

Exploring drug and substance use in relation to sexual and reproductive health access for adolescents and young people in Mbare and Epworth, Zimbabwe

„I will be living
in the present moment!“*



Author's note

The assessment team would like to express sincere gratitude to all the participants in Mbare who contributed to this assessment, placed their trust in our small team, and shared their personal stories and experiences. These included adolescents and young people, teachers and healthcare workers, all of whom navigate the challenges of supporting young people living in difficult circumstances.

While our assessment cannot create immediate change, we hope that the insights and conclusions presented here will support MSF and the Ministry of Health and Child Care, together with the Mbare team, in strengthening the program to better respond to the needs of adolescents in a comprehensive and inclusive way.

I am especially grateful to the assessment team, as well as to the entire MSF project team in Mbare, the country support team in Harare, and the cell in Johannesburg and SAMU in Cape Town for their invaluable support. A heartfelt thank you goes to all Zimbabwean and international colleagues who worked alongside me for their professionalism, deep knowledge of the country and its people, and for the many enlightening conversations we shared.

My experiences with MSF and particularly with this project, my colleagues, and the people of Mbare are deeply meaningful to me. They have my deepest respect for their resilience and strength in facing the complex challenges that affect adolescent and young people in their social environments.

This is dedicated to all those who are or will be part of the Mbare project in Zimbabwe in one way or another.

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*A group of young men who use drugs and substances explained that drug use allows them to live in the present moment, without thinking about the past and what they've been through, or the future, which they view as hopeless.

Cover picture: Adolescents and young people at Epworth Youth Centre. ©Doris Burtscher/MSF 2025

Backpage picture: Drawing on the walls of Matapi flats. ©Doris Burtscher/MSF 2025

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Disclaimer: The authors wish to emphasise that the views expressed in this report have been developed based on their assessment results and are theirs alone. The views expressed in this publication do not necessarily reflect the views of Médecins Sans Frontières or of the MSF Vienna Evaluation Unit.

Abbreviations

AYP	Adolescents and young people
ANC	Ante-natal care
CBO	Community Based Organisation
CeSHHAR	Centre for Sexual Health and HIV/AIDS Research
DSU	Drug and Substance Use
FGD	Focus Group Discussion
GD	Group Discussion
HCW	Healthcare worker
HIV	Human Immunodeficiency virus
HP	Health Promotion
HPAM	Health Promotion Activity Manager
HSB	Health Seeking Behaviour
IDI	In-depth interview
KAP	Knowledge Attitude and Practice
KP	Key Population
LGBTQIA+	Lesbian, Gay, Bisexual, Transsexual/Transgender, Queer, Intersexual and Asexual
MCAZ	Medicines Control Authority of Zimbabwe
MH	Mental health
MHM	Menstrual Hygiene Management
MoHCC	Ministry of Health and Child Care
MSF	Médecins Sans Frontières
OCB	Operational Centre Brussels
PE	Peer educator
PEP	Post-exposure prophylaxis
PI	Primary investigator
PMR	Project Medical Referent
PNC	Post-natal care
PreP	Pre-exposure prophylaxis
SRH	Sexual and reproductive health
STI	Sexually Transmitted Infections
VPE	Volunteer peer educator
WHO	World Health Organisation
YAADS	Youth advocates against drug and substance
YPSS	Young people selling sex
YPWUD	Young people who use drugs

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Executive summary

Cross-Cutting Findings¹

By Claude Nyatsine

Across the diverse adolescent and young people groups interviewed, several common trends emerged related to substance use and associated sexual and reproductive health behaviours:

1. Drivers of drug and substance use

Peer influence and social networks: Exposure to drug use behaviours by peers and admiration towards those who take drugs perceived as if they are cooler were identified as significant risk factors for substance use among young people in Mbare and Epworth.

Family dynamics: Family conflicts and exposure to drug use within the family were observed as risk factors at family level.

Economic stress: Unemployment and financial instability were prevalent among youth, contributing to substance use as a coping mechanism.

Emotional disturbance was one of the key push factors across all groups interviewed as a result of life hardships, relations with families or between a boyfriend and girlfriend etc.

