FIRST JOINT REPORT OF THE PORTFOLIO COMMITTEE ON HEALTH AND CHILD CARE AND THEMATIC COMMITTEE ON HIV AND AIDS

ON THE PETITION FROM THE ADVOCACY CORE TEAM (ACT) ON THE AGE OF CONSENT TO ACCESSING REPRODUCTIVE HEALTH CARE SERVICES BY ADOLESCENTS AND YOUNG PERSONS IN ZIMBABWE

THIRD SESSION—NINTH PARLIAMENT

Presented to Parliament June 2021

[S.C 10/2021]

ORDER OF APPOINTMENT

STANDING ORDER NO. 17

- At the commencement of every Session, there must be as many Committees to be designated according to government portfolios as the Committee on Standing Rules and Orders may deem fit.
- Each Select Committee must be known by the portfolio determined for it by the Committee on Standing Rules and Orders.

TERMS OF REFERENCE

STANDING ORDER NO. 20

Subject to these Standing Orders, Portfolio Committees must-

- examine expenditure administration and policy of government departments and other matters falling under their jurisdictions as Parliament may, by resolution determine;
- consider and deal with all Bills other than the Constitutional Bill and Statutory Instruments or other matters which are referred to them by or under a resolution of the House or by the Speaker;
- consider or deal with an Appropriation of Money Bill or any aspect of an Appropriation or Money Bill referred to them by these Standing Orders or by resolution of the House;
- monitor, investigate, enquire into and make recommendations relating to any aspect of the legislative programme, budget, policy or any other matter it may consider relevant to the government department falling within the category of affairs assigned to them, and may for that purpose consult and liaise with such a department; and
- consider or deal with all international treaties, conventions and agreements relevant to them, which are from time to time negotiated, entered into or agreed upon.

On Tuesday, 27th October, 2020, the Speaker announced that the Committee on Standing Rules and Orders had nominated the following Members to serve on the Portfolio Committee on Health and Child Care:

1. Hon. Banda Gift,
2. Hon. Chibagu Getrude
3. Hon. Chinhamo-Masango Precious
4. Hon. Kwaramba Goodluck
5. Hon. Dr. Labode Ruth
6. Hon. Madziva Susan
7. Hon. Makoni Roseweater Roselyn
8. Hon. Mashonganyika Dorothy
9. Hon. Dr. Mataruse Peter
10. Hon. Mathe Stars
11. Hon. Mguni Hlalani
12. Hon. Molokela-Tsiye Fortune Daniel
13. Hon. Mukuhlani Tavengwa
14. Hon. Munochinzwa Memory
15. Hon. Col. (Rtd.) Dr. Murire Joshua
16. Hon. Ndiweni Dought
17. Hon. Nhari Vairet
18. Hon. Paradza John
19. Hon. Saizi Tapera
20. Hon. Shava Josephine
21. Hon. Shongedza Elizabeth
22. Hon. Sibanda Lwazi
23. Hon. Toffa Jasmine
24. Hon. Tongofa Mathias,
25. Hon. Tshuma Dingilizwe;
26. Hon. Watson Nicola Jane; and
27. Hon. Zhou Perseviarance

Hon. Dr. Ruth Labode to be the Chairperson

1.0 INTRODUCTION

1.1 Pursuant to Section 149 of the Constitution of Zimbabwe, the Advocacy Core Team (ACT) petitioned Parliament of Zimbabwe on the age of consent to accessing reproductive health care services by adolescents and young persons in Zimbabwe. Accordingly, the petition was referred to the Portfolio Committee on Health and Child Care and Thematic Committee on HIV and AIDS for consideration. Thus, the Joint Portfolio Committee on Health and Child Care and Thematic Committee on HIV and AIDS considered the petition and resolved to inquire into the issues raised in the petition. This report is a summary of key findings on the enquiry into the subject matter.

2.0 OBJECTIVES

The objectives of the enquiry were:

i. To assess the level of access to reproductive health care services for adolescents and young persons in Zimbabwe;

ii. To understand the legal frameworks that support or hinder the provision of reproductive health care services for adolescents and young persons in Zimbabwe;

iii. To appreciate the barriers to accessing reproductive health care services by adolescents and young persons in Zimbabwe;

iv. To get first hand experiences and feedback from the public on the access to reproductive health care services for adolescents and young persons in Zimbabwe; and

v. To solicit for public views and recommendations for improved reproductive health care services for adolescents and young persons in Zimbabwe.

