

Sexual and Reproductive Health Needs Of Adolescents in Zimbabwe

Many obstacles prevent young Zimbabweans from acting on their desire to postpone parenthood and stay HIV-free. Protecting adolescents from unintended pregnancy and HIV infection by providing them with essential sexual and reproductive health information and services will be critical if Zimbabwe is to fulfill its long-term economic development goals. Supporting adolescents' needs will also bring the country closer to achieving two reproductive health-related Millennium Development Goals.

Little time remains for Zimbabwe to meet Millennium Development Goals 5 (reduce maternal mortality by 75%) and 6 (halt the spread of HIV) by the target year of 2015. Unfortunately, the maternal health goal does not take into account the extent of a country's HIV epidemic and the weight of its contribution to maternal mortality. For decades, Zimbabwe has been one of the countries most severely affected by the pandemic, and until very recently HIV was involved in 30–40% of maternal deaths.^{1,2} The country has thus made insufficient headway in lowering maternal mortality³—even with improvements in pregnancy and delivery care—and despite considerable progress, Zimbabwe will be unable to halt the spread of HIV by 2015.⁴

This report presents a snapshot of adolescents' ability to adequately protect their sexual and reproductive health.

*We refer to surveys conducted over a two-year period (i.e., the 2005–2006 and 2010–2011 surveys) by the latter year only.

By focusing on current behavior (using the 2010–2011 Zimbabwe Demographic and Health Survey), we hope to identify existing needs for sexual and reproductive health education and services and present recommendations on how to meet them. We also include data from the country's two earlier surveys, conducted in 1999 and 2005–2006, to highlight notable trends over time.* Because adolescents' health can vary widely by area of residence and socioeconomic status, where possible we examine the data by these characteristics.

Despite increasing urbanization, Zimbabwe remains a primarily rural nation—67% of its population lives in rural areas.⁵ Much of the country remains entrenched in poverty: Gross annual income is US\$650 per person,⁶ even following improvement since the worst of the hyperinflation and economic crisis that occurred in 2008. The educational attainment of young people, however, is improving. According to the 2011 survey,

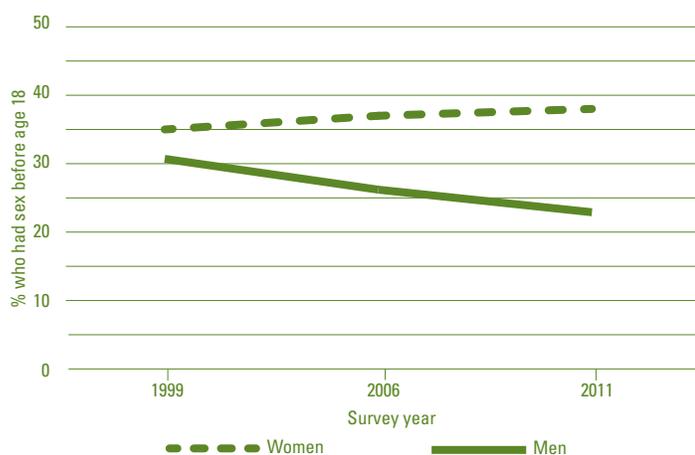
Key Points

- As of 2011, 38% of young Zimbabwean women have had sex by age 18, as have 23% of young men; this difference has widened over time. Females now first have sex nearly two years sooner than males.
- One-quarter of 15–19-year-old women have started childbearing; one-third of all births to adolescents are unplanned (wanted later or not at all).
- Favorable trends of rising modern contraceptive use in urban areas were likely interrupted by the worst of the economic crisis in 2008. Use among married adolescents declined in urban areas (from 50% in 2006 to 29% in 2011), even as it rose in rural areas (from 30% to 37%).
- Patterns in unmet need for contraception followed suit: In urban areas, the proportion of married adolescents who wanted to postpone childbearing but were not using a method rose between 2006 and 2011 (from 14% to 28%); among their counterparts in rural areas, unmet need fell from 20% to 15% over this period.
- Single, sexually active adolescents have by far the greatest unmet need—62% as of 2011, compared with 19% among their married counterparts.
- Existing policies need clarification to assure that no adolescent is illegally denied services because of age. Youth-friendly sexual and reproductive health programs should be prioritized so today's HIV-positive adolescents, many of whom have been infected since birth, do not transmit the virus to yet another generation.