2. Risky sexual behaviours

Multiple sexual partners and transactional behaviours

Substance use among adolescents and young people is strongly correlated with increased sexual risk-taking, including having multiple sexual partners and engaging in transactional sex. This trend was observed across all study groups but was particularly acute among young females, street-connected youth, and those using high-dependence substances like crystal meth.

i) Transactional sex driven by addiction and poverty

For many adolescent girls and young females who are addicted to drugs or substances but lack the financial means to sustain their use, transactional sex becomes a coping and survival mechanism. Participants reported instances where young females exchanged sex for drugs or money to purchase substances, often with older men or drug suppliers. This form of sexual exploitation is not always perceived as 'sex work' by the girls themselves, but rather a necessary trade-off to meet an immediate need, access to a high or relief from withdrawal. The power imbalance in such exchanges often leaves young women unable to negotiate condom use, further increasing their vulnerability to HIV, STIs, and unintended pregnancies.

ii) Drug-induced/substances changes in libido and behaviour

Certain substances, like alcohol or crystal meth, were reported to have a marked effect on sexual behaviour and libido. Several participants and community observers noted that crystal meth use heightened sexual desire, sometimes leading users to engage in frequent, impulsive, or unsafe sexual encounters. This increased libido, combined with impaired judgment and social inhibition, amplifies the risk of having multiple sexual partners during or shortly after drug use episodes. For female users particularly, this often resulted in loss of sexual boundaries, leaving them exposed to high-risk sexual environments, including unprotected sex with strangers or in group settings.

¹ In place of a traditional executive summary, we have chosen to present a summary of findings compiled by one of the research assistants involved in the assessment. This decision reflects our commitment to participatory research and values the direct contributions of team members closely engaged in the fieldwork.

These patterns reflect a dangerous intersection between addiction, economic desperation, and gendered power dynamics, all of which significantly elevate the SRH risks for adolescent girls and young females who use drugs.

Inconsistent or no use of preventive measures against STIs, HIV and pregnancies

One of the most consistent sexual health risks identified across all groups was the inconsistent or complete lack of use of preventive measures such as condoms, contraceptives, or PrEP. Despite varying levels of awareness about the risks of STIs, HIV and unintended pregnancies, actual preventive behaviours were weakly practiced or neglected altogether.

i) Substance use and impaired decision-making: Many adolescents and young people engaged in sexual activity while under the influence of drugs or alcohol, which impaired their judgment and significantly reduced the likelihood of using condoms or other protective methods. Intoxication was sometimes cited as a reason for 'forgetting' to use protection or not caring about the consequences in the moment.

ii) Low negotiation power, especially among girls: Girls, especially those engaged in transactional sex or dependent on male drug suppliers, reported having limited ability to insist on condom use. In some cases, condoms were intentionally avoided by clients or partners, who offered extra payment for unprotected sex or falsely claimed to be 'clean'.

iii) Misinformation and fear around contraceptives: Among school-going adolescents and those with limited education, there were widespread myths and misconceptions about contraception, such as the belief that contraceptives cause infertility or cancer. Some youth feared being judged or stigmatized if seen acquiring condoms or family planning methods from health facilities, which further discouraged proactive prevention.

3. Limited SRH knowledge and access

Across all groups, significant barriers to accessing accurate and youth-friendly SRH information and services were reported. Some of the adolescents and young people alluded that they did not know about the adolescents and young people friendly clinics and they were also not even aware of the MSF organisation in both communities of Mbare and Epworth. In some individuals also who happened to know about MSF adolescents and young people SRH-friendly clinics and youth centres they had limited knowledge about SRH as well as what MSF offers.

a) Lack of access to preventive supplies

Even when adolescents and young people were willing to use protection, access was not always guaranteed. Many reported frequent stock-outs at clinics, cost barriers at pharmacies, or simply not knowing where to obtain condoms or contraceptives discreetly. In certain cases, emergency contraception and STI treatment were unavailable, particularly in under-resourced clinics or during weekends and public holidays.

