Australasian Review of African Studies, 2024,45(2), 27-47 *AFSAAP*
http://afsaap.org.au/ARAS/2024-volume-45 *2024*
https://doi.org/10.22160/22035184/ARAS-2024-45-2/27-47

Perceptions of Parents and Guardians Regarding Adolescents' Access to Contraceptives and Sexual and Reproductive Health Services in Zimbabwe

Elias Maronganye*
Tinos Mabeza*
Isheanesu Leanard Makwambeni**
*Department of Social Sciences, Women's University in Africa, Zimbabwe
**Department of Obstetrics & Gynaecology, United Bulawayo Hospitals, Zimbabwe

Abstract

We explore parents' and guardians' perceptions of the access of adolescents to contraceptives and sexual and reproductive health services (SRHS) in Zimbabwe. Cowdray Park was purposively selected, convenience and purposive samplings were used to recruit participants, and focus group discussions were used to collect data. Most parents and guardians believe that adolescent access to contraceptives and SRHS will lead to cultural erosion and encourage promiscuity. They consider adolescent sexual activities to be taboo due to religion, cultural practices and policies. Parents' and guardians' perceptions have a significant impact on adolescents' access to contraceptives and SRHS in Zimbabwe.

***Keywords*:** perceptions, parents, guardians, adolescents, contraceptives, SRH, Zimbabwe

Introduction

Adolescent access to Sexual and Reproductive Health Services (SRHS) and contraception is often overlooked in underdeveloped countries despite 12 million births and 21 million pregnancies occurring each year among girls between the ages of 15 and 19 (Ahinkorah, Kang, Perry, Brooks & Hayen, 2021; Sully et al., 2020). Most teenage pregnancies occur in adolescents from socioeconomically disadvantaged backgrounds (Bhatt et al., 2021). Zimbabwe has a population of 15.2 million of which 1.8 million are adolescents aged 10 to 19 (UNICEF, 2023a). The country has high rates of teenage pregnancies, with 127,561 girls married before the age of 18 and 7,002 married before the age of 15 (UNICEF, 2023a). Adolescent pregnancies have serious risk factors such as low birth weights, premature

births, infant respiratory complications, and high infant mortality rates (Azevedo, Diniz, Fonseca, Azevedo & Evangelista, 2015). The responsibilities of parenthood can have a significant impact on the educational attainment, mental health, and lifelong financial prospects of young women who become mothers in adolescence (Ehiaghe & Barrow, 2022; Kabir, Ghosh & Shawly, 2019; Murewanhema, Moyo & Dzinamarira, 2024). In Zimbabwe, teenage mothers often end up engaging in informal occupations like cross-border businesses, vending, and commercial sex work, which increase their risk of contracting sexually transmitted illnesses like HIV (Murewanhema et al., 2024). Although Zimbabwe's policies aim to reintegrate pregnant women into school, prevailing conservative societal norms result in condemnation and marginalisation and create significant barriers. The paper explored the perceptions of parents and guardians regarding adolescents' access to contraceptive and reproductive health services in Zimbabwe.

Literature review

Drivers of adolescent pregnancy

Murewanhema et al. (2024) suggest that adolescent pregnancy is driven by socioeconomic, religious, and cultural factors, along with internet and social media exposure. Adolescents from economically disadvantaged homes face an increased risk of unintended pregnancies because they struggle to meet their basic needs, including obtaining contraceptives (Yakubu & Salisu, 2018). Zimbabwe's high rate of adolescent pregnancy is primarily attributed to its persistent economic issues, with many families struggling to meet basic needs (Nunu, Makhado, Mabunda & Lebese, 2020). The National Assessment on Adolescents Pregnancies in Zimbabwe Report 2023 states that the economic decline has led to widespread poverty, rising unemployment rates, and declining agricultural commodity value (UNICEF, 2023b). Poverty has caused parents to migrate to neighbouring countries and abroad for better opportunities. In some cases, children are left alone without adult supervision, and adolescents are more likely to engage in risky sexual behaviour and even become targets of sexual abuse (UNICEF, 2023b). Parental migration can benefit children through remittances but is harmful to the children who are left behind. The increased exposure to the internet and social media has heightened the vulnerability of young children, leading to early sexual activity indulgence (Nunu et al., 2020). In rural areas, girls continue to face significant discrimination, often dropping out of school to work and being married off to older men in polygamous relationships for bride price (Yah et al., 2020). Adolescent pregnancy is also primarily attributed to school bans on physical punishment, inadequate parental SRHS

communication, limited recreational facilities, prevailing social norms, and limited access to contraceptives (Yakubu & Salisu, 2018).

Benefits of contraceptive use to adolescents

Contraception is crucial in averting teenage pregnancy. Contraceptive methods aim to improve the quality of life of women and young girls by reducing the incidence of unwanted pregnancies and the need for subsequent abortions. Ignoring the family planning needs of adolescents leads to unwanted pregnancies and unsafe abortions, which can have serious health and social impacts and often play a significant role in maternal and child mortality in low-income countries (Nsubuga, Sekandi, Sempeera & Makumbi, 2015). Research shows that women who have access to contraception have better educational outcomes, higher economic status, and greater influence over their lives, all of which lead to better health outcomes and an overall higher quality of life. (Bhatt et al., 2021; Uprety, Ghimire, Poudel, Bhattrai, & Baral,2016). The United Nations Population Fund (2024) states that having safe and voluntary family planning is a fundamental human right as it plays a crucial role in fostering gender equality, empowering women, and alleviating poverty. Providing sexually active teenagers with access to contraceptives and other SRHS can help prevent unwanted pregnancies and is a successful strategy for reducing unsafe pregnancies and abortions. (Cavallaro, Benova, Owolabi & Ali, 2020; Darroch, Singh & Weissman, 2016).

