Factors influencing Sexual and Reproductive Health Self-Care amongst young people in Zimbabwe

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A thesis submitted in partial fulfilment of the requirement for the degree of Master of Science in Public Health

by
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Abstract

Introduction: Over the past years, there has been a global shift in the conceptualisation of healthcare. This has sparked emergence of different practises to improve access to SRH services including the concept of selfcare.

Problem Statement: Young people in Zimbabwe face a myriad of Sexual and Reproductive Health (SRH) related consequences as a result of poor access to SRH information and services. These include high unmet need for family planning amongst unmarried females at 37% for ages 15-19 and 17% for ages 20-24. High HIV prevalence 5.5% for females and 2.86 for males between the ages 15-24. High teenage pregnancy rate leading to high incidences of unsafe abortions and rising cases of birth complications and in some instances death.

Methodology and Objectives: The study is a literature review using the WHO Self Care conceptual framework to describe how SRH self-care is conceptualised in Zimbabwe. The study also seeks to identify and describe barriers, enablers for SRH selfcare and assess role of existing SRH selfcare interventions in improving SRH for young people.

Findings: The study showed that SRH selfcare for young people is still not conceptualised and considered as a practise that can be used alongside SRH facility-based interventions.

Recommendations: Integrating the concepts of SRH selfcare in the already existing SRH policy and SRH frameworks, can help in conceptualisation of SRH selfcare and stimulate implementation.

Conclusion: Using the WHO framework on Self Care, the study can deduce that SRH selfcare is still limited both in policy and practise and this has implications on implementation. However, following recommendations made in the study can help in addressing some of these challenges.

Keywords: Sexual and Reproductive Health (Rights), Self-Care, Zimbabwe, Young People, Conceptualisation

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Acronyms

AGYW	Adolescent Girls and Young Women
CSO/s	Civil Society Organisation/s
DHIS	District Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Information Management System
LMICs	Low- and Middle-Income Countries
MICS	Multiple Indicator Cluster Survey
MoHCC	Ministry of Health and Child Care
NASRHR	National Adolescent Sexual and Reproductive Health and Rights Strategy
NBSLEA	National Baseline Survey on Life Experiences of Adolescents
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
WHO	World Health Organisation
UHC	Universal Health Coverage
ZDHS	Zimbabwe Demographic Health Survey
ZNFPC	Zimbabwe National Family Planning Council

Definitions

Adolescent: WHO defines 'Adolescents' as individuals in the 10-19 years age group (1).

Young people: WHO defines 'Young People' covers the age range 10-24 years (1).

Self-care: WHO defines self-care as “the ability for individuals, families and communities to promote, maintain health, prevent disease and cope with illness with or without the support of a healthcare provider” (2).

Universal Health Coverage: WHO defines Universal Health Coverage as ‘’Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care’’ (3).

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Introduction

There has been a global shift in the conceptualisation of health and the delivery of health services. This is informed by several factors such as the evolving nature of some diseases, compounded humanitarian crises affecting populations and the changing health needs as influenced by the principles of Universal Health Coverage (UHC). While traditional methods in health service delivery are service provider oriented, the shift to self-care presents many positive prospects in improving the broad health goals at individual and national level. Self-care can also provide more opportunities for individuals to make informed decisions regarding their health and health care. The World Health Organization (WHO) defines self-care as "the ability for individuals, families and communities to promote, maintain health, prevent disease and cope with illness with or without the support of a healthcare provider" (2). The provider-to-receiver model that is at the heart of many health systems can benefit if complemented with a self-care model through which people can be empowered to prevent, test for and treat disease themselves (4).Self-care also builds upon existing movements, such as task sharing and task shifting, which are effective strategies to support health systems.

In order to meet the Sexual and Reproductive Health (SRH) needs, priorities and human rights of young people, innovative approaches are needed. The concept of self-care may not be new; availability of evidence-based technologies and products, outside of the traditional and formal healthcare systems, have pointed to the need of acknowledging the role individuals have in promoting, preserving their own health. (4) Examples of SRH related self-care practices which have been adopted by communities for decades now include self-care interventions for fertility regulation (for example, pregnancy tests and (5) contraception (6); sexual health promotion (for example, seeking advice and information through digital health for sexually transmitted infections, (7) virility enhancement, (8) and alleviation of menopause symptoms (9); disease prevention and control activities (for example, use of HIV pre-exposure prophylaxis (10); and treatment (for example, self-management of abortion (11) and that is self-administered HIV antiretroviral drugs in community based treatment clubs (12). Though practiced as an optional and sometimes peripheral health model, self-care has been proving over time why it should be considered as a prime strategy to achieving positive health outcomes

Background

The demographic profile of Zimbabwe exhibits conflicting characteristics which are both enablers and prohibitors to the adoption of self-care practises in general in relation to broader health and it even becomes more constricted when the self-care is related to young people and on SRH. For instance, a literacy rate which is among the highest in Africa would signify high prospects of young school going people being able to learn and apply self-care practices from school, family and community.

Demography, Ethnicity, Religion, Language and Population Distribution

Zimbabwe is a landlocked country that is located in the Southern African region, also officially known as the Republic of Zimbabwe. It shares its borders with the Republic of South Africa, Botswana, Zambia and Mozambique. Zimbabwe has an estimated population of 15, 331 426 people (13). In general the dominant ethnic group in Zimbabwe is African 98% (Shona 82%, Ndebele 14%, other 2%) with mixed and Asian constituting 1% while white is less than 1% (14).

The life expectancy in Zimbabwe is 54 years while the median age is 19 years. Literacy rate for the country is 90.7% for both males and females (13). The population growth for Zimbabwe is 4.38% and the country has an urban population of 38.6% (15).

Socio Economic Status

Zimbabwe can be considered a fragile state due to its poor economic performance, occurrence of natural disasters, poor health care systems. Before the COVID–19 pandemic, Zimbabwe's economy was already in recession, contracting by 6.0% in 2019.(15) Between 2011 and 2017 using the national extreme poverty line equivalent to 2011 Purchasing Power Parity (PPP) US$ 1.83 per day - rose from 23 to 30 % (16). It then increased further to 38 % in April-May 2019, with urban poverty rising faster in relative terms (from 4 % to 10 %) than rural poverty (43 to 51 %) (17). PPP is a theory of exchange rate determination. It asserts (in the most common form) that the exchange rate change between two currencies over any period of time is determined by the change in the two countries' relative price levels is used to measure the absolute purchasing power of the currency of a country, comparing through prices of specific similar goods in different countries (18) .As a means of measuring poverty, using PPP in Zimbabwe situates the socio-economic conditions of Zimbabwe within the global lenses of poverty.

Poverty is widespread in rural areas compared to urban areas and this has a huge bearing on the adoption of self-care practices by all populations particularly the young people within rural areas. Unemployment rate for young people in Zimbabwe stands at more than 80%, graduates have resorted to vending and cross boarder trading activities in order to survive (19) .Young people have to make difficult decisions between the ability to survive and accessing primary quality health care and exploring options for self-care. Food insecurity level is high, with 61 percent of the total population and 71 % of the rural population in severe or moderate food insecurity (13). Food security is one of the greatest determinants of behaviour within households by both the parents/guardians and children (13). At household levels priorities will change when there are existing food insecurities, because attention will be more on the immediate needs for survival vs good health outcomes-this choices are made between healthy meals vs having a meal for the whole family (13). The aforementioned economic stressors may have a negative effect on the knowledge, attitudes and perceptions of young people in regards to their health, including SRH outcomes and selfcare.

Zimbabwe's declining economy exacerbates the problems faced by young people in realising good SRH outcomes, particularly adolescent girls and young women (AGYW). The increasing prevalence of adolescent pregnancy has been co-related to high rates of child, early and forced child marriage (CEFM), barriers to education, including challenges paying school fees, and geographic and economic inequalities (18). Estimates of Zimbabwean girls aged 15-19 who are currently married or in unions similar to marriage, range from 22 % to 40 %, with higher rates in rural areas (17). Pregnancy rates among girls in rural areas are three times higher than among their urban counterparts (17). And for those who are poor (in the lower wealth quintile) rates are more than five times higher than their counterparts in the wealthiest quintile. Pregnancy amongst 15-19 year old is twice likely to happen amongst those who have only primary education , majority being in rural areas compared to those who got secondar education, majority being in urban areas (19). This highlight the challenges that girls and young women are likely to face a tripled burden to SRH

challenges compared to their male counterparts. And also shows across the girls and young women the disparities vary depending on geographical location , level of education , wealthy income and many other factors.