b) Judgmental and unfriendly healthcare workers

Some adolescents and young people reported negative experiences when attempting to access SRH services. Health workers were sometimes described as judgmental, dismissive, or even visibly disgusted, particularly toward those perceived to be engaging in 'immoral' behaviour, such as sex work, drug use, or the LGBTQIA+ community. This perception was especially pronounced among street-connected youth and adolescents seeking contraceptives or STI treatment as well as the LGBTQIA+ community.

c) Limited availability of adolescent-friendly SRH services

Beyond negative provider attitudes, practical and systemic gaps in service delivery were testified: Clinics in both Mbare and Epworth were reported to be understaffed or unequipped to deal with the unique needs of young people who need ASRH services. In certain cases, services such as emergency contraception, condoms and PreP were not consistently available, especially in public health institutions with high patient volumes and limited resources.

d) Stigma and judgment in the community

Beyond the clinic walls, adolescents also face community-level stigma for seeking SRH services. This social judgment reinforced feelings of shame and discouraged many from accessing care, particularly in smaller, tightly knit neighbourhoods where anonymity is limited. Some resorted to self-medicating or relying on informal advice from peers, which often perpetuated myths and unsafe practices.

4. Normalization of drug use

Community acceptance: In Mbare and Epworth, drug use has become normalized, with substances like weed and cough syrups being commonly used among adolescents and young people.

Group-specific observations and trends

Adolescents and young people involved in selling sex

This group, made up largely of adolescent girls and young women, faces compounded vulnerabilities due to the intersection of poverty, gender-based violence, substance use, and social stigma. Many of them entered sex work out of necessity, driven by economic survival, broken family systems, homelessness, or drug dependency, and are disproportionately exposed to SRH risks.

a) Causes for selling sex

Entry into sex work was mostly not a planned decision but a response to economic desperation. Many of these young people were either orphaned, living on the streets, in need of funds for daily survival or even to continue with their academics or supporting families. Some girls were introduced to sex work by peers or older women, often with the promise of earning quick money, food, or shelter. In other instances, although they are rare, adolescents ran away from their guardians as a reason of not wanting to be under the jurisdiction or submission of a guardian, this in turn propels them to do sex work as a means of earning a living. In many cases, drug/substance dependency played a critical role. Girls addicted to substances such as broncleer, crystal meth, or weed often engaged in sex work to finance their use.

b) Substance use as a coping mechanism

Drugs were commonly used before and after sex work to numb physical and emotional pain, reduce anxiety, or give a feeling of control in the sense that they use it so that they can perform better during sex with clients. Some alluded that they needed the drugs/substances to be able to do their work, they further explained that they require it for their self-esteem so as not to be ashamed. Cystal meth was widely used to increase alertness and energy during the night, while alcohol and marijuana were used to 'relax' after encounters as well as not to regret.

c) Sexual health risks and violence

Condom use was inconsistent, often depending on the client's offer of paying a substantial amount than the usual or agreed fee. Sex workers mentioned that some clients can even break the condom with the sex workers not being cognizant of it during penetration just to have more pleasure or to spread the STI deliberately to the sex workers. STIs and unintended pregnancies were common, with many girls reporting they rarely sought medical help due to lack of knowledge, fear, shame, or poor clinic experiences. Because of poor justice and law enforcement to the particular group of sex workers, boys and young men exploit this key population group where they can masacaraed as if they want to buy sex but they take the girls to isolated places then they steal and take their belongings

forcibly or refuse to pay after having sex. Some even end up personalizing them where they consider the girls like their girlfriends and won't be happy seeing them with other men especially doing sex work or dating. Also in other instances men can fight for the same sex worker if the one who has first hired the sex worker has been overbided by the other guy who comes after him and the girl chooses the one offering the highest amount.

d) Transactional drug exchange

Some adolescents and young sex workers engaged in direct sex-for-drug exchanges, especially when they cannot afford to purchase the substance. Drug suppliers (usually men) often take advantage of this dependency, offering 'free' drugs in return for sex. In some cases, it will not be safe sex due to inconsistent use of protection or loyalty.

e) Barriers to healthcare access

Participants described health facilities as unwelcoming, judgmental, and not confidential, particularly toward girls known to be in sex work or using drugs especially in health facilities not specifically meant for key population groups like sex workers. This stigma discouraged them from accessing services like contraception, HIV testing, STI treatment, or even general health checkups.

f) Psychological and social toll

The emotional burden of sex work, especially at a young age, was profound. Many participants showed signs of trauma, depression, and low self-worth. This was attributed to the treatment they get from society and the clients. Several expressed wishing to stop sex work, but felt trapped due to addiction, debt, or lack of alternative income sources.

