ZIMBABWEANS AND AMERICANS
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THEORY U - REPORT:

Promoting social dialogue to inform Sexual Reproductive and Health Rights (SRHR) program strategies for addressing SRHR issues affecting pre-adolescent and adolescent boys and girls in Guruve district

April 2015

Report compiled by the:

Women's Action Group (WAG) in the –
Zimbabwe Gender Challenge Initiative (GCI)

This project has been supported by the President's Emergency Plan for AIDS Relief (PEPFAR) through Cooperative between the Centers for Disease Control and Prevention (CDC) and the Research Triangle Institute (RTI) under the terms of Cooperative Agreement Number: 1U2GPS003118-01

GENDER CHALLENGE INITIATIVE

WOMEN'S ACTION GROUP
ZIMBABWE

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The opinions expressed herein are those of the evaluator and do not necessarily reflect the views of the funding agency.

ACRONMYS

AIDS	Acquired Immune Deficiency Syndrome
ASRHR-	Adolescence Sexual and Reproductive Health Rights
DNA-	Deoxyribonucleic Acid
HIV-	Human Immune Virus
ICDP-	International Conference on Population and Development
MOHCW-	Ministry of Health and Child Welfare
MRCZ-	Medical Research Council of Zimbabwe
NAC-	National Aids Council
PCC-	Pregnancy Crisis Centre
SADC-	Southern African Development Community
SRH-	Sexual and Reproductive Health
SRHR-	Sexual and Reproductive Health Rights
STD-	Sexually Transmitted Diseases
STI-	Sexually Transmitted Infections
UNAIDS-	United Nations Programme on HIV/AIDS
UNFPA-	United Nations Population Fund
WAG-	Women's Action Group
ZDHS-	Zimbabwe Demographic Health Survey
ZNFPC-	Zimbabwe National Family Planning Council

CONTENTS

1 EXECUTIVE SUMMARY

The study sought to promote social dialogue to inform Sexual and Reproductive and Health Rights (SRHR) program strategies for addressing SRHR issues affecting pre-adolescent and adolescent boys and girls in Guruve district. The study was done in four wards of Guruve namely wards 4, 6, 21 and 22. The study sought to answer the following questions.

- What are the current responses within the school and community to children under the age of 18 who engage in volitional sexual activity and how could these be improved?
- What improvements can be made to existing WAG SRHR program interventions to address SRHR issues affecting preadolescent and adolescent boys and girls in the WAG operational areas in Guruve district?

The study was qualitative in nature and Theory U was used in the dialogue process. Theory U is a change management method to change unproductive patterns of behavior. It allows participants to learn from the emerging future possibilities. Different participatory methodologies were used during the research process. These include the checking in exercises, dialogue walks, sculpting and focus group discussions. A "core team" of 20 participants was set up at the beginning of the research. Participants were systematically selected according to their involvement in working with youths and adolescents, thus participants were drawn from different Government Ministries including the Ministry of Education, Ministry of Social Services and the Ministry of Health and Child Care as well as community members.

Findings of this study concluded that early sexual debut was common among the youths 15-19 years in Guruve, which makes them vulnerable to HIV/AIDS, STIs and unwanted pregnancies. Culture, poverty, substance abuse and technology were pointed out as some of the factors that were contributing to early sexual debut. The study also revealed that in as much as parents blame their children for early sexual debut, ***the parents do not have the pre requisite information to talk to their children about sexual and reproductive issues***. The study also found out that the youth friendly center at one of the clinics is not reaching all the young people with information mainly because the adolescent are not confident to use this service. It also came out that some cases of sexual abuse go unreported or if reported they are not concluded in the courts. The study also found out that schools are not prioritizing guidance and counseling lessons because these are not examinable. Some of the teachers also do not have the capacity to deliver accurate messages on adolescent sexual and reproductive health and rights.

The main outcome from the social dialogue process in Guruve emphasized the need to work with different target groups; parents, health workers, teachers, community leaders and law enforcement agents to build the capacity of all relevant stakeholders on SRH in addressing issues of early sexual debut, sexual violence and public information dissemination tools and methods.

2 INTRODUCTION

This report outlines the processes and results that came out through social dialogue processes that were implemented in Guruve District of Zimbabwe. Dialogue was used to deepen understanding on early sexual debut among adolescents through listening, sharing and questioning. WAG has been implementing a Sexual and Reproductive Health and Rights (SRHR) program across the country with the aim to create an informed and empowered constituent of women. Inspired by the International Conference on Population and Development Program of Action (1994), WAG has identified SRHR as being a critical programming field for not just women but adolescents. As a result the organization embarked on a program to ensure that girls and young women are aware from an early age of their SRHR and can minimize the vulnerabilities they face in that respect. It is within the implementation of this project that WAG recognized the importance of a coherent social and action oriented community dialogue process on understanding of sexual issues affecting pre-adolescent and adolescent boys and girls in Guruve district.

According to the Zimbabwe Demographic Health Survey (ZDHS) (2011), 24% of young women age 15 – 19 have begun child bearing. Young motherhood is reported to be more in rural areas than urban areas. The ZDHS highlights that among the women who have had sex over 1 in 5 women had their first sexual intercourse forced against their will. The ZDHS also notes that six percent of women and 2% of men have had sex by age 15.These statistics support the fact that young people particularly in the rural areas are having early sexual debut.

Although the issue of early sexual debut has been topical among local leaders and service providers, there has been no systematic effort to bring together all the concerned parties to discuss priority issues for informed community action and response. Building on its community awareness and education program in Guruve district, WAG was strategically positioned to facilitate a participatory dialogue process involving multiple stakeholders and different levels to create a deeper shared understanding on the priority SRHR issues affecting pre-adolescent and adolescents and to develop actionable prototype improvements to the current education initiatives by WAG.

