

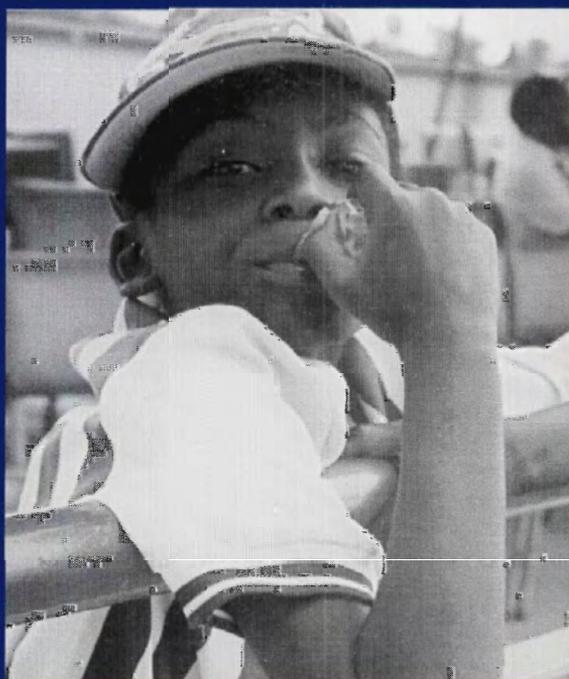
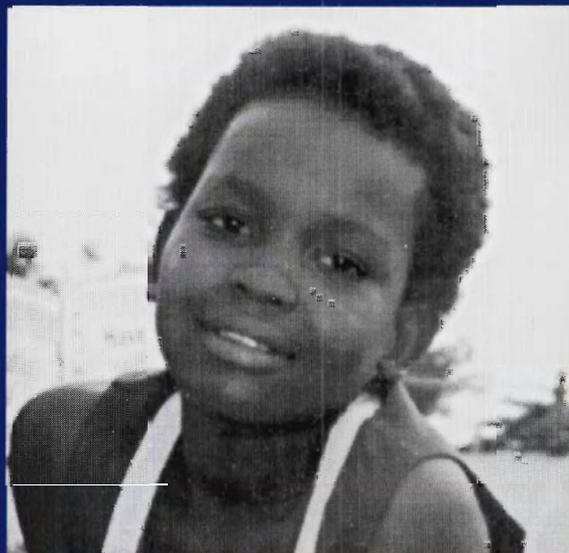


Zimbabwe National Family  
Planning Council

 *Population Council*

A SITUATION ANALYSIS  
OF THE  
ZIMBABWE NATIONAL  
FAMILY PLANNING COUNCIL'S  
YOUTH CENTRES

Baseline Assessment



Compiled by

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October 1997

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# ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
FLEP	Family Life Education Programme
FP	Family Planning
HIV	Human Immunodeficiency Virus
IEC	Information, Education & Communication
IUD	Intrauterine Device
MCH	Maternal & Child Health
MIS	Management Information System
PID	Pelvic Inflammatory Disease
PEP	Parent Education Programme
RH	Reproductive Health
SDP	Service Delivery Point
SDU	Service Delivery Unit
STI	Sexually Transmitted Infection
WHO	World Health Organization
YAS	Youth Advisory Services
ZNFPC	Zimbabwe National Family Planning Council

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# EXECUTIVE SUMMARY

A situation analysis of the Zimbabwe National Family Planning Council's three youth centres was undertaken with the ultimate objective of assessing the effectiveness of these youth centres in delivering reproductive health information, education and services to youth. Each youth centre employs a different programmatic model; the centre in Harare is virtually a vertical family planning clinic which targets youth, the Mutare centre is multipurpose with extensive recreational facilities and a library to attract youth, and the Bulawayo centre has a moderate amount of recreation, though not as much as Mutare. Data from the three youth centres was collected over a two week period at each of the centres through a combination of interviews, observations and transcription of service records.

All the youth centres were found to have good infrastructure in terms of commodities and equipment for delivering reproductive health information and services to young people. However, the accessibility of the centres to the target population (unmarried youth aged 10-24 years) is less than optimal. The signposts outside the youth centres tend to stigmatize the centres against the youth since they bear the ZNFPC logo which gives the impression that the centres are there for family planning services. The study findings indicated that the youth do not want to be associated with family planning. The centres were thought by many to be inconveniently located since the centres are far removed from the high density residential areas where the majority of young people live.

Staff at the centres were generally knowledgeable about family planning and reproductive health, but lacked the specific training to address young people's concerns and circumstances that impact upon their reproductive health, including boy/girl relationships, sexual abuse, drug abuse, interpersonal communication, and self-esteem. The quality of counselling provided by staff was viewed favourably by the clients interviewed; however, there were very few interviews on which to base this assessment.

The attendance for reproductive health information and services is poor at all the three centres. Over the past two years, the centres served, on average, between 8 and 38 clients per week. Despite the Mutare centre attracting a large number of young people with its recreational facilities and library, this centre served the least number of young people for RH/FP services, compared to the other two. During the two weeks of data collection, 3410 visits were paid to the Mutare centre by young people while the clinic at the same centre saw only 845 clients over the past two years. So, while Mutare centre's multi-purpose approach has been successful in attracting young people to the centre, it has not been successful in translating this investment into increased numbers of young people seeking FP/RH services there. Further, many of the clients served at the clinics were older than the target

youth aged 10 to 24 years and virtually no young people below the age of 15 visited any of the centres.

As currently configured, the ZNFPC youth centres are neither cost effective nor sustainable. ZNFPC should formulate strategies for increasing attendance at existing youth centres or find innovative means for reaching young people in a cost effective and sustainable manner.

## BACKGROUND

The Zimbabwe National Family Planning Council (ZNFPC) has been a pioneer in the development and implementation of reproductive health programmes for youth<sup>1</sup> in sub-Saharan Africa. Initially, the ZNFPC focused on educational activities targeted at youth through its Youth Advisory Services (YAS) Unit which was established in 1978. The primary function of the unit was to counsel and educate youth—then defined as those aged 11 to 25 years—on sexuality, family planning and reproductive health-related issues. This was done primarily through the Family Life Education Programme (FLEP) in which thirty-three Youth Advisors conducted family life education sessions with youth mostly in-school. In 1987, the Parent Education Programme (PEP) was initiated to educate parents on youth sexuality and reproductive health in order to promote parent-child communication on these issues. An assessment of the FLEP and PEP programmes in 1993 revealed that the programmes had limited coverage, partly due to the limited human resources devoted to the YAS Unit. The YAS Unit was subsequently absorbed into the Information, Education and Communication (IEC) Unit of ZNFPC in 1994 and the Youth Advisors became known as IEC Officers.

In recent years, the youth centre model has been increasingly utilized in sub-Saharan Africa as a mechanism to reach young people with reproductive health services. Youth centres have been established largely in response to the fact that unmarried adolescents often find it difficult or embarrassing to attend health facilities normally frequented by adults. Youth centres range from simple reproductive health (RH) facilities to multi-purpose centres which combine recreation and reproductive health services, using the recreational component to draw adolescents to the centres, and at the same time, exposing them to reproductive health services in a conducive and youth friendly environment.

With the recognition that youth require both reproductive health information and services in an environment that is conducive to their special needs, ZNFPC established three youth centres: one each in Harare (“Baker Avenue Youth Centre”), Mutare and Bulawayo. These youth centres fall administratively under both the Service Delivery Unit and the IEC Unit of the ZNFPC.

The Baker Avenue Centre was established in 1980, while the Bulawayo and Mutare Centres were established in 1990 and 1993, respectively. These centres have focused on providing both in- and out-of-school youth with reproductive health information, counselling and limited clinical services. Currently, ZNFPC’s primary target for the youth centre programmes is unmarried young people between the ages of 10 and 24 years. In addition, the centres offer some recreational activities, although the scope of these activities varies greatly from one centre to the other. The Mutare Centre offers a wide range of recreational activities which include video shows and indoor games, in addition to a library which is located on the premises. The other two centres have, comparatively, limited facilities for recreation. The centres are staffed by nurses who provide clinical services and counselling and by IEC Officers who educate and counsel the youth. Except for Bulawayo, the IEC Officers are not permanently based at the youth centres but operate on a rotational basis.

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<sup>1</sup> Throughout this report, the terms “youth,” “young people,” and “adolescents” will be used interchangeably.

Since the establishment of the youth centres, no formal assessment of the centres had been conducted. Anecdotal evidence indicated that the youth centres were not operating to their full potential and might not be reaching their intended target group. As a result, the ZNFPC recognized the need to understand, document and assess the functioning of the youth centres. In light of this, the ZNFPC, with technical assistance from the Population Council, undertook a situation analysis study of the youth centres to enable it to systematically map out the operations in order to guide the future development of the youth centres.

# 2

## STUDY OBJECTIVES

### 2.1 Ultimate Objective

The ultimate objective of the study was to assess the operations and functioning of the ZNFPC youth centres in Harare, Bulawayo and Mutare in delivering reproductive health information, education and services to youth.

### 2.2 Immediate Objectives

The study was specifically designed to:

- 1) assess the performance of ZNFPC youth centres vis-à-vis current usage and patterns of utilization;
- 2) describe the availability of services, functioning and quality of the programmes provided at the ZNFPC youth centres; and
- 3) understand management, youth centre staff and youth perceptions toward the youth centre programme.

