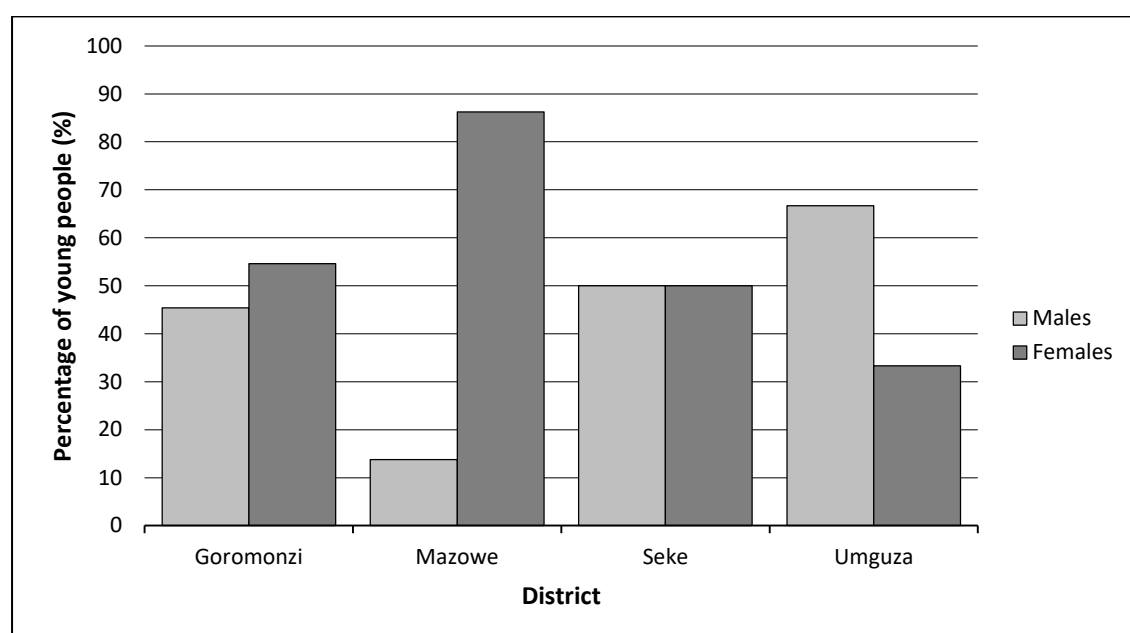
Similarly, awareness of community support networks that support people who have experienced GBV in communities, where these young people live, increased steeply with age in Mazowe but conversely decreased steeply with age in Seke and Umguza (Figure 3).

Figure 3: Awareness of community support networks that support people who have experienced GBV in communities where young people live by age across districts



Overall, an appreciable proportion (11% of males and 16% of females) of young people reported experiencing GBV/violence (Table 7). Report of GBV was relatively high in Mazowe where almost 15% of males and 25% of females reported that they had experienced some form of GBV/violence compared to other districts. In Goromonzi and Mazowe, experience of violence was higher among females compared to males, (55% vs 44%) and (86% vs 14%), respectively, while experience of violence was higher among males compared to females (68% vs 33%) in Umguza (Figure 4). In Seke experience of violence was identical (50%).

Figure 4: Experience of GBV/violence by sex across districts



The majority of young people (65% of males and 71% of females) reported having heard about sexual health (Table 8). However, in Umguza, less than half (39% of males and 48% of females) reported having heard about sexual health. Similarly, the majority of young people (81% among both males and females) reported that they know where to access SRHR services but it was again relatively low in Umguza where below half (44%) of females reported that they know where to access SRHR services. Among young people who reported to know where to access SRHR services, 98% reported that they can access SRHR services at clinics/hospitals.

Table 8: Knowledge and access of SRHR

	Goromonzi (N=131)		Mazowe (N=127)		Seke (N=42)		Umguza (N=54)		Total (N=354)	
	Males (N=61) n/N (%)	Females (N=70) n/N (%)	Males (N=27) n/N (%)	Females (N=100) n/N (%)	Males (N=23) n/N (%)	Females (N=19) n/N (%)	Males (N=23) n/N (%)	Females (N=31) n/N (%)	Males (N=134) n/N (%)	Females (N=220) n/N (%)
Have you ever heard about sexual health?										
No	17/60 (28.3)	22/62 (35.5)	8/26 (30.8)	20/97 (20.6)	7/22 (31.8)	2/18 (11.1)	14/23 (60.9)	15/29 (51.7)	46/131 (35.1)	59/206 (28.6)
Yes	43/60	40/62	18/26	77/97	15/22	16/18	9/23	14/29	85/131	147/206