Currently the Ministry of Education, Sports and Culture states that it provides guidance and counseling to all in school youth from Grade Five upwards. Despite this provision, in the work that WAG has been carrying out it has been noted that schools are recording an increase in sexual activity within the adolescent boys and girls age categories usually from age ten. This is evidenced by the resultant pregnancies among pupils. One school in Guruve reported that 16 girls had fallen pregnant in a year. This provides a challenge to both teachers and service providers who are not equipped with skills for dealing with sex within this sensitive group without adequate support from parents and other service providers. Through interactions that WAG has had with key stakeholders, it was revealed that having a dialogue to investigate SRHR issues affecting pre-adolescents and adolescents would help in identifying improvements to the current WAG SRHR program in Guruve district.

WAG used the social dialogue approach through application of the U-Theory to get a full understanding into the issue of early sexual debut for adolescents. The U-Theory was appropriate as it enables a collective analysis of the problem and co-evolution of solutions needed for action. The key steps in the U-process were:

Step 1: Co initiation
Step 2: Co sensing
Step 3: Presensing
Step 4: Co creation
Step 5: Co evolving

All the steps were implemented in 4 wards of Guruve District. This report presents the outcomes from each step, the synthesis of outcomes, the emerging solutions for addressing the problem, lessons learnt and recommendations for improved programming and policy advocacy work by WAG.

The Early Sexual Debut Problem in Guruve District

Young people are engaging in early sexual activities. The issue of early sexual debut has raised concern among different stakeholders in Guruve district. This problem was identified during WAG's community level engagement with young people during the implementation of the Young for Real programme in 2013. Early sexual debut has been credited by many researchers as increasing the risks of HIV infection in youth (Karim and Ndlovu 2000). However a challenge exists in providing children with the necessary information they need at the critical time.

2.1 Study Questions

The dialogue process sought to answer the following questions:

1. What are the current responses within the school and community to children under the age of 18 who engage in volitional sexual activity and how could these be improved?
2. 2. What improvements can be made to existing WAG SRHR program interventions to address SRHR issues affecting preadolescent and adolescent boys and girls in the WAG operational areas in Guruve district?

2.2 Significance of the study

Young people of today are tomorrow's future. The fertility behavior of adolescents is potential determining factor for future population growth in a country. The current trends show that young people are engaging in early sexual activity predisposing them to HIV infections, sexually transmitted infections and unwanted pregnancies. It is of paramount importance that an environment be created and adequate support provided to enable adolescents to develop their full potential and to enjoy a healthy and responsible adulthood.

2.3 Study area

This study is based on selected wards in Guruve district which are wards 4, 6, 21 and 22. The area was targeted chiefly because WAG conducted community initiatives with the adolescents in the four wards. The study area was also selected because WAG had implemented a programme for young people in the district. The primary target group was adolescent aged between 10-19 years for both male and females

Figure 2:1: **Zimbabwe map showing the geographical location of Guruve District**

2.4 Limitations of the study

The "U Theory" was a new methodology for the organization as well as the stakeholders involved in the collection of data. The study required a lot of travel to the study area in order to monitor the process

2.5 Definitions

- **Adolescent –** Is defined as a period between 10 and 19 years of age. It is a continuum of physical cognitive, behavioural and psycho social change that is characterised by increasing levels of individual autonomy, a growing sense of identity and self-esteem and progressive independence from adults (UNFPA, 2009)
- **AIDS-** Acquired Immune Deficiency Syndrome is the name of the fatal clinical condition that results from infection with the human immunodeficiency virus (HIV) which progressively damages the body's ability to protect itself from disease organisms (FAO, 1997)
- **Child marriage-** Is defined as marriage before the age of 18years and it applies to both boys and girls but the practice is far more common among young girls (WHO, 2014)
- **Early sexual debut-** Is defined as having had first sexual intercourse at or before age 14 and experience of sexual coercion or violence contribute to unintended adolescent pregnancy (Baungarther J.N and Cynthia W.C, 2009)
- **HIV-** Human immunodeficiency virus is contracted through sexual contracted through sexual contact via sexual contact via anal, oral or vaginal intercourse; blood exchange shared

intravenous syringes, mother to child during pregnancy, labour, delivery, breastfeeding (Krucik G,2013).

- **Sexual abuse –** Sexual abuse includes fondling of one's genitals, intercourse , incest , rape, sodomy , exhibition and commercial exploitation through prostitution or the production of pornographic materials .(Medical Dictionary, 2013)
- **STI- Sexually** transmitted Infection is an infection that can be transferred from one person to another through sexual contact (Medical Dictionary, 2012)
- **SRHR- Sexual** rights protect all people's rights to fulfill and express their sexuality and enjoy sexual health with due regards for the rights of others and within a framework of protection against discrimination (WHO, 2006)

3 LITERATURE REVIEW

3.1 Policy Framework

Adolescents' reproductive rights are firmly rooted in the most basic human rights principles, as enunciated in major international and regional human rights treaties as well as international conference documents. Globally, all international agreements affirm that adolescents have a right to age appropriate sexual and reproductive health information, education and services that enable them to deal positively and responsibly with their sexuality (MOHCW 2009). The instruments include the 1994 International Conference on Population and Development (ICPD), which embraced the new broader concept of reproductive health, and rights that include ASRH. The SADC has also shown commitment to the need for providing a framework for sexual and reproductive health by developing a Sexual and Reproductive Health Strategy for the region (2006 – 2015). The strategy identifies adolescent health through article 17, which highlights one of the strategies as "to encourage adolescents to delay engaging in early sexual activities".

Zimbabwe has developed a number of policies that guide provision of SRHR services for adolescents. There is the National Reproductive Health Policy (2006). The Policy recognizes that the reproductive health of adolescents has been largely neglected until recently although there are significant physical and psychological problems, which can arise in this age group. Another policy document is the National Adolescent Sexual and Reproductive Health Strategy (2010 – 2015). The policy highlights the patriarchal nature of the Zimbabwe society that is characterized by male dominance, which exposes females to reproductive health problems more than their male counterparts do.