# 3

## STUDY DESIGN AND METHODOLOGY

The research methodology involved two sub-components: 1) a mini-situation analysis of the youth centres, and 2) retrospective analysis of the management information system (MIS) data from the three centres.

### 3.1 Situation Analysis Of The Youth Centres

The Situation Analysis technique was adopted to render a broad picture of the quality and functioning of the three ZNFPC youth centres. This methodology was originally developed by The Population Council in 1989 as a means of evaluating family planning programs. Since then, the method has been adapted to a variety of programmes including, most recently, educational institutions. The present study is considered a “*mini*” situation analysis since traditional situation analyses investigate a larger number of service delivery points (SDP).

Situation analyses are systematic assessments of the availability and functioning of institutional subsystems, as well as the quality of care delivered by the SDPs. The subsystems of interest are:

- a. logistics/supplies;
- b. facilities;
- c. staffing;
- d. training;
- e. supervision/management;
- f. information, education and communication (IEC); and
- g. record-keeping.

The situation analysis methodology employs a combination of interviews and observations with key players at the institution to assess each of these subsystems.

The following six data collection instruments were used for the present study:

- 1) An Inventory of the Youth Centers which catalogued equipment, supplies, operating procedures and infrastructure;
- 2) An Exit Interview for Counselling Clients that was administered to all clients that received counselling and measured their satisfaction with the service, reasons for visiting the centres, level of reproductive health knowledge and demographic profile;
- 3) An Exit Interview for Non-Counselled Clients was administered to clients who had come for reasons other than counselling;
- 4) An Interview for Youth Center Staff was used to assess the level of preparedness to handle youth, their competence at giving services, and job satisfaction;
- 5) A Senior Management Discussion Guide was used to guide in-depth interviews with individual selected members of management; and

- 6) A Youth Centre sign-in /sign-out register was used to record all the clients who visited the centres and the purpose and duration of their visit, during the two weeks of data collection. Basic demographic information such as age and sex was also collected.

### **3.2 Retrospective Analysis Of MIS Data**

Data from clinic records for the period August 1994 to September 1996 at each of the three youth centres were coded and entered into a database. This was done to assess past attendance and pattern of utilization at the youth centre clinics. Data included information on age and sex, as well as treatment and/or family planning methods given during the visit to the clinic.

### **3.3 Fieldwork**

A total of thirteen Research Assistants were trained during a one week period on all instruments and interviewing techniques. The teams for Harare and Bulawayo Youth Centres consisted of one supervisor and two research assistants each, while the Mutare team consisted of a supervisor and six research assistants. The majority of data collection personnel had been involved in the previous situation analysis studies and other studies that have been conducted by the ZNFPC. Data collection at each of the centers was undertaken over a two week period. The Mutare youth center is open six days per week (Monday to Saturday) while the Baker Avenue and Bulawayo centers are open from Monday to Friday. Data presented here, therefore, reflect a total of twelve days of data collection at the Mutare Youth Centre and ten days, each, at Baker Avenue and Bulawayo youth centres.

### **3.4 Sampling**

All clients that visited the Baker Avenue and Bulawayo centres were to be interviewed on exit. In Mutare, all clients who had been counselled were also to be interviewed on exit. However, on average, the Mutare centre is visited by 200 clients per day. On the basis of this, a total of 2 400 (i.e. 200 x 12 days) clients were expected to have visited the centre by the end of the twelve day data collection period. This large volume of clients who frequent the Mutare Youth Centre for reasons other than reproductive health services made it impossible to interview all clients. Therefore, a representative sample of non-counselled clients was calculated at 300. In order to achieve this, every eighth non-counselled client was to be interviewed on exit (i.e. sampling interval =  $2\ 400/300 = 8$ ).

All staff members at each of the three centres were also interviewed. These included support staff such as groundsmen and receptionists. Below is a summary of the final sample size for each of the sources of data:

**Table I: Final Sample Size for the Study**

<b>INSTRUMENT</b>	<b>MUTARE</b>	<b>BAKER AVENUE</b>	<b>BULAWAYO</b>	<b>TOTAL</b>
1. Youth Centre Inventory	1	1	1	3
2. Exit Interview with Counselling Clients	14	16	7	37
3. Exit interview with Non-Counselled Clients	342	43	32	417
4. Interview with Youth Centre Staff	8	6	4	18
5. Sign-In Register, 14/10/97-26/10/97; (No. of Entries)	3074	107	230	3411
6. Clinic Register, 8/94-9/96 (No. of Entries)	845	2331	3972	7157

In addition, in-depth interviews were held with a total of eleven members of management using a discussion guide. These included two staff at each of the Provincial Offices for Harare, Bulawayo and Mutare, and five members of the ZNFPC senior management at the headquarters level.

Data entry, editing and analysis were done using the statistical package Epi-Info 6.

# 4

## STUDY FINDINGS

### 4.1 Accessibility Of The ZNFPC Youth Centres

#### 4.1.1 Signboards and Advertising

All three youth centres have signs outside them indicating the presence of youth services. The sign board at the Baker Avenue Centre is relatively small and not easily seen compared to the sign boards at the Mutare and Bulawayo Centres which are large and readily visible. The sign board at the Baker Avenue Centre reads "Youth Advisory Services" and indicates the hours of operation. The sign boards at the Mutare and Bulawayo Centres read "Zimbabwe National Family Planning Council" and also display the ZNFPC logo and hours of operation. Only 7 percent of the interviewed clients first learned about the youth centres from the signboards. This reflects that signboards are not a key source of information about the youth centres. Members of the senior management expressed the concern that signboards bearing the ZNFPC logo stigmatize the centres as places where sexually active youth obtain contraceptives. Management, the youth centre staff and the youth suggested that the signboards be replaced with youth-friendly logos. There was also general consensus among management that the Bulawayo and Baker Avenue Youth Centres are not well publicized to youth.

#### 4.1.2 Days and Hours of Operation

All the centres operate from Monday to Friday between 8:00 a.m. and 4:30 p.m. In addition, the Mutare centre opens on Saturday from 8:00 a.m. to 4:30 p.m. Only 10 percent of the clients interviewed felt that the hours of operation of the centres were not convenient for them. Sixty-one percent of the clients visited the centres before 12:00 noon while 39 percent visited the centres after 12:00 noon.

#### 4.1.3 Location of the Youth Centres.

All the three centres are located in the centres of their respective cities. Most of the members of ZNFPC management interviewed felt that the existing youth centres were improperly located. The Baker Avenue Centre is located in the vicinity of residential areas where, management felt, there is a high proportion of commercial sex workers who frequent the centre. A majority of respondents felt that the Baker Avenue Centre should be relocated to a more accessible and youth friendly environment. Similarly, the Mutare Centre was said to be inappropriately located as the majority of youths reside in the high density residential areas. The Bulawayo centre was also seen as attracting youth from low density rather than high density suburbs, whereas residents of high density suburbs were seen as a more appropriate target for the programme. Its location, close to a market place, also resulted in it attracting clientele outside the target population.

## 4.2 Availability Of Services And Functioning Of The ZNFPC Youth Centres

### 4.2.1 Services Available At The Youth Centres

All the three youth centres offer counselling, contraceptive services, diagnosis and treatment of STIs, and are equipped with TV/Video for educational and recreational purposes. Only the Baker Avenue Centre performs PAP smears.

The ZNFPC youth centres stock condoms, pills, injectables and foaming tablets. The Bulawayo and Mutare centres also stock IUDs. During the six months prior to the survey, there were no significant stock-outs of these methods. Only the Bulawayo youth centre had had a stock-out of creams, diaphragms and Multi-Load™ IUDs. Table II displays the quantity of contraceptives normally stocked. The Baker Avenue Youth Centre does not offer diaphragms, jellies and creams. These methods are offered at the Lister Clinic (Harare). The Bulawayo Youth Centre sometimes stocks contraceptives for the other ZNFPC clinics in Bulawayo, hence the large stocks of pills and condoms observed in the study

Library facilities are only available at the Mutare Youth Centre. Although clients can borrow books,

the library had only 91 books and 7 magazines at the time of the survey. All centres had equipment such as a TV, video recorders, radio cassette recorders, audio and video cassettes. The TV/VCR at the Mutare Centre tends to be used for entertainment purposes, while those at the other two centres are usually used to screen educational videos. The Baker Avenue Youth Centre had, in addition, equipment such as a slide projector, film projector, films and village TVs. The Mutare Youth Centre also had equipment for games such as chess, darts, table tennis, draught, monopoly and soccer.

**Table II: Quantities of Contraceptives Normally Stocked**

CONTRACEPTIVES STOCKED	BAKER AVE.	BULAWAYO	MUTARE
Condoms (pieces)	12000	60000	12000
Pills (cycles)	200	20000	200
Injectables (vials)	100	300	200
Foaming Tablets (tubes)	50	200	60
IUD	0	40	20
Diaphragms	0	5	0
Jellies (tubes)	0	10	4
Creams	0	0	1

Source: Youth Centre Inventory

### 4.2.2 Physical Infrastructure

The counselling rooms at all the three centres provide both visual and auditory privacy. While the counselling rooms at the Mutare and Baker Avenue Centres were described as very clean and moderately clean respectively, the rooms at the Bulawayo Youth Centre were found to be quite unclean<sup>2</sup>. The rooms for clinical services at Baker Avenue and Bulawayo Centres provided both visual and auditory privacy and were also found to be moderately clean. While the room for the

<sup>2</sup> For this study, "moderately clean" was defined as having no bad odours, more than half the furniture/facilities in good order, some stains, and only a small amount of litter. "Unclean" was defined as about half of the facilities damaged, with odour and litter.

clinical services at Mutare Youth Centre was very clean, it only provided visual and not auditory privacy. Baker Avenue and Bulawayo Youth Centres do not have toilet facilities specifically for the clients. The clients use the same toilet facilities as the youth centre staff.