	(71.7)	(64.5)	(69.2)	(79.4)	(68.2)	(88.9)	(39.1)	(48.3)	(64.9)	(71.4)
Do you know where to access SRHR services?										
No	11/56 (19.6)	16/59 (27.1)	3/25 (12.0)	5/95 (5.3)	3/21 (14.3)	2/18 (11.1)	6/16 (37.5)	15/27 (55.6)	23/118 (19.5)	38/199 (19.1)
Yes	45/56 (80.4)	43/59 (72.9)	22/25 (88.0)	90/95 (94.7)	18/21 (85.7)	16/18 (88.9)	10/16 (62.5)	12/27 (44.4)	95/118 (80.5)	161/199 (80.9)
Where you can mainly access SRHR services?										
Clinic/hospital	45/45 (100.0)	42/43 (97.7)	22/22 (100.0)	90/90 (100.0)	16/18 (88.9)	15/16 (93.8)	10/10 (100.0)	11/12 (91.7)	93/95 (97.9)	158/161 (98.1)
Other	0/45 (0.0)	1/43 (2.3)	0/22 (0.0)	0/90 (0.0)	2/18 (11.1)	1/16 (6.3)	0/10 (0.0)	1/12 (8.3)	2/95 (2.1) (2.1)	3/161 (1.9)
Have you ever accessed SRHR services?										
No	44/60 (73.3)	51/67 (76.1)	13/27 (48.1)	32/100 (32.0)	13/23 (56.5)	11/19 (57.9)	18/20 (90.0)	23/31 (74.2)	88/130 (67.7)	117/217 (53.9)
Yes	16/60 (26.7)	16/67 (23.9)	14/27 (51.9)	68/100 (68.0)	10/23 (43.5)	8/19 (42.1)	2/20 (10.0)	8/31 (25.8)	42/130 (32.3)	100/217 (46.1)
Where mainly accessed SRHR services?										
Clinic/hospital	14/16 (87.5)	15/16 (93.8)	13/14 (92.9)	66/68 (97.1)	8/10 (80.0)	6/8 (75.0)	2/2 (100.0)	8/8 (100.0)	37/42 (88.1)	95/100 (95.0)
Other	2/16 (12.5)	1/16 (6.3)	1/14 (7.1)	2/68 (2.9)	2/10 (20.0)	2/8 (25.0)	0/2 (0.0) (0.0)	0/8 (0.0)	5/42 (11.9)	5/100 (5.0)
Were you satisfied with the services you received at the facilities?										
No	1/15 (6.7)	0/16 (0.0)	0/14 (0.0)	2/68 (2.9)	0/10 (0.0)	1/8 (12.5)	0/2 (0.0) (0.0)	0/8 (0.0)	1/41 (2.4) (2.4)	3/100 (3.0)
Yes	14/15 (93.3)	16/16 (100.0)	14/14 (100.0)	66/68 (97.1)	10/10 (100.0)	7/8 (87.5)	2/2 (100.0)	8/8 (100.0)	40/41 (97.6)	97/100 (97.0)

4.6 Access to SRHR services

Thirty-two (32%) of males and 46% of females reported having accessed SRHR services. Of those who had accessed SRHR services, 88% of the males and 95% of the females accessed the services at clinics/hospitals (Table 8). Among those who reported to have accessed SRHR services, almost all of them (98% of males and 97% of females) reported that they were satisfied with services they received at the facilities. Proportion reporting satisfaction differed by age group across districts – in Goromonzi, Mazowe and Seke, a higher proportion of older people reported to be satisfied compared to young people (Figure 5). In Umguza, young people aged 10-14 were more likely to report that they were satisfied with SRHR services they received compared those aged 15-19 or 20-24.

We looked at the youth friendliness of SRHR services using the KABP and the FGDs. Although about 91% of young people aged 10-14, 90% of those aged 15-19 and 97% of those aged 20-24 reported that the services were provided in a youth friendly manner, FGD participants painted a different picture. They cited a number of issues (discussed below under barriers in accessing SRHR services) that compromised their level of satisfaction as well as the unfriendliness of some of the SRHR services.

Figure 5: Satisfied with SRHR services received at health facilities by age across districts