3.2 HIV Gender and Sexuality

Human sexuality and gender relations are recognized as critical under Chapter VII section D of the International Conference on Population and Development Plan of Action (Cairo 1994).The Center for Reproductive Law and Policy (2002) observes that in Zimbabwe, the onset of sexual activity generally begins before marriage, typically by age 17 and as early as 12. It further notes that it is the female adolescents who start sexual activity earlier than males. According to the ZDHS (2010/2011) by age 20, 6 in 10 Zimbabwe women have had sexual intercourse while 4 in ten men have initiated intercourse by the same age ZDHS (2010/11). Median age at first marriage among women is 19.7 while that for men is 24.8. (ZDHS 2010-2011) The ZDHS further notes that the average people and

woman in Zimbabwe initiate sexual intercourse before marriage. The median age at first sexual intercourse is 18.9 years for women and 20.6 years for men. Although all men eventually marry, men tend to marry later than women with only 1 in 10 men age 20-49 marries by age 20 compared with 5 in 10 women in the same age group. These statistics show that girls engage in sexual activity earlier than boys do which exposes girls to HIV at an early age.

The National Reproductive Health policy notes that sexual activity among adolescents can lead to STDs, with HIV and AIDS. This is might be followed up by infertility arising from the sexually transmitted diseases. HIV infection among young women is clearly associated with age mixing i.e. sexual relationships with older partners. The Young Adult Survey (Center for Disease Control and Prevention 2001-2002) states that young women (15-24years) are six times more likely to be infected by HIV than young men. UNAIDS (1998) notes that research has shown that being female and an orphan is strongly associated with HIV prevalence in Zimbabwe. Risk perception of HIV infection is generally low among adolescents. National AIDS Council (NAC 2006) notes that delay of sexual debut has been the most prominent focus in both secular and religious HIV prevention efforts among young people. NAC further recommends a more differentiated targeting of sexually active and non-sexually active youth.

The Global HIV/AIDS epidemic report (June 2000) reveals that the group most vulnerable to new HIV infection is that of adolescents. The report states that over half of all new infections globally occur in people between the ages of 15 and 24. Another factor contributing to challenges faced by adolescents is "Lack of empowerment against prejudicial cultural and traditional practices in sexual and reproductive health matters and relationships that restrict their decision making on sexual matters" (NAC 2006:24).

3.3 Availability of ASRH Services

The Ministry of Health and Child Care has the primary responsibility of providing and coordinating the provision of Adolescent Sexual and Reproductive services. An assessment commissioned by the Ministry in 2008 revealed that there was no standard package for the provision of ASRH services at all the facilities selected for the assessment. The findings are in line with the observation that is made through the SADC SRH strategy, that the present youth friendly services are inadequate. Regional strategy. The assessment also revealed that there was no standard definition of "youth friendly corners" as each facility had a different definition that depended on physical location, furnishing and visibilities of these corners.

The results of the assessment also showed that the commonly reported ASRH services at primary, secondary and tertiary levels of care were family planning services; maternal health services; screening of STIs and general counseling. It was noted that there was limited availability of comprehensive social and behavior change communication material. The ASRH strategy (2010-2015) identifies an individualistic approach that emphasizes an individualistic approach that emphasizes on abstinence while promoting safer sexual practices. Karim and Ndlovu (2000) speak on the limitations on knowledge of factors surrounding early sexual debut. The authors support that research has already shown that premarital sexual initiation is a risk factor for HIV infection in the country. However, they note, as with other authors that knowledge on what factors affect this initiation of premarital sex are limited. As a result while work is being done to try to address adolescent SRHR,

understanding of key issues and interventions among stakeholders is still a major gap that needs to be closed.

According to WHO (2009) youth-friendly, services alone do not meet adolescents' sexual and reproductive health needs and an important link with their wider developmental needs has been established. Overall, it seems that a comprehensive approach is most promising. Ultimately, young people need relevant information, life skills and access to care when needed.

3.4 Parent /Guardian and Community Participation

There have been arguments that support the involvement of communities development is good practice because communities know their needs and understand issues that influence their health. The Inter- Agency Working Group (IAWG) (2007) argue that in order to ensure sustained behaviors among adolescents, the community must view these behaviors as beneficial, and community members must support change. The IAWG further notes that adults influence young people's access to SRH information and services as well as their ability to make healthful decisions.

The National Reproductive Health Policy is the only policy, which recognizes the importance of male adolescence and parents in SRH decision-making (N.Khan 2007). Khan also notes that majority of policies have SRH needs but the proposed services are more curative than preventive and limited to sexually active adolescence. One of the strategies in the policy is that adolescent reproductive health programmes should be implemented through a wide variety of sectors in consultation with parents. It states that parents must continue to be given the responsibility for their children's behavior patterns. The SADC Reproductive Health Strategy recognizes the role of parents when it highlights some of the transitional problems faced by adolescents, which are; lack of parental guidance, eroded community norms and lack of access to health services.

The ASRHR strategy identifies parent and community participation in ASRH interventions. The strategy highlights the need for a multisectoral and participatory approach that also recognizes the participation of adolescents at all levels of SRHR programming.

3.5 Community knowledge and awareness on SRHR issues

The SADC Reproductive Health Strategy highlights that ASRHR merits special consideration because this a population that faces vulnerabilities resulting from causes such as lack of parental guidance, eroded norms and lack of access to health services. This observation shows that there are low levels of knowledge among parents to support ASRH needs. The ASRHR strategy however recognizes the role traditionally played by aunts and uncles to educate adolescents as they grew into puberty. The practice has been eroded by modern practices such as urbanization and access to radio and print media. The strategy notes the challenge faced by parents in responding to the information needs of adolescents.

The work that WAG has done in Guruve District has shown that there is limited knowledge on ASRHR at community level. WHO (2009) highlight the need for community involvement when they stated that "ASRH programs that focus solely on individual behavior change among adolescents will not likely effect changes in socio-cultural norms and structural barriers that directly influence individual

health behaviors". This is particularly true for young people, whose access to SRH information and services, and even their ability to make healthful decisions, is influenced (and, in some respects, controlled) by adults in the community.