Health care system

The 2013 Constitution of Zimbabwe provides for the right of persons in Zimbabwe to accessing basic health care, including SRH services and management of chronic conditions, however a sub clause explicitly also provides delivery of such service is based on availability of resources (20). This becomes a salient condition when considering that Primary Health Care (PHC) services coverage reaches less than 50% of the 62.9% of the population that live in rural areas (21). Evidence showed that in 2015, 24% of health expenditures came from household out of pocket payments in Zimbabwe (22). The health financing system in Zimbabwe is largely out of pocket, due to the non-existence of a national health insurance(22). This creates barriers for young people, when they need to access SRH selfcare commodity using out of pocket expenses. Young people who are facing are high unemployment rate end up depending on the ability of their families to meet their health needs where user fees and payments are required to get SRH services. This reality is compounded by the fact that the majority of citizens, including young people, do not have health insurance as they are either unemployed or their guardians cannot afford health insurance for them. Providing primary health care is therefore the responsibility of the government, despite its substantial challenges in developing youth-oriented health delivery models.

Table 1 Health Facilities profile in Zimbabwe

Secondary Health Facilities	**Urban**	**Rural**	**Primary Health Facilities**	**Urban**	**Rural**
Central Hospitals	6	0	Clinics	158	964
Provincial Hospitals	8	0	Polyclinics	5	10
District Hospitals	22	22	Mission Clinics	0	25
Mission Hospitals	0	62	City Council/Municipal Clinics	96	0
Rural Hospitals	0	62	Rural Health Centers	0	307
1392	364	1452	Private Clinics	69	0
Total	**36**	**146**	**Total**	**328**	**1306**

Table illustrating distribution of health care services in Zimbabwe (24: p.32).

SRHR Policy Environment

Despite the development of policies aimed at improving the SRH for adolescents and young people, including the National Adolescent and Youth Sexual and Reproductive Health (National ASRH) Strategy II (2016-2020), the School Health Policy, implementation still lags behind. Zimbabwe does not have clear guidelines, strategies and policies which provide a roadmap on how

young people and the other population groups can practice self-care in health at a broad level. Resultantly self-care becomes an implicit and not deliberately designed health concept. The policy and legislative environment in Zimbabwe is not designed to support SRH self-care and this becomes a structural challenge in achieving positive SRH health outcomes.

Problem Statement

There are poor Sexual and Reproductive Health outcomes for young people in Zimbabwe and these outcomes are characterised by high teenage pregnancy and fertility, high incidence of HIV, high mortality rates due to HIV and AIDS, unsafe abortions and lack of comprehensive knowledge on HIV, amongst others.24.1% of women aged 20-24years gave birth before the age of 18 (24).There is a high unmet need for family planning amongst unmarried girls and young women 37% for 15-19 years and 17% percent for 20-24 years, compared to 12.6% and 10% of married girls and young women of the same age respectively (25).

An estimated 1,2 million people ages 15+ are living with HIV, 81 300 of this population are adolescents between 10-19, and 14 700 are pregnant adolescent girls and young women (26). Amongst the most vulnerable young people's knowledge of HIV is in decline (27) .It decreased from 54% in 2011 to 43% in 2015 (25). Around 50 percent of 15-24-year-old men and one third of 15-24-year-old women have never tested for HIV (25). HIV prevalence for females 15-24 years is almost twice at 5.15% compared to their male counterparts at 2.86% (26). In this age group an estimated 2400 annual AIDS deaths were recorded, making HIV and AIDS the number one killer of adolescents in Zimbabwe (26).

In Zimbabwe abortion is permitted under special circumstances including conceiving through incest, conceiving as a result of rape, to save a woman's life or in the case of fetal abnormalities (28) .Abortion related mortality and morbidity due to unsafe abortion hugely affects women and girls in Zimbabwe (28). A study conducted showed that 12% of less educated, unmarried and from rural areas young adolescents are more likely to experience adverse unsafe abortion complications (29 .Post abortion care services in Zimbabwe are limited, judgmental and non-supportive (29) .The legal restrictions on abortion, even limits innovations around safe, self-abortions.

SRH services and products which should be reported with high uptake because they require limited or no assistance by a health worker thereby promoting self-care are still not yet meeting or surpassing set targets. These include condom use, oral contraceptive use, adherence to ART, and uptake of HIV self-testing among others. Self-care is an implicit concept for a significant number of SRH services and products offered in Zimbabwe. The Ministry of Health and Child Care does not explicitly have national guidelines and programmes which spell out how the general population can prioritise self-care as a means to achieving positive health outcomes. While for older generations ,particularly women, SRH self-care becomes a default priority due to experiences of parenthood, being mothers and wives. A huge gap still remains amongst young people who do not hold with the same regard the importance of SRH self-care. Specific SRH services and products have in their nature promoted self-care such as HIV Testing, Anti-Retroviral Therapy, Family Planning and Menstrual Health Management services.

Justification

The global shift in health care from the traditional facility-based service delivery of services towards a blended approach of both service provider and client-initiated interventions has necessitated the need for the study. Research into self-care is not exclusively Zimbabwean but a global phenomenon. Public health emergencies like COVID 19 pandemic, provides a basis to amplify the importance of self-care considering preventive measures adopted which included wearing masks, washing hands. In the absence of vaccines or limited availability of vaccines communities relied on these self-care interventions. Therefore, looking at the SRH context, selfcare can play an important role in disease prevention e.g. HIV and STIs, limiting SRH consequences for young people e.g. through use of contraceptives to prevent unwanted pregnancies. Overall the demographic profile of Zimbabwe places young people at greater likelihood of not adopting broader health self-care including some recommended SRHR self-care practices because of the socio-economic and political factors. These factors as has been illustrated above include limited access to primary health services, inability to adopt self-care practices which require money, unsupportive legislative and policy environment as well as harsh conditions inhibiting access to basic education and other social services. Despite all the existing SRH policies, frameworks and strategies in Zimbabwe, young people are still facing huge SRH challenges. A solution to this requires exploring innovative, methodologies like self-care that have a human centered approach and allows adolescents and young people to have autonomy over their health.

Research Questions

1. What is the concept of self-care from an SRH perspective -what does it mean, are there any guidelines, why do people use this concept, why now?
2. What are the barriers to SRH self-care amongst young people-what limitations exist?
3. What are the enablers for SRH self-care amongst young people -what motivates people to be active agents in their health?
4. What role do existing SRH selfcare interventions in Zimbabwe play in SRH outcomes for young?
5. What is missing from already existing interventions on SRH and young people with regards to the selfcare approach?

General Objective

To identify and describe factors influencing SRH selfcare amongst young people 10-24 years in Zimbabwe in order to make recommendations for further studies and a basis for policy review or strategy development for SRH selfcare.

Objectives

1. To describe the conceptualisation of SRH self-care amongst young people in the context of Zimbabwe.
2. To identify barriers and challenges faced by young people in Zimbabwe in practising SRH self-care.
3. To identify enablers that support young people in Zimbabwe to practise SRH self-care.
4. To assess the role of existing SRH self-care interventions in Zimbabwe in improving SRH outcomes for young people in Zimbabwe.

5. To proffer recommendations that can be used to inform further research, and a basis for policy review or strategy development.

Hypothesis

The study is premised on the alternate hypothesis that young people practice SRH self-care as a result of numerous factors. In explaining this hypothesis, the predictor variables are the existing social, economic and political factors. The presence of these predictor variables will influence the adoption of SRH self-care practices by young people. The null hypothesis for the study is that the young people do not practice SRH self-care at all. The null hypothesis will be premised on the assumption that the factors identified instead of acting as enablers for young people to practise self-care have the contrary effect resulting in the young people not practising self-care.

Methods

To contextualise and situate the study within the existing body of knowledge, a literature review was used as the methodology. A literature review is a non-experimental design in which the researchers objectively critique, summarise and make conclusions about a subject matter. (30,31,32). This is done through a systematic search, categorisation and thematic analysis of literature which can be from past studies, both quantitative and qualitative (30,31,32). Literature review involves researching, reading, analysing and summarizing scholarly literature, that is, articles or report on factors influencing SRH self-care amongst young people in Zimbabwe. Literature review addresses research questions on perceptions, experiences and motivation for using self-care among young people, the barriers they face and the mechanisms that support them to practise selfcare.