Figure 1

Initiating Sexual Activity

The proportion of 20–24-year-olds who have had sex before age 18 has declined among young men, but not among young women.



Sources: references 7, 8 and 10.

74–76% of male and female adolescents* have some secondary education,⁷ compared with 68–70% just over a decade ago.⁸

Sexual activity, marriage and childbearing

Given the long-standing stigma toward young people’s sexual activity and childbearing outside of marriage in Zimbabwe,⁹ it is important to consider the context in which adolescents first become sexually active. Moreover, in a country with a declining, but still very high, HIV prevalence (15% of 15–49-year-olds were HIV-positive in 2011),⁷ sexual activity without consistent condom use can expose adolescents to the risk of HIV infection.

*We use the term “adolescents” to indicate 15–19-year-olds, even though this term can encompass a broader age range.

†In this report, marriage includes both legal and informal (living together) unions.

‡The Termination of Pregnancy Act of 1977 also allows for exceptions of fetal abnormality incompatible with life and of pregnancies that result from unlawful intercourse (source: reference 16).

In Zimbabwe, 34% of adolescent females have had sexual intercourse, as have 25% of adolescent males. This proportion has not changed much over the past decade among women, but it has declined slightly among men.^{7,8,10} A related measure—the proportion of 20–24-year-olds who have had sex by their 18th birthday—shows a similar trend: No decline among young women between 1999 and 2011 (35–38%), but a drop among young men (from 31% to 23%—Figure 1). These national-level findings are echoed in smaller-scale studies (e.g., in the most populous province, Manicaland), one of which showed a recent decline in the proportion of 15–17-year-old males who had ever had sex, but no decline among their female counterparts.¹¹

These trends are further echoed in data on age at first intercourse. In 1999, there was little difference by gender in the median age at first sex. As of 2011, however, young men first have sexual intercourse

almost two years later than do young women: Median age at first sex has stayed stable at 18.8–18.9 over all three surveys among women, but it has risen steadily, from 19.1 to 20.0 to 20.6, among men.^{7,8,10}

Nearly one-quarter of all 15–19-year-old Zimbabwean women (23%) are currently in a union,[†] and the proportion in rural areas is almost double that in urban areas (28% vs. 16%).¹² Poorer adolescent women are more likely than better-off ones to be married (31% vs. 19%). Furthermore, 13% of 15–17-year-olds have been in a union as of 2011, and these very early marriages are more common in rural than in urban areas (16% vs. 8%).

The fact that only 1% of Zimbabwean males enter into a union during adolescence reflects a widespread phenomenon found throughout Sub-Saharan Africa: Adolescent women usually marry older men.¹³ Wide age differences between spouses (often referred to as “age mixing”) can lead to power imbalances in relationships and an increased risk of HIV infection for young wives, since married couples rarely use condoms and older husbands have more years of sexual experience and thus higher HIV prevalence.¹⁴

In Zimbabwe, teenage marriage is closely associated with teenage motherhood, since entrenched traditional values call for newly married women to solidify their union by giving birth within the first year of marriage.¹⁵ The large urban-rural differential in the proportions of adolescent women who are married is echoed in the proportions who have already given

birth—23% of rural adolescents, but only 12% of their urban counterparts.⁷

The birthrate among adolescents—one of the indicators that has been targeted to meet the maternal health Millennium Development Goal—changed little between 1999 and 2011, and stands at 115 births per 1,000 women aged 15–19 (Figure 2). Rural adolescents give birth at twice the rate of urban adolescents (144 vs. 71). Moreover, the rate of teenage childbearing increased in rural areas (from 120–125 births per 1,000 in 1999 and 2006 to 144 births per 1,000 in 2011), whereas in urban areas it declined between 1999 and 2006 (from 93 to 70), and has not fallen since. The proportion of current 15–19-year-olds who have started childbearing (i.e., those who are pregnant plus those who have already given birth) has risen slightly, from 21% in 1999 and 2006, to 24% in 2011.^{7,8,10}