ZNFPC management felt that the centres' physical infrastructure was inadequate in meeting the service needs of the youth. Baker Avenue was seen as having inadequate space and insufficient amounts of entertainment facilities and materials. The Mutare centre was said to be overcrowded most of the time and this resulted in it being unhygienic. Bulawayo centre was viewed by management as dilapidated; they indicated that the premises are used as a car park for ZNFPC provincial vehicles, resulting in a significant amount of disruption from the movement of staff and vehicles. Further, they felt that the dura-wall (i.e. the high wall surrounding the centre) was a barrier which resulted in most youth not knowing about the centre. However, it should be noted that Mutare Youth Centre has a dura-wall but still attracts a significant number of clients.

#### **4.2.3 Availability of IEC Materials**

Overall, the majority of the IEC materials at all the centres were posters displayed on the walls. This was followed by a variety of pamphlets for distribution at Baker Avenue and Bulawayo Youth Centres. The pamphlets were primarily on FP, HIV/AIDS and other reproductive health related issues. Also in stock were booklets and magazines. At Mutare Youth Centre, there was a wide range of both video and audio cassettes mostly on FP and reproductive health. Most of the IEC print materials at the Bulawayo youth centre meant for distribution were kept in a storeroom in large quantities rather than being displayed. At the other centres, the materials were in the counselling rooms or other offices where they were not easily accessible to clients, as few clients entered the counselling rooms.

#### **4.2.4 Youth Centre Staffing**

One of the main factors in service provision is having adequate staff, both in terms of numbers and quality. The involvement of youth in programme planning and implementation is also a vital component in the success of programmes for young people. Therefore, an assessment of the staffing and involvement of the youth at the youth centres gives important insight into the functioning of the centres.

Altogether eighteen staff were interviewed. Staff interviewed included one Senior IEC Officer, eight IEC Officers, four nurse counsellors, one nurse aide, a messenger, a cleaner and two youth volunteers at the youth centres<sup>3</sup>. Table III displays the number of staff interviewed at each youth centre.

The services offered by the staff and volunteers were mainly counselling (mentioned by 12), provision of contraceptives (8) and client education (3).

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<sup>3</sup> Volunteers at the youth centres are not considered ZNFPC staff. However, as they interact with clients at the youth centres, on behalf of ZNFPC, they were interviewed to assess their level of preparedness to undertake those duties.

**Table III: Youth Centre Staff Interviewed**

DESIGNATION	BAKER AVE.	BULAWAYO	MUTARE	TOTAL
Senior IEC Officer	0	1	0	1
IEC Officer	3	1	4	8
Nurse Counsellor	2	1	1	4
Nurse Aide	0	0	1	1
Cleaner	1	0	0	1
Messenger	0	1	0	1
Youth Volunteers	0	0	2	2
<b>TOTAL</b>	<b>6</b>	<b>4</b>	<b>8</b>	<b>18</b>

Source: Interview with Youth Centre Staff

Eight of the eighteen staff had been working at the youth centres for between 2 and 4 years and on average the staff had been at the centre for 3 years. Nine of the fourteen professional staff were females. The average age of the professional staff was 45 years.

Distribution of condoms at the Baker Avenue Centre is done by IEC officers while the nurse counsellors distribute contraceptives. At the Bulawayo Centre the nurse counsellor and messengers distribute contraceptives and condoms,

respectively. At the Mutare Centre, all the staff, including IEC officers, nurse counsellors, groundsman/janitor, nurse aide and the security guard are involved in the distribution of either contraceptives (professional staff) or condoms (support staff). Such "informal" distribution of condoms, would, in many cases, be more comfortable for the youth than getting the condoms from a service provider at the centre. It is, therefore, important that all staff, and not just professional staff, have the basic knowledge of how contraceptive methods work and how they are used, to enable them to give correct information to clients.

Of the fourteen professional staff interviewed, only seven were oriented on youth-related issues when they first started working at the youth centres. Only two of the eight IEC Officers had received such orientation. The orientation that the staff received was mostly on clinical and technical topics; many reported to have received orientation on counselling methods (6), modern family planning methods (5), types of STIs (3) and human anatomy and physiology (3). Few of the staff had received orientation on psycho-social aspects germane to the situation of youth such as boy/girl relationships (2) or negotiation skills in a relationship (1). The support staff and volunteers at the centres reported that they had not received any orientation on matters related to youth although they were providing some services to the youth.

Many members of the senior management felt that staff working at the youth centres were not properly trained to handle youth. They emphasized the lack of training as an impediment to the provision of adequate and quality youth services at the centres.

To assess the level of provider competence and the effectiveness of the training they received, staff were asked questions on FP/RH-related issues. Table IV portrays the number and proportions of staff that were able to correctly answer specific questions on reproductive health and family planning.

**Table IV: Reproductive Health Knowledge of Youth Centre Staff (n=18)**

REPRODUCTIVE HEALTH KNOWLEDGE	PROFESSIONAL STAFF (n=14)	SUPPORT STAFF (n=4)	ALL STAFF (n=18)
Knew the fertile period during the monthly cycle	11	0	11
Knew that a man can still make a woman pregnant even if he withdraws before ejaculation	10	0	10
Knew that condoms do not have holes that allow the HIV virus to pass through.	12	4	16
Knew that condoms are not laced with HIV.	14	4	18
Knew that family planning methods do not cause deformed babies later on.	13	4	17
Knew that family planning methods do not cause infertility later on.	12	4	16
Knew that irregular periods in young girls are usually not a sign of something seriously wrong.	12	2	14
Knew that IUDs can cause heavier menstrual flow and backache.	9	1	10
Knew that a man cannot always tell when a woman has a sexually transmitted disease.	13	2	15
Knew that one cannot get HIV/AIDS from mosquito bites, fleas, or bedbug bites.	12	4	16

Source: Interview with Youth Centre Staff

All staff interviewed were aware that a cure for HIV/AIDS had not been discovered; that one can get HIV/AIDS the first time they have sex; that one cannot get HIV/AIDS from shaking hands with someone who has AIDS; and that one cannot contract HIV/AIDS from hugging someone with AIDS.

Knowledge of the mode of transmission of HIV was also assessed. Staff were asked to name the ways in which HIV/AIDS can be transmitted. The proportions of staff who mentioned specific modes of transmission are summarized in Table V.

**Table V: Number of Staff Mentioning Modes of HIV/AIDS Transmission (n=18)**

<b>MODE OF HIV/AIDS TRANSMISSION</b>	<b>PROFESSIONAL STAFF (n=14)</b>	<b>SUPPORT STAFF (n=4)</b>	<b>ALL STAFF (n=18)</b>
Sexual Intercourse	14	4	18
Transfusions	13	2	15
Circumcision	14	1	15
Injections	11	2	13
Pregnancy	8	0	8
Childbirth	4	0	4
Breastmilk	1	0	1

Source: Interview with Youth Centre Staff

When asked about the most appropriate family planning methods for unmarried adolescents, a majority of the professional staff cited the pill (12), foaming tablets/jellies/creams (10) and condoms (9). It is noteworthy that the condom was cited less often than pills and foaming tablets, despite it being an important means of preventing STIs, which is of particular importance to youth who tend to be in unstable relationships and at increased risk of STI infection. When asked which methods unmarried adolescents should avoid almost all of the professional staff mentioned permanent methods (11). However, one felt that oral contraceptives should be avoided by unmarried adolescents and quite a number felt that injectables (7) and IUDs (7) should be avoided. This is in spite of the fact that oral contraceptives and injectables are not contraindicated for adolescents and are very effective especially when used in conjunction with a barrier method to prevent STI infection<sup>4</sup>. While the IUD should not be the first method of choice for unmarried adolescents because of increased risk of STIs and pelvic inflammatory disease (PID), there is no medical rationale behind the prohibition of the method for adolescents<sup>5</sup>. As such, there seems to be a lack of consensus among youth centre professional staff on what methods are safe and appropriate for the youth.

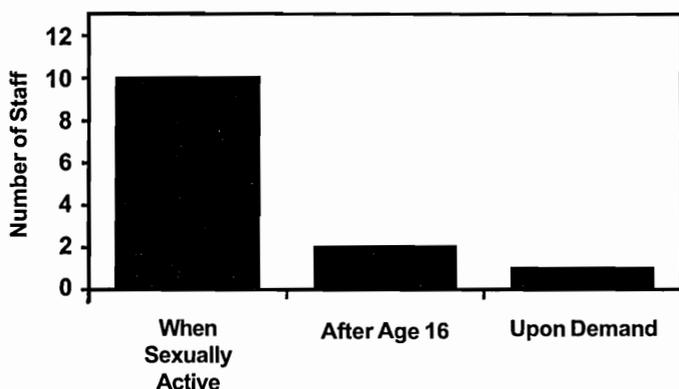
Knowledge of HIV/AIDS is high among both professional and support staff. Support staff had limited knowledge of reproductive health related issues although they sometimes distribute condoms to the youth which, in itself, exposes them to questions from youth. While most of the professional staff were quite conversant on FP/RH-related matters, a few did not have correct information on matters related to family planning and fertility. As all staff have to interact with youth, it is important that all of them are equipped with the requisite skills and knowledge.