Adolescents, sexual and reproductive health

In adolescence, a person transitions from childhood to adulthood and undergoes puberty-related changes marked by observable physical, biochemical, and emotional changes (Styne, 1994). The adolescent years are a period of potential, susceptibility, and danger, especially in terms of one's physical well-being and willingness to engage in risky sexual behaviour, leading to unwanted pregnancy (Ojeda & Terasawa, 2002). SRH remains a global public health concern (Ngum Chi Watts, Liamputtong, & McMichael, 2015). SRH refers to a comprehensive state of physical, mental, and social wellness in all issues about the reproductive system (WHO, 2017). The significant challenges impacting adolescents in the domain of SRHS include gender-based violence, limited sexual education, restricted access to contraception, unsafe abortions, and unwanted pregnancies (Krugu & Van der Kwaak, 2019). Though a large part of the population, teenagers are more prone to reproductive diseases and mortality like STIs, early pregnancies, abortions, and HIV and AIDS. A mix of physiological and behavioural variables contributes to adolescents' susceptibility.

In developing countries, approximately 11% of girls and 6% of boys aged 15 to 19 had their first sexual experience before turning 15 (Ram, Andajani & Mohammadnezhad, 2020). Studies document the importance of comprehensive sex education in assisting young people to become safe, successful adults (Castillo, Derluyn, Jerves & Valcke, 2020; Goldfarb & Lieberman, 2021). Adolescents who have SRH education along with parental consent are less prone to teenage pregnancy, engaging in unprotected sex, having many partners, and are more likely to use condoms or delay sexual activity (Francis & DePalma, 2014; UNESCO, 2015). Studies in the West have shown that parents generally support comprehensive sex education, including in different US states, the Netherlands, and Canada (Barr, Moore, Johnson, Forrest, & Jordan, 2014). Parents in Canada support age-appropriate school sex education, emphasising abstinence-only or abstinence-plus based on adolescent mental maturity (Ram et al., 2020).

Adolescents are more prone to engaging in early unprotected sex, increasing the risk of unwanted pregnancies and sexually transmitted infections. Studies indicate that sex education can postpone the initiation of sexual activity, reduce the likelihood of teenage pregnancy, and promote safer sexual practices (Ramírez-Villalobos et al., 2021; Stanovic & Lalic, 2010). Adolescents must have early access to high-quality and pertinent SRH services and information to be healthy and safe. Despite the numerous benefits of comprehensive sex education for teenagers in the West, it has faced resistance in other parts of the world. Parents in Fiji expressed hesitation and reluctance to break perceived taboos surrounding adolescent sexuality and to address teenage pregnancies honestly and openly; the subject of adolescent reproductive health is persistently touchy and divisive (Ram et al., 2020). In South Africa, teachers who were asked about their opinions on condom distribution in schools echoed the belief that condom availability would increase early sexual engagement and promiscuity among students (Hlalele, 2011). In Namibia, condom distribution in schools was heavily criticised as inappropriate and equivalent to encouraging evil (Shipanga, 2012). However, research has shown that youth who get HIV and sex education are more inclined to practice safer sexual behaviour and less likely to engage in sexual activity (Stanovic & Lalic, 2010).

Barriers faced by young people towards SRH

In Zimbabwe, young people face significant barriers when seeking SRH services, with policy and legal frameworks, religion, and cultural practices being significant deterrents.

Policy and legal frameworks

The World Health Organisation (WHO, 2020) states that health program managers, legislators and health professionals need to learn more about and advocate for the positive role that sexuality and sexual health play in people's lives. They also must enhance health care services to support healthy sexual communities. According to Chinyoka and Mugweni (2020), Zimbabwe's health systems and policies inadequately promote adolescent sexual and reproductive health (ASRH). Legislation and policies that deal with women's sexuality, sexual health, or concerns connected to them are challenging to put into practice due to many overlapping social and cultural oppositions that encompass the legal system. Zimbabwe has been refractory in changing the situation on the ground by effecting laws and policies that support adolescents' access to contraceptives. Regarding SRHS for young adults specifically, there is a deafening silence in Zimbabwe despite international pressure. The many intersecting factors of socioeconomic, religious, political, and cultural influences shape how these issues are dealt with in society.

Dr. Dokora, former Minister of Primary and Secondary Education, strongly opposed the distribution of condoms in schools, describing it as a threat to national dignity. The Vice President and former Health Minister Constantino Chiwenga stated that women under 16 cannot receive contraception because they are legally unable to consent to sexual activity (Chinyoka & Mugweni, 2020). Zimbabwe's Public Health Act of 2018 further supports this position by prohibiting children under 16 years of age from accessing SHRS, like contraceptives and emergency family planning pills, as they do not have legal consent to have sex. However, these restrictions do not guarantee that young people will continue to abstain from sex. Although Zimbabwe raised the minimum age for marriage to 18 in 2021, early marriages are still common in certain parts of the country despite these restrictions. Society and the government oppose adolescents accessing contraceptives due to concerns that this may promote teenage sex. However, the evidence from reported teenage pregnancies consistently shows that teenagers are engaging in sexual activity at younger ages without protection from pregnancy and disease (Chinyoka & Mugweni, 2020). Given the staggering number of school dropouts brought on by teenage pregnancy, this paper promotes candid dialogue and acknowledgement of access to contraception for sexually active adolescents. The authors propose that instead of dismissing the issue, we should focus on finding suitable solutions, such as determining the appropriate methods, timing, and channels for providing contraceptives to adolescents. This approach can help reduce adolescent pregnancies and promote educational and personal development among young people (Chinyoka & Mugweni, 2020).