3.0 METHODOLOGY

3.1 Due to the exigencies of Covid-19 pandemic, the Joint Portfolio Committee on Health and Child Care and Thematic Committee on HIV and AIDS received separate oral evidence submissions from the petitioner, the Advocacy Core Team on the 1st and 14th of September 2020 respectively. The oral submissions were aimed at explaining in detail the issues that were raised in the petition.

3.2 On the 28th of September 2020, the Joint Portfolio Committee on Health and Child Care and Thematic Committee on HIV and AIDS held an oral evidence meeting with the Hon. Vice President and Minister of Health and Child Care, General (Rtd.) Dr. C.G.D.N Chiwenga on the subject matter. The purpose of the meeting was to afford the Hon. Vice President and Minister of Health and Child Care the opportunity to respond to issues that were raised in the petition.

3.3 The Joint Committees considered the oral submissions from both the Advocacy Core Team and the Hon. Vice President and Minister of Health and Child Care. Thereafter,

they resolved to conduct public hearings in selected areas in the ten provinces of the country from 9th to 12th November 2020. This was meant to solicit for public views on the subject matter. Accordingly, the Joint Committees split into three (3) teams as tabulated below.

Team 1

Date	Place	Venue	Time of Public Hearing
09/11/2020	Hwange	Lwendulu Hall	1100hrs-1300hrs
10/11/2020	Bubi	Tatazela Hall Inyathi	0900hrs-1100hrs
10/11/2020	Nkayi	Agape Mission	1400hrs-1600hrs
11/11/2020	Gwanda	Gwanda Hotel	0900hrs-1100hrs
11/11/2020	Plumtree	Plumtree Community Hall	1430hrs-1630hrs
12/11/2020	Bulawayo	Nkulumane Hall	0900hrs-1100hrs
12/11/2020	Bulawayo	Pumula South Hall	1400hrs- 1600hrs

Team2

Date	Place	Venue	Time of Public Hearing
09/11/2020	Wedza	Wedza Sunshine Inn	1000hrs-1200hrs
09/11/2020	Marondera	Mbuya Nehanda Hall	1430hrs-1630hrs
10/11/2020	Bindura	Chipadze Hall	1000hrs-1200hrs
10/11/2020	Mt Darwin	Mt Darwin Community Hall	1400hrs-1600hrs
11/11/2020	Karoi	Chikangwe Community Hall	1000hrs-1200hrs
11/11/2020	Chinhoyi	Cooksey Hall	1400hrs-1600hrs
12/11/2020	Chitungwiza	UNIT L Hall	1000hrs-1200hrs
12/11/2020	Harare	City Sports Centre	1430hrs-1630hrs

Team 3

09/11/2020	Gokwe	Gokwe Community Hall	1030hrs-1230hrs
10/11/2020	Gweru	Mkoba Hall	0900hrs-1100hrs
10/11/2020	Gweru	Gweru Main Theatre Hall	1400hrs-1600hrs
11/11/2020	Masvingo	Mucheke Hall	0900hrs-1100hrs
11/11/2020	Bikita	Better Schools Program Nyika Hall	1400hrs-1600hrs
12/11/2020	Mutare	Sakubva BeitHall	0900hrs-1100hrs
12/11/2020	Rusape	Vengere 602 Hall Makoni	1400hrs-1600hrs

3.4 In addition, the Joint Committees also received written submissions via email and webinar platforms. The public hearings were funded by Parliament in conjunction with the National AIDS Council with its Strategic Partners namely: Joint United Nations Programme on HIV and AIDS (UNAIDS), United Nations Educational, Scientific and Cultural Organisation (UNESCO) and World Health Organisastion (WHO).