In Zimbabwe, the government policy is that young people should have access to contraceptives only after the age of sixteen, the legal age of consent. Staff opinion was sought as to when a youth should have access to contraceptives. Figure 1 portrays the distribution of professional staff opinion on this issue.

<sup>4</sup> McCauley, A.P. and Salter, C. "Meeting the Needs of Young Adults. *Population Reports*, Series J, No. 41. Baltimore, Johns Hopkins School of Public Health, Population Information Program, October, 1995.

<sup>5</sup> "Network: Intrauterine Devices" Family Health International, Vol. 16, No. 2, 1996.

**Figure 1: Professional Staff Opinion on Access to Contraceptives for Youth (n=13)**



Source: Interview with Youth Centre Staff

Importantly, none of the staff interviewed took the most conservative stance on provision of contraception in believing that young people should only have access to contraceptives after marriage or after having a baby. Most of the staff (10) felt that young people should have access to contraceptives once they are sexually active. Only two of the professional staff said when the youth is above 16 years of age (i.e. age of consent) while one staff felt that adolescents should have access to contraceptives upon demand.

These findings reveal that there is no standard position among service providers as to when young people should have access to contraceptives. This is probably due to the sensitive nature of provision of contraceptives to young people particularly those that are below 16 years of age and are unmarried.

The involvement of youth in the planning and implementation of youth activities and services is a vital ingredient in the success of youth projects<sup>6</sup>. Only the Mutare Youth Centre has youth volunteers who are involved in the day to day activities of the centre. The volunteers are involved in counselling and organizing aerobics, soccer, drama and video shows at the centre. At the same time, these youth have never received training to counsel other young people. None of the centres seem to have involved youth in the planning of activities, in any significant way.

#### 4.2.5 Supervision

One of the greatest impediments to effective management and supervision of the youth centres, mentioned by senior management, was a lack of clearly defined objectives for the programme. The youth centres administratively fall under both the Service Delivery Unit (SDU) and the IEC Unit. A majority of the senior management staff interviewed expressed a concern that the coordination between the IEC Unit and the SDU was poor and they felt that the youth centres should only be administered by one unit. Senior management felt that the question of "ownership" of the youth centres should be decided on the basis of the ultimate objectives of the youth centres, which, in themselves, were not defined.

There was also a feeling that neither the IEC Unit nor the SDU were equipped to serve youth, but adults. It was argued that the existing administrative system should remain in force until alternatives are found.

<sup>6</sup> Senderowitz, Judith, "Health Facility Programs for Young Adults: Best Practices," for FOCUS on Young Adults, draft report, 1996.

Some of the respondents felt that the youth centres should be run by the IEC Unit in close collaboration with the SDU in order to avoid labelling the youth centres as places where contraceptives are provided. These respondents argued that the initial thrust of the centres should be the provision of information and education to the youth. It was felt that this is the only strategy that can be used to “cover-up for services which should stay in the background”. There were also arguments such as “we should use the IEC Unit as a rocket launcher and not put services up-front”.

On the contrary, there were respondents who felt that the youth centres should be run by the Service Delivery Unit (SDU) with the back up of well-trained IEC Officers. It was argued that the SDU can attend to all categories of youth who come for both counselling and services without having to refer them elsewhere and yet the IEC Unit only gives information, education and counselling and then refers for clinical services.

Youth centre staff were asked about the number of supervisory visits they had received from their immediate supervisors during the 12 months prior to the survey. Only 5 staff members indicated that they were visited twice while the rest were visited once or not at all. This underscores the need for more frequent supervision of the staff at the youth centres.

#### **4.2.6 Record Keeping and Monitoring**

As mentioned, the study involved a retrospective analysis of clinic data. Review of the data highlighted that the clinic registers are not standard across the youth centres and that information on clients is often incomplete. For example, very few entries in the register had data on sex, marital status or age of the clients. There is need to standardize the client information recorded in the youth centre clinic registers and the information should include the basic socio-demographic characteristics of the client and the type of services provided. There is need to train staff on record-keeping in order to improve the quality and completeness of data collected.

Further, an inventory of all records kept at the youth centres revealed that the three centres maintain a wide range of different records. For example, Bulawayo maintains a condom register while the other centres do not. There is need to review and standardize the record-keeping system at the centres in order to make it effective and efficient.

### **4.3 Quality of Services at The ZNFPC Youth Centres**

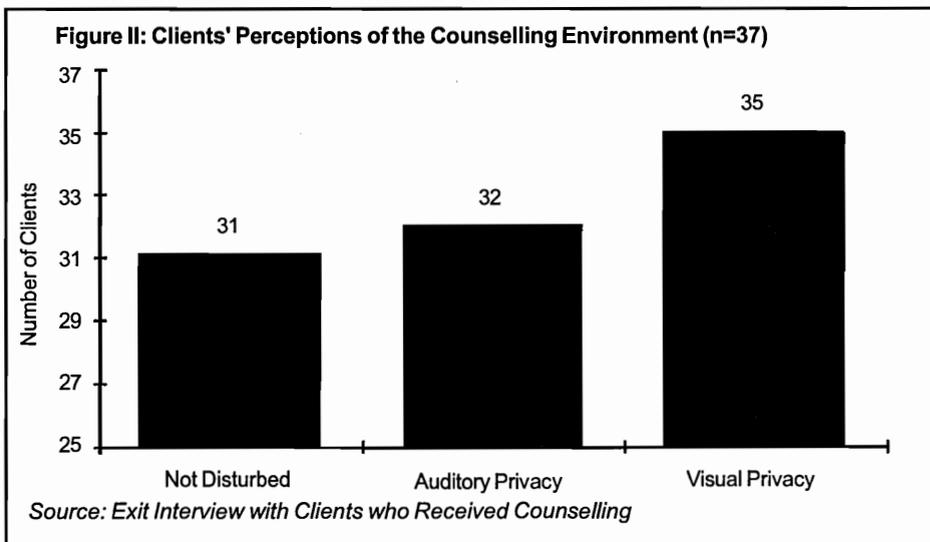
During the study period, all thirty-seven clients who received counselling were interviewed in order to assess the quality of care that clients receive when they interact with the service providers at the youth centres. It should be noted that the number of clients that came to the centres for counselling during the two week data collection period is extremely small. This, in itself, could reflect some deficiency in quality or in demand for services as they are currently structured.

Unlike a traditional situation analysis where counselling sessions are observed, sessions with youth were only tape recorded to minimize embarrassment since many of the issues on which youth are counselled are more sensitive than the family planning counselling for married women. The information on quality of care presented here is, therefore, less detailed due to this limitation in the data.

Only six of the 37 clients counselled were males while the rest (31) were females. The males were, on average, 24 years old while the females were 22 years old. Seventeen of the counselled clients indicated that they were currently married, while an additional three were divorced, widowed or separated. Although the number of counselled clients was small, more than half (20) were either married or divorced/separated/widowed.

Overall, 22 of the 37 clients had visited the youth centres previously, while 15 were visiting the youth centres for the first time. The majority (35) of the clients indicated that they were satisfied with their visit to the youth centres.

Figure II gives the clients' assessment of the counselling environment. It is clear that, in a majority of cases, there was both visual and auditory privacy and that the majority felt that their session was not disturbed. Generally, clients felt that the environment was conducive, except in a few cases where they felt there was no auditory privacy (5) and the sessions were disturbed (6).



Counselled clients were asked about their views of the counsellor. Figure III reveals that clients felt that the counsellors were understanding, attentive, patient, comfortable and had a positive attitude.

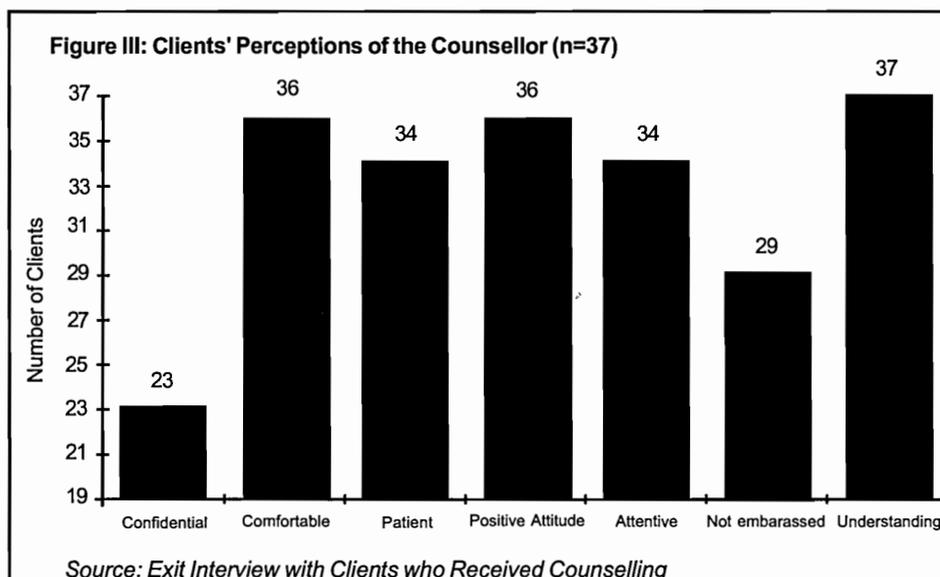
Eight clients felt that the counsellors were embarrassed by what they had to say while 10 clients were either not sure or did

not know whether their discussions were going to be kept confidential. Four clients indicated that the counsellors would not keep what they had discussed confidential.