Religion and cultural practices

Cultural norms and religious principles significantly shape SRH outcomes, often perpetuating harmful practices and behaviours, such as stigma, discrimination, and denial of essential services, which can have detrimental consequences for adolescents and communities. For decades, sex education has been considered taboo in African communities due to restrictive and conservative cultural and regional practices (Tuyisenge, Hategeka & Aguilera, 2018). Alomair, Alageel, Davies & Bailey (2020) argue that Islam significantly influences Arab women's views on bodies, sexuality, and SRH, with both Christians and Muslims in the Middle East embracing customs and beliefs that allow for the promotion and perpetuation of abuse and violence against women. The state and family determine access to SRH knowledge and services, making it challenging to advance women's rights and combat gender based violence in Arab culture.

In South Africa, according to traditional customs among tribes such as Zulu, Xhosa, Vha-Venda, Shangaan, and Pedi, sexual intercourse was supposedly delayed until after marriage (Afolayan, 2004). These ethnic groups observed the mandated puberty rites during initiation ceremonies to mark the achievement of maturity. Children today grow physically and sexually faster than in previous societies. Sexual maturity occurring at a younger age would appear to be a result of sociocultural changes in lifestyle, sexual views, and behaviours. Teenagers today live in sociocultural contexts that are very different from those of previous generations. Teenagers learn about the world via their classmates, the media (television, radio, and periodicals), and popular culture. According to South Africa's 2022 census population results, the population may rise to 100 million by 2050 (South African Goverment, 2025), with far-reaching adverse effects on the environment, unless teenagers get appropriate sex education and are allowed to access contraceptives in schools. Silberschmidt and Rasch (2001) reported that the median age at which the first pregnancy occurred was 12 years in Dar es Salaam. This suggests that conventional social institutions in general and traditional family arrangements in particular have undergone alterations. It appears that attitudes and responses towards sexual permissiveness are not rigorous enough to prevent teenage females from getting pregnant.

Zimbabwe is a predominantly religious country and most of the population attaches great importance to religion in their everyday life. To combat teenage pregnancy, some are advocating for easier access to contraceptives. However, conservative groups and churches strongly oppose this, believing it would undermine cultural values. This contrast represents an obstacle to solving the problem and highlights the tension between religious beliefs and reproductive health needs. The conflict hampers efforts

to provide comprehensive health care to adolescents and leaves them vulnerable to unplanned pregnancies and related challenges.

Intersectionality of SRH and health outcomes

The study used intersectionality theory, first introduced by Kimberlé Crenshaw in the context of black feminism, to examine how individuals and groups experience multiple, intersecting forms of discrimination and disadvantage (Crenshaw, 2013). This framework moves beyond a simplistic binary approach to gender differences and instead considers how different identities and circumstances intersect to produce nuanced experiences of inequality. Intersectionality recognises that inequalities are interconnected and reinforce each other, resulting in complex and contradictory social patterns (Anthias, 2005; Hankivsky, 2012). By examining these intersections, researchers can better understand how systems of domination and subordination shape individual and group experiences, leading to a more comprehensive understanding of social injustices and their impacts.

Intersectionality in SRHS studies focuses on how interdependent systems of prejudice affect adolescents, including women's bodies and oppression. Mann (2013) highlights how patriarchal and state power suppress discussions about SRH, restricting women's access to services and safe dialogue. This study used intersectionality theory to examine how patriarchy and state power intersect with gender, class, sexuality, power dynamics, oppression, shame, ignorance, and silence to objectify women's bodies in a variety of social contexts. Analysis shows how these merging discourses maintain systemic inequality and shape women's experiences. The paper suggests that culture, religion, community associations, and the social-political context influence the perceptions of parents and guardians about the access of adolescents to SRHS and contraceptives. Sociocultural influences significantly affect sexual health outcomes as a result of the exploitative patriarchal framework in society, and it is people from marginalised populations who are more likely to have negative health consequences (Collins, von Unger & Armbrister, 2008; Crenshaw, 2013).

Methodological issues

A qualitative cross-sectional investigation was conducted among parents and guardians of adolescent girls aged 10–17 years from Cowdray Park in Bulawayo Metropolitan Province. Cowdray Park is the second-most populous ward in Zimbabwe and is home to a diverse population from different socio-cultural and ethnic backgrounds. It was purposefully selected as the study site due to its more comprehensive and diverse population composition, which can better provide valuable baseline information for this study. Research assistants recruited participants in the study area through

community WhatsApp groups and public leaflet distribution, following permission from local authorities and ethical approval from the Women's University in Africa ethics committee. Participants who met the criteria were recruited through purposive sampling and scheduled for Focus Group Discussions (FGD) (with open-ended questions) at the participants' convenience. Research assistants also encouraged early participants to share study information on social networks. To be eligible, participants met the following criteria: being a parent or guardian of a girl child between the ages of 10 and 17, living in the study area, and being over 18 years old (the legal age of adulthood in Zimbabwe) at the time of data collection. The sample consisted of 42 parents and guardians of adolescent girls aged 10–17 years living in the study community and spanning a wide range of ages, education levels, genders, marital status, employment status, and religion. Female participants dominated this study, with 28 females and 14 males. The ages of the participants ranged from 25 to 50 years old. Participants spoke various English, including Ndebele and Shona. To allow participants to express themselves, the researchers allowed them to choose their preferred language for the interviews, which were then transcribed verbatim in the original language and translated into English for analysis. Each FGD had 7–12 participants. All four research assistants had a Bachelor of Science in Social Work and expertise in FGD. The focus groups were organised by age and gender. The most insightful FGD transcripts were selected for in-depth analysis, yielding key themes.