Since Zimbabwean social mores strongly condemn childbirth outside of marriage, many unmarried adolescents’ pregnancies are likely to be unintended. Such unwanted pregnancies can lead to clandestine—and therefore likely unsafe—abortions, since Zimbabwe’s penal code legally restricts all abortions, except those needed to save the woman’s life or physical health.¹⁶ But because of legal restrictions and the resulting clandestine nature of abortion, information about how often adolescents with unintended pregnancies resort to abortion is lacking. However, among births to all women (of any marital status) who were adolescents when they delivered, 33% are unplanned.¹²

Contraceptive Use and Unmet Need

Method use and unmet need among Zimbabwean women aged 15–19, by selected characteristics, 2011

Measure	All	Age-group		Residence		Wealth	
		15–17	18–19	Urban	Rural	Low	Middle/high
% using a modern method*							
Married	34.6	24.0	39.9	29.4	36.5	34.4	34.8
Single, sexually active in past three months	24.7	22.7	26.4	(24.1)	25.0	(31.0)	21.0
% with unmet need for contraception†							
Married	18.5	23.5	16.0	27.5	15.2	18.5	18.6
Single, sexually active in past three months	62.2	63.6	61.1	(62.4)	62.1	(54.1)	67.0
% used a condom at last sex							
Married	4.9	2.7	5.9	6.7	4.2	6.0	3.9
Single, sexually active in past year	33.3	34.9	32.2	41.3	28.1	24.5	38.1

*Includes the pill, implant, injectable and male condom. †Unmet need is defined as being exposed to the risk of pregnancy but not using a contraceptive method despite not wanting a child in the next two years. Notes: Because of small sample sizes, wealth quintiles were collapsed into the two lowest and the three highest. Figures in parentheses indicate that the denominator includes 25–49 cases, so the percentages should be interpreted with caution. Source: reference 12.

The proportion of births to women younger than 20 that are unplanned is higher in urban than in rural areas (40% vs. 30%), and highest among young women living in the most well-off households (44% among those in the top income quintile vs. 28% among those in the bottom quintile).¹⁷ In urban areas, a general decline in the proportion of births that are unplanned stalled in 2006, and the proportion increased slightly in 2011. In contrast, in rural areas, the downward trend has been consistent and uniform.

Contraceptive use and unmet need

Two-thirds of married 15–19-year-old women say they do not want to become pregnant for at least two years, yet only about half of them (35% of all married adolescents) use a modern contraceptive method* (Table 1). The pill accounts for the vast majority (86%) of this use.¹² Overall, use of modern methods changed little in the decade covered by the three surveys, staying at 35–38% among these women.^{12,18,19} However, the lack of overall change at the national

level masks an increase in use between 2006 and 2011 in rural areas (from 30% to 37%), and a sharp decrease in urban areas (from 50% to 29%).¹² Moreover, modern method use in urban areas declined not just among adolescents but among all women of reproductive age (15–49), from 68% to 60%.^{12,18} (There was no change over the period in use among married women of all ages in rural areas.) The worst of the economic crisis in 2008—with its attendant deterioration of reproductive

health services, migration from rural to urban areas and flight of medical professionals—likely contributed to a decline in the availability and accessibility of services for adolescents and all women in urban areas.²⁰ Furthermore, the fact that urban authorities impose fees for contraceptive services may have also affected use more in urban areas than in rural ones.

The picture changes when we look at contraceptive use among adolescents who have the most to lose should they experience an unwanted pregnancy—those who are not married and are sexually active (i.e., have had sex in the previous three months). Just one-quarter of these women use a modern method as of 2011. Not only is this proportion lower than that among married adolescents, but it has been steadily declining over the past decade—from 48% in 1999 to 34% in 2006 to 25% in 2011.^{12,18,19} Thus, these women would appear to have a harder time preventing unintended pregnancy now than in previous years.