4.0 PETITIONERS' PRAYER

In the petition, the Advocacy Core Team was beseeching Parliament to consider amendments to the relevant legislations that ensure all adolescents and young persons under the age of 18 years can consent to accessing reproductive health services by ensuring that:

i. The Public Health Act of 2018 is amended to provide that, there should be no age restrictions on accessing Reproductive Health Care Services by persons aged 12 years and above, and these services include: HIV testing, pre and post counselling, access to contraceptives and other pregnancy prevention management services for adolescents and young people; and to ensure that there are proper administrative measures to monitor and provide Reproductive Health Rights for persons aged 12 years and above.

ii. The Children Justice Bill is enacted to provide for access to reproductive health services for adolescents and young people aged 12 years and above;

iii. All other appropriate legislations are amended to ensure consistency among policies guaranteeing access to critical and often lifesaving health care services for adolescents and young people.

5.0 SUMMARY OF SUBMISSSIONS

5.1 EVIDENCE FROM ORAL SUBMISSIONS
Access to Reproductive Health Care Services Among Adolescents: The requirement of Consent as a Barrier

5.1.1 Unpacking the petition to the Joint Committees, the Advocacy Core Team explained that the petition **does not seek to adjust the age of consent to sexual behaviour or the minimum age of marriage,** hence, this should not be linked to the age at which adolescents can access reproductive health information, education and services.

5.1.2 The Advocacy Core Team argued that:

> *In spite of Section 76 and 81 (f) of the Constitution of Zimbabwe guaranteeing everyone the right to health care services including Reproductive Health Care Services (RHS), the setting of legal minimum age with which an adolescent can access RHS without parental or third party consent has created a barrier for adolescents to effectively access these services.*

5.1.3 For instance, reference was made to Section 35 of the Public Health Act of 2018 and the National HIV Testing Guidelines of 2014 which limit the age to accessing Reproductive Health Care Services to 16 years.

5.1.4 The Advocacy Core Team also cited the National Adolescents and Youth Sexual Reproductive Health Strategy II, 2016-2020 (ASRH Strategy II) as the Government of Zimbabwe's guiding document for the provision of Reproductive Health Care Services for adolescents and youths. They stated that the ASRH Strategy II targets the age groups between 10-24 years and advocates for Reproductive Health Care Services for adolescents to be provided in a youth friendly way.

5.1.5 During the oral session held on the 28th of September 2020, the Hon. Vice President and Minister of Health and Child Care concurred that Section 76 of the Constitution of Zimbabwe guarantees health for everyone including Reproductive Health Care Services. He also confirmed the existence of the National Adolescents and Youth Sexual Reproductive Health Strategy II, 2016-2020 (ASRH Strategy II) but emphasized that the ASRH Strategy II is premised on-age appropriate sexual reproductive health information and services. Furthermore, the Hon. Vice President and Minister of Health and Child Care confirmed the existence of the National HIV Testing Guidelines of 2014 which limits the age to access these services to 16 years.

5.1.6 However, the Advocacy Core Team further argued that the requirement of consent is also limiting Health Care Service Providers from effectively attending to adolescents when providing Reproductive Health Care Services due to inadequate legal protection where services are rendered without the legal consent. The petitioners implored the Joint Committees to consider legislation that protects health care service providers and third parties from liability where they provide Reproductive Health-care Services or consent to provision of such services in matters involving persons below the age of 16.

5.1.7 The Hon. Vice President and Minister of Health and Child Care asserted that:

> *Ideally, individuals with the capacity to consent should be allowed to do so, no matter what their age. Assessment of capacity, however, is rarely straightforward for adolescents. Capacity to consent requires the ability to communicate a choice, to understand the options, to reason effectively about these options, and to make an un-coerced decision... Active involvement of a concerned and capable parent is the best possible situation for sexually active adolescents… Parents are presumed to be competent decision makers. They have legal and financial duties to care for children including adolescents…*

5.1.8 The Advocacy Core Team further purported that the restrictions have resulted in a public health concern in matters relating to the increasing spread of HIV and STIs among adolescents, unplanned parenthood, illegal termination of pregnancies, and the perpetual vulnerability of adolescents in particular the girl child. To buttress their case, the Advocacy Core Team presented the following statistics:

- The national teenage pregnancy rate was at 22%;
- Studies show a general **lack of comprehensive information and knowledge** about Reproductive Health-care Services (RHS) among adolescents and according to *Zimbabwe Demographic Health Survey, 2015(ZDHS 2015)* only 41% of boys and girls in the 15-19 age groups have sufficient knowledge or information on reproductive health;
- Zimbabwe has one of the highest maternal mortality in the region and 15% of these are among adolescents and young people,
- AIDS is the **leading cause of death among adolescents** and is the cause of an increase of 50% in adolescent mortality giving negative RHS outcomes according to *World Health Organization (WHO)*;
- According to the progress report on the 90-90-90 Global fast track targets on HIV, 48% of young people in Zimbabwe do not know their HIV status as they need parental consent. One of the key contributors to this outcome is the age of consent for accessing SRHR, HIV and AIDS services as there is no law that explicitly define the age of consent for accessing SRH services

5.1.9 Causes of Early Sexual Activity among Adolescents

The Advocacy Core Team attributed the causes of early sexual behviour to:

- Modern Food and Diet;
- Peer Influence/Pressure;
- Social Context; Technology-Internet,
- TV and Globalisation of Western Culture;
- Parental Behaviour—some parents are absent from their homes in pursuance of jobs while others subscribe to religious sects that promote child marriages;
- Reduction in Abstinence Messaging;
- Genetics – (may be subset of Modern Food and technology); and
- "Coercion."

5.1.10 On the same note, the Hon. Vice President and Minister of Health and Child Care singled out poverty as the key driver to early sexual behaviour among adolescents in Zimbabwe. He, therefore, emphasised that key issues to be addressed are the underlying causes of early sexual activity like poverty, school drop-outs and orphanhood.

5.2 EVIDENCE GATHERED DURING THE PUBLIC HEARINGS

It is imperative to state on the onset that young women, adolescents and youths were mostly in support of the petition while older women, men and religious leaders formed majority of the resenting voice.

5.3 Key drivers of early sexual behaviour among young people

Submissions that were made during the public hearings also spoke to some of the issues that were presented to the Joint Committees during the oral evidence meetings with the Advocacy Core Team and the Hon. Vice President and Minister of Health and Child Care. These include the key drivers to early sexual behaviour among adolescents and young people in Zimbabwe and barriers that restrict access to the SRHR services by adolescents and young persons in Zimbabwe. It was higlighted that the diverse nature of young people affects their sexual behavior. The categories mentioned were namely: orphaned children; child-headed families; children on the streets; children in school; children out of school; children indulging in alcohol and drug abuse. The following is a summary of the submissions made in relation to the key drivers of early sexual behaviour:

5.3.1 **Poverty**—It was noted that economic challenges among young people in Zimbabwe and their diverse backgrounds were forcing them to irk out a living by selling sex (child prostitution). Absence of social safety net for the orphans and vulnerable children further intensify their dire situation.

5.3.2 **Exposure to technology**-Unguided use of technology was exposing children to sex related material on internet for example, pornography. Consequently, children were tempted to experiment on what they see.

5.3.3 **Alcohol and drug abuse**—It was submitted that Vuzu parties were rampant in Bulawayo and other parts of the country, where adolescents and young persons were said to be indulging in sexual behaviour.

5.3.4 **Communication between parents and children**—It was observed that there was poor or lack of communication as parents either are too busy, absent (diaspora) or think it is inappropriate to talk about sexual reproductive health issues with their children.

5.3.5 **Lack or inadequate information on SRHR**—It was observed that young people fail to make informed decisions about their SRHR needs due to lack of or inadequate information about their bodies and risks associated with indulging in early sexual behaviour.

5.3.6 **Indiscipline—**It was pointed out that deviant behavior by young people was leading them to making wrong decisions or choices on their SRHR needs.

5.3.7 **Broken down families and social fabrics**— It was submitted that families and societies were no longer as closely-knitted as they were in yester years, hence, children were now vulnerable as they are exposed to abuse from some rogue elements in both the families and societies. The submissions that were made to the Committee also revealed that most of sexual abuse cases involving children, the perpetrators are parents, guardians, close relatives or pastors and most of these cases go unreported.

5.3.8 **Early Puberty**—It was observed that early puberty may be due to inorganic food or lifestyles. Thus, as children develop physically faster than their real age, it changes how they think about themselves and how people relate to them socially. Consequently, young persons were more likely to hang out with friend older than themselves who engage in risky behaviours such as early sexual behavior and substance abuse.