Findings

Knowledge of contraception, SRHS and family planning

The study participants showed knowledge regarding contraception, recognised its significance in reducing unintended pregnancies, and were aware of available contraceptive methods. Most participants, however, did not know what SRH meant. The researchers had to explain the meaning of SRH, and then some participants agreed that they were aware of some SRHS, such as prenatal care and HIV and AIDS testing during pregnancy. The researchers observed that some of the participants associated contraception, SRH, and family planning with child spacing, which was only meant for adults who are married or cohabiting together. Some participants said:

> Yes, I know contraception and its importance. I am also aware of family planning, but I am not sure what SRH stands for. I first met the term in this discussion. (Participant 3)

> I know family planning, contraception, the pill, and the injection called Depo Provera. SRH is something new and I am hearing these words in this group. (Participant 2)

The researchers also noted that the majority of the male participants were not well-informed about contraception. For instance, in one of the groups, a participant said

> The problem is that nurses at public clinics do not explain much. I remember the last pregnancy with my wife; we went for HIV testing, that's all. Nothing was explained to me. We were not even given counselling. (Participant11)

Parent and guardians' discussions with adolescents on sexual issues

The study's findings indicate that most participants found it awkward to discuss SRH concerns with their children, who are adolescents. They reported that it was difficult, even though they viewed themselves as a significant and reliable source of SRH knowledge for their children. Some responses from participants were as follows:

> It is somehow a complex subject to talk to a 14-year-old child; I feel as if I am encouraging her... Most conversations concern reprimanding her to avoid boyfriends, men, and dating. (Participant 23)

> I cannot speak to my child about SRH; I do not feel comfortable at all when it comes to talking about sex issues, though they learn from TV and at school. (Participant 32)

> What SRH discussion can I have with someone who is 15 years old? To me, she is still a child and should stay away from bedroom issues. (Participant 15)

Talking about sex seems to be impeded by age because parents are often uncomfortable discussing sex with teenage girls, whether or not they are already involved in it. Other participants stated that it is the responsibility of aunts and educators to teach about SRH issues. Adolescent access may be difficult due to the limited sexuality options, especially if they must seek

SRHS with their mothers. On the other hand, it seems that some parents are open to discussing sexual issues with their daughters, while others are not.

Some parents believe that unmarried adolescent females should not be in relationships with the opposite sex or engage in sexual behaviour. One participant said

> I will not allow her to indulge in sexual activities or to have a boyfriend at 15 years old. If she is not at school, I expect her to be helping with household duties. (Participant 9)

Such views highlight how strictly regulated and controlled female sexuality is. Additionally, it suggests that girls were less likely to seek out SRH information or services and frequently spent more time on household chores than teenage boys. This demonstrates the intersection of gender, cultural expectations of female sexuality, and access to SRH knowledge. Some of the participants disputed the value of SRH for teenagers.

SRHS needs of adolescents

Participants were somewhat divided when it came to discussing the SRHS needs of adolescents. Some participants were referring to SRHS as contraceptives, and vice versa. The researcher, however, had to keep on explaining through the FGD. The participants said:

> We should respect our children's rights. Everyone is entitled to health care and health education. We are robbing them of their rights by refusing to provide SRH services. (Participant 6)

> Young people should be educated and have access to contraceptives because education and training guarantee safe usage. (Participant 18)

> The age of consent should remain at 18, but we should abolish laws that prevent young people from accessing SRH services. As for contraceptives, I am undecided, although it's a challenge considering many young girls drop out of school because of unplanned pregnancies. (Participant 29)

> I have a 17-year-old daughter who is pregnant. The boyfriend is also 17; contraceptives can ensure safe sex. When children are allowed to get emergency pills, they avoid pregnancies since some girls end up dying from illegal abortions. (Participant 20)

Other participants were, however, against the idea of allowing adolescents below the age of 16 to have access to contraceptives and even SRH information. The opposing participants said:

> I do not think unmarried adolescents have any need for SRHS information. It is like you are saying, go and do it; make sure you do not fall pregnant. Bedroom activities are supposed to be left to adults who are married. I propose that we emphasise abstinence and say no to sex before marriage. (Participant 1)

> I also agree that SRHS is for adults and the bedroom and is supposed to be limited to adults only. Kids should focus on learning and working hard. (Participant 25)

Despite the erosion of traditional norms, parents continue to have significant influence on their children's SRH. Various factors shape adolescents' sexual behaviour, including social status, place of residence, religion, family structure, parental wishes and life experiences. In particular, parents are often reluctant to discuss sexual topics with their children because they fear it might encourage sexual exploration. This reluctance can result in a lack of guidance and support, highlighting the need for parents to effectively navigate these conversations and provide accurate information to help their children make informed decisions about their SRH.