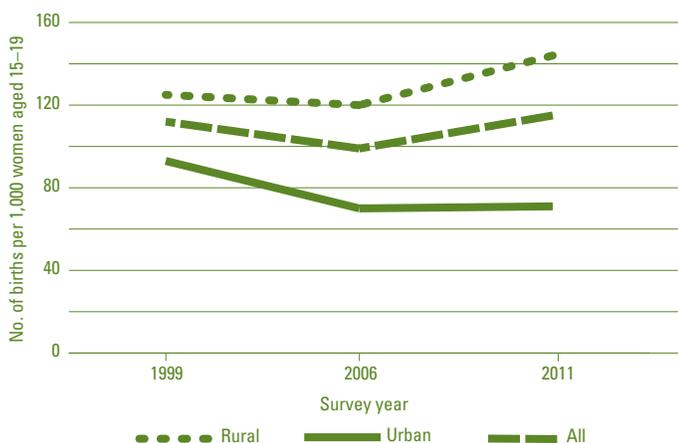
Anecdotal evidence suggests that providers have been using clients’ seemingly young age to deny them services²⁰ (i.e., those who appear to be younger than the age of majority, which is 18 in Zimbabwe²¹). For this reason, it is important to assess how contraceptive use varies by age among adolescents. There is little difference in modern method use among single, sexually active adolescents in the 15–17 and 18–19 age-groups (23% and 26%, respectively). Among married adolescents, however, 15–17-year-olds are far less likely than 18–19-year-olds to be using a modern method (24% vs. 40%).¹² We hypothesize that the low level of use among the youngest married adolescents stems from factors other than their being turned down for services because of

*Modern methods currently used by married adolescents in Zimbabwe include the pill, implant, injectable and male condom; other modern methods asked about in Zimbabwe’s surveys, but not used by women in this age-group, are female sterilization and the female condom. The Demographic and Health Surveys categorize the lactational amenorrhea method as modern, but in this report it is considered a traditional method (sources: references 7, 8 and 10).

Figure 2

Adolescent Childbearing

Adolescent childbearing has increased recently in rural areas and its decline has stalled in urban areas.



Sources: references 7, 8 and 10.

their age; these could include pressure to solidify a union by having a child, and barriers to contraceptive use created by poverty and providers' beliefs that young married women should have children.

Women who want to delay or stop having children but are not currently using a method are considered to have unmet need for contraception.* Adolescents have the highest unmet need of all women of reproductive age. Overall, 19% of married adolescents have an unmet need, compared with 15% of all married women aged 15–49.²² The level of unmet need among married adolescents living in urban areas is nearly twice that of their rural counterparts (28% vs. 15%), both because urban women are usually far more likely than rural adolescents to want to postpone childbearing and because, in contemporary Zimbabwe, urban adolescents are also less likely to use a method.

As suggested by the recent trends in married adolescents' method use by area of residence, the related measure of unmet need increased substantially between 2006 and 2011 in urban areas (from 14% to 28%), while it came down in rural areas (20% to 15%).^{12,18} These time trends are mirrored to some extent among all married women of reproductive age (i.e., between 2006 and 2011, unmet need among married 15–49-year-olds declined slightly in rural areas, from 18% to 15%, but rose minimally

*In 2012, the MEASURE DHS program revised how it calculates unmet need. The values presented here use the revised definition, so will not match those published in Zimbabwe's survey reports (source: Bradley SEK et al., Revising unmet need for family planning, *DHS Analytical Studies*, Calverton, MD, USA: ICF International, 2012, No. 25).

in urban areas, from 11% to 13%).²² One possible reason for the rise in unmet need over this period among urban married women—but not among their rural counterparts—could be that cities were more affected by the economic collapse than villages because the weakened infrastructure is concentrated in urban areas.²⁰

Because it is unknown to what extent adolescents resort to abortion, we have no way of knowing whether rising unmet need in urban areas has led to rising rates of unintended pregnancy. We do know that unmet need is much higher among single adolescents than among married ones (Figure 3). In Zimbabwe, as throughout all of Sub-Saharan Africa, strong taboos against premarital sexual activity make it difficult for single, sexually active adolescents to obtain the effective contraceptives they need to prevent unwanted pregnancy.¹⁵ As of 2011, 62% of such 15–19-year-olds had an unmet need, a level three times higher than that of their married peers.¹²

Moreover, despite the lack of substantive change over time in unmet need among married adolescents, unmet need increased steadily among single adolescents, from 44% in 1999 to 51% in 2006 and to 62% in 2011. And there is little difference in the level of unmet need between the 15–17 and 18–19 age-groups (Table 1), which belies widespread assumptions that single minors are being denied services because of age requirements.²⁰

Why would adolescents not use contraceptives despite their wish to avoid pregnancy? We know the reasons for only a small sample of these women, half of whom

said they were not doing so because they were unmarried.¹² This reason is perhaps unsurprising in a culture that stigmatizes sexual activity outside of marriage,¹⁵ and suggests that some of the very adolescents who need to avoid pregnancy the most—unmarried adolescents—are dissuaded from protecting themselves from pregnancy out of fear of being judged or rejected by providers for not meeting a false rumored “requirement” that they be married.