5.3.9 **Peer pressure among young people—**It was noted that in the absence of appropriate guidance, children were prone to give in to pressure and to conform to what their peers do.

5.4 Barriers in Accessing SRHR Services By Adolescents and Young People

5.4.1 **Restrictive legal framework**—Public Health Act requires that a minor below the age of 16 years be accompanied by a parent or guardian when seeking health care services. It was noted that this requirement makes it difficult for young people to access SRHR services especially in cases where the parent or guardian is a perpetrator. Further to this, there is absence of a legal framework that protects the service providers in providing SRHR services to young people.

5.4.2 **Unfriendly services**—There were concerns that service providers had a judgmental attitude towards young people who seek SRHR services and information.

5.4.3 **Cultural and religious beliefs**—It was regarded a taboo in both African culture and Christianity in general for young people to indulge in sexual intercourse at a tender age.

5.4.4 **User fees—**It was highlighted that young people did not afford the costs associated with accessing SRHR services.

5.5 Submissions in Support of the Petition

5.5.1 The Committee was informed that, young persons in Zimbabwe should be permitted to access healthcare services without parental consent since facts on the ground show that children are engaging in sexual acts yet it is culturally a taboo for a child to discuss sexual matters with a parent.

5.5.2 Children were already exposed to a lot of misguiding sexuality information from the internet and social media and it was better to give them comprehensive sexuality education and avail Sexual Reproductive Health and Rights (SRHR) services at their

disposal to safeguard them from negative consequences of bad sexuality decisions and practices. Opening up access to SRHR services would help children make informed decisions about their sexual health and avoid health hazards such as unintended pregnancy, illegal and unsafe abortions and sexually transmitted infections. It would further promotes awareness of HIV/AIDS status by adolescents and the young persons in Zimbabwe.

5.5.3 It was submitted that upholding the Constitutional principle of "best interest of the child" first was critical since some young persons and adolescents were being sexually abused by their parents or guardians as well as close relatives. Therefore, restricting them to only accessing healthcare services with parental or guardian consent would present a conflict of interest for the perpetrator who happen to be the guardian or close relative. Consequently, the parental or guardian consent becomes an impediment to adolescents and young persons in such circumstances and may result in increasing cases of unwanted pregnancies, illegal and unsafe abortions and sexually transmitted infections.

5.5.4 It was also submitted that, the restriction on accessing health care services by adolescents imposed by Acts and policies should be amended to take into account the needs for access by children in child headed families and those that are on the streets. It was further submitted that Zimbabwe health systems should work towards achievement of Sustainable Development Goal (SDG) 3 that seeks to promote good health and well-being by ensuring healthy lives and promoting well-being for all at all ages.

5.5.5 Some members of the public submitted that promoting access to reproductive health care services for adolescents and young people in Zimbabwe without the need for parental consent would encourage young persons and adolescents to seek guidance on sexual reproductive health from the right platforms such as youth friendly corners. There were concerns that the current socio-cultural system does not provide room for adolescents to discuss with their parents about sexual reproductive health as a result they tend to seek advice or guidance from wrong platforms that can be misleading.

5.5.6 The Committee was also informed that, there was need to amend the Public Health Act and open up access to health to protect children living with disabilities who are vulnerable to abuse and face communication barriers with health personnel too.

5.5. 7 It was submitted that abstinence and morality messaging should continue but for those children who fail to abstain, Government should open up services and yet still prefix such assistance with proper counselling and removal of user fees. Only children that would need the services due to different circumstances are the once who should access services and it should not be mandatory.

5.5.8 Moreover, it was highlighted that, health personnel responsible for providing healthcare services should be educated on the proper code of conduct that does not discourage adolescents and young persons to access such services. There was need for a reliable toll free line to ease access to information. In addition, legislation that protects the health service providers should be in place to ensure effective service delivery on reproductive health care services for adolescents and young people.

5.5.9 Some members of public noted that SRHR is broad and is not just about sex, but covers other non-sex issues which are difficult to open up to parents like menstrual hygiene and other matters of puberty. Allowing children access to SRHR services would ensure that they get the needed help in every facet of SRHR.