Parents and guardians on adolescent's access to contraceptives

Regarding the appropriateness of providing contraception to teenage girls, researchers received a variety of responses. Some parents believed that there was nothing morally wrong with allowing unmarried teenage girls access to contraceptives and SRHS. However, other participants believed it was morally wrong to allow unmarried adolescent girls access to contraceptives and SRHS. Participants argued that it was like saying you could go and do it. When the researcher presented them with cases of teenage

pregnancy and the possibility of a 16-year-old boy impregnating another 16-year-old girl, the debate took a different form. Participants said:

> The issue must be honestly addressed, and any measures should focus on securing our children's future rather than leaning on morality. Contraceptives guard against unplanned pregnancies and early marriages, not encourage sexual activity. (Participant 6)

> We need to stop living in denial and accept the fact that our kids are having sex; wait until you start seeing your 16-year-old girl gaining weight and having morning sickness. I am also of the view that even schools should implement a required sex education curriculum. (Participant 11)

> I am against the idea of allowing unmarried youth access to contraceptives and SRHS because they are children and should not engage in sexual activity. Only married adults should have access to SRHS, but not contraceptives. God never created contraceptives but white people brought them to reduce the African population. (Participant 30)

Policy and legislation barriers

Participants said that the state must play an important role in ensuring that women's health and rights are realised. They recommended that the government create laws, policies and programs on women's health, with a focus on SRH services and information on young women. Adolescents in Zimbabwe do not adequately use contraceptives to prevent unwanted pregnancies. Contraception is underutilised by adolescents in Zimbabwe to prevent unplanned pregnancies. In Zimbabwe, adolescents under the age of 18 have limited access to contraception. The policies are Zimbabwe's most significant obstacle. Laws that forbid or restrict young or unmarried females from acquiring contraceptives and requirements that contraception be administered with the approval of parents or husbands are some of the hurdles to accessing contraceptives. However, some participants agree with the current legislation and policies that prohibit the access of contraceptives and SRH information to children under the age of 18. Parents also understand the implications this has for the girl child. They also understand how many girls dropped out of school when they fell

pregnant during the lockdowns in 2020 and 2021. Some of the participants said:

> The government's decision to reject contraception use by children below the age of 18 was poorly thought out. This is not an action that should be taken. Even if it means compromising our morality and cultural norms, we cannot deny the necessity of addressing the new pandemic of adolescent pregnancies. (Participant 9)

> I think the provisions in the Public Health Act that prevent minors under the age of 16 from accessing SRH should be reviewed. For how long do we want to keep fighting with reality? (Participant 6)

> The Public Health Act is okay like that; they should not be given access; otherwise, we will be another Sodom and Gomorrah. Children should remain children. (Participant 13)

Discussion

The parents and guardians linked contraception, SRHS, and family planning with the practice of spacing children among adults who are either married or cohabiting. Sexual activities are considered appropriate only for adults. Therefore, adolescents should not know of or engage in such behaviours despite the significant occurrence of unwanted pregnancy and abortion among teenagers. In Zimbabwe, the birth rate for people between the ages of 15 and 19 is 121 per 1000, and this is due to a lack of access to contraception (UNPFA, 2023). The level of communication between parents and their adolescents was found to be limited, a phenomenon that can be attributed to the conventional Zimbabwean culture. Most parents and guardians felt uncomfortable discussing SRH topics with their adolescent children despite admitting that they are an invaluable and dependable source of knowledge for their children. Discussions frequently revolved around warnings, particularly to girls, to stay away from boys to avoid teenage pregnancy, and this aligns with a study conducted by Mbachu et al. (2020), which reported that parental interactions with adolescents are characterised by a cautious and authoritative approach, primarily focusing on the dangers of engaging in heterosexual relationships at an early age.

Sexuality appears taboo in many Zimbabwean societies (Bhatasara, Chevo & Changadeya, 2013). Certain cultures virtually never discuss sexuality at home because they view it as culturally improper for parents to

discuss sexual concerns with their children. People view sexuality as a domain exclusively for adults, with specific requirements for their physical and social growth. Consequently, people often perceive ideas about child sexuality as forbidden, opposed, unimportant, or even harmful, leading to moral panic. The literature on youth sexuality is rich with notions of "high-risk adolescents" and "unknowledgeable or ill-informed adolescents" (Ignaciuk & Kelly, 2020). Adult sexual cultures, along with religious and moral discourses, stigmatise adolescent sexuality. Despite legislative attempts to remedy this, mixing sexuality and children is nonetheless tricky and ethically repugnant to many (Ignaciuk & Kelly, 2020). The myth that an asexual child requires protection from harmful sexual information stems from the underlying ideologies that associate adolescents with sexual innocence. This regulatory mechanism shapes how we view morality, sexuality, and young people. Long-standing sexual innocence stereotypes present the child as an issue that stifles sexual enchantment (Bhana, 2013). Despite such limited conceptions of childhood, several studies show that teenagers are sexually active beings.

This paper notes that despite the eroding of traditional norms and values, parents still exert enormous influence on their children when it comes to sexual and reproductive health matters. Many factors, such as social position, location of residence, religion, family structure, parents' educational goals, and life experience, have an impact on adolescent sexual behaviour. Parents' reluctance stems from fear that broaching sexual topics with their children might arouse their curiosity and concern about the reaction of the broader community. Most cultures in Africa stigmatise sexual activity outside of marriage (Iyer & Aggleton, 2014). Despite the recommendation to delay sexual activity until marriage, many adolescents are sexually active and need comprehensive sexual health education and access to contraceptives to make informed decisions and protect their health. Denying teenagers access to SRH information and services will not stop them from engaging in sexual activity, but it will leave them vulnerable to unwanted pregnancies, sexually transmitted diseases, including HIV and AIDS, and other harmful consequences The need for comprehensive information and support is thus underlined (Swanepoel & Beyers, 2019). Policies have been created and put into practice in Nigeria and South Africa to guarantee that teenagers have access to contraception and other reproductive health care treatments. In Nigeria, for example, government-run clinics cater to adolescents (Swanepoel & Beyers, 2019). Youth-friendly facilities are offered by non-governmental organisations (NGOs) (Swanepoel & Beyers, 2019). Providing SRH information and family planning can assist Zimbabwe in curbing the scourge of unwanted teenage pregnancies and abortions (Swanepoel & Beyers, 2019).