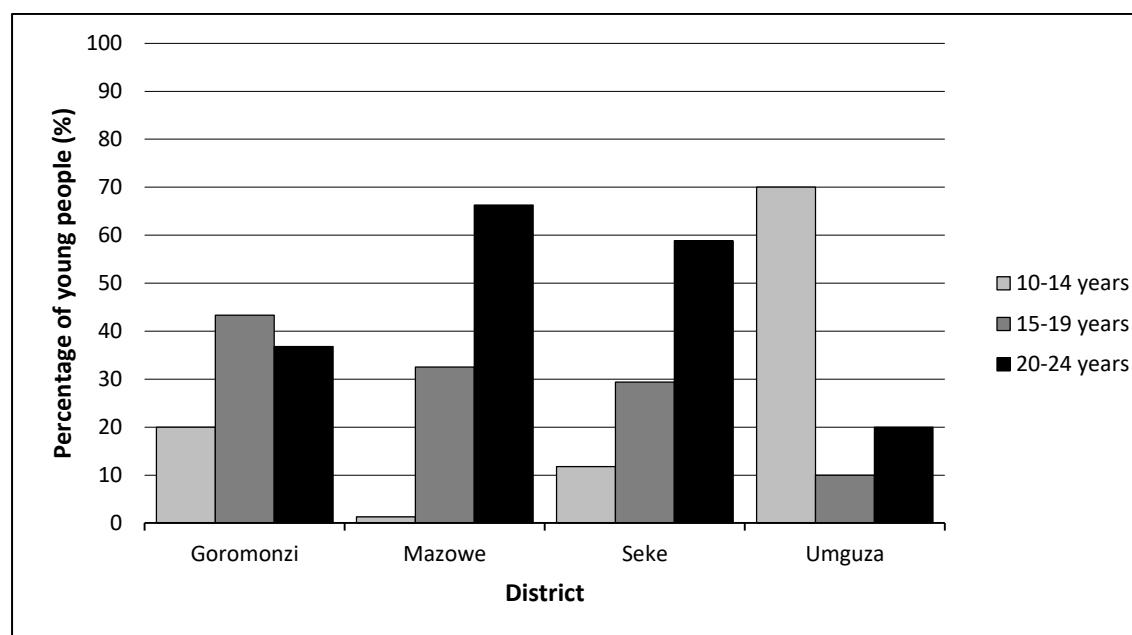
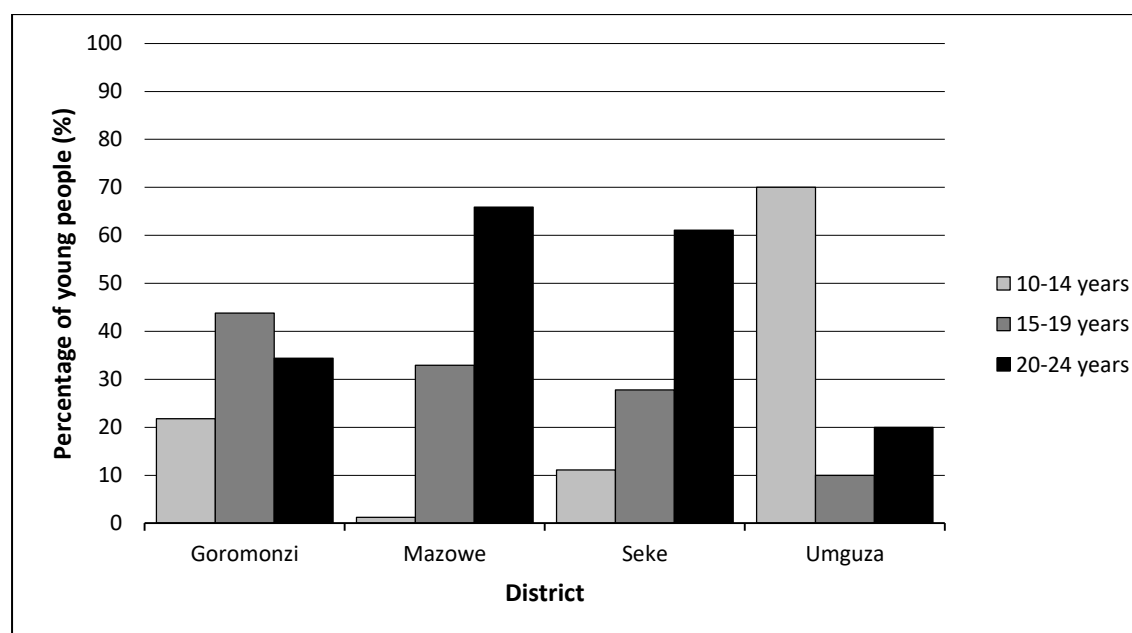
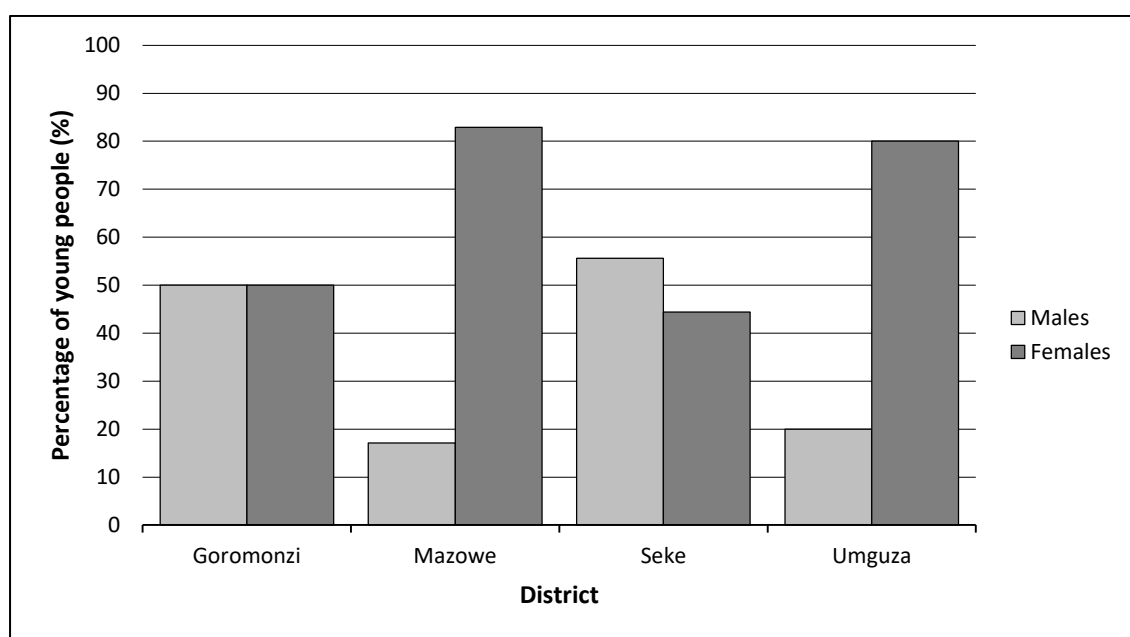


Figure 6: Access to SRHR services by age across districts



We also compared ever access of SRHR services by age and found that access rose steeply with age in Mazowe and Seke (Figure 6). Between males and females, in Mazowe and Umguza more females reported accessing SRHR services than males while the reverse was true in Seke (Figure 7).

Figure 7: Access of SRHR services by sex across districts



4.6.1 SRHR communication

The majority of young people (62% of males and 55% of females) stated that SRHR communication was not acceptable in their households. Few young people (38% of males and 44% of females) were comfortable speaking about SRHR issues with their parents/guardians but were generally comfortable (77% of males and 67% of female) doing so with their peers. FGD participants also shared the same views that both parents and young people were not comfortable speaking about SRHR issues at home. Parents were accused of being judgemental and making it very difficult for young people to open up. Parents also felt that talking about SHR issues would inadvertently promote sexual activity, making talk about sexuality with children off limits.