Adolescents and young people living and working in the streets

High frequency of substance mixing: These individuals reported the highest rates of substance cross-mixing, often combining substances like glue, alcohol, and marijuana. Early sexual debut: Early sexual debut was common, with many engaging in survival sex in exchange for food, protection, or shelter. Nineteen out of twenty of these people are into risky sexual behaviours because of the hesitation of going to health facilities. They also complain about the treatment they get from health care workers that they seem impolite and seem disgusted by them. This group is usually impatient, and they are usually under the influence of substance/drugs almost all the time. They say the circumstances of their living conditions compel them into using substances/drugs all the time. They also get intoxicated by any substance/drug available at the time due to lack of money to finance the substances/drugs. They do not have a stable source of income which is one of the key factors that makes the circumstances of their livelihood so intense.

LGBTQIA+

This group included casual and habitual users, some of whom were still in school, others out of school and unemployed. Substances used included cannabis, crystal meth and codeine-based cough syrups. While some engaged in solitary drug use, many reported social group drug use, often linked with weekend parties or specific community zones. Some of the individuals in this group also do sex work to both the males and the females, they perceive it also as a way to make money in order to earn a living. This is attributed to the rejection they face from the society, so they usually hide and have their secret society where they know their comrades. In these so-called LGBTQIA+ societies is where they plan their excursions, sympathise as well as empathize with each other. Most of them are left stranded since even their own family and guardians reject them or even kick them out of their homes. The use of protection and health consciousness is very low since most of them are under substance/drug use. It is also attributed to the offers they get from their clients when they do sex work or when they have sex with partners of the same sex.

Adolescents and young people in schools

Substance use patterns were noted within school environments, especially involving cough syrups, marijuana, and alcohol that is cheap high alcohol content such as whiskies or spirits but mostly they are into marijuana and cough syrup. Drug use was often hidden, with a sense of experimentation and peer-fuelled curiosity, trying to fit in a particular group of drug/substance users who are perceived as cooler kids. This group also alluded to the fact that they sometimes are involved into partying where they get to share substances/drugs. This is when sometimes they indulge into risky sexual behaviours since they have less experience in using substances/drugs and have limited knowledge about sexual and reproductive health. Some teenage pregnancies emerge from these so-called parties. This group also complains about how they are not really into going to health facilities since they are still young, they dread being scolded or judged even denied getting access to sexual and reproductive health service in public health facilities by health care workers especially in the MoHCC (Ministry of Health and Child Care). They prefer going to adolescents and young people friendly clinics where they can express themselves, get emotional and psychological support as well as to get vast knowledge through health education sessions.

Teen Mums

Due to the challenges faced by adolescents in getting access to sexual and reproductive health service such as contraception in particular, this is one of the key drivers of teenage pregnancies. However, there are also other factors such as experimentation on having sex, sexual exploitation by the male figures who are mostly older than the teenage girls, some of the interviews indicate that some males take advantage of the girls providing materialistic things in return they require sex. In some instances, they even neglect or deny using protection when having sex. Some of the teen mums get pregnant doing sex work since they come from a less privileged background. This is not mostly common but it's one of the cause teenage pregnancies. In particular the teen mums who did sex work prior or who are still into sex work are also involved into drug/substance use. The desperation of earning a living in order to take care of themselves as well as the child/pregnancy leaves them vulnerable to many things such as getting exploited sexually.

Conclusion of Results Section

The findings demonstrate that drug and substance use among adolescents and young people in Mbare and Epworth is deeply interconnected with a range of risky sexual behaviours, socio-economic hardships, and service accessibility barriers. Each group faces unique vulnerabilities, which require differentiated approaches in MSF's adolescent SRH programming. This also highlights the key causes and effects of drug and substance use among AYP and offers valuable insights into how to address these critical pain points.