Although there was no complete agreement on whether adolescents should have access to contraceptives and SRHS, the majority of participants were in favour, particularly female participants. Those in total agreement argued that whether they agreed or not, it was useless since these children were doing sexually active. They also argued that parents should be able to move with time; times have changed, and therefore, they cannot use the standards of their days for today's children. Further, the participants reported that TV and media are also teaching them; as such, they should not wait. Opposing parents argue that allowing them to have access to contraceptives is like allowing them to indulge in bedroom activities, and so much focus should be aimed at educating them on the benefits of abstinence and waiting for the right time. We found that the majority of those who spoke against access to contraceptives and SRHS were men, and those who cited religion, particularly Christianity. Zimbabwe is a religious nation, and when asked about religion, a large proportion of the public profess belief in God and affirm that religion is at least "most important" in their everyday lives. It is essential to note the stance of particular churches concerning contraceptives. For instance, the Roman Catholic Church views contraception as "intrinsically wicked"; as a result, Catholics are only permitted to use natural birth control methods, regardless of the repercussions (Ignaciuk & Kelly, 2020).

Despite the high rate of contraceptive use in Zimbabwe, adolescents who are sexually active face social, legal, and financial obstacles that make it difficult for them to obtain contraception, making them more susceptible to STDs and unwanted pregnancies (UNFPA, 2023). Children under the age of 16 are prohibited from getting SRH services like contraceptives and emergency family planning pills under Zimbabwe's present legal framework, specifically the Public Health Act [Chapters 15–17] of 2018. This is because they lack the legal capacity to consent to sex. Laws governing the age of consent are a tool for controlling the sexual behaviour and activity of children and adolescents. However, restrictions do not ensure that young people will abstain from sex. According to a report released in 2021 by the Zimbabwe National Family Planning Council (ZNFPC), the United Nations Population Fund (UNFPA), and the Ministry of Health and Child Care, approximately 48% of teenagers have confirmed unintended pregnancies. Hence, even though the legal consent age in Zimbabwe is 18, young girls and boys under the age of 18 nonetheless engage in sexual activities.

The paper used intersectionality theory as its conceptual framework to examine the various factors that influence parents' and guardians' perspectives on adolescents' access to contraception in SRHS in Zimbabwe. Intersectionality theory emphasises how interactions within different social contexts influence individuals. The theory was utilised to analyse the several

elements, including gender, patriarchy, economic difficulties, and other discriminatory systems, that hinder young women's access to SRH information and services. We observed that concomitant factors such as religion, class and culture work with legislation in interconnected and complex ways to influence parents' and guardians' decisions about ASRHS. Examining current contraception and SRHS disparities among teenagers in Zimbabwe using an intersectional perspective reveals how the historical exclusion of certain groups of individuals along various forms of discrimination contribute to these inequities. An intersectionality approach to ASRH is beneficial because it allows for the simultaneous assessment of all the factors and creates an analytical space for them. No one major factor is given more weight than the others. The intersectionality theory was applied to understand the power dynamics, power hierarchies, and obstacles young women in Zimbabwe encounter regarding contraception and SRHS. Zimbabwean young women face challenges in contraception and SRHS due to power dynamics, age, class, socioeconomic factors, cultural norms, religious misconceptions, patriarchy, religion, and state control, which give men even more incredible privileges to control and monitor the reproduction systems of women.

Conclusion

The study emphasises how difficult it is for adults to recognise the sexual agency of teenagers, especially girls since it is frequently thought of as something that should be restrained and controlled. Teenagers are viewed as weak and in need of adult supervision. The idea that children and adolescents are developing sexual and reproductive capacities has not found resonance with the public or policymakers despite support for ending child marriages in Zimbabwe. This kind of thinking makes it more difficult to provide comprehensive services for sexual health and education, which puts young people at risk for risks related to their sexual and reproductive health.

The paper also claims that Zimbabwe lacks the political will to enforce laws and public policies prioritising gender equality, health equity, and women's health. Policies are rarely followed, even when they are present, as evidenced by the number of child marriages. Zimbabwean society is implicitly committed to upholding patriarchal beliefs, customs, cultural norms, gender roles, patriarchal legislation, and religious misconceptions. In this paper, intersectionality is a practical theory for understanding the intersections of cultural, religious, socioeconomic, educational, age, class, identity, and gender that lead to disparities in women's SRH results. It offers a perspective through which to examine the many different types of oppression that women encounter.

Recommendations

For adolescents to make informed decisions, it is essential to ensure that they have adequate information on SRHS and contraception. The researchers suggest that the government and the parents rethink their position. Until this is addressed, sexually active teenagers will continue to suffer the consequences. To protect the future of female children who bear the brunt, it is imperative that social and political perspectives regarding adolescent contraceptive use change. Studies that concern adolescents' welfare should also include their voices. Future research should focus on how adolescents in Zimbabwe view contraception and SRHS.

Declaration of conflicting interests

The authors disclosed no potential conflicts of interest in this article's research, authorship, or publication.

Funding

The authors received no financial support for this paper's research, authorship, and publication.