Further, 13 clients indicated that they were not asked if they had any questions at the end of the counselling sessions. Thirty-five clients said they would visit the same counsellor while the same number said they would refer a friend to the same counsellor.

Perceptions of the counsellors by clients were generally positive. However, counsellors need to ensure that there are no interruptions during the counselling sessions. The fact that some clients

felt that some counsellors were uncomfortable with the topics discussed and were not sure whether the discussions would be kept confidential, stresses the need for staff to be trained on matters that directly affect adolescents and on the concept of confidentiality.



#### 4.4 Volume of Client Visits to The ZNFPC Youth Centres

Attendance at the three ZNFPC youth centres for any reason, including clinical services, recreation or visiting the library, was measured during the two week data collection period through a sign-in register system. Any client who entered the centre was asked to fill in a sign-in register where they indicated their name, age, sex and reason for visiting the centre. Times of entry and exit were also recorded.

The system enabled the measurement of client load at the centres. It must be emphasized that the register measured **client load, or client visits**, as opposed to the number of **individual clients** since the same client was required to sign-in even if he/she had visited the centre the previous day. **The unit of analysis is, therefore, client visits as opposed to individual clients.**

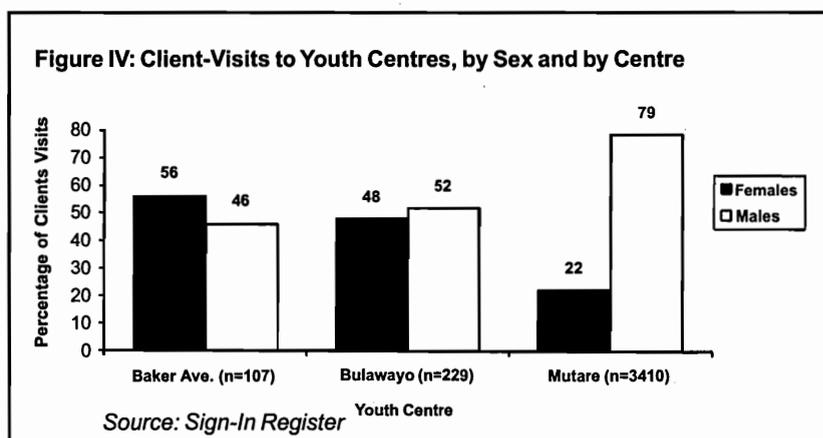
During the two weeks of data collection, the centres experienced a total of 3410 client visits. Table VI describes the number of client visits experienced by each of the three centres.

**Table VI: Client-Visits per Youth Centre**

CENTRE	FEMALES	MALES	TOTAL
Baker Avenue	60 (56%)	47 (44%)	<b>107 (100%)</b>
Bulawayo	110 (48%)	119 (52%)	<b>229 (100%)</b>
Mutare	658 (21%)	2415 (79%)	<b>3073 (100%)</b>
<b>TOTAL</b>	<b>828 (24%)</b>	<b>2582 (76%)</b>	<b>3410 (100%)</b>

Source: Sign-In Register

Ninety percent of the visits were made to the Mutare Youth Centre. The other two centres saw significantly fewer clients than did the Mutare centre, with the Bulawayo and Baker Avenue youth centres experiencing 229 visits (7%) and 107 visits (3 %) respectively.



Overall, 76 percent of the client-visits were by males while 24 percent were by females. However, this sex differential was, to a great extent, a result of the great differences between male and female visits to the Mutare youth centre. Figure IV displays the sex distribution of client-visits by centre.

While the Baker Avenue Centre and the Bulawayo Centre saw a client load that was fairly equitable in terms of sex distribution, visits by males far outnumbered those by females at the Mutare Centre.

Clients to the Mutare Centre stayed for a significantly longer time than those at the other two centres. This is most likely due to the special activities that are offered at the Mutare centre, that are not at the other centres. On average, visits to the Baker Avenue centre lasted 8 minutes; those to the Bulawayo centre lasted 14 minutes. Clients to the Mutare centre stayed at the centre for an average of 2 hours and 30 minutes<sup>7</sup>.

## 4.5 Youth Centre Clients

### 4.5.1 Client Profiles

A total of 454 clients were interviewed. Thirty-seven (8 percent) of the clients interviewed were counselled while the remainder, 417 (92 percent), had visited the centres for reasons other than counselling. The majority of the clients interviewed were males (58 percent) while 42 percent were females.

Figure V portrays the sex distribution of exit interview clients at each of the centres. Both the Baker Avenue and Bulawayo Centres saw more than twice as many women than men. However, the opposite is true for Mutare; nearly 65 percent of clients interviewed were males.

The ages of the clients ranged from 12 to 44 years and were on average aged 21 years. Clients that received counselling were slightly older than those that did not. This is probably due to the fact that older youth are already experiencing some reproductive health problems, hence they come forward for counselling. Counsellled clients were on average 22 years old while those that

<sup>7</sup> It should be pointed out that at the Mutare youth centre there was a problem of some clients coming in and going out a number of times before they finally signed-out. This partly contributed to the rather long average duration of the visits to the centre.

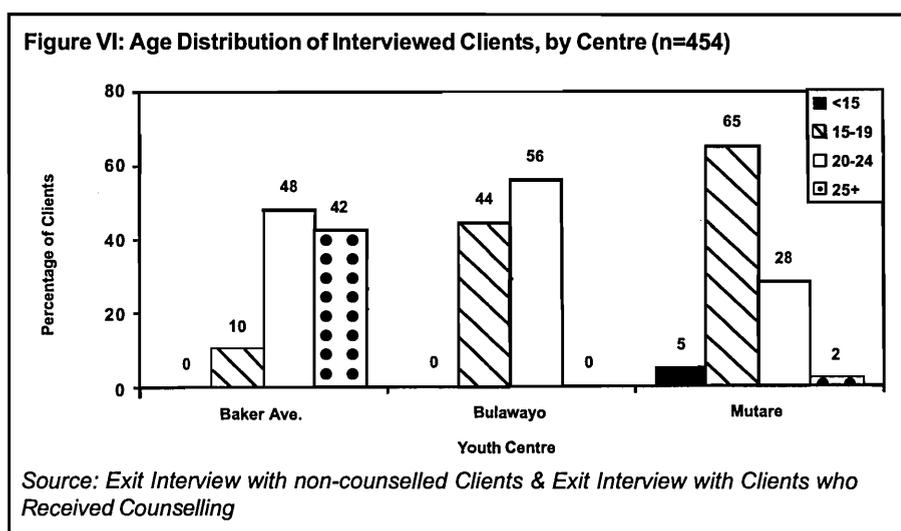
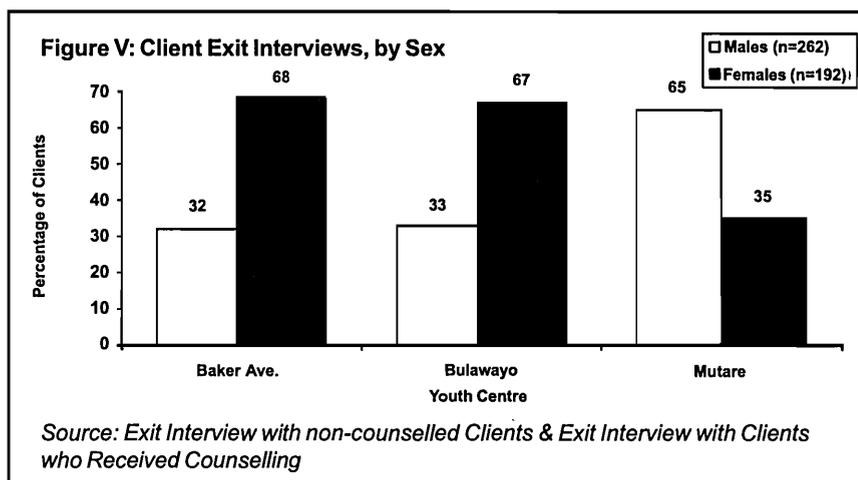
came for other reasons were, on average, aged 19 years. Figure VI displays the age distribution of clients by centre.

Given that ZNFPC's target group for the youth centres is primarily unmarried young people aged 10 to 24 years, both the Bulawayo and the Mutare youth centres seem to have had moderate success in reaching the target age group. None of the

clients at the Bulawayo centre were outside the target age range of 10-24 years. Only seven clients (2 percent) that visited Mutare were above 24 years of age. At the same time, both of these centres served virtually no young people under the age of 15. A majority of the youth below the age of 15 are most likely to be doing their primary or junior-level secondary education, hence they might shun visiting the youth centres since they are associated with the provision of family planning services. The Baker Avenue Youth Centre attracts a significant proportion of clients that are outside the target age group. Forty-two percent of the clients who visited the centre were aged 25 years or more.