Only one contraceptive method protects against both unintended pregnancy and HIV—the condom. One-third of single 15–19-year-old women who had sex in the past year used a condom with their most recent partner.¹² (The comparable proportion among adolescent males, regardless of marital status, is nearly twice as high.) The proportion of adolescent married women currently using a condom is far lower, at 5%. This minimal level of condom use in marriage is unsurprising in a culture that

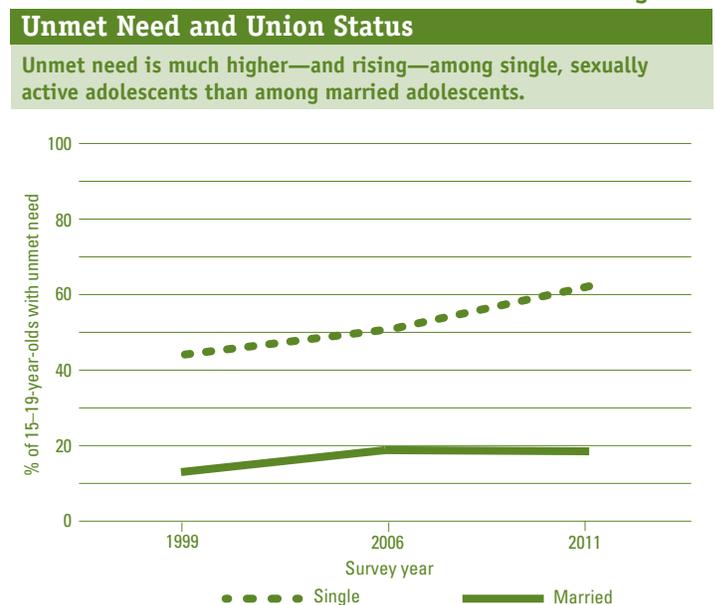
equates such use with extramarital and commercial sex.²³

Adolescent women's ability to negotiate condom use in marriage is especially difficult, since they are often married to much older spouses. In Zimbabwe, wide age differences between partners are common among all 15–19-year-old women, but especially among those who are married: Nineteen percent of the husbands of adolescent wives are at least 10 years older, compared with 5% of the partners of single 15–19-year-old women (Figure 4). Unlike nearly every other variable examined for this report, the proportion of married adolescents whose husbands are at least 10 years older does not vary by area of residence or household wealth.

HIV and AIDS

As of 2012, HIV prevalence (the proportion currently infected) among Zimbabwean 15–24-year-olds is an estimated 6.3% among women and 3.9% among men.²⁴ This current prevalence

Figure 3

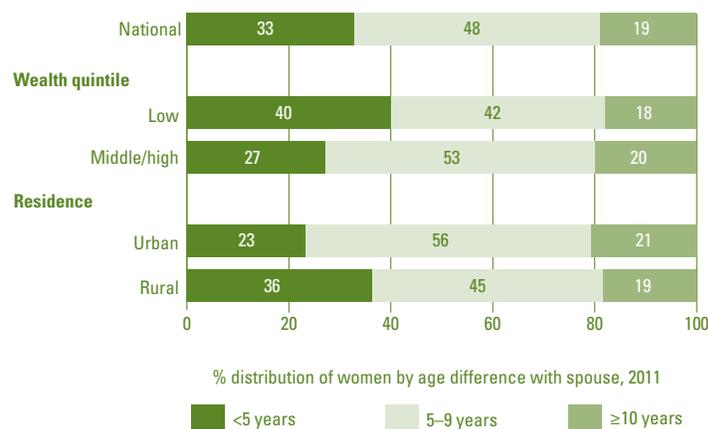


Note: Unmet need is defined as being exposed to the risk of pregnancy but not using a contraceptive method despite not wanting a child in the next two years. Sources: references 12, 18 and 19.

Figure 4

Spousal Age Differences

The proportion of adolescent women married to men at least 10 years older varies little by residence or wealth.



Source: reference 12.

shows a substantial decline since 2005 for young women (from 14.7%)*, but no real change for young men (from 4.4%).²⁵ Among 15–19-year-olds, 4.2% of females and 3.4% of males were HIV-positive as of 2011.⁷ However, the extent to which these represent new infections or the long-term survival of untreated individuals infected since birth is unknown.