The study reviewed articles which were published in the past 15 years in relation to SRH in Zimbabwe and other Low and Middle Income Countries (LMICs). Literature was searched using keywords (Sexual and Reproductive Health (Rights), Self-Care, Zimbabwe, Young People, Conceptualisation) . Sub topics were developed based on each objective in order to categorise the search and data for different sections. Search engines including Google Scholar was used and platforms including VU Online library, PubMed were used. Peer-reviewed primary research papers and conference abstracts were also included to provide insights.

Table 2 Search Strategy per Objective

Objective	**Databases**	**Keywords/Search terms. Boolean approach**	**Link with framework**
One - Concept of Self Care and Policy Landscape in Zimbabwe	-WHO Publications -Zimbabwe Ministry of Health and Child Care Resources	-Sexual and Reproductive Health -Self-Care -Low- and Middle-Income Countries -Policy	Relates to all the elements although the policy landscape is tied to the Enabling Environment where there is need for

		-Zimbabwe -Young People -Reproductive Health -Youth	supportive laws and policies.
Two - Barriers faced by young people in practising self-care	Zimbabwe National Planning Council Publications and Resources	-Sexual and Reproductive Health -Self-Care -Zimbabwe -Young People -Access to services	Relates all the fur spheres of the framework as barriers relate to human rights, places of access, enabling policy environment and accountability.
Three - Enablers that support young people to practise self-care	Zimbabwe Ministry of Health and Child Care Resources	-Sexual and Reproductive Health -Self-Care -Zimbabwe -Young People	Relates closely to the sphere of an enabling environment on the WHO Framework
Four - Role of SRH Self Care Interventions in improving health outcomes in Zimbabwe	-Zimbabwe National Planning Council Publications and Resources -Zimbabwe Ministry of Health and Child Care Resources	-Sexual and Reproductive Health -Self-Care -Health facilities -Zimbabwe -Young People -Health outcomes	Relates mostly to the spheres of places of access and enabling environment
Five - Recommendations for future research or policy and strategy development	-Zimbabwe National Planning Council Publications and Resources -Zimbabwe Ministry of Health and Child Care Resources	-Sexual and Reproductive Health -Self-Care -Policy -Zimbabwe -Young People -Health outcomes	Relates more to the spheres of enabling environment and accountability which are high level

Analytical Framework

The study will adopt the World Health Organisation Selfcare Conceptual Framework which was popularised by the development of the WHO Consolidated Guideline on self-care interventions for health in 2021. This conceptual framework on self-care interventions has core elements from both “people-centred” and “health systems” approaches, underpinned by the key principles of human rights, ethics and gender equality (2). WHO selfcare framework combines both people centred approach and health systems approach to selfcare that can support introduction of new interventions, upscaling existing interventions in intersectionality with key principles in SRHR with include gender equity and equality, ethics, human rights based, throughout one's life course

and comprehensive services and information. The Framework acknowledges the interconnectedness of different health systems building blocks and functions to ensure that people are in control of their own health and become active agents in their own health care.

In Low- and Middle-Income countries such as Zimbabwe where the health sector is challenged by perpetual challenges such as violations of human rights relating to health, inadequate services, limited civic knowledge on health information, economic instability and high levels of poverty, the Framework becomes useful as it spreads across these themes. The analysis conducted in this study will look at specific elements within the 4 spheres of focus of the WHO Self Care Framework. Broadly the specific elements which have been singled out for application in this study were selected for 3 reasons; Relevance to Zimbabwean context, Likelihood of data availability, and Comparability of elements with regional and global data. The specific elements selected for focus from the Framework being utilised are provided in the table below:

Table 3 WHO Self Care Framework Analysis Elements

Sphere	**Specific Element**	**Rationale**
Key Principles	a. Human Rights b. Gender Equality	The two elements resonate with objectives 1 and 2. An understanding of Human Rights and Gender heralds an introspection into political, legal and social factors related to SRH self-care in Zimbabwe and how this translates to conceptualisation of self-care in the health and wellbeing of Zimbabweans.
Places of access	a. Health Services b. Pharmacies c. Traditional medicines and social cultural practises d. Caregivers	The four elements shed more light on research questions 2 and 3. To unpack the barriers and enablers to self-care in Zimbabwe.
Enabling environment	a. Supportive Laws & Policies b. Commodity Security c. Health Financing	The three elements assist to answer question questions related to objective 1, 3 and 4 of the study. An exploration of the laws, policies, funding for health sector and availability of commodities will provide essential data to explain the landscape, enablers and existing interventions
Accountability	a. Government Accountability b. Private Sector Accountability c. Donor Accountability	The three (government, private sector and donor are the tripod holding together all health efforts hence accountability at these three levels becomes mandatory and not optional. The elements relate as well to objectives 1, 4 and 5. The study should be referenceable by all three.

Limitations of the Study Design

There are two major limitations of the study based on the chosen methodology that is literature review and using the WHO analytical framework

1. Using literature review as the only methodology in unpacking a complex concept like SRH selfcare for young people in Zimbabwe, may not be sufficient enough. This is because there is already limited research on SRH and young people in Zimbabwe and further narrowing down to focus on SRH selfcare, narrows down the availability of credible data sources that are relevant to Zimbabwe.
2. The WHO framework has broader components, so to explore them using the literature review method would not have been possible with the available time for the research process. This meant using some components of the framework, choosing them based on relevance to the Zimbabwean context, availability of data and applicability to the context of young people in Zimbabwe.

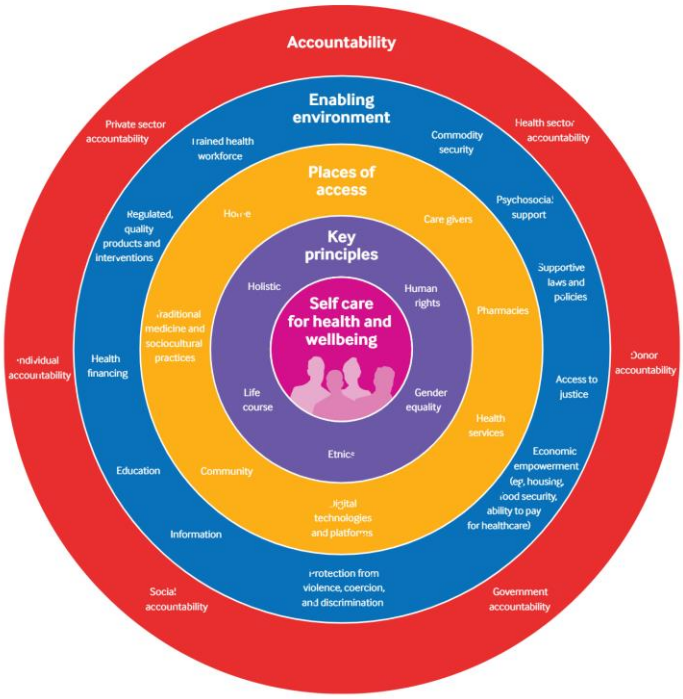

Figure 1 of the WHO Self Care Framework (2:p.3)

Study Findings

In this section, the study results and findings will be shared using the WHO Selfcare framework (see Figure 1) and organised using the detailed approach (see Table 2). Data discussed in this section will focus on SRH broadly and narrow down to self-care interventions which relate to contraception, abortion and self-management, HIV testing, HIV prevention, STI management, SRH information, and reproductive cancers

Key Principles

Human rights

Conceptualising SRH selfcare in the context of Zimbabwe can be challenging especially from a Human Rights perspective. Human rights, accountability frameworks can be used to better understand the responsibilities of the health sector, (both government and private) and individuals themselves with regard to access to, uptake and use of SRH interventions (33). International frameworks such as the WHO Self-care framework are rendered weak in terms of the principles of human rights. This is because frameworks are not enforceable documents but rather rely on the goodwill of member states and signatories to domesticate into national legislation or policies. In the context of Zimbabwe SRH self-care as a human rights issue departs broadly from the Constitution of Zimbabwe and other existing acts, policies and frameworks as explained see Table 4 below:

Table 4 Implication of Human Rights on SRH Self-care in Zimbabwe

Law/Policy/Guideline	**Narration**	**Implications for SRH self-care**
Constitution of Zimbabwe, Section 76	"(1) Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health (2) Every person living with a chronic illness has the right to have access to basic healthcare services for the illness (3) No person may be refused emergency medical treatment in any health-care institution,	The recognition of reproductive health rights in the constitution provides a legal basis for young people to access the services as a right. However, the misalignment of this provision with other SRH laws and policies which should encourage SRH self-care leaves a huge gap. Young people still require consent for HIV Testing, STI Screening as per guidelines despite this

	(4) The State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realization of the rights set out in this section"	provision hence making self-care as a child difficult in the household with parents.
Public Health Act of 2018, Section 35	(1) For the purposes of this section "informed consent" means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 34 (2) A health service shall not be provided to a user without the user's informed consent	Primary health care in Zimbabwe is chiefly facility oriented hence requirement for parental or guardian consent to access SRH services at the facility which serves as the nucleus for offsetting self-care practices discourages the young people from going to health facilities in the first place.
Medicines and Allied Substances Control (General) Regulations, 1991, Section 52(2) Statutory Instrument 150 of 1991	"No person shall sell any medicine to any person apparently under the age of 16 years — (a) in the case of a household remedy or a medicine listed in Part I of the Twelfth Schedule, except upon production of a written order signed by the parent or guardian of the child known to such person; (b) in the case of any other medicine not referred to in paragraph (a) except upon production and in terms of a prescription issued by a medical practitioner, dental practitioner or veterinary surgeon."	Pharmacies and other places of access to the young people for any SRH products and services are rendered inaccessible due to the provisions in this Act and regulations. Over the counter medication, family planning pills and other services which could be easily accessed outside a health facility as part of self-care practices becoming challenging to access
National HIV Testing Guidelines of 2014	A child under the age of 16 is unable to consent to HIV testing and counseling (HTC)	A young person is unable to access HIV self-test kits without the parental consent despite some of the young people requiring the tests because of experiences of sexual abuse by family. Self-test kits are one example of a self-care practice

National Family Planning Guidelines for Zimbabwe 2018	Health providers must thus be aware of risk factors for adolescent pregnancy and offer comprehensive integrated RMNCAH services inclusive of educational, counseling and contraceptive services where needed	Young people by right and national guidance can access family planning services at any age when they feel they need the services. However, evidence shows that health professionals oftentimes do not offer youth friendly services because of stigma, and judgmental attitudes.

Gender equality

AGYW in the Eastern and Southern Africa Region (ESAR) face serious challenges to fulfilling their SRHR, including vulnerability to HIV, STIs and unintended and unsafe pregnancy (34). SRHR Selfcare interventions for AGYW should be equitably designed in light of the disproportionate burden they have. Selfcare when promoted throughout the lifecycle of a woman, provides empowerment to proactively maintain their health. For girls and young women who are mostly impacted by adverse SRH outcomes, selfcare supports them to have agency and a voice, and capacity to speak to their own needs (35).

The 2016 National Adolescent Fertility Study raises "negative attitudes regarding sexual activity before marriage" as contributing to the lack of knowledge of contraceptives among young women. (36) .The ASRH Strategy II (2016-2020) puts emphasis on the importance of increasing adolescents' knowledge of their SRHR as a pathway to reducing harmful religious, cultural and social norms and associated health risks (37). However, the National Gender Policy 2013- 2017 fails to make any substantive reference to addressing patriarchy, cultural norms or stereotyping, which underlie Zimbabwe's profound gender inequality (38) .Failure to address these underlying inequalities has huge implication in how SRH is perceived from a gendered perspective, and limits autonomy and agency of girls and women (38). The policy also has 4 themes that mainly focus on social-economic empowerment leaving out overall health and wellbeing where issues of SRH selfcare are likely to have been addressed from a gendered perspective (38).

Places of access

Health Services

Health inequalities are widened by varying access to healthcare within different ethnic groups, socioeconomic, geographical locations, gender and age. Long distance and long travel times to health facilities, ability to pay for the travel, availability of services and medical drugs at the healthcare centre and availability of competent health workers are some of the factors that influence access to healthcare services in developing countries including Zimbabwe (39). More than 63% of young people interviewed by the Young People's Network (YPN) described their environments as discouraging for them to access SRH services as service provision is characterised by moral judgements, stigma, discrimination and negative service provider attitude (40) .73% of respondents in a survey conducted by the YPN, on the barriers for young people to access condoms, lubricants, family planning pills and HIV self-test kits, indicated that attitudes of

pharmacy personnel and health personnel particularly of older generations from public facilities have discouraged them from accessing the aforenamed services and products (40).

Young people in urban areas have better chances to access SRH self-care information or education and accompanying commodities such as condoms, family planning pills, HIV and pregnancy self-test kits and refills for antiretroviral medicines, compared to young people in rural areas. For example, in Zimbabwe, people in rural areas often have to walk between 10 km and 50 km to access the nearest health facility (25).The share of rural-urban population stood at 61.4 percent for rural and 38.6 percent for urban in 2022, compared to 67 percent rural and 33 percent urban in 2012 (25). When narrowed, 75.2% of the youth population in Zimbabwe (10-24years) are found in rural areas, while the remaining 24.8% is urban based (41). Despite the bigger proportion of people including young people being located in rural areas, the availability of health facilities in Zimbabwe is urban centric which poses a barrier in advancing SRH self-care interventions which have to be hinged on and spearheaded by the health facilities themselves.

Pharmacies

It is estimated that in Zimbabwe about 51% of young people (15-19 years) access their contraceptives from private pharmacies (39). The Zimbabwe National Family Planning Council (ZNFPC) also noted that pharmacists are a key stakeholder that cannot be left behind in promoting contraceptive uptake by adolescents as they constitute 22% in the distribution of family planning commodities (39). Access to SRHR selfcare commodities through pharmacies is an enabler for those in urban areas, where you find a pharmacy for every 1.8kms radius of a residential area (42). Pharmacies as a source for commodities and information are a barrier for improved SRHR selfcare for young people in rural areas, where you find a pharmacy only in peri-urban centres commonly referred to as Growth Points. The majority of rural areas will only access any medical services, information and commodities from clinics which are accessible within a huge radius of 6-15kms. (43). Of great concern is that for urban youth, the pharmacies are located in areas where public transport is available for travel while for rural youth most distances are traveled on foot. In one study that sought to ascertain the distance traveled to health facilities by professional nurses and health care users in rural areas, it could be established that the health care users could travel distances beyond 10kms (see figure 2 below) .

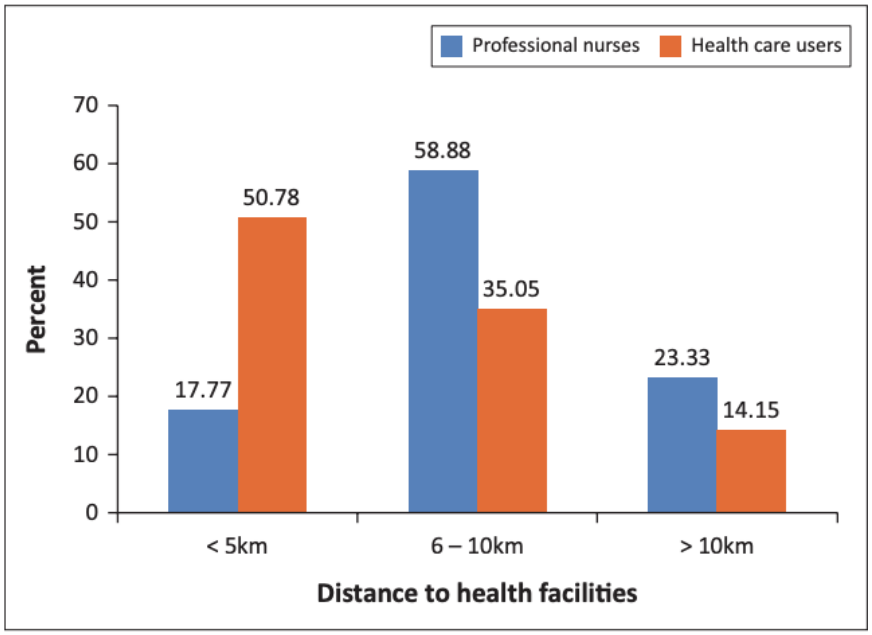

Figure 2 Showing estimated distance travels for professional nurses and health care users in rural areas (23)

Traditional medicines and social cultural practices

Young people in Zimbabwe, like any other youths in the world deal with multiple complex SRH challenges, due to entrenched cultural norms, values (44). Use of traditional medicines for treatment of STIs, infertility, menstrual health management are self-care based however, are also barriers to medical SRH selfcare for young people. Zimbabwean socio-cultural landscape frowns upon sex and sexuality and this has an impact on SRH for young people (44). This is evidenced by existence of taboos, around boy functions, sex, menstruation (45). Cultural norms, that are unwritten for example that young unmarried people should not be having sex, can play a huge role in how young people perceive the need to access SRH selfcare commodities for safer sex (44).