Very few youth below the age of 15 years have been reached through the youth centres. No youth in the 10 to 14 age group visited either the Baker Avenue Centre or the Bulawayo Centre. While Mutare Youth Centre saw a very small proportion of youth under 15 years of age. This could be due to the fact that these centres are largely oriented toward family planning information and service provision. Such services might be irrelevant to a large proportion of this age group, or might be difficult to access when most of this age group are in school. Further, it is probably difficult for these younger youth to enter facilities marked "family planning" because of the stigma attached to it.

Similarly, the marital status of clients varied markedly across the three centres. Only 44 percent of the Baker Avenue clients were single and had never been married. The percentage of single/never married clients in Bulawayo and Mutare were 90 percent and 97 percent respectively. There was a larger proportion of married clients among those



that received counselling than among those that did not. While 46 percent of the counselled clients were married, only 5 percent of those that were not counselled were married.

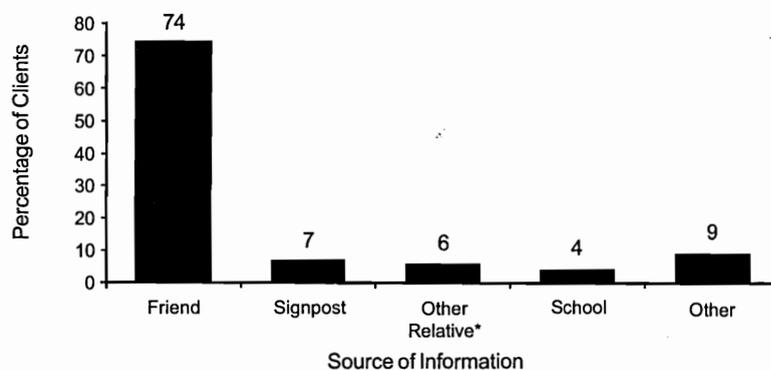
A majority, 85 percent, of the clients interviewed had visited the youth centres before. However, clients who had been counselled tended to be first time clients more than the clients who had not been counselled. Of those who received counselling, 41 percent (15) were visiting the centre for the first time compared to 16 percent (65) of the clients who were not counselled.

Most clients, 87 percent, were satisfied with their visit to the centres. Those that received counselling tended to be more satisfied than those that did not. While 95 percent (35) of the counselled clients were satisfied with their visit, 86 percent (359) of the non-counselled clients were satisfied.

#### 4.5.2 First Source of Information about the Centres

Clients were asked about their first source of information about the youth centres. Friends were, by far, the most important source of information. Other important sources were the signpost outside the centres and other relatives. Figure VII portrays the sources of information where clients first learned about the centres.

Figure VII: First Source of Information About the Youth Centres (n=454)



\* All other relatives excluding parents

Source: Exit Interview with non-counselled Clients & Exit Interview with Clients who Received Counselling

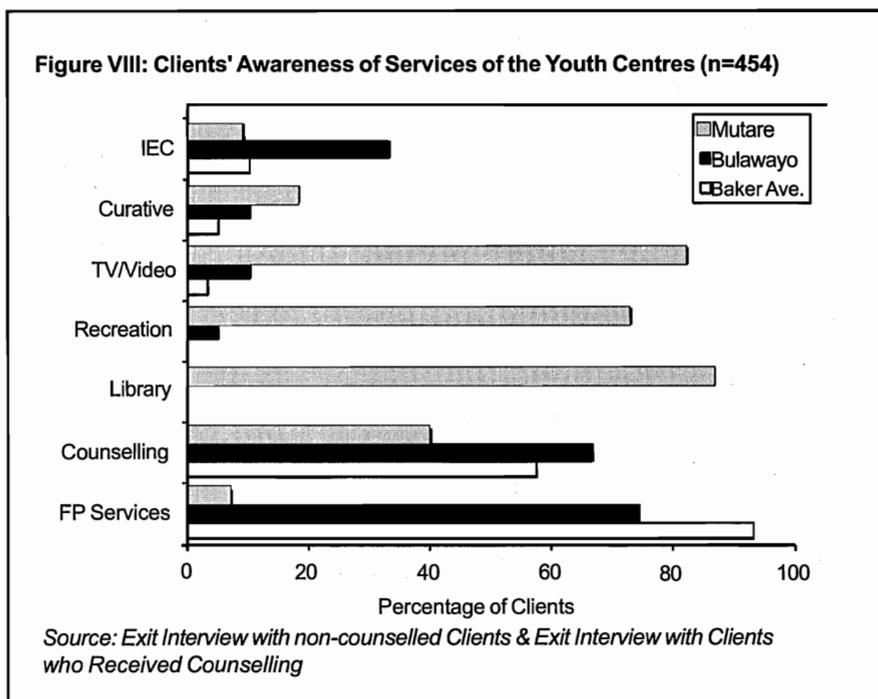
The "other" category includes service providers (2 percent), posters (2 percent) and ZNFPC staff (1 percent), among others. However, hearing about the centre from friends was more common among clients that came for reasons other than counselling. Of those who did not receive counselling, 76 percent (317) had heard about the centre from friends compared to 54 percent (20) of the counselled clients. Friends were an important source of information particularly to clients who visited the Mutare Youth Centre, with

81 percent of clients having first heard about the centre from friends. The respective figures for Baker Avenue and Bulawayo youth centres were 48 percent and 54 percent respectively.

### 4.5.3 Awareness of Services at the Youth Centres.

Awareness of services offered differed greatly by clients of different centres. Figure VIII displays the proportion of clients knowing about the different services offered at each of the centres. Percentages add up to more than 100 percent because clients could know more than one type of service.

Differences in awareness of services are to be expected, in part, because some of the centres do not have the facilities for certain services. For example, neither Baker Avenue nor Bulawayo have library facilities and the schedule of TV/Video viewing is largely unstructured, compared to Mutare. However, this cannot account for the differences in awareness of family planning services, that are available at all the centres. Awareness of family planning and counselling services was very low (7 percent) at the Mutare Centre, despite there being a full clinic.

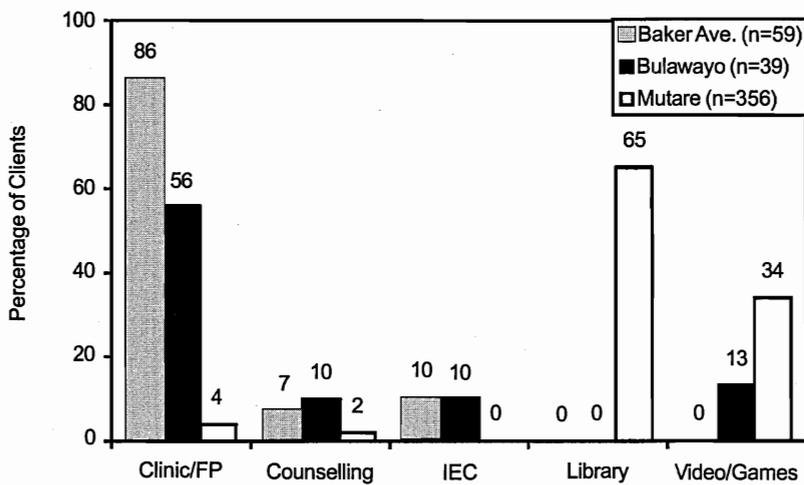


Clients at the Mutare Youth Centre were mostly aware of the recreational activities (73 percent), the TV/video (82 percent) and the library (87 percent). Interestingly, clients at Mutare were more aware of curative services, such as those for STI treatment than clients at the other two centres.

### 4.5.4 Reason for Visiting the Youth Centres

Reasons for visiting the centres were influenced, in part, by the availability of services. For example, the Mutare Centre offered significantly more recreational activities than do either of the other two centres. Figure IX displays clients' reasons for visiting the youth centres.

**Figure IX: Reasons for Visiting the Youth Centres, by Centre**



Source: Exit Interview with Non-counselled Clients & Exit Interview with Clients who Received Counselling.

If clients visited the centres for more than one reason, all the reasons were recorded. Therefore, percentages may add up to more than 100 percent. The majority of clients who visited the Baker Avenue and Bulawayo centres came for clinical and family planning services. At Baker Avenue, 86 percent of clients visited for this reason, compared to 56 percent of clients at the Bulawayo centre. Although the youth centres are largely geared towards family planning

information, education, counselling and service delivery, very few clients came for counselling. Only 7 percent of the clients at Baker, 10 percent of Bulawayo clients, and 2 percent of Mutare clients came for counselling. However, it can be assumed that, at least, some of the clients that came for clinical services, were counselled in the process of receiving the services.