A study in the eastern province of Manicaland hinted that the latter scenario is partially true, since “increases” in prevalence from 2004 to 2007 among 15–17-year-olds who had never had sex were likely attributable to their aging into this age-group, as opposed to their acquiring new infections.¹¹ Some 2007–2008 clinical data support this hypothesis, as HIV was the most common cause of acute admission to public hospitals in Harare among 10–18-year-olds, most of whom had been infected since birth.²⁶ Incidence, or the annual rate of new infections, is a better marker of progress in countries with mature epidemics, such as Zimbabwe. Overall, HIV incidence declined by half among 15–49-year-olds between 2001 and 2011.²⁷ A mix of factors likely led to this, the most important being a reduction in multiple partners.^{28,29}

One promising avenue of HIV prevention among men is

circumcision, which has been shown to substantially reduce men’s risk of acquiring HIV through heterosexual sex.³⁰ However, just 5% of 15–19-year-old Zimbabwean males have been circumcised as of 2011.⁷ Because the proportion circumcised rises uniformly with age (up to 12% among 45–49-year-olds), sexually active adolescents are currently benefiting the least from circumcision.

The long-standing three-pronged approach to reduce sexual transmission of the virus is through abstinence, mutual monogamy, and consistent and correct condom use. Increasing condom use is challenging in a country where the majority of adults—63% of women and 52% of men—do not believe that 12–14-year-olds should be taught about how condoms can prevent HIV infection.⁷ Opposition to such instruction is far stronger in rural than in urban areas (16% higher among women and 23% higher among men). Adults’ (including many likely parents’) widespread disapproval of teaching about condom use in school makes it difficult for adolescents to learn how to protect themselves from HIV infection. Furthermore, as urbanization and globalization have eroded the tradition of aunts (for girls) and uncles (for boys) providing informal

sexuality education, parents have been reluctant to fill this gap.^{31,32}

Indeed, adolescents are not as informed about HIV as they should be: Fewer than half have comprehensive knowledge about HIV and AIDS,[†] with relatively little difference by gender (42% of males and 46% of females).⁷ Unlike unmet need for contraception, there is no comparable “unmet need” measure for protection against HIV. At the very least, teenagers need to feel that they can get a condom on their own to avoid HIV infection. Unfortunately, a far lower proportion of female than of male adolescents say they are able to do so (28% vs. 62%—and getting a condom does not always translate into convincing a male partner to use one).

Since women’s reproductive biology places them at greater risk of HIV infection,³³ it is important to address this gender gap in self-efficacy. Moreover, women’s early age at first sex has been found to be significantly and independently associated with an increased likelihood of

being HIV-positive.³⁴ Part of the consistently higher prevalence of HIV infection among women than among men is likely related to age-mixing (which is more common in marriage than in casual sexual relationships³⁵) and to limited condom use within marriage.

Policies and programs that address adolescents’ reproductive health

In Zimbabwe, the scope of the AIDS epidemic has overshadowed adolescent reproductive health policies. Through at least the first two decades of the epidemic, most national-level policies promoted abstinence as the sole strategy to avoid HIV infection.²³ More recently, several youth policies that encompass both pregnancy and HIV prevention have yielded a more comprehensive strategy by complementing abstinence with partner reduction, delay of first intercourse and condom use. These newer policies include the National Adolescent Sexual and Reproductive Health Strategy, 2010–2015,³² and the National Policy on HIV/AIDS.³⁶ Moreover, as part of its most recent

*This decline reflects not only fewer infections among newly tested individuals but, when HIV mortality is high, the impact of deaths from AIDS. Given the large contribution of HIV to maternal mortality and the likelihood that many 15–24-year-olds want to have a child, women’s considerable decline in HIV prevalence may be related to maternal deaths, but we lack verifying data. The decrease in prevalence attributable to deaths from AIDS would have been even greater if not for the widespread use of life-saving antiretrovirals among infected 15–49-year-olds (85%) and, less commonly, among children aged 14 or younger (43%) (source: National AIDS Council, *Global AIDS Response Country Progress Report: Zimbabwe, 2014*, Harare, Zimbabwe: National AIDS Council, 2014).