Validation Statement²

Christina Gwati and Claude Nyatsine

Research assistants-MSF Mbare anthropological assessment 2025

This validation statement reflects our professional opinion on the results and recommendations sections of the draft research report, which we have reviewed carefully. We confirm that the content in these sections accurately represents what we witnessed in the field and what was shared by participants. Our feedback is based on lived observations and direct interaction with respondents, not assumptions.

1. Validation of results

The results presented in the report are consistent with the voices and experiences of the young people who participated in the research. The report accurately captures how crystal myth and other substances have reshaped the lives of adolescents and young people in Mbare and Epworth.

- ◆ Early exposure to drugs, often starting in adolescence due to peer pressure or poverty.
- ◆ Disrupted education, many dropped out of school, making them more vulnerable to drug use, transactional sex, and violence.
- ◆ Unstable living conditions: youth living in bases or shared housing described environments of neglect, exposure to abuse and limited adult support.
- ◆ Gendered experiences: Girls using drugs often face layered vulnerabilities including sexual violence, transactional sex, and unintended pregnancies.

These lived experiences highlight intersecting vulnerabilities and validate that drug use is both a coping mechanism and a driver of further social and health risk.

Effects of drug use on SRH behaviours and choices

The study found a strong link between drug use and risky sexual behaviour. Young people under the influence of drugs described:

- ◆ Engaging in unprotected sex while high
- ◆ Participating in transactional sex, particularly among girls and young women, often without negotiation of condom use.
- ◆ Increased exposure to STIs and HIV due to these behaviours, along with an inability to follow through with PeP, PrEP, or testing due to fear and mobility issues.

Fear of judgement and stigma in health facilities

During data collection, we both witnessed repeated accounts of stigma, shame, and a lack of trust in healthcare systems. For example:

- ◆ Teen girls shared how they were scolded or humiliated by nurses when asking for contraception, especially if they were unmarried or already pregnant.
- ◆ Young people who use drugs specifically crystal myth users reported avoiding the clinic out of fear that being near a police station would lead to arrest or judgement.
- ◆ Boys expressed being left out of support programs, even though they also suffer from poverty, lack of hygiene, and vulnerability.

² Note: Following the development of the results and recommendations, a data validation process was conducted by the research team. This document, compiled by the team members themselves, reflects their review and confirmation of the findings, ensuring that the voices of participants were accurately interpreted and represented. Including this validation strengthens the credibility and participatory nature of the assessment.

- ◆ Participants often talked about feeling unsafe or unwanted, even at spaces that were supposed to support them.
- ◆ Young women involved in sex work particularly expressed this, saying they felt “looked down upon” or ignored when they sought SRH services.
- ◆ Even healthcare workers themselves acknowledged a lack of training on how to deal with young drug users and key populations in a supportive way.

Youth friendly spaces are valued -but limited

The Matapi youth hub and Epworth youth centre were consistently praised as safer spaces where young people could learn about health (HIV, STIs, contraception), access condoms and sanitary products and spend time safely in non-judgmental environments.

However, youth also pointed out limitations such as:

- ◆ Lack of consistent services (e.g., MHM (menstrual hygiene management) like stockouts of pads, irregular nurse presence)
- ◆ Discrimination in access, especially in Epworth, where familiar faces were allegedly favoured.
- ◆ Gender imbalance: girls felt there were fewer activities designed for them (e.g., beauty clubs, dance, or income-generating projects).

Motivation and barriers to seeking healthcare

We validate the findings mentioned in the report regarding the motivations and barriers to seeking healthcare.

Motivations included:

- ◆ Peer encouragement: many youths said they only attended clinics or testing centres because a peer educator guided them.
- ◆ Hope for better health: several participants, especially those living with HIV, valued adherence clubs and peer support groups.
- ◆ Health knowledge: young people understood the importance of knowing their status, accessing PrEP, and using contraception.

Barriers included:

- ◆ Fear of being seen going into a clinic, especially those located near police stations (e.g., Epworth youth centre) or associated with stigma.
- ◆ Distance and time constraints, particularly for young women involved in transactional sex who feared losing clients.
- ◆ Mistrust of healthcare providers, based on prior negative interactions.