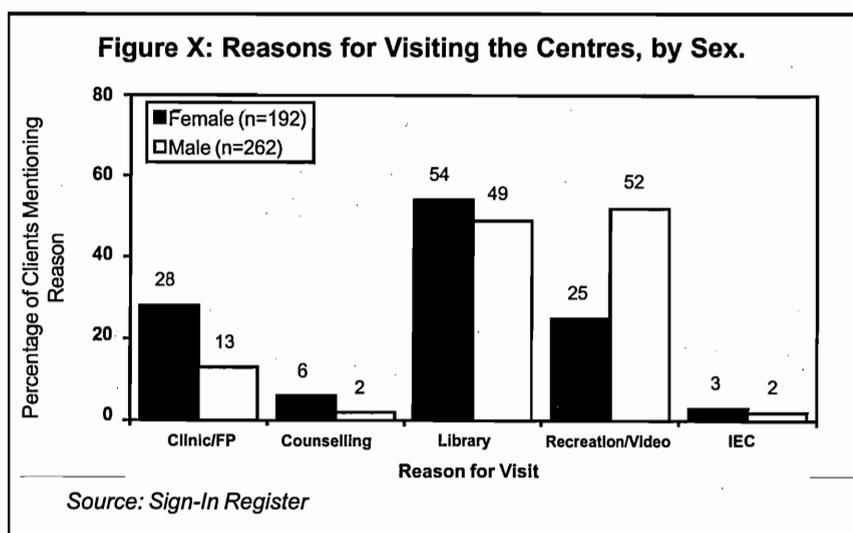
Visits to the Mutare Youth centre were for a variety of reasons. Recreation (video and games) and the library were the main reasons for clients' visits during the two weeks of data collection. About 65 percent of the clients came for the use of the library and 34 percent of the visits were for the use of the recreational facilities. The relatively high proportion of client visiting the library was partly due to the fact that data collection took place during the examination period in Zimbabwe. Only a small proportion of clients at the Mutare Centre came for clinical or IEC services. Four percent of the clients came for the clinic while 2 percent of clients came for counselling.

Male and female clients tended to visit the centres for different reasons (Figure VII).

Females came mostly to use the library facilities (54 percent) and to a lesser extent for clinical or family planning services (28 percent). The majority of males came for the recreational facilities (52 percent) and 49 percent of the male clients came to use the library.

#### 4.5.5 Parental Approval of the Youth Centres

Clients who were either staying with their parents or guardians were asked whether the parents were aware that they had come to the youth centres. Sixty percent of the clients indicated that their parents were aware of the visit. Eighty-eight percent of these clients further indicated that their parents approved of their going to the centres. Therefore, parents of youth who currently visit the youth centre generally approve of their visiting.



#### 4.6 Clients' Reproductive Health Knowledge

The success of the ZNFPC youth centre programme can be measured in terms of the numbers of youth it reaches with counselling and family planning services. The success can also be measured by the programme's impact on youth's reproductive health knowledge, as studies show that greater reproductive health knowledge increases safer sex practices among young people, including condom use and fewer sexual partners<sup>8</sup>. Clients who visited the youth centres were asked questions to assess their knowledge of matters related to reproductive health.

Table VII portrays the proportion of clients who correctly answered specific questions on fertility:

**Table VII: Client's Reproductive Health Knowledge (n=454)**

KNOWLEDGE STATEMENT	% CORRECT
Knew that man can make a woman pregnant, even if they have previously had sex without a family planning method and not conceived	70
Knew when a woman is most likely to get pregnant during the monthly cycle	16
Knew that a man who withdraws can still cause pregnancy.	18
Knew that a couple can conceive the first time they have sex.	89
Knew that family planning methods do not cause deformed babies.	78
Knew that family planning methods do not cause infertility.	55

Source: Exit Interview with Non-counselled Clients & Exit Interview with Clients who Received Counselling.

<sup>8</sup> Grunseit, A. and Kippax, S. "Effects of Sex Education on Young People's Sexual Behaviour," 1993.

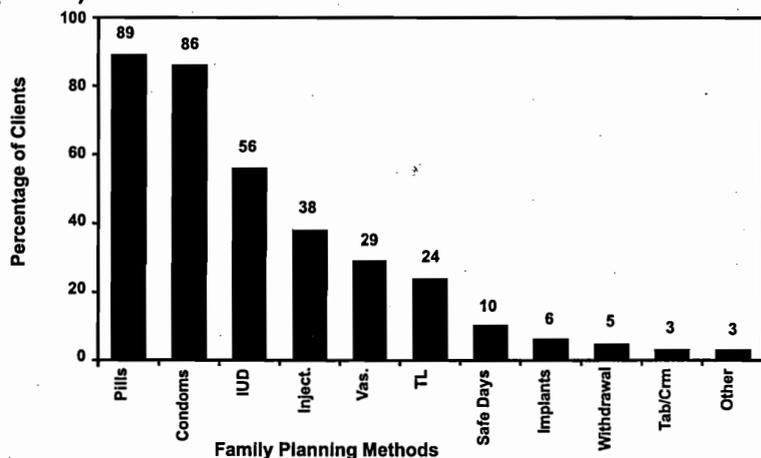
A large proportion (89 percent) of clients knew that one can get pregnant during the first sexual intercourse while 78 percent knew that family planning methods do not cause deformed babies. However, knowledge of a woman's fertile period (16 percent) and the low effectiveness of withdrawal (18 percent) was very low. Such low knowledge levels are a cause for concern as safe period and withdrawal are the methods used by many sexually active adolescents.

Nine statements were read to clients concerning STI/HIV/AIDS and respondents were asked whether the statements were true or false. Overall, the respondents were knowledgeable on issues pertaining to STI/HIV/AIDS with males being more knowledgeable than females. However,

many clients did not know whether condoms have small holes that allow the HIV to pass through. Only 57 percent of the clients knew that they did not, while 43 percent thought that they did. This is of concern because young people who are not sure of the safety of condoms, might not use them, leaving them vulnerable to HIV infection.

Clients were asked if they were aware of family planning methods or methods to prevent STI transmission. Over 92 percent of centre clients were aware of such

**Figure XI: Clients' Knowledge of Family Planning Methods (n=454)**



Source: Exit Interview with Non-counselled Clients & Exit Interview with Clients who Received Counselling.

methods. Clients were asked to mention all the family planning methods of which they were aware. Figure XI shows the proportion of respondents that spontaneously mentioned specific family planning methods.

#### 4.7 Clients' Sexual Behaviour & Family Planning Use

Interviews with clients revealed that 39 percent of them had ever had sexual intercourse. Similar proportions of males (38 percent) and females (40 percent) had had sexual intercourse as shown in Table VIII. It can also be seen from Table VIII that both male and female clients who were sexually experienced, started to have sexual relationships at almost the same average age. Males were, on average, aged 17.6 years when they first had sex and females were aged 18.1 years when they had sex for the first time. However, age of first sexual partners differ between males and females. Males tend to have partners that are about three years their junior, while females' partners are about four years older than themselves. Females are, therefore, most likely at risk of STI/HIV infection since they are dealing with older partners who might already be sexually experienced.

**Table VIII: Clients' Sexual Behaviour (n=454)**

SEXUAL BEHAVIOUR CHARACTERISTICS	MALES	FEMALES
Ever had a boy/girlfriend	82%	87%
Average age at first relationship	16.6 years	16.8 years
Average age of first partner	15.5 years	19.9 years
Currently have a boy/girlfriend	68%	74%
Ever had sexual intercourse	38%	40%
Average age at first sexual intercourse	17.6 years	18.1 years
Average age of first sexual partner	14.8 years	22.8 year
Average age at first impregnation or pregnancy	22 years	17.6 years

Source: *Exit Interview with Non-counselled Clients & Exit Interview with Clients who Received Counselling.*

A very high proportion, 97 percent, of clients at the Baker Avenue Youth Centre had had sex perhaps because this clientele tends to be older than that for the other two centres. Comparable figures for Bulawayo and Mutare Centres were 77 percent and 24 percent respectively.

Altogether, 83 percent of the sexually experienced clients had ever used a family planning method; 17 percent of the sexually experienced clients had not used a method. Of those that were sexually experienced, 77 percent had used a condom, 40 percent had used contraceptive pills, 6 percent had used the injectable while the IUD and vasectomy had been used by 1 percent each.

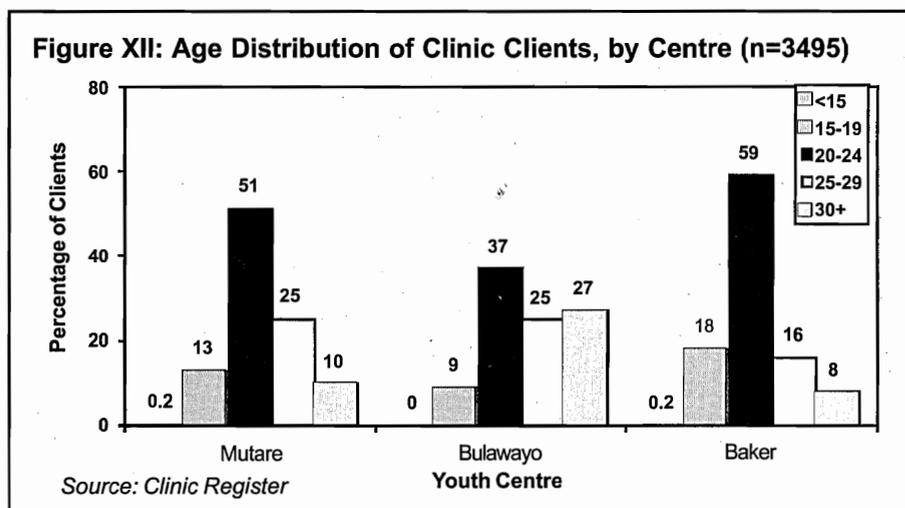
#### **4.8 Family Planning/Reproductive Health Service Provision at the Youth Centre Clinics**

Clinic records at the youth centres were transcribed for the two year period prior to data collection (August, 1994 to September, 1996). Information recorded in the clinic registers included age, marital status and sex of the clients and the type of services and commodities provided. In many cases, clients who just came to pick up condoms at the centres were not entered into the clinic registers and as a result the statistics reflected in the registers underestimate the number of condom clients seen at the clinics. The completeness and quality of information in the registers varied by centre and by the period of time, depending on who was present to fill in the information. Many records have missing information on one or more variables. Although the records give a rough reflection of the volume of clients seen at each of the youth centre clinics, as well as the types of services provided to the clients, caution should be exercised when interpreting the clinic service statistics.