Most parents and children are not free to discuss issues of SRHR and in some cases parents tend to judge, or shout at a child if they ask about such issues [SRHR]. Children then end up not opening up to the parents. The parents stated that it is hard for them to have talks with the children because they felt that in a way, they will be encouraging them [young people] to have sex at a young age more like you will be teaching them on how to go about it. (Parents/carer FGD, Umguza district).

It's very difficult to discuss such issues [SRHR] at home. The moment you ask about it the discussion does not end well. Most parents would think that one is already indulging in sex even though one is genuinely asking. So, we prefer to discuss with our friends at school than with our parents (young people FGD, Umguza district).

Although the majority of young people (64% of males and 72% of females) reported that they can advocate for SRHR, their confidence levels were relatively low – only 47% of males and 54% of females reported that they were comfortable with their ability to advocate for SRHR.

Table 9: SRHR communication

	Goromonzi (N=131)		Mazowe (N=127)		Seke (N=42)		Umguza (N=54)		Total (N=354)	
	Males (N=61) n/N (%)	Females (N=70) n/N (%)	Males (N=27) n/N (%)	Females (N=100) n/N (%)	Males (N=23) n/N (%)	Females (N=19) n/N (%)	Males (N=23) n/N (%)	Females (N=31) n/N (%)	Males (N=134) n/N (%)	Females (N=220) n/N (%)
Is SRHR communication acceptable in your household?										
No	41/61 (67.2)	37/67 (55.2)	15/27 (55.6)	50/98 (51.0)	12/23 (52.2)	12/19 (63.2)	12/19 (63.2)	18/28 (64.3)	80/130 (61.5)	117/212 (55.2)
Yes	20/61 (32.8)	30/67 (44.8)	12/27 (44.4)	48/98 (49.0)	11/23 (47.8)	7/19 (36.8)	7/19 (36.8)	10/28 (35.7)	50/130 (38.5)	95/212 (44.8)
Are you comfortable to speak to your parent(s)/ guardian(s) about SRHR issues?										
No	38/60 (63.3)	35/68 (51.5)	16/24 (66.7)	59/96 (61.5)	12/23 (52.2)	11/19 (57.9)	13/21 (61.9)	13/29 (44.8)	79/128 (61.7)	118/212 (55.7)
Yes	22/60 (36.7)	33/68 (48.5)	8/24 (33.3)	37/96 (38.5)	11/23 (47.8)	8/19 (42.1)	8/21 (38.1)	16/29 (55.2)	49/128 (38.3)	94/212 (44.3)
Are you comfortable to speak to your peers about SRHR issues?										
No	9/61 (14.8)	28/67 (41.8)	7/27 (25.9)	24/100 (24.0)	7/23 (30.4)	5/19 (26.3)	7/22 (31.8)	14/30 (46.7)	30/133 (22.6)	71/216 (32.9)
Yes	52/61 (85.2)	39/67 (58.2)	20/27 (74.1)	76/100 (76.0)	16/23 (69.6)	14/19 (73.7)	15/22 (68.2)	16/30 (53.3)	103/133 (77.4)	145/216 (67.1)
Do you think you can advocate for SRHR?										
No	24/61 (39.3)	26/69 (37.7)	7/27 (25.9)	20/100 (20.0)	8/23 (34.8)	5/19 (26.3)	8/21 (38.1)	10/30 (33.3)	47/132 (35.6)	61/218 (28.0)
Yes	37/61 (60.7)	43/69 (62.3)	20/27 (74.1)	80/100 (80.0)	15/23 (65.2)	14/19 (73.7)	13/21 (61.9)	20/30 (66.7)	85/132 (64.4)	157/218 (72.0)
Do you feel confident in your ability to advocate for SRHR?										
Comfortable	23/61 (37.7)	26/70 (37.1)	19/27 (70.4)	62/100 (62.0)	14/23 (60.9)	14/19 (73.7)	7/23 (30.4)	17/31 (54.8)	63/134 (47.0)	119/220 (54.1)
Neutral	8/61 (13.1)	13/70 (18.6)	1/27 (3.7)	16/100 (16.0)	1/23 (4.3)	1/19 (5.3)	4/23 (17.4)	0/31 (0.0)	14/134 (10.4)	30/220 (13.6)
Uncomfortable	30/61 (49.2)	31/70 (44.3)	7/27 (25.9)	22/100 (22.0)	8/23 (34.8)	4/19 (21.1)	12/23 (52.2)	14/31 (45.2)	57/134 (42.5)	71/220 (32.3)

In emphasizing the lack of SRHR discussion at home, one healthcare worker stated that:

Parents leave it in the hands of science lessons and biology but at home they don't want to talk about it. The emphasize is on abstinence and children do not open up about their sexual activities until they are pregnant (Healthcare worker, Seke district).

4.6.2 Barriers in accessing SRHR services

We explored the barriers that limit AGYW's access to SRHR services. A combination of individual level, household level and community level factors were raised. At the individual level, shyness, fear of stigma and lack of knowledge on what services were available and how to access the services were cited as the main barriers.

Young people are shy about sex and do not want to open up that they are sexually active. They are shy and are scared to be labelled sex workers (Community cadres FGD, Umguza district).

Most AGYW do not have enough information about the services that they can and should access from health facilities and those that do have information, lack the funds to go to the health facilities as these are far away from their community. For others, its cultural constrictions that make it difficult for them to access SRHR services- young people are discouraged from indulging in sexual intercourse at a young age and they are therefore reluctant to seek help as they fear judgement (Parents/carers FGD, Umguza district).

FGD with young people also confirmed the same issues.