3.6 Sexual debut

According to the WHO (2000) sexuality is a central aspect of being human throughout life, it encompasses sex, gender identities and roles, sexual orientation, intimacy and reproduction. Sexuality is constructed as a domain exclusive to adults with preconditions of social and physical maturity. Notions of child sexuality are therefore often viewed as taboo, dangerous and cause for moral panic. Early sexual debut has been defined by the WHO as that happening before 15 years. Researchers have used various definitions in studies about sexual debut but regardless of the precise cut off age, the timing of sexual debut has major health consequences. A study among sexually active women in Harare found that early sexual debut was significantly associated with being HIV positive, having more than 1 sexual partner and not completing high school (Pettifor et al 2004)

A Case study carried out in Zimbabwe by Kasule J et al (1995) reflects that 17% of the adolescents' respondents, who were still in the school system, reported having had sexual intercourse. The findings demonstrate that young people continue to take part in risky sexual behavior despite knowledge on the incidence of HIV and other sexually transmitted infections. ZDHS (2010-2011) also identified early sexual debut as a problem that predisposes young people to SRHR complications such as maternal deaths and HIV infection.

3.7 Using the U-Theory as a social dialogue tool

Scharmer O (2009) identifies the U-theory as a process that taps on people's collective capacity. He observes that "We live in a time of institutional failure, collectively creating results that nobody wants". Scharmer argues that using the U theory enhances collective leadership capacity to meet challenges in a more conscious, intentional and strategic way. The U Theory has come to be understood in three primary ways which are; framework, method of leading profound change and as a way of being. The theory acknowledges that learning and knowledge rest in the diversity of opinions and that nurturing and connection is needed to facilitate continual learning.

3.8 Conclusion

The Chapter focused on literature from works of various authors in the form of publications, policies and reports. From the analysis of the available literature, the researcher concludes that the issue of early sexual debut among adolescents is an issue that needed attention. There is very little information on community knowledge levels on ASRHR even though there though there is evidence on the importance of community involvement in such programmes

4 METHODOLOGY

4.1 Participants

Participants in this study were drawn from different ministries including Ministry of Education and Culture, Ministry of Social Services and the Ministry of Health and Child Care as well as community members who also included a village head. Young people including two who work with their peers at Ruyamuro youth friendly corner were also part of the group. Most of the participants had children and some were guardians of pre- adolescent and adolescent children. Participants were selected because of their relevance on adolescent sexual and reproductive health. These stakeholders formed the "Core Group." Participants were selected because of their relevance on adolescent sexual and reproductive health. Capacity and availability throughout the study was also considered. The Theory U methodology requires that there be a "core group" that is involved in all the stages of the process. The participants were systematically selected according to their involvement in working with youths and adolescents. It was easy for the stakeholders to have continuous engagement with adolescents' SRHR issues because they engage with them frequently. The core group is the group that is committed to hold the intention, process, people and results all the way through. The "Core Group" was involved in collecting, analysing and interpretation of data from areas where young people frequent. Such places included beerhalls, clinics, schools, hotels and churches.

During the co-sensing exercise the group reached a total of 180 participants as they observed and held discussions with different groups of people. Participants were drawn from wards 4, 6, 21 and 22. These are the wards where WAG was implementing a project for young people. Stakeholder participants in the social dialogue process participated in data collection, analysis, and interpretation. WAG staff took the responsibility for analysing the information generated by the social dialogue process and for generating reports from the process. The WAG staff members were a part of this team and were supported by an RTI action research specialist.

4.2 Design

The study methodology used is the 'Theory U'. Theory U is a change management method to change unproductive patterns of behavior. It was developed by Otto Scharmer of the Presencing Institute. Theory U proposes that the quality of the results that we create in any kind of social system is a function of the quality of awareness, attention, or consciousness that the participants in the system operate from. Different participatory methodologies were used during the research process. These included checking in exercises, dialogue walks, sculpting and focus group discussions. More information on the methods is given below;

i. **Checkin in-** This process was meant to create a rapport with participants. It involved asking participants how they felt before engaging in the dialogue processs that a conducive environment is created.

ii. **Dialogue Walks**- the dialogue walk enabled the participants to engage with the situation deeply and practice effective listening skills. Participants walked in pairs one listening effectively while the other one spoke without disruption. The dialogues enabled flexibility

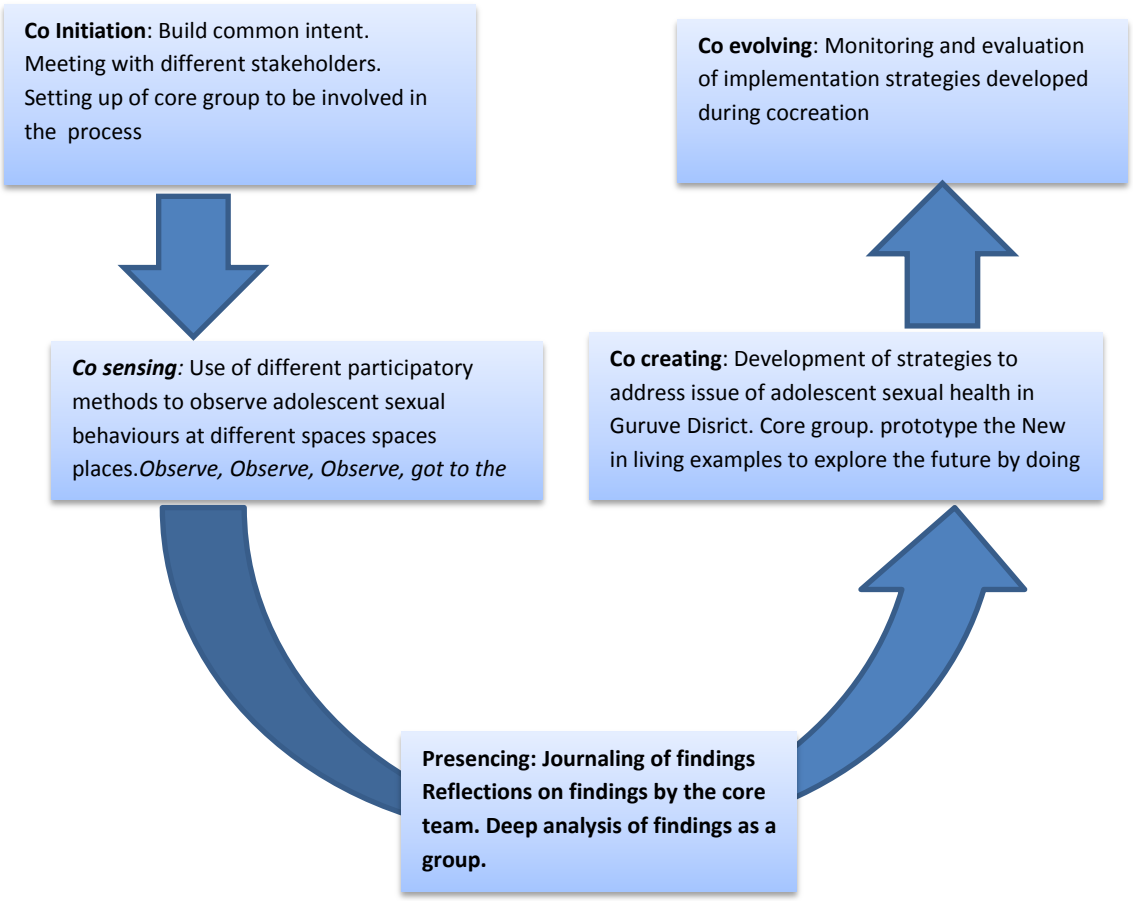
and deep sharing of real experiences.**Case Clinics** – One person would be a "case giver". This person would share an experience which the other group members (coaches). The coaches would listen quietly without judgment and ask questions only for clarification. The Case clinic enabled the members of the core group to practice active listening as well as providing possible solutions to help the case giver make a choice