As research assistants, we translated many of these stories word to word. The themes of fear, embarrassment, and discrimination came up repeatedly. In that regard, we confirm that the reports results section is valid, reflective of real community voices, and presents the lived challenges that we saw first-hand during our fieldwork.

2. Validation of Recommendations

The recommendations outlined in the report were not imposed by outsiders -they came directly from the participants themselves. Young people made specific requests and suggestions throughout the FGDs and interviews. We helped translate and document many of these ideas and can confirm that they have been fairly captured in the report.

Promotion of truly youth friendly staff

We support the urgent need for context specific training for MSF and MoHCC (Ministry of health and childcare) staff. Youth frequently cited judgmental attitudes, lack of empathy and moral policing from healthcare workers as barriers. Several young women, especially those in survival sex, avoided care due to previous scolding and ridicule. These insights confirm the need for soft skills training that builds empathy and practical support systems for AYP living under high stress and vulnerability.

Inclusive Targeting: Reaching both girls and boys

This recommendation accurately reflects the imbalance we witnessed in service access. While the focus on girls is commendable, many adolescent boys feel left out, and even mocked when asking for hygiene materials. Participants highlighted the importance of including boys, involving community figures, and targeting the surroundings of adolescents, such as families and peers with a harm reduction and stigma free approach.

Expanding safe spaces and harm reduction

AYP repeatedly demanded non-judgmental spaces where they can relax, socialize, and seek help. Participants advocated for a dedicated safe space at Edith Opperman Clinic and more youth clubs, especially those tailored for drug users. They also called for outreach to drug bases, recognizing these places as unavoidable realities rather than distant dangers. They push for harm reduction, rather than abstinence -only messaging, was prominent throughout.

Empowerment through lived experience and role models

This recommendation is well founded in what AYP shared. Participants felt more connected to mentors who lived similar struggles. The call to involve community icons like Fantan in outreaches and messaging was consistent and strategic. These figures hold cultural weight and can bridge gaps between MSF and AYP.

Collaboration and integration with broader networks

We affirm the need for stronger links between MSF and other organizations for example MUFARO, CeSHHAR, GALZ, and DREAM. Combining efforts could strengthen referrals, share resources, and improve sustainability, especially when addressing structural challenges like poverty or education access.

Bridging the gap beyond antenatal care

Many adolescent mothers described feeling abandoned on post-delivery. Although MSF provides excellent ante-natal care (ANC), there's little continuity afterwards. Some adolescent mothers return to sex work almost immediately due to financial pressure. We confirm this concern and support the call for postnatal follow-up and referrals to community livelihood initiatives.

Reinforce and expand AYP activities

Young people consistently requested more engaging, skill building activities. Girls wanted beauty courses, while boys mentioned sports and digital skills. These activities provide not only income but self-esteem and community. The current efforts at Matapi and Epworth youth centres are a solid base, but AYP want more variety, consistency and inclusivity.

Injectable PrEP access

The preference for injectable PrEP was a strong and repeated finding. AYP appreciated oral PrEP but struggled with adherence. Many asked directly for injectable options, indicating high awareness and motivation to protect themselves. The recommendation to introduce long-acting PrEP is timely and grounded in real demand.

Reliable access to long term contraceptive

Limited access to contraceptives, especially in Epworth, was a major issue. Participants described missing clinic days, myths around contraception, and lack of continuity. We support the call for consistent and youth friendly contraceptive services, along with clear information, school outreach and potential MSF-led delivery when partners are unavailable.

Improvements to Epworth Youth Hub

AYP raised issues with broken equipment, gender imbalances in the games access, and exclusion by peer educators. There is need for fairer access to games, better ventilation, more academic resources in the library, and activities that attract girls as well. Token shortages and menstrual hygiene supply gaps also need addressing.

Tailored engagement for YPWUD in Epworth

The call for greater outreach to drug users in Epworth is valid. Many participants expressed that monthly visits are not enough and that community-level skill training is more meaningful than clinic-based handouts. Participants proposed welding, hairdressing, and moonlight outreach. Youth preferred mobile tents and discretion, citing fear of police and judgement.