The challenge is that some of us don't want to be seen asking for say condoms or family planning pills because our parents will eventually get to know about it so it's this fear that prevent us from accessing the service (Young people FGD, Seke district).

At the family level, socio-cultural belief and social expectation of how young people should handle themselves acted as a barrier limiting AGYW's access to services. Women and men who participated in the FGDs were vehemently against AGYW accessing SRHR services. They argued that unmarried young people must abstain from sexual activities until marriage. They saw the parent's role as teaching girls to avoid sex and for the girls to stay away from boys – abstinence. The reality is however different as many adolescent girls do not abstain and end up falling pregnant.

Young people that are not married should not indulge in sexual activities and are not to be seen taking SRHR services in public places (Parents/carers FGD, Mazowe district).

As parents we cannot watch our children loose track. We cannot give the youth freedom to be mischievous and to sleep around but our aim as parents is to promote abstinence, and if we allow them to access these services, we are indirectly promoting prostitution (Parents/carers FGD, Goromonzi district).

Most of the parents do not advise their children to access the SRHR/HIV/GBV services. They believe that you must access these services when you are married. Children must concentrate books. As a result, AYGW end up having no power to make decisions over their bodies (Parents/carers FGD, Umguza district).

At the community level, attitude of the healthcare workers, lack of youth friendly and comprehensive services, the distance and cost of accessing the services were major hindrances. The

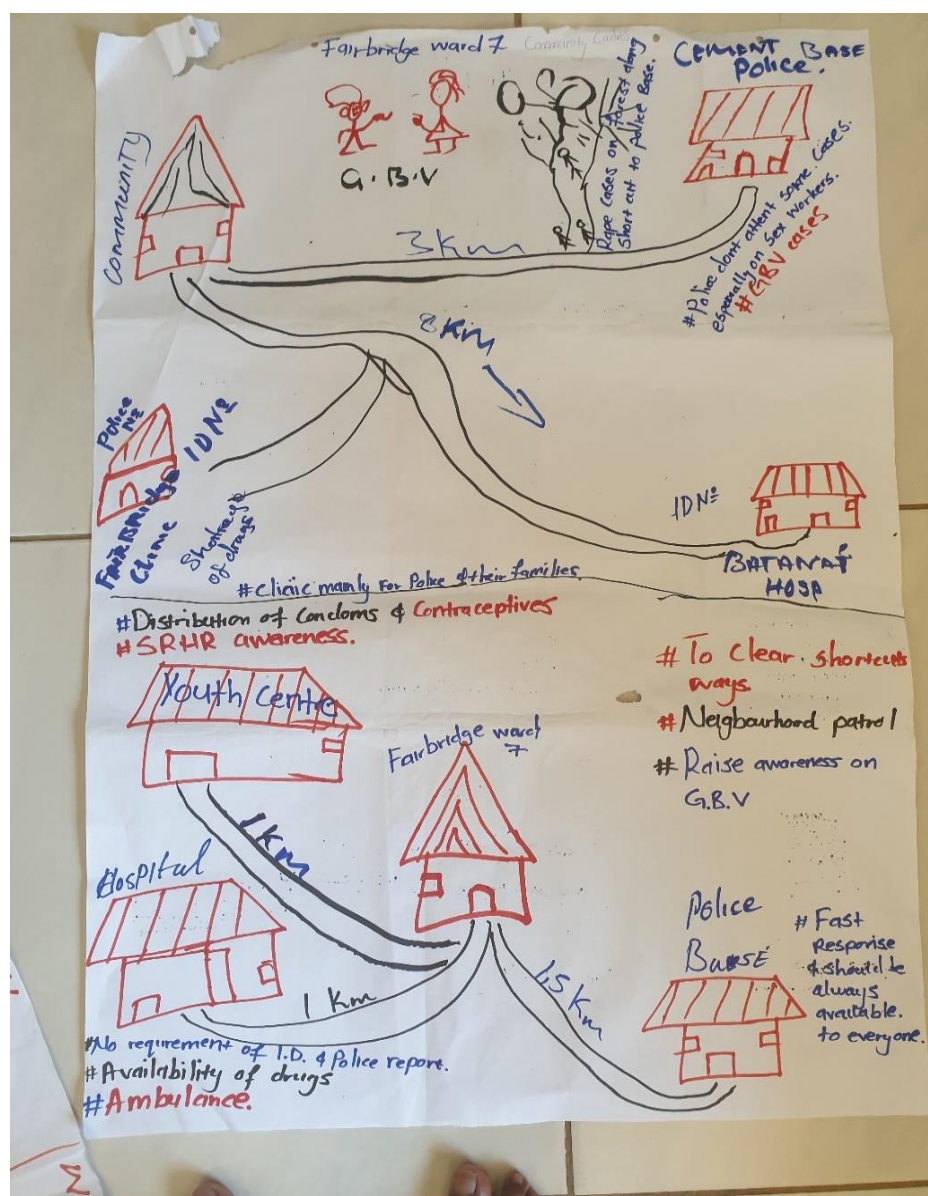
young people stated that even if they knew about the services, they would probably not be able to access them because of the attitudes from healthcare workers as well as distance

Services are easily available for those above 25 years but for those who are between the ages of 10-24years accessing the services is difficult because the healthcare workers would possibly not agree to help them because of their age and because of attitudes stemming from their culture. Some of the services providers don't allow them to access contraceptives without the parent consent some even ask for national identity cards making it difficult for young people to access the services (Community cadres, Mazowe district).