iii. **World Café-** is a simple, effective and flexible process for leading collaborative knowledge sharing processes. Participants engaged in a conversational process in which groups of people discussed a topic in tables, with individuals switching tables periodically and getting introduced to the previous discussion at their new table by a table host.

iv. **Focus Group Discussion**- is a way to gather together people from similar background or experiences to discuss a specific topic.

Theory U study design has five steps described in the illustration below.

4.3 THE "U" THEORY



The steps taken during the process are further elaborated below:

a) **Co Initiation**

This stage was aimed at framing the social dialogue process which is a process that includes all types of negotiation, consultation or simply exchange of information between, or among, representatives on issues of common interest relating social policy. During the Co-initiation stage, WAG formed the Core group. The outcome at this stage was a shared commitment by members of the core group to further investigate and understand the early sexual debut issues and problems among adolescents in Guruve District.

b) Co-sensing

This process involved deeper and intensive observation that enabled collective sensing of the situation through informed observations, discussions, and interviews. This process was conducted by the "Core Group" in an independent manner to enable issues to be captured and reviewed in a more systematic basis. This process created a collective sensing and appreciation of the existing realities on adolescent sexual health that demand collective learning and reflection from diverse perspectives. The group was responsible for organizing and coding the data in a manner that allowed easy digestion and analysis by all relevant stakeholders. The emerging issues were also appropriately documented and logged. During this stage the core group met for two days to deliberate on issues of adolescents and sexual and reproductive health.

The core group then went out in groups of 4 to observe as well as conduct interviews and focus group discussions with young people in beer halls, shopping centers and other public spaces. Observations and interviews were also done at Ruyamuro youth friendly corner and Guruve hospital. The two health centers were selected in to enable members to observe what was happening at these centers. This initial exercise was done as strategy to build the capacity of the core group to use different participatory methods during this stage. Participants shared their findings in the main group. All the findings were appropriately documented and logged.

After the two day co-sensing workshop participants were given tasks for data collection which was to be done over a period of two weeks. During this period members of the core group would observe, conduct interviews and focus group discussions with young people as well as older people. This exercise was done at public places such as churches, shops, schools and shopping centers. Each member would then write their findings in a note book at a time convenient to them. These results were then shared during the next stage of the research.

c) **Journaling/Reflection***.*

This stage of the process is designed for complex and extensive reflection of information generated in the co-sensing stage. It is a stage where data begins to settle within the minds of all the participants as they quietly listen to what the information harvested is telling them. This was done before coming together again to share ideas about responsive actions that could be taken to address the emerging issues on preadolescent and adolescent boys and girls. Through a facilitated session the core group brought together information from the co -sensing exercise they had done during the two weeks. Their findings were recorded as they came through. A lot of qualitative data was collected during this stage. The data was then used in the next stage which is co-creation.

d) Co- Creation

Collective Action Defined. This stage involved the core group in the identification of one prototype SRHR improvement initiative. The prototype would have indicators and ways to measure them that will help them to determine the effectiveness of a collective approach to addressing adolescent SRHR issues. The core group came together to develop prototypes that would assist in addressing issues of early sexual debut and the other adolescent and reproductive health issues. Participants discussed the different prototypes at length until they agreed on one.

e) **Co evolving**

During this stage the prototype adolescent SRHR improvement initiatives were evaluated as an iterative dynamic learning process with specific measures as well as qualitative reflection. This leads to refinements of the actions as they emerge. This stage will be implemented after the prototypes that were developed are tested.

5 DATA ANALYSIS AND OUTCOMES

The data analysis process was guided by two key evaluation questions:

1. What are the current responses within the school and community to children under the age of 18 who engage in volitional sexual activity and how could these be improved?
2. What improvements can be made to existing WAG SRHR program interventions to address SRHR issues affecting preadolescent and adolescent boys and girls in the WAG operational areas in Guruve district?

These key questions required an in depth understanding of the key issues for dialogue, reflection and dialogue process with stakeholders. A collective approach to analyzing data, strategy formulation, and development of solutions was used. The data analysis process was done at every stage of the dialogue process guided by the steps in Theory U.