Caregivers

Caregivers, despite being noted as a place of access by the WHO Self-care framework, also have their challenges (46) .Commonly known types of caregivers are professional caregivers, family caregivers, independent caregivers, private duty caregivers, informal caregiver and volunteer caregiver. In the context of Zimbabwe, there are three types mostly used namely professional, family and informal. The family which plays the biggest role of caregiving for the young people entails father, mother, grandparents, sisters/brothers and uncles/aunts. Using data from a 12-month prospective cohort of caregivers of HIV-positive children aged 9–15 on ART and pre-ART in rural Zimbabwe, the study found that caregiver self-efficacy to talk about sex predicted whether conversations about HIV transmission would occur between caregiver and the young person (46). However, by the end of 12-months, nearly two-thirds of caregivers of HIV-positive teenagers in the sample had still not explained how their adolescents could spread the virus to others despite these caregivers saying their adolescent should know this information at baseline (46). This is evidence that information giving, one of the key practices that promotes SRH selfcare amongst young people is still limited. Efforts have been made for caregivers and community health care workers collaborate to bridge the gap between community and health facilities. Programs like

Parent to Child Communication in Zimbabwe, have been implemented since 2017, young people still have limited SRHR information (47) .Without adequate information, young people have limited agency to practise SRH selfcare.

Enabling environment

Supportive laws and policies

The majority of countries in the ESA region do not have provisions that clearly set out the right of adolescents to access SRH services(48).Zimbabwe is no exception as there is huge disconnect between laws, policies, guidelines, and practices governing how (places of access) and when (age of consent) young people should access SRH services (43). The discordance has created a huge gap for the young people who have ultimately failed to access SRH services and subsequently practice SRH self-care. The National Health Strategy in Zimbabwe does not articulate how an enabling environment will be created for the realisation of the health outcomes spelt out in the same document. The strategy does also not specify where selfcare, is when there is an analysis of the healthcare pyramid (49).

Outcome three of the National SRH Strategy focuses on Strengthened protective environment for adolescents and young people (50). One of the three outputs under that outcome is Output 3.1: A policy, legal and institutional framework that protects the SRHR of adolescents and young people is in place and enforced (50). Objective 4 of the Zimbabwe National Family Planning Strategy 2016-2020 is '*To increase availability, access and utilisation of integrated SRHR and HIV services for young people aged 10 – 24 years* (51). However, regardless of such available guidelines in SRH frameworks, Zimbabwe has not moved to explicitly develop an SRH and self-care policy.

Commodity security

Young people have a higher likelihood of practising SRH self-care when the commodities they need are available and easily accessible such as HIV self-test kits, anti-retroviral drugs, family planning products, condoms and lubricants. Reported stock outs of the second line antiretroviral and limited access to public sector condoms for rural girls have tainted the perceptions of commodity security among the young people (52). Shortages discourage young students from accessing services hence disabling them from practising self-care. Zimbabwe, with the support of UNITAID and Population Services Health has implemented self-testing through the STAR initiative, which has distributed more than 645,000 kits to date in the country (52). Zimbabwe has seen large increases in testing among three key groups as a result of self-testing: men, adolescents and those who had never previously tested for HIV (52). Among the population of 16 to 24-year old, uptake of testing increased from 35 to 74 percent (52) .The availability of HIV self-kits has contributed to improved HIV testing among adolescents and young people who dreaded going to public health facilities out of fear of receiving judgment or being asked to bring a caregiver as the age of consent for HIV tests is 16 in Zimbabwe.

The Zimbabwe National Family Strategy Costed Implementation Plan notes the significant advancements made in improving commodity security for the benefit of the citizens. Before 2004, contraceptive resupply was through a "traditional pull system" whereby service delivery points placed their orders of the required commodities (53). In 2004, a more informed push system called Delivery Team Topping Up (DTTU) was introduced based on past consumption patterns of the

contraceptives per each service delivery point (53). In April 2014, MoHCC piloted the new Zimbabwe Assisted Pull System (ZAPS) consolidating DTTU and three other existing commodity distribution systems (53). The ZAPS system has created a distribution system which ensures consistent supply of family planning commodities as informed by consumption trends and not waiting on orders received. Improvements in SRH selfcare commodities like oral contraceptives, highlights how SRH selfcare interventions can play a role in improving SRH outcomes for young people. However, despite these efforts to make contraceptives available in the country, issues such as funding for procuring commodities, availability of a broad range of contraceptive products and management of the supply chain must still be addressed to make even more progress towards commodity security.

Health Financing

The structure of the national budget in Zimbabwe leaves no room for support of self-care interventions. By design and prioritisation the focus of the health budget is on curative services which are largely clinical and facility centered (54). Curative services by their nature focus on care with the aim to cure a disease or promote recovery from an illness, injury or impairment. This financing model places priority on facility based services and leaves less room for self-care. Although the budget does not publicly release the allocations per thematic area, the priority areas set out in the National health Strategy which is the basis for allocation do not mention self-care. Figure 5 below shows a breakdown of 2021 MoHCC budget, US$ millions and percent of total;

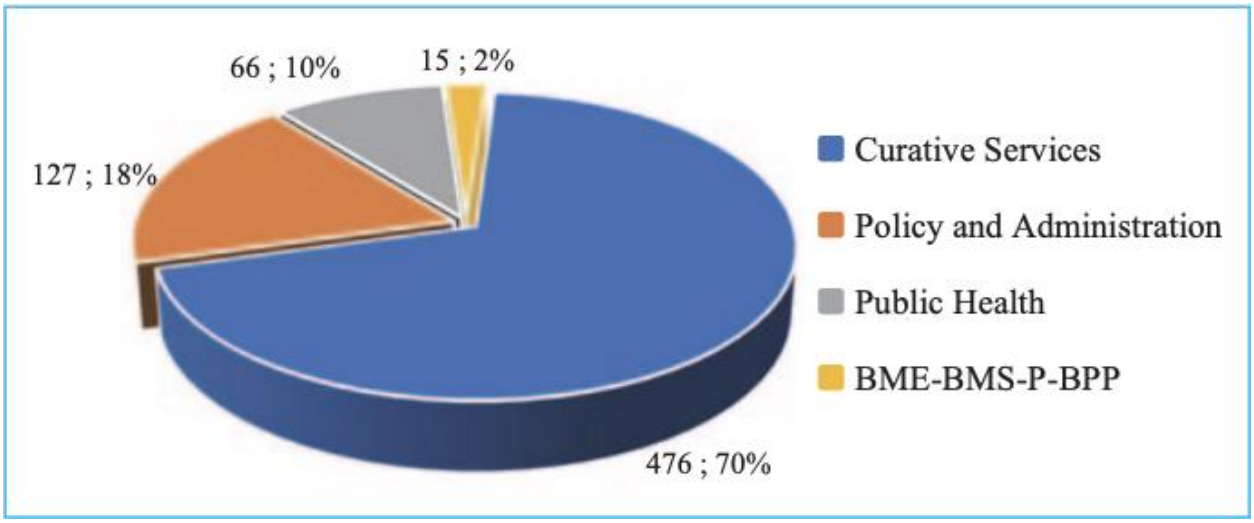

Figure 3 Showing Breakdown of 2021 MoHCC Budget (54:p5)

As a share of the total MoHCC budget, the Curative Services Programme has the highest proportion and was allocated 70% in 2021 (54). The curative services budget, covers all expenses related to treatment services, from health posts to Central Hospitals.(54) .The financing structure within the Ministry of Health follows the guidance of the National Health Strategy which has the same flaw of missing self-care interventions as primary models of realising positive health outcomes nationally. The resources set aside for curative services are then further allocated based on the priority areas specified in the National Health Strategy which is silent on SRH Self Care. The budgeting structure itself is problematic as it has emphasis on disease control and treatment at the expense of every other health theme.