References

Afolayan, F. (2004). *Culture and customs of South Africa*. Westport, CT: Greenwood Press.

Ahinkorah, B. O., Kang, M., Perry, L., Brooks, F., & Hayen, A. (2021). Prevalence of first adolescent pregnancy and its associated factors in sub-Saharan Africa: A multi-country analysis. *PloS one*, *16*(2), e0246308.

Alomair, N., Alageel, S., Davies, N., & Bailey, J. V. (2020). Factors influencing sexual and reproductive health of Muslim women: a systematic review. *Reproductive health*, *17*, 1-15.

Azevedo, W. F. D., Diniz, M. B., Fonseca, E. S. V. B. D., Azevedo, L. M. R. D., & Evangelista, C. B. (2015). Complications in adolescent pregnancy: systematic review of the literature. *Einstein (Sao Paulo)*, *13*(4), 618-626.

Barr, E. M., Moore, M. J., Johnson, T., Forrest, J., & Jordan, M. (2014). New evidence: data documenting parental support for earlier sexuality education. *Journal of School Health*, *84*(1), 10-17.

Bhana, D. (2013). Introducing love: gender, sexuality and power. *Agenda*, *27*(2), pp.3-11.

Bhatasara, S., Chevo, T., & Changadeya, T. (2013). An exploratory study of male adolescent sexuality in Zimbabwe: the case of adolescents in Kuwadzana extension, Harare. *Journal of Anthropology*, *2013*(1), 298670.

Bhatt, N., Bhatt, B., Neupane, B., Karki, A., Bhatta, T., Thapa, J., ... & Budhathoki, S. S. (2021). Perceptions of family planning services and its key barriers among adolescents and young people in Eastern Nepal: A qualitative study. *PloS one*, *16*(5), e0252184.

Castillo, J., Derluyn, I., Jerves, E., & Valcke, M. (2020). Perspectives of Ecuadorean teachers and students on the importance of addressing comprehensive sexuality education. *Sex Education*, *20*(2), 202-216.

Cavallaro, F. L., Benova, L., Owolabi, O. O., & Ali, M. (2020). A systematic review of the effectiveness of counselling strategies for modern contraceptive methods: what works and what doesn't? *BMJ sexual & reproductive health*, *46*(4), 254-269.

Chinyoka, K., & Mugweni, R. (2020). Contraceptives use among form two learners: interrogating perceptions of parents in Zimbabwe. *Academic Research International Vol. 11(3)*

Collins, P. Y., von Unger, H., & Armbrister, A. (2008). Church ladies, good girls, and locas: Stigma and the intersection of gender, ethnicity, mental illness, and sexuality in relation to HIV risk. *Social science & medicine*, *67*(3), 389-397.

Crenshaw, K. W. (2013). Mapping the margins: Intersectionality, identity politics, and violence against women of color. In *The public nature of private violence* (pp. 93-118). Routledge.

Darroch, J. E., Singh, S., & Weissman, E. (2016). Adding it up: the costs and benefits of investing in sexual and reproductive health 2014—estimation methodology. *Appendix B: estimating sexual and reproductive health program and systems costs. New York: Guttmacher Institute*.

DePalma, R., & Francis, D. A. (2014). The gendered nature of South African teachers' discourse on sex education. *Health Education Research*, *29*(4), 624-632.

Ehiaghe, A. D., & Barrow, A. (2022). Parental knowledge, willingness, and attitude towards contraceptive usage among their unmarried adolescents in Ekpoma, Edo State, Nigeria. *International Journal of Reproductive Medicine*, *2022*(1), 8533174.

Goldfarb, E. S., & Lieberman, L. D. (2021). Three decades of research: The case for comprehensive sex education. *Journal of Adolescent health*, *68*(1), 13-27.

Hankivsky, O. (2012). Women's health, men's health, and gender and health: Implications of intersectionality. *Social science & medicine*, *74*(11), pp.1712-1720.

Hlalele, D., & Alexander, G. (2011). Perceptions of women teachers on condom availability in schools: South African perspective. *Journal of Social Sciences*, *28*(2), 145-151.

Ignaciuk, A., & Kelly, L. (2020). Contraception and Catholicism in the twentieth century: Transnational perspectives on expert, activist and intimate practices. *Medical history*, *64*(2), 163-172.

Iyer, P., & Aggleton, P. (2014). 'Virginity is a Virtue: Prevent Early Sex'–Teacher perceptions of sex education in a Ugandan secondary school. *British Journal of Sociology of Education*, *35*(3), 432-448.

Kabir, M. R., Ghosh, S., & Shawly, A. (2019). Causes of early marriage and its effect on reproductive health of young mothers in Bangladesh. *American Journal of Applied Sciences*, *16*(9), 289-297.

Krugu, J. K., & van der Kwaak, A. (2024). Research in Brief Adolescent Sexual and Reproductive Health in low-and middle income countries: A synthesis of research findings for improved program development and implementation. Retrieved 20 December 2023 from https://www.kit.nl/wp-content/uploads/2019/05/Adolescent-Research-in-Brief_Sida.docx

Mann, E. S. (2013). Regulating Latina youth sexualities through community health centers: Discourses and practices of sexual citizenship. *Gender & Society*, *27*(5), 681-703.

Mbachu, C. O., Agu, I. C., Eze, I., Agu, C., Ezenwaka, U., Ezumah, N., & Onwujekwe, O. (2020). Exploring issues in caregivers and parent communication of sexual and reproductive health matters with adolescents in Ebonyi state, Nigeria. *BMC Public Health*, *20*, 1-10.