5.1 Outcomes of the Social Dialogue Process

The outcomes in response to the evaluation questions are presented in the table below

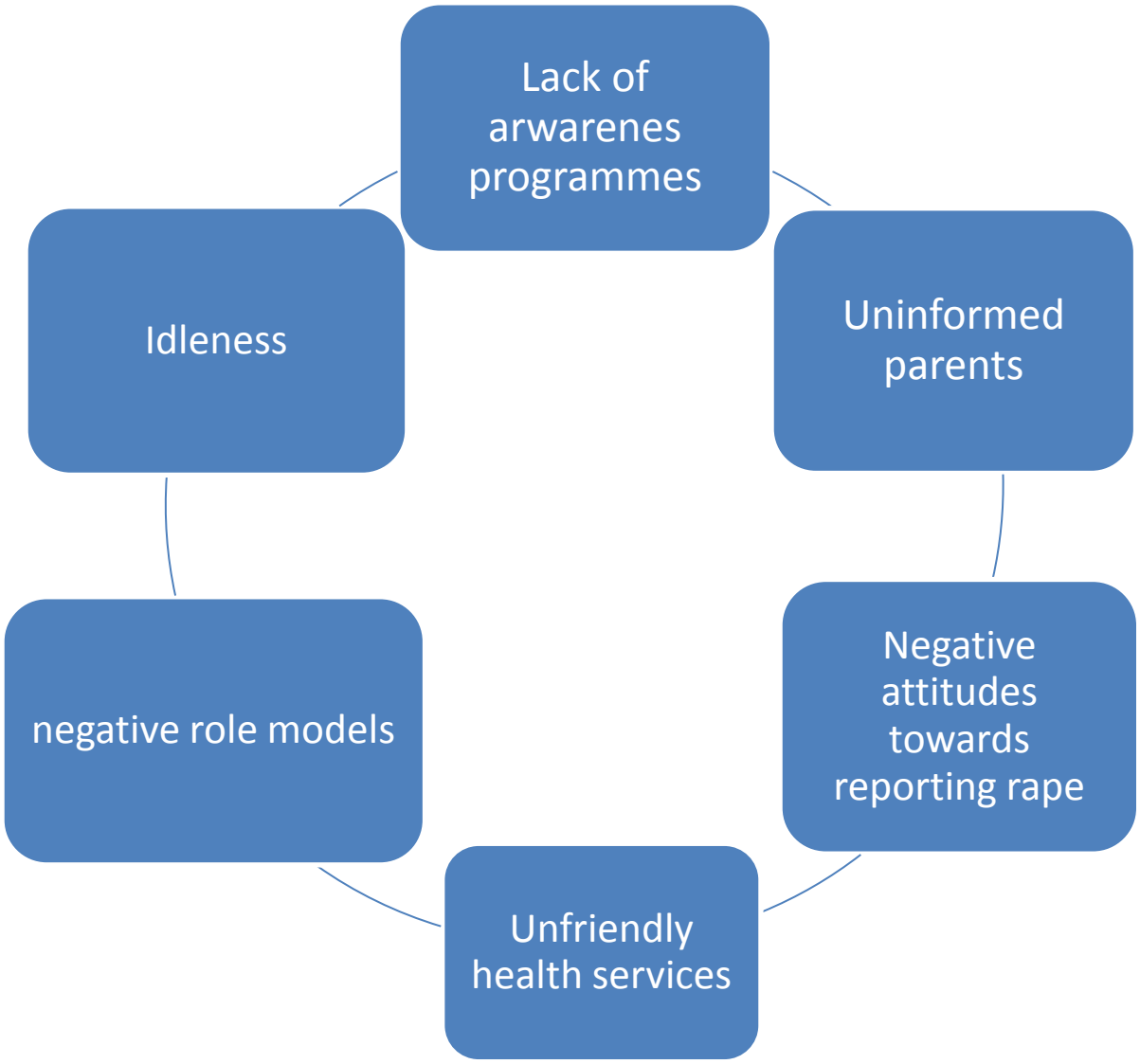
Figure 5:1: Outcomes in response

Identified issue	Outcomes/Results
Current Responses with the School and Community Initiatives	
Adolescent Sexual debut dialogue initiation	Sexuality issues are a taboo not talked about openly at community level. Parents are aware of the fact that young people are having sexual intercourse but they are not able to talk to their children about this. Adults reflected on their sexual debut, which they were not comfortable to share with others because for some they also had had early sexual debut. Parents have no information ASRHR and therefore find it difficult to talk to their children.

Attitudes of parents to adolescent sexuality	Parents do not have the capacity to deal with adolescent sexuality issues There is a belief that issues of sexuality can only be discussed once someone gets married not before. Reporting rape is not encouraged because of fear to deal with the outcome from the courts
SRHR programmes in schools	School programmes are not responding to the needs of pupils. Limited capacity of teachers to respond to the needs of adolescents SRHR not an examinable subject therefore not much effort was put in teaching SRHR

5.2 Interventions at community level

The diagram below summarizes the situation at community level concerning ASRHR



The diaologue process revealed that early sexual debut was common among the youths in Guruve. It was however noted that at family level, it is quite difficult for parents to discuss sexual issues with their children as the subject of SRHR is taboo. The process also showed that parents had little knowledge on adolescent SRHR, hence they struggle to discuss issues of sexuality with their children which they regarded as taboo. This was highlighted as one participant stated that "*nyaya dzebonde dzinonetsa kukurukura nevana*" meaning that it is difficult to talk about sexuality issues with young people. Participants reported that parents were doing little as far as talking about ASRHR to their children is concerned. Some of the participants expressed that it easier to talk to boys than girls. Parents were busy to talk to their children as was said by one participant; "*Sevabereki we have tight schedules*". Another participant also said *"Vamwe vabereki vari so harsh*" meaning that there are parents who are harsh resulting in strained communication between parents and their children.

The dialogues revealed that parents tend to give orders as to what children should do without an explanation on why. An example was when parents tell young girls not to play with boys once they start menstruating. Furthermore it was reflected that there is always a tendency of wanting to tell the youths what to do and how to do things, hence prescribing things for them. Participants also mentioned that aunts and uncles who are expected to discuss ASRH issues with young people are no longer doing so. Participants highlighted that some aunts would just say the following when talking about sexual issues *"musi waunoenda kumurume uchachekwa nechigero"*, implying that the girl would have to be cut to allow for penetration when she gets married if she is a virgin.