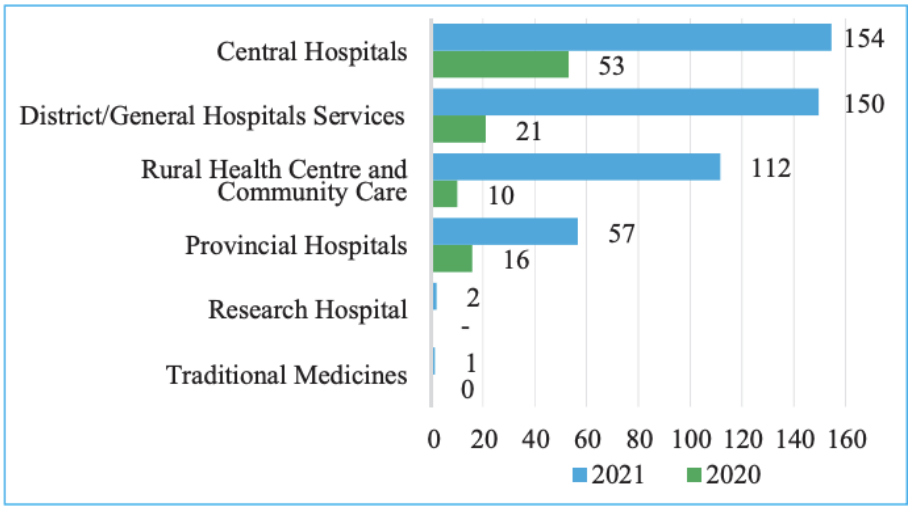

Figure4 Illustrates allocation of MoHCC buget across health care facilities for curative services US$ millions (54:p5)

From the Figures 3 and 4 above, two observations which can be made of factors that contribute in compromising the ability of young people in strategic terms is the lack of an allocation for self-care as well as urban centric funding focus for facilities which widens the urban-rural divide.

Accountability

Government Accountability

As the 4th broad pillar of the WHO SRH Self Care Guidelines, accountability plays a pivotal role in safeguarding against numerous vices such as corruption, redundancy, and prioritisation of resources. Accountability is a process where government actors are responsible and answerable for the provision of high quality and non-discriminatory goods and services (including the regulation of private providers) and the enforcement of sanctions and remedies for failures to meet the obligations'' (55). In Zimbabwe accountability models such as the Results Based Funding (RBF) created mechanisms which account for resources and time set aside for interventions which promote SRH self-care.

With RBF, results are defined in advance and funding is only released upon the achievement of these results that are verified independently (56). The rationale behind this approach is to link financing more directly with outputs and outcomes, rather than inputs and processes and the objective is to increase accountability and create incentives to improve programme effectiveness(56). Through RBF, parallel systems have also been established for purchasing commodities and products which contribute to the realisation of RBF indicators (57) .Resultantly, the accountability of the purchasers is to funders as much as to the government (57). The government accounts more for funding received which is tied to indicators as that elevates its prospects for more funding. The gap created by this accountability framework is that self-care falls away from the priority areas and is therefore not actively tracked by the set indicators.

Private Sector Accountability

The private sector in Zimbabwe has played a pivotal role to complement the efforts of the government. The role and impact of the for-profit private sector in healthcare delivery, especially in low income countries, remains a highly-debated and contentious issue both from an ideological and practical perspective, with particular regard to healthcare equity and access issues. Consistent with evidence gathered elsewhere, the private sector in Zimbabwe has limited access to products and services due to costs beyond low and middle-income earners (58). Empirical evidence has been presented over the years, for and against private sector participation in healthcare; with critics arguing that private sector-run health facilities' high prices limit the poor's access to and use of healthcare facilities, thereby undermining healthcare consumption affordability, access and equity (58).

The private sector play a role in service delivery through supporting health services outreach programs in underserved communities and supporting with incentives for staff retention in Zimbabwe to enable service delivery(58). The private sector mainly through pharmacies in urban areas a sources of information, and play a role in commodity security (58).While regulatory authorities such as the Medicines Control Authority of Zimbabwe handle issues of quality assurance, and accountability a huge gap still remains on monitoring the distribution and uptake of self-care products and services being provided by the private sector either through pharmacies or selling points like stores.

Health system building block	Stakeholders and their interventions	Impact	Existing gaps
Service delivery	Individuals and consortia setting up private hospitals, private clinics and private wards in public hospitals	Improved service provision in most urban and provincial hospitals.	Populations in rural and farming communities still underserved
Health workforce	Medical school bursaries by some mobile phone companies and health insurers and health staff retention allowances by bilateral and multilateral donors	Stabilisation of staff numbers, morale and skills levels in some health facilities	Staff retention mainly in urban facilities. There is also unequal burden sharing between health facilities in that government trains and loses staff to private health sub-sector. Underfunded MOHCW unable to absorb all trained nurses. Emigration of junior doctors due to poor emoluments
Information	Support from mobile phone companies for health information systems, solar energy and internet connectivity at rural hospitals across the country	Up to 80% of rural hospitals and clinics able to provide and access information instantly	Some rural and farming communities still lack infrastructure for internet and would benefit from resuscitation of abandoned technologies such as radio communication systems
Medical products, vaccines and technologies	Support by multilateral donors for decentralisation of screening and treatment services for NCDs	Specialist NCD centres mainly in major cities Harare and Bulawayo.	Disconnect between diagnosis and treatment e.g. chemotherapy still centralised and costly
Financing	Public and private medical insurance schemes to cover user fees	Country has 33 medical insurance providers, with diverse and innovative packages that include individual and family packages, which allow access to different categories of health facilities	Only 10% of the Zimbabwe's 13million population has medical aid cover; the urban and rural poor cannot access specialist health care unless they can pay for it out-of-pocket
Leadership/Governance	Multilateral donor, civil society and corporate sector support of the review of the Public Health Act	Public Health Act 15:09 now in place, emphasising need for broad-based stakeholder awareness and collaboration	Awareness-raising efforts on Act and other strategies are under-resourced, not widely spread and ad hoc, hence many social and institutional actors remain unaware of their role in implementation

Figure 5 Shows Private sector involvement in Zimbabwe's health system (2013–2015)

Donor Accountability

Donors to Zimbabwe have greater inclination towards upward accountability. This form of accountability focuses on the provision of narrative and financial reports to donors at periodic

intervals. In Zimbabwe, donor funding through various mechanisms has consistently been the largest pool aside from the Consolidated Revenue Fund (CRF) that offers financial protection, predictability and equity in most instances (59). Various donor pools

exist in Zimbabwe such as The Global Fund for HIV/AIDS, Malaria and TB, HTF/HDF for RMNCH and adolescent health, the European Union (EU) and other foreign government pools such as PEPFAR. Alongside multi-funder pools PEPFAR and World Bank also provide resources targeted at various interventions. (60) External pools contribute over 55% of public sector resources to health though most of the funds are earmarked for specific interventions and specific geographic areas thus limiting equity and access to care for other diseases and populations. There are no funders who have clearly demonstrated interest in SRH Self Care as all of the aforementioned focus on priority areas set by the national health strategy.

Discussion

This section will discuss the findings from the previous section in light of the research objectives. Research questions posed in earlier sections will be answered in this section as the findings and existing literature will be discussed.

Understanding the Concept of SRH Self Care and Policy Landscape

Self-care is difficult to conceptualise in the context of Zimbabwe due to these four basic reasons. The first reason is that there are no clear referenceable guidelines which articulate what SRH self-care is in the context of Zimbabwe. In countries like Nigeria where the Guidelines are there and clear, the concept becomes easier to understand. The Primary Health Care system in Zimbabwe is skewed towards facility-based care models. The National Health Strategy has four Priority Areas and Objectives for each area. These Priorities are: Communicable Diseases; Non-Communicable Diseases; Reproductive, Maternal, Newborn, Child and Adolescents; and Public Health Surveillance and disaster preparedness and response.

For all the objectives, particularly those set under Priority three which speaks about adolescents, there is no objective which relates to Self-Care or themes which have a clear contribution towards SRH Self-care for young people. There are both definitions and conceptual limitations to understanding SRH self-care in Zimbabwe as it is not expressly explained in any of the key documents which provide guidance to SRH and young people such as the ASRH Strategy, National Family Planning Guidelines, and Zimbabwe School Health Policy.