The quality of services being given to AGYW is fair but there still more that needs to be in terms of offering youth friendly and comprehensive information and services. As healthcare workers we need to learn to be non-judgmental and meet the needs of these young people. The nurses must always be conscious of their role but they have a tendency to become parents (Healthcare worker, Goromonzi district).

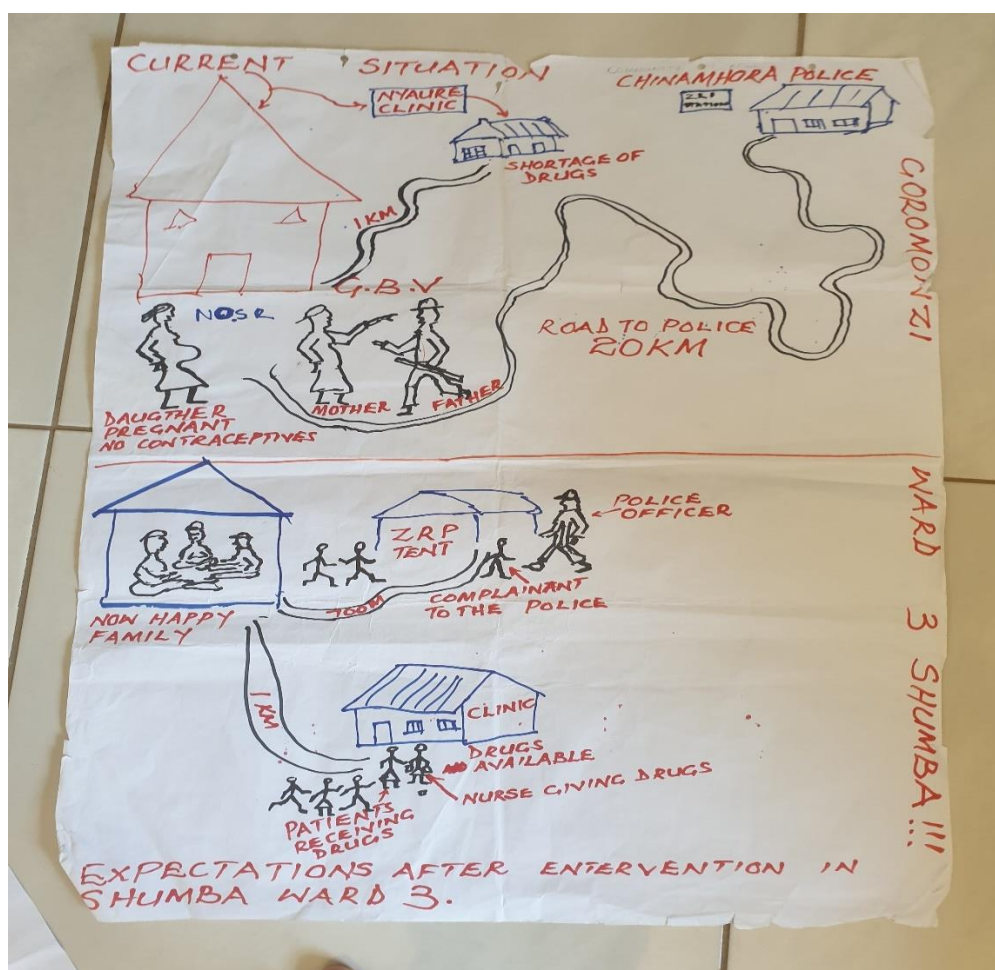
The drawing from the Seke district parents/carers illustrated the request for a national identification card and the persistent shortage of drugs as barriers (see drawing 1 below). In the same drawing, although there is a nearby clinic, it only serves the police and their families which makes distance another significant barrier as the nearest clinic is 8kms away.

Drawing 1: Parents/carers drawing, Seke district



A number of participants highlighted that some of the health facilities are not within their reach and young people might require transport money to access the services. Drawings from all the FGD groups highlighted similar challenges; distance and shortage of drugs especially contraceptive pills which limit access to services (Goromonzi drawing 2 below).