5.5.10 Concerns were raised regarding adolescent or teenage pregnancies which promote the vicious poverty cycle involving school drop outs, child marriages and Sexual Gender Based Violence (SGBV) in society and which also condemns especially the girl child to suffering and sometimes death. It was felt that it was better to give even the so called naughty children a second chance in life and not let a sexual morality failure prescribe perpetual doom for their future.

5.5.11 Opening up SRHR services will help the children in need and will not promote promiscuity or errand behaviour just like children who know where to get drugs of abuse but still choose not to use them.

5.6 Submissions opposed to the Petition

5.6.1 It was submitted that statistics showed that the national teenage pregnancy rate was at 22%. Additionally, Zimbabwe Demographic and Health survey in 2015 reveals that the highest percentage of teenage girl pregnancies was among 18 and 19 years of age. Of these, almost two thirds were in rural areas. It further reveals risk factors for teenage pregnancy as low level of education, living in rural areas and teenagers in the lowest wealth quantile. Against this backdrop, young persons and adolescents did not require access to sexual reproductive health services without parental or guardian consent rather they need access to education, opportunities of higher education and employment, improved protection from sexual abuse and information on reproductive health.

5.6.2 It was also submitted that, section 60(3) states that parents and guardians of minor children have the right to determine, in accordance with their beliefs, the moral and religious upbringing of their children. Contrary to section 60(3), the petition seeks to take away the parents' right to preside over the moral and religious upbringing of their children and a child's right to belong and be identified with a family through values. Furthermore, Criminal Law (Codification Reform Act) stipulates that a child below the age of 16 is not capable of consenting to sexual intercourse and it is an offense to have

sex with children below that age. In their views, the petition seeks to encourage an offense that is prohibited by the criminal law of Zimbabwe.

5.6.3 It was further submitted that promoting access to reproductive health services for adolescents and young people in Zimbabwe without parental consent was seen as a way to encourage young persons and adolescents to indulge in immoral behaviors. Thus, they underscored the need to revive social clubs or recreational facilities that will occupy young persons and discourage idle time that leads to sexual immorality.

5.6.4 The Committee was also informed that, some services that were being advocated for by the petition such as access to contraceptives were viewed as harmful to adolescents and young persons in Zimbabwe. They therefore, argued that such reproductive health services should be rendered to responsible individuals and not adolescents and young persons who are still maturing. They also proposed that a comprehensive study be conducted to ascertain the long term effects of contraceptive use by minors. They further argued that the health system was currently struggling to provide contraceptives to women in Zimbabwe hence there was no need to increase the number of those accessing contraceptives.

5.6.5 Zimbabwe was regarded as a Christian state and rooted in morality and in their view ,the petition suggested that our trusted religions had failed, which they totally disputed and for them, getting back to the roots and Christianity was the solution. Accepting the petition was seen as tantamount to giving up on children. Teaching children abstinence and moral righteousness were the only solution to SRHR challenges that the petition seeks to solve.

5.6.6 It was pointed out that disobedient children should not cause change of law or be protected but face the consequences.

5.6.7 They also pointed out that parental guidance and protection was an integral part of our Ubuntu and children will always need their Parents support and should never be let to run their sexuality before reaching adulthood. Taking away parents' protection from children would in their view, have a detrimental implications which would lead to an immoral society.

5.6.8 In their view, opening up access to SRHR will result in more child exploitation, statutory rape, shortage of contraceptives, abortion on demand, rights without responsibility, collapse of family structure and spiritual bondages.

5.6.9 They advocated for the age of consent restriction to remain, arguing that the very fear of getting pregnant or sick would ensure that children abstain and remain safe; but once they get access to SRHR services on their own, they will be tempted to indulge.

6.0 JOINT COMMITTEES' OBSERVATIONS

The Joint Committees made the following observations on the submissions received on the petition:

6.1 In spite of the diverse nature of adolescents and young people in Zimbabwe which brings about differences in their SRHR needs, they do not have access to reproductive healthcare services.