Nigeria became the first country in 2021, worldwide to develop and implement a national self-care guideline , in a bid to expand access to self-care. This move from Nigeria has set precedence on how countries in LMICs can also conceptualise self-care as part of the broader health system. The National Guideline on Self-Care for Sexual, Reproductive and Maternal Health 2020 Guideline developed by the Federal Ministry of Health in Nigeria makes provision for understanding Self-Care in the lenses of other Frameworks (61). The Guideline contains a table of the policy mapping of self-care interventions for sexual, reproductive, and maternal health in Nigeria (61) .Contrary to the context of Zimbabwe, Nigeria has clear frameworks which provide guidance in the introduction of SRH Self-care interventions. In the case of India, the Sexual and Reproductive Health and Rights in India Self-care for Universal Health Coverage Guideline was developed to

provide a framework for Self-Care. This Guideline serves well as the Framework upon which all SRH Self-care work can be carried out contrary to Zimbabwe.

The second reason was that in order to understand the elements of SRH self-care using data available in the public domain presented a problem of data deficiency. The data collected by other agencies i.e. government, civil society, private players is available using the data management guidelines for those entities, which is mostly on SRH not particularly SRH selfcare. For example, data on HIV incidence does not then clearly disaggregate between data from self-test kits and facility-based testing to enable the researcher and others to see the contribution of HIV Self-Test kits towards increasing testing numbers.

The third reason is policy and the legal environment in Zimbabwe is not harmonised which makes it difficult for young people to enjoy their SRHR let alone practice SRH Self-care for example HIV self-testing, pregnancy self-test. The limitation of access to SRH services to persons above 16 years of age is often linked to the age of sexual consent, which in Zimbabwe is set at 16 by the Criminal Law (Codification and Reform). The notion is that a person under the age of 16 cannot legally have sexual intercourse and, therefore, can only access SRH services with a police report or adult accompaniment. Young people below the age of 16 are prejudices as they seek SRH services, as there is a presumption that any child below 16 years cannot consent to sex, should not be having sex hence no need for SRH services like contraceptives (48). This confusion is compounded by the government's stated intention of aligning the legal age of sexual consent to 18, just like the legal age of marriage (48). Therefore, the influence of cultural and religious norms and attitudes, and the confusion at law between age of consent to sex, age of consent to accessing services and age of consent to marriage challenges the conceptualise of SRH self-care interventions for young people. There is no clarity of where to draw the line on what a child at law below 18 can or cannot do with regards to their autonomy and selfcare.

The fourth reason which compromised the conceptualisation of the SRH Self Care concept is that there is very limited literature available for SRH Self-care in Zimbabwe. Existing literature is mostly on SRH interventions that are mainly health facility based, and the study needed to focus on those that are selfcare oriented. Research on the subject matter is reflected to be limited hence inability to reference direct articles but using inference. This limited the scope of the analysis considering the broadness of the WHO selfcare framework and how unpacking each component would have supported the analysis of conceptualising SRH self-care in Zimbabwe.

Limitations/Barriers to SRH Selfcare for young people in Zimbabwe

Young people face multifaceted and heterogeneous barriers to access SRH services on a broad scale. Beyond the prescriptions of policies, laws, strategies and guidelines which can be clear in some instances ie Family Planning Guidelines allow for anyone who is sexually active to access family planning services, service providers, community and family will still deny or subtly discourage the young people from accessing self-care products and services. What is provided for structurally has been compromised by social barriers and what is socially enabling is being compromised by the structural challenges. Also, the WHO selfcare framework has key principles that focus on gender equality only and not gender equity and other key disaggregation variables of

age, gender identity and gender expression are not part of the framework. This limits analysis, as there is a need to address SRH issues for young people from a heterogenous perspective.

Structural and Social Barriers

Limited range of SRH services in peri-urban and rural health facilities, incoherent policy environment, poor infrastructure within designated health facilities, lack of youth friendly personnel, and inadequate health financing are some of the notable structural challenges which have been illustrated as barring or diminishing the odds of young people accessing services. Looking at HIV antiretroviral therapy (ART) adherence one of the most common SRH self-care practised by young people in Zimbabwe living with HIV barriers are economic, institutional, political and cultural related (62). Young people living with HIV in Zimbabwe are also part of the thousands of unemployed youths and they also face poverty-related barriers that can affect their HIV self-care. These include competing demands having to make a choice between food security and other basic needs, poor health literacy (62). Compounding the poverty-related barriers, institutional factors including drug stock outs, overburdened health care facilities and limited access to psycho-social support mechanisms, worsens the situation (62).

One of the structural barriers that has a huge impact on the practice of SRH selfcare by young people is how health systems are financed in most low- and middle-income countries including Zimbabwe. In the financial year 2009/10, the Kenyan government allocated about US$12.20 per person (equivalent to 5.4 % of the domestic budget) to health, and in Uganda the domestic budget was about US$11.20 per person equivalent to 7.4 % of the budget (63). This is against a backdrop of US$ 34 per person recommended by the WHO Commission on Macroeconomics and Health for governments to spend per year to provide a set of essential interventions (64).In the case of Zimbabwe, the same scenario of underfunding for SRH broadly and SRH self-care specifically is also a major barrier. Attention is also paid to other diseases leaving huge funding gaps for SRH related services, thus resulting in stock out of products like condoms, pregnancy self-test kits, HIV ART medication that promote SRH selfcare.

Young people are often treated as a homogenous group regardless of known differences which have been shared in the findings such as gender, geographic divide (urban youth vs rural youth), literacy status and social class. In the absence of an explicit SRH self-care guideline which takes cognisance of the differences in the challenges faced by the different sub-populations of young people, self-care interventions will be difficult to implement as they will not meet the need. A study conducted in Tanzania, Mbeya indicated that young people had preferences on where-how-from whom- they prefered to receive information on SRHR and accompanying services (65). Preferences included strong gendered biases in getting information from females in the families than males, age bias getting information from peers than adults(65).

The self-care priorities and options for adolescent girls and young women are different from those of boys and young women due to gender inequality which was noted in the findings. AGYW grapple with issues such as child marriages, teenage pregnancies, sexual violence and abuse, high HIV incidence, compromised access to ante-natal care services and limited access to family planning products and services. Whereas the boys and young men mostly deal with social stigma and discrimination in accessing SRH services from health care facilities. This homogenous

application of interventions is one of the biggest barriers for young people to practice SRH self-care.

Enablers for SRH Self Care

Rolling out of the HIV self-test kits, widening of information channels for SRH education, periodic formulation and reviewing of policies, inter-ministerial collaboration and increased funding mechanisms have been some of the enabling factors for SRH Self Care as was noted in the study. Enablers for SRH selfcare , according to a study conducted could also include availability of free or commodities, friendly health care providers, confidentiality and privacy and reliability in the supply of commodities (66). The development of the Zimbabwe School Health Policy for instance which was a process involving the Ministry of Primary and Secondary Education and the Ministry of Health and Child Care is an inter-ministerial collaboration enabler for self-care (67). This policy supports access to comprehensive SRHR information for learners in school through the Ministry of Education and the Ministry of Health will be supporting with ensuring access to youth friendly SRH services. Following years of experiencing poor health outcomes among students in secondary schools such as teenage pregnancies, drop outs and relatively HIV incidence rates, the introduction of the policy raises new prospects of schools encouraging the learners to know and demand for their SRH and potentially practice SRH self-care (65). The availability of that policy among others which were acknowledged previously serves to provide a framework upon which some level of SRH self-care efforts can be encouraged for young people.

Role of Existing SRH Self Care Interventions

The majority of existing SRH self-care interventions in Zimbabwe were not deliberately designed but a result of other primary health efforts which relate to self-care. The ambitious targets set for 90-90-90 for example resulted in the scaling up of HIV programmes and rolling out of new models such as the HIV self-test kits. As a typical example, the positive outcomes being recorded by the rolling out of HIV self-test kits is not a reflection of an SRH self-care programme achieving results but an HIV response programme intensifying. Self-care results being achieved are unplanned and unintended as they do not form part of results frameworks crafted for the key documents generated i.e. National Health Strategy and National ASRH Strategy.

Through the Zimbabwe National Family Planning Council, Peer Education has been developed as a model which enables the young people to access information, products and services via their own peers. This model has ushered in numerous self-care practices among the young people while contributing to two key aspects in the WHO Self-care framework which is information under Enabling Environment as well as Places of Access. Peer Education has bridged the gap between the health facilities which are sometimes characterised by personnel with unfriendly and discriminatory attitudes towards young people and the young people themselves by availing commodities such as condoms and HIV self-test kits. Community Healthcare Workers who are spread across the country in wards of various districts have also played a huge role of promoting self-care among the young people through providing information commodities and becoming a referral point for a young person to get more services they may require.