A total of 7157 clients visited the clinics at the centres during the two year period under review. A majority, 3972 (56 percent) of the clients were seen at the Bulawayo youth centre clinic. The Baker Avenue Centre saw 2331 clients (33 percent), while the Mutare clinic was visited by 845 clients (12 percent). Averaged over the 104 weeks of the two year period, the Bulawayo youth centre clinic attended to 38 clients per week while Baker Avenue and Mutare youth centre clinics attended to 22 and 8 clients per week respectively.

During the two year period, all 2331 clients recorded at the Baker Avenue register were females. Bulawayo saw only 15 male clients out of 3972 clients. At the same time, 26 percent (n=210) of the clients seen at the Mutare clinic were male. Marital status was largely not recorded in the registers, especially at the Baker Avenue and the Mutare clinics. Only a total of 871 entries at the Bulawayo clinic had information on the marital status of the clients. Forty-seven percent of these clients were single while 53 percent were married. Age was another variable that was incompletely recorded. However, available data indicate that the ages of the clients ranged from 10 to 50 years with 45 percent of them being older than 24 years, the upper age limit for what is conventionally considered "youth".

Figure XII displays the age distribution of the clients who visited the clinics.

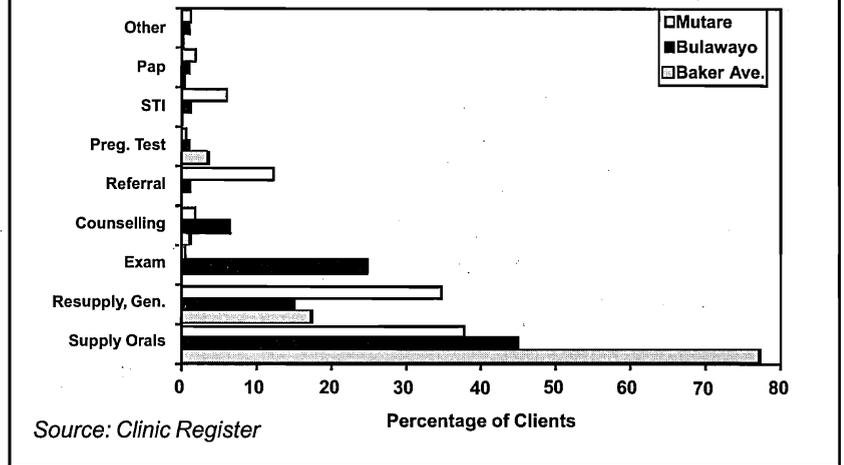


The clientele at the clinics is relatively old, with 45 percent of the clients being older than 24 years. The recording of client age was quite incomplete in the clinic registers. However, for the data that was available, Baker Avenue clients averaged 23 years, Bulawayo clients were on average aged 26 years and Mutare clients, 24 years<sup>9</sup>.

<sup>9</sup> Caution should be exercised in interpreting age data as young people might tend to misreport their age, especially when seeking family planning or reproductive health services.

According to the clinic register data, most of the clients were supplied/re-supplied with oral contraceptives. This was particularly so for the Baker Avenue clinic where 77 percent of the clients received oral pills. This was followed by 45 percent and 38 percent of the clients at the Bulawayo and Mutare Centre clinics respectively who also received oral pills.

Figure XIII: Services Received at Youth Clinics (n=6990)



## 5 CONCLUSIONS AND RECOMMENDATIONS

The situation analysis of ZNFPC youth centres collected information on the availability, quality and functioning of services provided at the three ZNFPC youth centres, in Harare (“Baker Avenue”), Bulawayo and Mutare. Each of the three youth centres is quite different, making it difficult to compare one with the other. The Baker Avenue Centre in Harare is virtually a vertical family planning clinic; the centre in Mutare places heavy emphasis on recreation as a strategy for attracting adolescents to the centre and, thereby, exposing them to reproductive health messages and services; and the Bulawayo youth centre offers a moderate amount of recreation, though substantially less than the Mutare centre.

One of the main weaknesses of the youth programme is the lack of clear objectives, as cited by many members of management. As one member of management put it, “We (ZNFPC) are not currently clear of and focused on what we want to do for the youths.” This lack of objectives makes it difficult to set programme priorities, refine supervision and have clear lines of authority, especially in terms of whether the programme should be run by the Service Delivery Unit (SDU) or the IEC Unit. This “dual ownership” results in unstandardised and uncoordinated running of the Youth Centres. The administrative structure of the Youth Centres needs to be reviewed so that they are run by one unit. This will ensure the standardisation of various subsystems such as record keeping, staffing patterns, planning and implementation of activities and types of services provided.

Accessibility of the centres, however, is less than optimal. The current locations of the centres, in the city centres, was seen as a barrier to young people visiting the centres and it was suggested that they be relocated to high-density neighbourhoods where there is a high concentration of youth. However, there is a need to take note of the cost implications of relocating the youth centres.

A multi-faceted approach should be used in publicising the Youth Centres. Some of the clients interviewed suggested that there should be "open days" at the Youth Centres as a way of publicising and promoting the centres' activities. The signboards with the ZNFPC name and logo were said to be stigmatising the centres, especially to younger adolescents who might feel embarrassed to be associated with "family planning." These should be replaced with a logo which youth can comfortably identify with.

The hours of operation (8:30 a.m. - 4:30 p.m.) are, at first glance, not convenient for adolescents, especially those attending school. However, the data suggested that few current clients were unhappy with the hours and that more clients come in the morning, rather than the afternoon. At the same time, given the data collected, it is not possible to assess whether changing the hours would increase the utilization of the centres by clients who cannot otherwise come to the centres, such as those aged 10 to 14 years.

Generally, the attendance at all three centres for reproductive health services was extremely poor and, judging from the study period, very few young people took advantage of the counselling services. Statistics over the past two years reveal that the Bulawayo Centre saw an average of 38 FP/RH clients per week, Baker Avenue saw 22 clients per week and the Mutare centre saw only 8 clients per week. Young people at the centres had inadequate knowledge of fertility and family planning methods and 17 percent of the sexually experienced clients had never used a family planning method. This is further indication that the centres are missing opportunities for educating young people that go there and in providing reproductive health services to those that need them.

Of the three centres, the Mutare Youth Centre is the only one that offers IEC and reproductive health services alongside a wide range of recreational services. The study findings indicate that the clients are more aware of the recreational activities than the IEC and reproductive health services at the centre. In fact the clients' awareness of the existence of IEC services at the Mutare Youth Centre was very low. Apparently, the centre has become more of a recreational centre than a place where youth should be getting counselling and reproductive health services. There is, therefore, need to integrate reproductive health information, education and services into all recreational activities at the youth centres. This will guard against turning the youth centres into mere recreational institutions.

Only the Mutare Centre had been successful in attracting a sizable number of young people for recreation. The young people attracted were predominantly boys which could have the effect of making that centre intimidating environment for adolescent girls and one which would be unacceptable for girls' parents. Also, adolescents in the 10 to 14 year age group were not being

reached through the programme, while the centres, in particular Baker Avenue and Bulawayo, were serving a significant number of clients who were older than the target age group.

Though staff had good knowledge of reproductive health issues and family planning, very few were trained specially to deal with the needs of young people. Staff required more information on fertility, on family planning methods for youth and on social topics that concern young people such as boy/girl relationships. Support staff, especially, needed this information as it is often easier for a young person to approach a support staff for information than a service provider.

There is also a need for the Youth Centres to be manned by staff who are properly trained in areas such as youth sexually, reproductive health and interpersonal communication skills.

The quality of the services could only be assessed on the basis of data from the very few interviews with clients that received counselling. It is, therefore, difficult to get a representative picture of the quality of counselling offered and the low number of clients, in itself, might be an indicator of deficiency in quality. However, counselled clients were, generally, satisfied with the counselling they received.

ZNFPC has been at the forefront of making reproductive health services available to young people in Zimbabwe. However, the youth centres, as they are currently configured, are reaching inadequate numbers of young people, far fewer females than males, virtually no youth under the age of 15 years, and many older people that are not considered their target. Currently, the cost of the programme is much greater than its returns and cannot be sustained over a long period, a view expressed by many members of management. Clearly, measures are required either to increase utilization of clinical and information services at the youth centres by the target group, or to investigate alternative means of reaching young people with information and services in a cost effective way, such as through community-based initiatives or through collaboration with existing youth-serving organizations.



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