6.2 Although Section 76 (1) of the Constitution of Zimbabwe provides for healthcare services including reproductive healthcare services for every citizen, the Public Health Act of 2018 restricts age of consent to access the same to 16 years. Furthermore, there is no law or policy that protects the service providers when they provide the SRHR services to adolescents and young people in Zimbabwe.

6.3 Apart from the restrictive legal framework, culture, religion and the judgmental attitudes of the service providers act as barriers impeding adolescents and young persons in Zimbabwe from accessing SRHR services.

6.4 The Education Amendment Act allows pregnant girls to be in school yet provision of SRHR services is restricted to 16 years.

6.5 Most young women, adolescents and youths who participated during the public hearings were in support of the petition while older women, men and religious leaders formed majority of the resenting voice.

6.6 While parents/guardians, culture and religion play a very important role in the upbringing of children, statistics have shown that adolescents and young persons in Zimbabwe are indulging in early sexual intercourse when they are ill-prepared for the risks associated with such behavior, hence the petition to Parliament.

6.7 Some of the young people could not express their opinions freely in the presence of their elders and religious leaders during the public hearings.

6.8 There was an outstanding misconception that the petition sought to lower the age of consent to sex and promote mandatory distribution of contraceptives to all children.

6.9 Despite the divergent views, there remained a unanimous agreement on the gravity of the Sexual Reproductive Health and Rights matter as raised in the petition. However, it was on the solutions that the submissions would differ.

6.10 Considerable number of participants, especially those against the petition attested to lacking appreciation of the petition's contents. Consequently, they had misconceptions from social media and other lobby groups thus, the committee had to intervene to clarify its mission more often. As is the case with most parliament hearings, majority of people

in the grassroots did not get a copy of the document under discussion ahead of the meetings.

6.11 Despite it not being the core of the petition, there was an overwhelming support for harmonisation of ages of consent to sex and marriage at 18 years.

7.0 JOINT COMMITTEES' RECOMMENDATIONS

Flowing from the above observations, the Joint Committees recommend the following:

7.1 Adolescents are not a homogenous group of people, hence the MoHCC should provide case by case assesment of this diverse group in order to provide for their varying SRHR needs especially the at-risk adolescents and young persons by December 2021.

7.2 The MoHCC should amend Section 35 of the Public Health Act to provide SRHR services for young people under the age of 18 years and provide for the protection of the service providers by June 2022. Furthermore, service providers should be trained on how to provide friendly SRHR services to adolescents and young persons by April 2022.

7.3 The MoHCC should embark on awareness campaigns on SRHR issues for young persons in Zimbabwe by August 2022.

7.4 The Ministry of Primary and Secondary Education and MoHCC should immediately ensure that pregnant girls in school access SRHR services without difficulties.

7.5 MoHCC should ensure that adolescents and young persons friendly corners are established where it is convenient for them to access the SRHR services by June 2022.

7.6 The custodians of culture and religion should not tire in strengthening their systems in the upbringing of children and should continue to preach the abstinence message in order to instill moral values in children.

7.7 The Ministry of Youth, Sport, Arts and Recreation should provide recreational facilities for adolescents and young persons in Zimbabwe in order to occupy themselves reasonably by December 2022.s

7.8 The Ministry of Finance and Economic Development should allocate substantial budget to the Ministry of Public Service, Labour and Social Welfare in the 2022 National Budget to enable it to provide the social protection measures for the vulnerable adolescents and young persons in Zimbabwe in meeting their financial needs.

7.9 The Ministry of Justice, Legal and Parliamentary Affairs should immediately expedite the amendment of relevant legislations to provide for more deterrent sentences to perpetrators of child sexual abuse or rapists or child sexual exploitation.

10.0 CONCLUSION

10.1 Despite the divergent views on the most appropriate course of action to take, it is evident that the issues that were raised by the Advocacy Core Team in their petition were lived realities in the communities of Zimbabwe. Adolescents and young persons in Zimbabwe are indulging in early sexual behaviour and what drives them into this varies depending on circumstances. What is worrying are the undesirable consequences associated with this risk behavior, which the prayer of the petition attempts to address. It is, therefore, important for the Ministry of Health and Child Care to ensure that access to SRHR services by adolescents and young persons in Zimbabwe is accomodative to carter for them in their diverse nature.