Conclusions and Recommendations

Conclusions

Concepts of SRH Self Care In Zimbabwe

Zimbabwe lacks a broad fundamental SRH Self Care Framework both theoretically and practically. The key strategic documents which provide guidance on the health sector interventions priorities, implementation and funding have all not identified or alluded to SRH Self Care in any manner as a priority area or alternative means of public health delivery. The primary guiding document for health in Zimbabwe which is the National Health Strategy and the corresponding Costed Implementation Plan for the strategy both have key priority areas which do not identify SRH self-care in any way. The most referenced strategic document for Adolescent Sexual and Reproductive Health which is the ASRH strategy also fails to spell out SRH Self Care which is a huge gap. SRH Self Care as a concept is implicit and not explicit in Zimbabwe. In practical terms, as has been illustrated above there are limited operational programmes and interventions which have been offset in SRH Self Care. Programmes and infrastructure follow the strategic guidance of strategies, guidelines and policies. The silence of these in explaining SRH Self Care interdicts the guided implementation of any programmes or development of supportive structure.

Structural, policy, legal and social barriers

A plethora of barriers challenge the ability of young people to practice SRH Self Care. To fully appreciate these challenges however, the study revealed that there is a need to characterise barriers based on the different variables. Age, gender, social structure, legislation, geographic divide and the specific SRH element present varied challenges to young people. An adolescent girl and a young woman for example due to reasons such as consent, face different challenges barring them from practising SRH self-care. While young women aged 18-24 can legally access HIV testing services without requiring parental consent, adolescent girls aged 16-17 have a completely different barrier.

Similarly, females and males of the same age group do not face similar challenges due to the gender disparities which affect the two as has already been noted above. Social structures play a role in intensifying or neutralising the challenges faced by young people to practice SRH self-care. Whereas a young person with means can opt to purchase condoms from a pharmacy, a young person from a poor family can only go to a public health facility to access free condoms if they overcome the fear of stigma and discrimination by health facility personnel. One structural barrier affecting the prospects of young people practising SRH self-care is the incoherent policies and laws in the country. As already discussed, no clear laws speak to SRH Self-care and for the legislative documents which relate to SRH Self, there is a conflation of what's allowable and prohibited. Young people in rural and urban areas face different barriers to practising SRH self-care and appreciating that it was useful for the study. The specific SRH element itself under discussion determines what sort of barriers the young person can face in adopting SRH self-care practices. Family planning and HIV Testing Guidelines have different provisions which will then influence adopting different SRH Self-care practices for both types of services.

In order to address barriers based on the COVID 19 experiences , implementing SRH interventions that seek to meet the diverse health needs and priorities of diverse young people requires guiding frameworks that are explicit on what needs to be delivered to whom, when and how. This will allow the interventions to also address barriers to services uptake, social exclusion and discrimination of young people in healthcare facilities , stigma by introducing and promoting self-care strategies. Lessons learnt from the Covid 19 pandemic has shown that selfcare is indeed a concept that can be used in the absence of vaccines or treatments. This similar context if applied to improving the SRH outcomes of young people through selfcare may yield intended outcomes.

Facilitators of SRH Self care

A review of the SRH interventions in Zimbabwe has also shown that there are both programmatic and legislative enablers for SRH self-care. Programmatic evidence presented from entities such as ZNFPC has shown that integration with pharmacies and rolling out of the Self-Test kits have been promising programmatic interventions which enable young to practice SRH self-care. Young people are able to access family planning products and self-test kits which they then use at home. Civil Society Organisations (CSOs) have also played a huge role as enablers of SRH self-care. Health facilities have been supported by CSO mostly in 3 ways; financial support to secure commodities, technical support through youth friendly training, and structural support through development of infrastructure. These 3 forms of support to the facilities then have a ripple effect on the young people who then benefit as the end users. Despite challenges in adherence to legislative provisions by health personnel, the fact that some of the SRH Guidelines are designed in a way which indirectly supports SRH self-care is important i.e. every sexually active female has the right to access family planning services regardless of age as provided for in the National Family Planning Guidelines.

Existing SRH interventions and their impacts

Family Planning and HIV testing have exhibited the prospects of championing SRH Self-care in Zimbabwe. The combined efforts of Civil Society Organisations, pharmacies and parastatals such as the Zimbabwe National Family Planning Council have contributed to the scalability of interventions targeting young people within communities. The young people in the urban areas will ordinarily rely on the abundance of health facilities, pharmacies and private health care centers. The interventions set in motion therefore by the CSOs as a compliment of the government of Zimbabwe, syncs with this reality of urban settings. With rural young people, the availability of health care workers and community cadres complements the coordinated work by CSOs to implement interventions which contribute to SRH Self Care. Although there are no dedicated SRH Self Care Interventions and programmes in Zimbabwe being propelled by the government, the role played by the CSOs has made significant strides towards closing the gap.

Recommendations

Guided by the findings of this study, the following are recommended towards improving SRH Self-care among young people in Zimbabwe.

Recommendations for Ministry of Primary and Secondary Education, Ministries of Health and Child Care

1. The study revealed that there is a Zimbabwe School Health Policy which was developed by these 2 ministries and launched in 2018 to improve the health outcomes of learners. The Policy does not speak to SRH self-care of learners despite the overwhelming evidence demonstrating its need. The study therefore recommends the 2 ministries review the Policy of 2018 and include SRH self-care interventions which can be supported through the school. The review should also be used to inform the development of a costed implementation plan for the policy to curb the likelihood of it becoming a white elephant after its review.
2. The study revealed that there is no explicit guideline for SRH Self-care in Zimbabwe. It was also clear in the study findings that all the existing guidelines and strategies developed by the Ministry of Health and Child Care ie National Health Strategy, National Adolescent Sexual and Reproductive Health Strategy, National Family Planning Guideline, and National HIV Testing Guideline do not mention or consider SRH Self-care as broad health model. The study therefore recommends the Ministry of Health through its various Units and Parastatals to conduct an end term review of these policies within the lenses of self-care and its prospects for improving health outcomes. Given that all of these strategies lapsed in 2020, the process of developing strategies for the next strategic period should include SRH self-care in the discussions.
3. An in-depth policy analysis, to support understanding of the SRH selfcare concept in Zimbabwe is needed. Based on the findings of the study, SRH is not a new concept in Zimbabwe, however there is need to also provide a clear policy landscape and provisions on where it fits in and how. This can be a starting point that can lead to further development of guidelines, frameworks or strategies to conceptualise SRH selfcare in Zimbabwe.

Recommendation for Legislators

1. The study revealed that there are legislative inconsistencies with the laws that relate to SRH in Zimbabwe. Issues of age of consent to sex and marriage as well as permissible age to access SRH services are not clearly addressed by the existing laws which has left room for ambiguity. It is the recommendation of this study that the legislators conduct a harmonisation of laws exercise led by the Parliamentary Portfolio Committee on Health. The process should ensure that there is coherence of all laws which influence the manner in which SRH self-care can be practised by young people in Zimbabwe.

Recommendations for Civil Society Organisations

1. The findings of the study revealed that rural young people have compounded challenges prohibiting them from practising SRH self-care with one of these being limited places of access for commodities and products such as condoms, lubricants and family planning products. Health oriented Civil Society Organisations are therefore encouraged by this study to widen the places of access to SRH services and products by the rural young people

through outreach activities, construction of facilities and supporting training of more Health Care Workers.

2. The study examined the Key Principles of the WHO Self Care Framework in light of the Gender Equality element. It was revealed by the study that gender inequality has left the adolescent girls and young women more vulnerable hence less likely to practise SRH self-care compared to the young man and boys. The study therefore recommends CSOs working with Adolescent Girls and Young Women to intensify programmes which destablise the social barriers they face in trying to practise SRH self-care.

Recommendation for Future Studies

1. The findings of the study utilised data from national population-based surveys, national strategies and programme reports. The study however revealed that the data available was not specifically collected in monitoring SRH self-care which therefore left a data gap for some SRH elements which could not be analysed. In light of this gap, the study therefore recommends that future studies on SRH self-care in Zimbabwe should utilise field study with primary data collection as a methodology to avoid reliance on insufficient data from reports and strategies.

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