†Comprehensive knowledge is defined as knowing that HIV risk can be reduced by consistent condom use and by having just one uninfected monogamous partner; knowing that a healthy-looking person can have HIV; and rejecting the two most common misconceptions about HIV transmission in the country—that it can be spread by mosquito bites or sharing food.

National Sexual and Reproductive Health Policy, the Ministry of Health and Child Welfare committed to clarifying the misperception that adolescents younger than 18 need parental consent to receive contraceptive and HIV services. In this policy, the ministry says it will “develop and disseminate guidelines that will give direction towards the provision of [sexual and reproductive health] services for pregnancy, rape, STI, HIV infection and contraception to minors.”³⁷ (p. 22)

The National Adolescent Sexual and Reproductive Health Strategy incorporates three approaches to programming: community-based (youth centers offering counseling, recreational activities and condoms), health-facility-based (on-site youth-friendly corners, which are supposed to offer voluntary counseling and testing, as well as condoms and other family planning methods) and school-based (life skills training and counseling).³² The operation of some of these programs falls to the Zimbabwe National Family Planning Council, which partnered with the United Nations Population Fund to create youth-friendly corners that provide confidential services in both behavior-change messaging and clinical care.³⁸ In the nongovernmental sector, Population Services International offers services (youth-friendly information and clinical care through mobile and fixed sites) and training (of both health professionals and young people to act as peer counselors and “distributors” of condoms).³⁹

The national life skills education syllabus, which is mandated to be taught in primary and secondary schools, is cur-

rently under revision. The Life Skills, Sexuality, HIV and AIDS Education Strategic Plan for 2012–2015⁴⁰ calls for revising the syllabus to add the following topics to its current focus on abstinence: testing and counseling, condom knowledge and self-efficacy, age disparities between partners and male circumcision, to name a few. As with all government-issued plans and strategies, however, follow-through is far from given and the implementation of promised revisions needs to be carefully monitored.

Implications for policies and programs

Adolescents’ actual sexual and reproductive health, as opposed to what the foregoing policies envision or promise, is dependent on a complex set of cultural, social, economic and political influences. Numerous barriers prevent adolescents from taking protective actions, and some of these barriers are amenable to intervention.

Attitudinal barriers

Many parents and providers fear that providing unmarried adolescents with information on contraception to prevent pregnancy in general, and on condoms to prevent HIV in particular, will lead to their becoming sexually active at a young age.^{15,41} These attitudes are consistent with cultural norms that severely stigmatize adolescent sexuality in Zimbabwe^{23,42} and with the related emphasis on abstinence in strategies to protect youth’s reproductive health. However, unmet need for contraception among single, sexually active adolescent women is high and rising, so innovative solutions are necessary.

The National Adolescent Sexual and Reproductive Health Strategy Addendum acknowledges several problem areas that need immediate attention, including insufficient funding and low use of services by young women, who perceive that services are not “girl-friendly.”⁴³ Providers would benefit from training on the importance of maintaining confidentiality and having non-judgmental attitudes, so that fear or embarrassment does not keep adolescents from protecting themselves from unwanted pregnancy and HIV. Providers would also benefit from reviewing the country’s family planning guidelines, which dispel the commonly held misperception that age criteria—and related parental or spousal consent requirements—exist for receiving family planning services.²⁰ The guidelines clearly specify that “age alone does not constitute a medical reason for denying any method to adolescents” and that those “who are sexually active should be offered a contraceptive method of their choice.”⁴⁴ (Sect. 1.5.2)

Encouraging parent-child communication, which is a “key strategy” in the Addendum,⁴³ would help strengthen both generations’ understanding of the epidemic and how to protect against HIV and unintended pregnancy. Several religious sects in Zimbabwe actively reject programs for young people that speak of anything other than abstinence until marriage, including the growing Apostolic faith (currently 38% of adult women are adherents⁷). To correct suspicions about the disproved link between adolescent counseling services and the timing of sexual activity,⁴⁵ church groups could be included

in discussions about the evidence on this and on effective strategies to reduce risk among adolescents.⁴¹

Educational and information barriers

Some of the stigma toward adolescents being sexually active outside of marriage can be addressed through community education campaigns, which need to be conceived and conducted in local languages to resonate in local contexts. Most Zimbabwean adolescents know the two most common ways to prevent HIV infection, but they lack more in-depth understanding, as shown by their only moderate levels of comprehensive knowledge.⁷ The proposed changes in the mandatory curricula are positive developments and are meant to address demonstrated knowledge gaps.⁴⁰ The new education plan also calls for teaching about the importance of correct and consistent condom use in schools, but not for providing condoms, for which adolescents are referred outside the school. This policy will work only if referred adolescents have access to contraceptives elsewhere. The current minimal availability of youth-friendly services⁴⁶ suggests that adolescents’ needs are not being fully met.