It was further noted that the youths from the child headed households were at higher risk of engaging in early sexual debut since they lack parental guidance. In addition, these children are most likely to drop out from school, thus they find themselves in the streets abusing drugs. Vulnerability for these children are mainly due to financial challenges, leading to prostitution as their source of income thus engaging in early sexual debut.

Besides the general lack of information, participants also spoke about the cultural beliefs that deter parents from talking to their children. One of them asked "Is it possible to talk to a grade seven pupil on issues of sexuality?" All this points to the fact that parents are not comfortable to talk to their children at a family level. The findings reflected that the community still has certain cultural practices which contributed to early sexual debut. Participants reflected on the Muslim sex initiation which makes the youths to rush into sexual activities as they would want to experiment on what they have been taught. Furthermore, participants pointed out that some churches were marrying off their children whilst they were young, hence promoting early sexual debut. The practice of early marriages put the youths at higher risk of serious health complications related pregnancies, HIV and STIs. From the interviews held with the youths, one reported that she was now engaging into prostitution as a means of survival since she ran away from home because her parents had married her off to an old man.

Respondents also pointed out that poverty was one of the reasons why the youths were engaging in early sexual debut or early marriages. Coming from a poor background, the youths were being lured by fancy things by older man. This was reflected as one participant echoed that "*vechidiki ava vanonyengedzwa netunhu tunodhura, ndozvavari kufira vana ava"* meaning that the young people engage in transactional sex which makes them vulnerable to HIV related deaths. These adolescents

get back to the community where there is no support. In order to run away from problems the girls end up getting married at a young age.

Overally the group noted that young children's behavior is being shaped by society where there are parents who are irresponsible and propose love from young women "*Vamwe vedu tisu tirikudanana nevana vaduku ava"* (Some of us are proposing love from these young girls)

"The young children are approaching the Ministry of Youth Indigenisation and Economic Empowerment to seek information on SRHR we don't have qualified counselors." This was also said by one of the group members.

This dialogue process also revealed that some youths are not engaging in early sexual activities willingly, but this is as a result of sexual abuse. Participants highlighted that most of the cases of sexual abuse were not being reported since the perpetrators are relatives who support them financially. However, the community is not doing enough to assist the youths who are being abused by their family members .Unwanted pregnancies was highlighted as one of the consequence of sexual abuse. It was also noted that sexual abuse put the youths at risk of contracting HIV and STIs. Participants also highlighted on the psychological impact of sexual abuse as it triggers psychological disorders such as trauma, stress, anxiety and schizophrenia. In order for them to cope with these psychological disorders, the youths are using unhealthy coping strategies such as substance abuse, thus taking drugs like beer, mbanje and tambirani, which is imported from Mozambique, hence creating another problem. The issue of sexual abuse is supported by the testimony that was given by one of the members of the core team. The testimony highlights the numerous challenges experienced by adolescents in terms of SRHR.

Testimony

I was raped at the age of thirteen (13) by my uncle after my father had passed on in 1997. I was repeatedly sexually abused by the uncle while staying in Mhangura. When I told my aunt (her father's sister) she beat and accused me of trying to snatch her husband. The sexual abuse recurred and I was forced to drop out of school at the age of fourteen (14) in 1998. I ran away from Mhangura and then went to Chirundu Boarder post to work as a sex worker. In Chirundu, I met a clearance agent officer and a police officer and started having unprotected sex with both of them for financial gain. The men later realised that I was dating both of them. They both jilted me. I later discovered that I was pregnant but did not know who the biological father of the baby was. I wanted to terminate the pregnancy and went to Mvurwi Hospital where I was fortunate enough to be referred to Pregnancy Crisis Centre (PCC). PCC housed me until I gave birth to twins but one of the twins passed on. Both men refused paternity of the child. It was later on after three years that the police officer alleged that if the child had birthmarks on certain parts of the body then the child was his. The child apparently had the birth marks and the police officer accepted paternity on that basis without DNA testing. I later re-married, but the husband did not want to take care of the out of wedlock child. At the moment i have moved out of my matrimonial home.

It was also observed that even though rape and child marriage is a criminal offence, communities are not prepared to use the law to protect young girls. This is because of the dynamics that exist at community level and the challenges experienced when going through the courts. This was expressed by one respondent who said "*Kunyange tikamhan'ara nyaya ye rape munoona munhu uya adzoka achiti hapana zvandinoitwa*" Meaning "even if we report cases of rape the rapist comes back to the community bragging that nothing was done to them by the courts.

5.2.1 Interventions at schools

The respondents agreed that the school was not doing enough in terms of programmes that deter school adolescents to delay sexual debut. The dialogue process revealed that school going children in uniforms were being found in beer halls buying alcohol. The areas where the dialogue process was conducted had several bottle stores. Ruyamuro business center had about four bottle stores as well as a lodge. Guruve growth point has several bottle stores where youths were seen during school time. Furthermore, it was also reported that some school children were being dropped and picked at the school gates by sugar daddies who are old enough to be their fathers. These intergenerational relationships expose young people to unwanted pregnancies, HIV and STI infections. The dialogue also revealed that even though there was family life education in schools not much emphasis was being given to this subject as this was not examined. It was also noted that teachers were not able to respond to the needs of adolescents boys and girls as they did not have enough information on SRHR.

5.2.2 Interventions at health centers

The Ministry of Health and Child Care had created youth friendly corners at health centers. There was one such center at Ruyamuro clinic. Health service personnel reported that most pregnant and breastfeeding mothers who were coming to the clinics were young, 18 years and below. This observation therefore reveals that young people were engaging in early sexual activities. However, participants noted that the youths were not utilizing the youth friendly corners. Some young participants reported that it was difficult for them to ask for condoms from the nurses as they regard them as young people who should not engage in sexual activities. Some participants reported that some nurses are not friendly to the youths who go for STI treatment as they assume that young people should not indulge into sexual activities. The youth friendly centers were manned by young people but from the dialogue process it was observed that very few young people come to the center. An average of 1 person per day visited the youth friendly center. It was also observed that it was mainly boys who go to the center. Young people seek health services when they are pregnant or when they get an STI as was confirmed by the clinic nurses.