Murewanhema, G., Moyo, E., & Dzinamarira, T. (2023). Teenage pregnancy in Zimbabwe: A call for expedited interventions. *Children and Youth Services Review*, *150*(C).

Ngum Chi Watts, M. C., McMichael, C., & Liamputtong, P. (2015). Factors influencing contraception awareness and use: the experiences of young African Australian mothers. *Journal of Refugee Studies*, *28*(3), 368-387.

Nove, A., & Boyce, M. (2019). The state of the Pacific's reproductive, maternal, newborn, child and adolescent health workforce. *Suva: United Nations Population Fund Pacific Sub-Regional Office*.

Nsubuga, H., Sekandi, J. N., Sempeera, H., & Makumbi, F. E. (2015). Contraceptive use, knowledge, attitude, perceptions and sexual behavior among female University students in Uganda: a cross-sectional survey. *BMC women's health*, *16*, 1-11.

Nunu, W. N., Makhado, L., Mabunda, J. T., & Lebese, R. T. (2020). Strategies to facilitate safe sexual practices in adolescents through integrated health systems in selected districts of Zimbabwe: a mixed method study protocol. *Reproductive health*, *17*, 1-16.

Ojeda, S. R., & Terasawa, E. (2002). Neuroendocrine regulation of puberty. In *Hormones, brain and behavior* (pp. 589-659). Academic Press.

Ram, S., Andajani, S., & Mohammadnezhad, M. (2020). Parent's perception regarding the delivery of sexual and reproductive health (SRH) education in secondary schools in Fiji: A qualitative study. *Journal of environmental and public health*, *2020*(1), 3675684.

Ramírez-Villalobos, D., Monterubio-Flores, E. A., Gonzalez-Vazquez, T. T., Molina-Rodríguez, J. F., Ruelas-González, M. G., & Alcalde-Rabanal, J. E. (2021). Delaying sexual onset: outcome of a comprehensive sexuality education initiative for adolescents in public schools. *BMC public health*, *21*, 1-9.

Shipanga, S. (2012). *Namibia: Swapo youth want condoms at schools.* Retrieved December 10 2023 from https://allafrica.com/stories/201209070726.html

Silberschmidt, M., & Rasch, V. (2001). Adolescent girls, illegal abortions and "sugar-daddies" in Dar es Salaam: vulnerable victims and active social agents. *Social science & medicine*, *52*(12), 1815-1826.

South African Government (2025). People of South Africa Retrieved on January 15 2025 from https://www.statssa.gov.za/?p=15918

Stanovic, J. & Lalic, M. (2010). Sexuality education and attitudes. Nova Science Publishers, Inc.

Styne, D. M. (1994). Physiology of puberty. Hormone Research in Paediatrics, 41(Suppl. 2), pp.3-6.

Sully, E. A., Biddlecom, A., Darroch, J. E., Riley, T., Ashford, L. S., Lince-Deroche, N., ... & Murro, R. (2020). Adding it up: investing in sexual and reproductive health 2019.

Swanepoel, E. & Beyers, C. (2019). Investigating sexuality education in South African schools: A matter of space, place and culture. *TD: The Journal for Transdisciplinary Research in Southern Africa*, *15*(1), pp.1-9.

Tuyisenge, G., Hategeka, C., & Aguilera, R. A. (2018). Should condoms be available in secondary schools? Discourse and policy dilemma for safeguarding adolescent reproductive and sexual health in Rwanda. *Pan African Medical Journal*, *31*(1).

UNESCO. (2015). *Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education: A Global Review*, Paris, France, 2015, Retrieved February 10 2024 from http://unesdoc.unesco.org/images/0023/ 002357/235707e.pdf.

UNICEF. (2023a) .*Adolescents: Nothing for us, without us!* available at Retrieved November 15 2023 from https://www.unicef.org/zimbabwe/adolescents-nothing-us-without-us#:~:text=Zimbabwe%20has%20a%20total%20population,10%20and%2019%20years%20old.

UNICEF. (2023b). *National Assessment on Adolescents Pregnancies in Zimbabwe Retrieved January 10 2024 from* https://www.unicef.org/zimbabwe/reports/national-assessment-adolescent-pregnancy-zimbabwe.

United Nations Population Fund (2024) *Family planning Retrieved December 29, 2023, from* https://www.unfpa.org/family-planning#:~:text=Access%20to%20safe%2C%20voluntary%20family,key%20factor%20in%20reducing%20poverty.

Uprety, S., Ghimire, A., Poudel, M., Bhattrai, S., & Baral, D. D. (2016). Knowledge, attitude and practice of family planning among married women of reproductive age in a VDC of eastern Nepal. *Journal of Chitwan Medical College*, *6*(1), 48-53.

WHO (2023) *Adolescent health.* Retrieved October 29 2023 from https://www.who.int/health-topics/adolescent-health#tab=tab_1 #

WHO. (2017). *Evidence Brief: The Importance of Sexual and Reproductive Health and Rights to Prevent HIV in Adolescent Girls and Young Women in East and Southern Africa*. Geneva: World Health Organization.

Yah, C. S., Ndlovu, S., Kutywayo, A., Naidoo, N., Mahuma, T., & Mullick, S. (2020). The prevalence of pregnancy among adolescent girls and young women across the Southern African development community economic hub: A systematic review and meta-analysis. *Health promotion perspectives*, *10*(4), 325.

Yakubu, I., & Salisu, W. J. (2018). Determinants of adolescent pregnancy in sub-Saharan Africa: a systematic review. *Reproductive health*, *15*, 1-11.