As indicated earlier, traditional routes for sensitive information exchange are being eroded. Promising new means of communication to reach all adolescents, such as through social media platforms and mobile phones with Web access, are currently being promoted by Population Services International.³⁹ Additional non-school-based strategies are needed to appeal to married adolescent women, perhaps the group most vulner-

able to HIV and the least likely to be enrolled; one such strategy could be specially designed counseling prior to marriage.

Infrastructure and economic barriers

The economic uncertainty in Zimbabwe has meant the loss of trained health professionals, ongoing shortages of medical supplies and a deteriorating medical infrastructure. Levels of modern contraceptive use among adolescents have declined—and levels of unmet need have consequently risen—in urban areas only, where the infrastructure tends to be concentrated. The possible impact of these trends can be seen in the rise in unplanned births among urban adolescents.

Although financial conditions are starting to improve, the crisis has hampered the hiring and training of a new generation of community-based distribution workers, who are needed to replace the original workers who have reached retirement age. The most important method currently used by married adolescents—the pill—is especially amenable to delivery via this system. However, the fact that a single method dominates the method mix suggests the need for expanded options to assure that adolescent women have a range of available methods. For adolescent men, widespread implementation of the strategy of combining HIV counseling and testing with circumcision services would go a long way toward protecting them (and their partners) from HIV infection. For young women, testing and counseling should be integrated into family planning and prenatal services to give them more control over their sexual and reproductive lives.

Conclusions

The consistent finding, using a range of measures, that age at first sex is rising among men but not among women suggests that males likely have more agency to respond to messages about postponing the initiation of sexual activity. Nonetheless, this finding deserves further research. If validated, it is a call to action, given that early age at first sex has been associated with an increased likelihood of being HIV-positive among young Zimbabwean women.³⁴ Much of the gender differential in initiation of sexual activity could correspond to females' far greater likelihood of marrying during adolescence. Unfortunately, the proportion of 15–19-year-old women who have married is changing little over time. Moreover, adolescent women who are married off by their families, or who desire to enhance their status by marrying much older men, have little choice in postponing the first time they have sex. The “marriage rights” section of the recent 2013 national constitution confers the right to “found a family” only to persons who have “attained the age of 18,”⁴⁷ and hopefully this will help to deter illegal early marriages that lead to early childbearing.

The evidence clearly shows that adolescent women have a high level of unmet need for contraception. Overall, some 56,500 Zimbabwean adolescents do not want to become pregnant but are not acting on that desire by practicing contraception.^{12,48} Most of these women—62%, or some 35,000—are married and are thus unable to respond to government messages to abstain from sex. Moreover, given

women's heightened biological vulnerability to HIV infection and the minimal condom use within marriage, married adolescents' need for testing and counseling is especially high.

That the rate of adolescent childbearing is increasing in rural areas is unexpected and cause for concern, even though the proportion of births reported as unplanned is declining in these areas. In Zimbabwe, higher educational attainment has been independently associated not only with delaying childbearing but also with staying HIV-negative.^{49,50} Thus, it is essential that rural adolescent women remain in school as long as possible. And although adolescent fertility declined in urban areas in the early 2000s, that decline has stalled in recent years and the level of unmet need in these areas has risen. The weakened health infrastructure and exodus of trained professionals may have hindered urban adolescents' ability to exercise control over their sexual and reproductive health.

The defining characteristics of a maturing HIV pandemic are revealing themselves first in countries such as Zimbabwe, where the spread of HIV and AIDS started early. The country will likely see increasing numbers of infants infected at birth who survive and grow to adulthood. To halt the epidemic—and to make progress toward Millennium Development Goals 5 and 6—Zimbabwe must rise to the challenge of prolonging adolescents' lives and giving them all possible means to prevent spreading the virus among their own generation and to the next.

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CREDITS

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