6 CONCLUSIONS AND RECOMMENDATIONS

This dialogue process highlights four major issues,

- Inadequate community participation and parental involvement in SRHR issues affecting adolescents in Guruve District. Communities are skeptical about current approaches to sexual, gender based violence, it is time to take stock and formulate new strategies, and action plans with communities as part of the drivers of change in the fight against GBV and sexual exploitation.
- Access to health information for stakeholders to be more aware of SRHR issues emerged as a key area of concern that need to be addressed if communities and parents are to play their role in addressing SRHR issues in the community.
- For success, youth based initiatives would need the support of all stakeholders to ensure youth are able to access essential reproductive health services from Zimbabwe's National Health System. Currently, public health attitudes towards youths accessing reproductive health services are a major obstacle towards empowering youth to participate and to fight for their SRHR rights.
- There is a major gap in participation of other key sector ministries in addressing SRHR issues that affect adolescents especially the Ministry of Education that has easy reach for this target group.

The main recommendations for action are outlined in the table below:

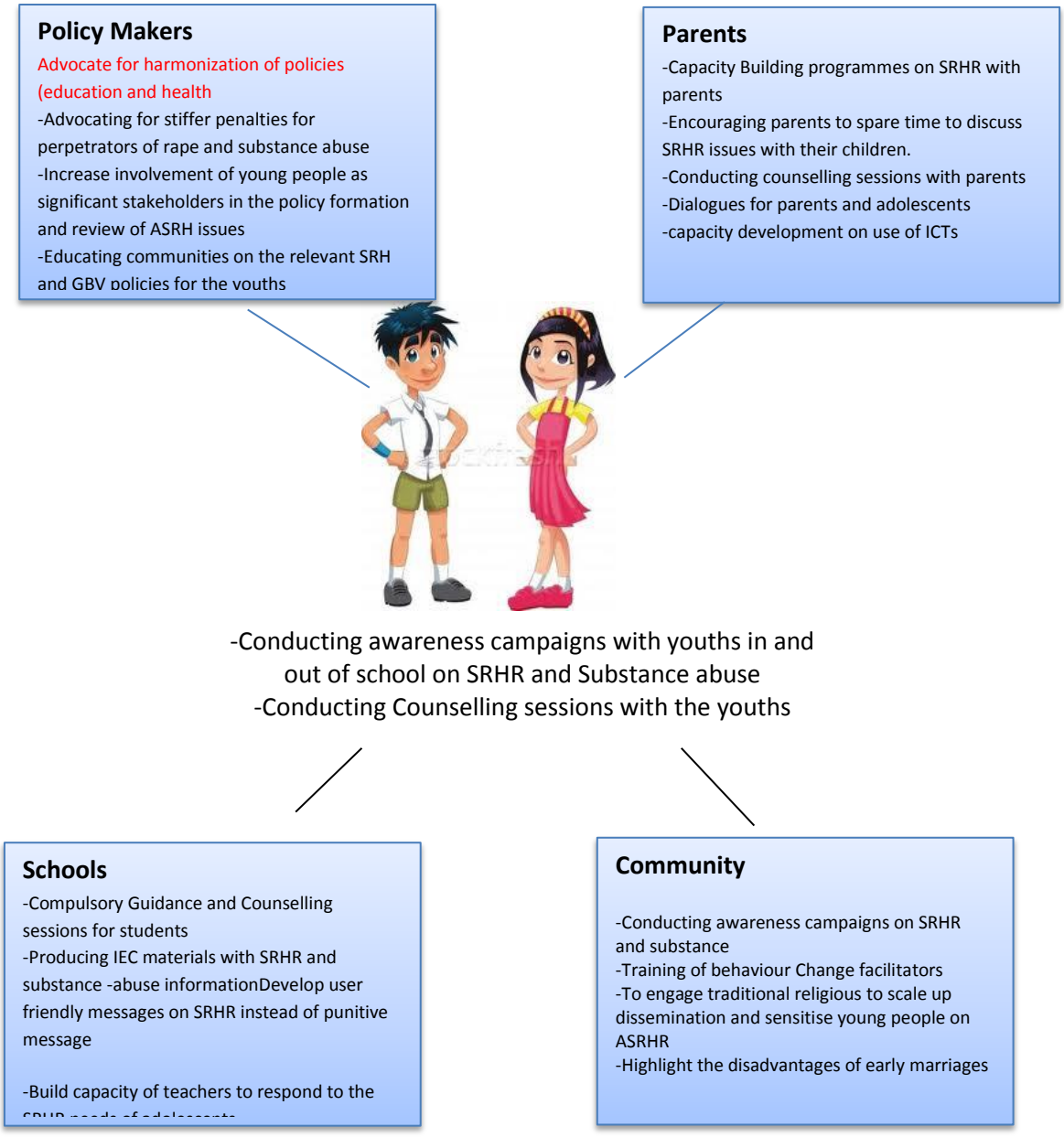
Table 6.1: Recommendations

Level	Action Priorities	Programme	Long-term
Community	Mobilize communities to support ASRHR through Identification and addressing cultural and religious practices that contribute to gender based violence Community awareness on laws and policies such as the Criminal Codification Act. Development of leadership skills for identified community members	Parent child dialogues on ASRHR Anti-gender based violence and child marriage campaigns Support groups for girls who have suffered sexual violence should be initiated. Strengthen youth friendly services and raise awareness for these to encourage early reporting of violence Laws that prohibit young people from bottle store should be enforced	Poverty reduction interventions at community level
Schools	Build the capacity of teachers to disseminate and respond to the SRHR needs of schoolchildren. Develop ASRHR IEC material	Youth led ASRHR activities in schools facilitated by teachers	Policy that recognizes ASRH as an examinable subject

National	Advocate for timeous trial for rapists.		A favorable legal environment for young people
Health	Advocate for a structural change in initiatives that serve the young people.	Youths freely using the services	

A multi sectoral approach is highly recommended in the response to the findings of the dialogue process.

The diagram below illustrates some of the action improvements that WAG would want to focus on as a result of this social dialogue process in Guruve District.



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