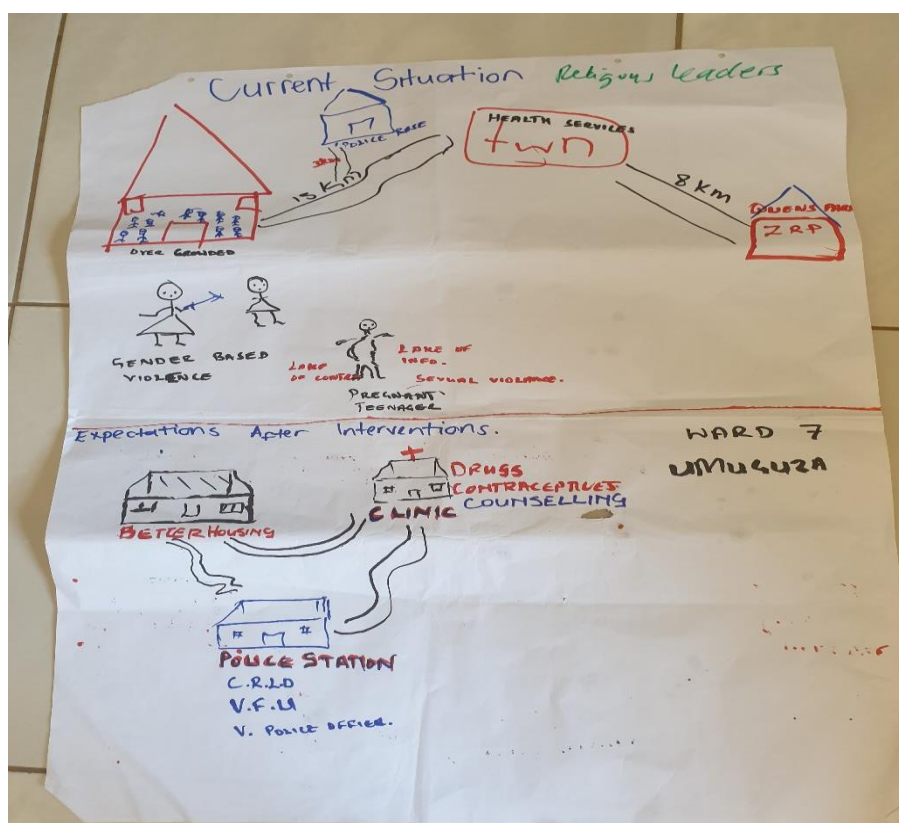
Drawing 2: Goromonzi drawing



Limited access to family planning services came out strongly in the FGDs. Some of the family planning methods such as the implants or intra uterine devices are not available for free. In most clinics the supply of contraceptive pills which are ordinarily the most accessible and affordable has been erratic in the past year. This therefore severely limit AGYW's access to family planning methods as most of AGYW can't afford the other family planning options due to lack of money.

Lack of SRHR information came out in three of the Umguza district drawings (Young people, parents/carers and community and religious leaders) but was not mentioned in the other three districts (Umguza drawing 3 below).

Drawing 3: Umguza drawing



Gender inequality that favour boys at the expense of girls was also discussed as limiting AGYW's access to service while at the same time enabling boys and young men to access the same services.

Boys and young men can easily access condoms from the male figures in their life and indulge in sex more comfortably since it is deemed to be part of their manhood. It is harder for girls to discuss sex because pregnancy is a scary topic. They are taught to abstain or not to get pregnant. Abstinence however is emphasized (Community cadres FGD, Seke district).

Furthermore, the community and religious leaders maintained that AGYW under the age of 18 should not be given access to SRHR services as they are still too young.

4.7 The use of Community based to cadres support SRHR/HIV care

There were mixed feelings in almost all the FGDs with regards to the use of community-based cadres in supporting the provision of SHRH/HIV services. Some participants felt that community-based cadres were within reach of most young people and were trusted and respected in the communities.

The use of Village Health workers is very effective since they can be accessed free of charge as well as the services. They offer e.g. condoms and family planning methods. In addition, a majority of parents know them and the trust them to offer services even if it comes to their children (Parents/carers FGD, Umguza).

However, a number of FG participants felt that the community-based cadres lacked information, skills and they worried about their ability to uphold confidentiality.

They are not ideal because there is no guarantee of privacy and confidentiality. Most of the cadres are well known by the young people's parents and there are cases in which they alerted parents on some of the issues the young people would consult on. Some are rumour mongers who spread gossip around and some of them are not well versed with SRHR and do not give in depth knowledge. For instance, they just distribute condoms or say 'tine ma sweets enyu kumba, muuye kuzotora' [we have your sweets at home and come and get them]. They do not even teach them how to use the condom (Young people FGD, Seke district).

5.0 Conclusion

The Baseline evaluation highlighted a number of factors that put young people at risk of contracting HIV. Early sexual debut, transactional sex, sex work, low condom use and peer pressure to indulge in sex were the most cited behavioural risk factors. Early sexual debut was more pronounced in Mazowe where the majority of young people were already sexually active. Sexual coercion by the illegal artisanal miners and older men and limited capacity of young people to negotiate for safer sex and to protect themselves from GBV were acknowledged as worsening AWYG vulnerability. Although young people had reasonable knowledge on HIV transmission and prevention, this does not appear to be translating into behaviour change as AGYW continue to engage in transactional sex and or sell sex at a very young age. To make an impact, Simba Utano will need to come up with tailor-made interventions such as innovative communication strategies that promote behaviour

The most harmful practice that the study identified was early/child marriage. What came out strongly was the link between poverty, religious belief and early marriages. Apart from the religious influence, in districts such as Mazowe, the problem was compounded by economic hardships, which saw many girls drop out after school. Interventions need to include economic empowerment components in order to cushion AGYW from hunger which often drives them into engaging in risky behaviours.

The evaluation highlighted the vulnerability of AGYW to GBV/violence which is higher among females than males with the exception of Umguza. This underlines the need to target AGYW as an important group for HIV and SRH programming. It is important to note that in all four districts, women and girls were blamed for the sexual violence. By blaming women, men exonerate themselves and, in the process, justify violence against women. This approach prevents women and

girls from accessing services and destroys their self-esteem – and in the end serves to promote the normalization of GBV in communities.

Knowledge of SRHR and where and how to access SRHR services was uneven across the selected districts, with Umguza reporting consistently low numbers compared to other districts. The different levels of knowledge will call for a nuanced approach to awareness raising programmes. The socio demographic characteristics of Umguza are not sufficiently different from the other three districts to explain why the lack of information consistently came up in both the KAPB and the FGDs. The difference might be due to limited exposure to SRHR/HIV education as a result of limited NGOs working in the district. NGOs have been criticized for concentrating on districts that are very close to the capital city at the expense of distant districts. All the other three districts are peri urban districts within 50kms radius from Harare while Umguza is approximately 400kms away. Furthermore, there are limited economic activities in Umguza, a rural district composed mainly of farm workers.

The findings have shown that the young people do not have the confidence to advocate for SRHR. This lack of confidence might emanate from either their suboptimal SRHR knowledge or their limited access to SRHR information. The Simba Utano intervention can capitalize on this gap and engage young people in discussing and improving their knowledge of SRHR/ HIV/GBV information.

The baseline evaluation has shown the effect of cultural beliefs and attitudes on young people's access to SRHR services. The belief that young people should abstain from sexual intercourse, coupled with the discomfort of both parents and children to discuss sex at home results in reluctance by young people to seek assistance in accessing SRHR services. This in turn affects their willingness to ask about other social concerns. Although cultural beliefs are generally perceived to protect young people, they actually limit opportunities to seek information and access services. There is need for interventions that target parents/carers in order to educate them on how best to engage and communicate with young people on SRHR issues without being judgmental and apprehensive. Awareness raising that addresses the above beliefs and cultural factors is needed.

Similarly, in all four districts, parents/carers and community and religious leaders were against the idea of young people accessing SRHR services. They believed in abstinence. Barring young people from accessing services does not necessarily mean that they will not indulge in sexual intercourse, evidenced by the number of teenage pregnancies that are prevalent in the four districts. Unfortunately, this contradiction does little to encourage community and religious leaders to be more open minded and promote the creation of youth friendly SRHR services.

Across all districts, the barriers to accessing SRHR services were similar. They included a lack of information, fear of stigma, the distance to health facilities, the costs of accessing services, transportation costs, healthcare workers attitudes, lack of youth friendly and comprehensive services and socio- cultural barriers. Most AGYW do not have enough information about the services offered by health facilities; those that do have difficulty visiting the clinics because of distance or financial constraints. Interventions to address costs and distances will need to be addressed by bringing services closer to the people through the establishment and strengthening of village level structures.

6.0 Recommendations

Based on the study findings, we recommend the following:

- Provide targeted interventions for sexually active young people and those reporting low levels of knowledge in order to improve their knowledge about STI and HIV transmission and prevention, including new biomedical approaches.
- Provide targeted interventions for parents, traditional and religious leaders in order to promote behavioural and attitudinal change – to be more accepting, less judgmental and tolerant of young people’s SRHR issues. Interventions should focus on behaviour change to influence individual and community attitudes, practices and beliefs relating to the harmful practices.
- Provide ongoing and in-service training for nurses on how to provide youth friendly services.
- Integrate GBV with SRH programmes to ensure that adolescents can access contraceptives when they need them.
- Equip AGYW with skills and information to address their fear of stigma and discrimination associated with going to a health facility.
- Equip community-based cadres (i.e. Village Health Workers) with SRHR information and training on the need for upholding confidentiality.

Key district highlights	
Mazowe <ul style="list-style-type: none"> • Highest number of sexually active AGYW (sex work and transactional sex) • Highest number of AGYW with current sexual partners • Upsurge of illegal artisanal miners • Sexual coercion on the increase 	Goromonzi <ul style="list-style-type: none"> • AGWY had more access to SRHR services than males • Long distances to nearest health facility and police station. • Upsurge of illegal artisanal miners
Seke <ul style="list-style-type: none"> • Requesting for national identification card and parental consent to access SRHR services • Knowledge of community support networks/safe places is age dependant and the older AGYW were less likely to know about these. 	Umguza <ul style="list-style-type: none"> • Low levels of HIV transmission and prevention knowledge • Lack of SRHR information • Males more vulnerable to GBV/violence
Cutting across all four districts <ul style="list-style-type: none"> • Prevalence of GBV/ violence • AGYW being blamed for violence that happens to them • Long distance to nearest health facility • Shortage of contraceptives • Limited SRHR talk at home • Limited access to SRHR services 	

7.0 References

1. ZIMSTAT, Z.N.S.A., *Zimbabwe Demographic and Health Survey 2010-11*, Z.I. International, Editor. 2012, Zimbabwe National Statistics Agency & ICF International: Calverton, Maryland USA.
2. ZIMSTAT, Z.N.S.A., *Census 2012 Preliminary Report*. 2012, ZimStat: Harare
3. UNAIDS, *Global HIV & AIDS statistics – 2018 fact sheet 2018*
UNAIDS, Editor. 2018.
4. ZIMPHIA, *Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA) 2015-16*, PHIA, Editor. 2017, Ministry of Health and Child Care (MOHCC), Zimbabwe. : Harare, Zimbabwe
5. Mavhu, W., et al., *Sexual behavior experiences and characteristics of male-female partnerships among HIV positive adolescent girls and young women: Qualitative findings from Zimbabwe*. PLOS ONE, 2018. **13**(3): p. e0194732.
6. UNAIDS, *Global plan Country Fact sheet*. 2016, UNAIDS Geneva, Switzerland
7. Boamah-Kaali, E.A., et al., *Opinions of Health Professionals on Tailoring Reproductive Health Services to the Needs of Adolescents*. International Journal of Reproductive Medicine, 2018. **2018**: p. 7.
8. Marie Stopes International, *Delivering sexual and reproductive health services to young people: Key lessons from Marie Stopes International's Programmes h*.

APPENDICES

Appendix A: KABP questionnaire



Baseline_KABP_questionnaire-Simba_Utano

Appendix B: Client Satisfaction questionnaire



Baseline_CS_questionnaire-Simba_Utano_P

Appendix C: Healthcare workers questionnaire



Baseline_HCWs_questionnaire-Simba_Utano

Appendix D: Young people FGD topic guide



FGD_interview guide-Young people.docx

Appendix E: Parents/carers FGD topic guide



FGD_interview guide-Parents-carers.docx

Appendix F: Community cadres FGD topic guide



FGD_interview guide-HCWs and Community

Appendix G: Community and Religious leaders FGD topic guide



FGD_interview guide-Community and Religious