Involve ambassadors from drug bases

This is one of the most innovative yet grounded recommendations. Youth suggested recruiting those associated with bases as owners and those into selling at bases (thus plugs) or respected users as harm reduction ambassadors. These figures already hold influences and could help guide safer behaviours from within. Participants even described how plugs could say “You’ve had enough today” as a way to subtly reduce harm.

Strengthening peer educator outreach

Many AYP trust peer educators but raised issues around reach and effectiveness. Peer educators tend to engage the willing, leaving out the most hidden or intoxicated youth. Training peer educators to manage resistance, work discreetly in drug bases and navigate mistrust-especially where police fear is high is essential. We strongly emphasize the call for more support, training, and recognition for peer educators.

Promoting self-care and provide discreet uniforms

We validate the recommendation to expand self-care distribution; community-based distribution by trained peer educators would reach those unable to come to clinics. Also, the request for neutral MSF t-shirts-particularly from sex worker groups is reasonable. These would allow safer participation without unwanted exposure, helping them blend in, reducing the risk of being identified or followed due to their association with MSF transport, and enhance self-esteem by signalling formal program participation.

We remember these conversations vividly because we were present in the room and helped translate them. These are not abstract recommendations, they came from real people in real situations.

3. Final Reflections

This report did not create stories, it documented them. We are proud to have supported this process. The recommendations are strong because they come from the community itself, not from assumptions. What is now needed is action.

We encourage MSF and its partners to use this report as a working tool, not just a document. The young people of Mbare were very open and honest in their feedback, not because it was easy, but because they hoped someone would listen and respond with respect. We believe this report honours their voices.

As research assistants who were fully involved in the field process, we stand by the results and recommendations of this report and confirm that they are based on true, lived experiences of the youth in Mbare.

1 Introduction

1.1 The Mbare project³

1.1.1 Mbare

The project is based in Mbare, one of the oldest and most densely populated suburbs of Harare, the capital of Zimbabwe. Established in 1907 during the colonial era, Mbare was originally designed as a dormitory suburb for black male workers. Housing structures mainly consist of blocks of flats intended to accommodate single men who had migrated from rural areas in search of employment in the city.

Today, these flats are severely overcrowded, and most residents live under difficult socio-economic conditions. Mbare is easily accessible from various parts of the country, and its population is highly mobile. According to the 2022 national census, Mbare has an estimated population of 71,402, with 60% aged between 10 and 24 years⁴. However, the population may be underestimated; the 2012 Demographic and Health Survey estimated the population to be between 84,168 and 142,195.

The overcrowded living conditions and challenging environment contribute to risky behaviours that increase the spread of STIs (Sexually Transmitted Infections) and HIV (Human Immunodeficiency Virus), further amplifying the vulnerability of adolescents and young people in the area.

Mbare functions as a major hub of informal trade in Zimbabwe, often seen as its unofficial capital. It hosts key markets such as 'Mupedzanhamo' for second-hand clothes, the vegetable market, 'Siya-So' for small-scale manufacturing, and 'Mbare Musika', the country's largest farm produce market. Most residents rely on informal trading, with no savings, making each lost day of work a setback into deeper poverty. Farmers travel from across the country daily to sell their produce in Mbare.

1.1.2 Epworth

In January 2022, the Mbare ASRH (adolescent sexual and reproductive health) project integrated activities from the FOE (Field Opportunity Envelope) project in Epworth, which had run as a community SRH (sexual and reproductive health) programme from January 2020 to December 2021 under MSF Zimbabwe.

Epworth, located 12 km southeast of Harare's Central Business District, is part of Harare Province and includes areas like Stopover, Zinyengere, and Overspill. It is largely informal, with poorly built housing and limited service delivery, lacking proper water, sewage, and roads. The area faces high youth unemployment and attracts many new city migrants. Established in 1890 by a Methodist mission, Epworth had a population of 206,365 according to the 2022 census.⁵

Epworth, originally an unplanned settlement, became the only informal community tolerated by the Zimbabwean government post-independence due to its long-standing history and size. Rather than demolish it, the government opted for upgrading, introducing public utilities like water, sewage, and electricity.⁶ A Local Board, established in 1986 under the Urban Councils Act and elected by the community, manages the area, including the collection of rates and levies.

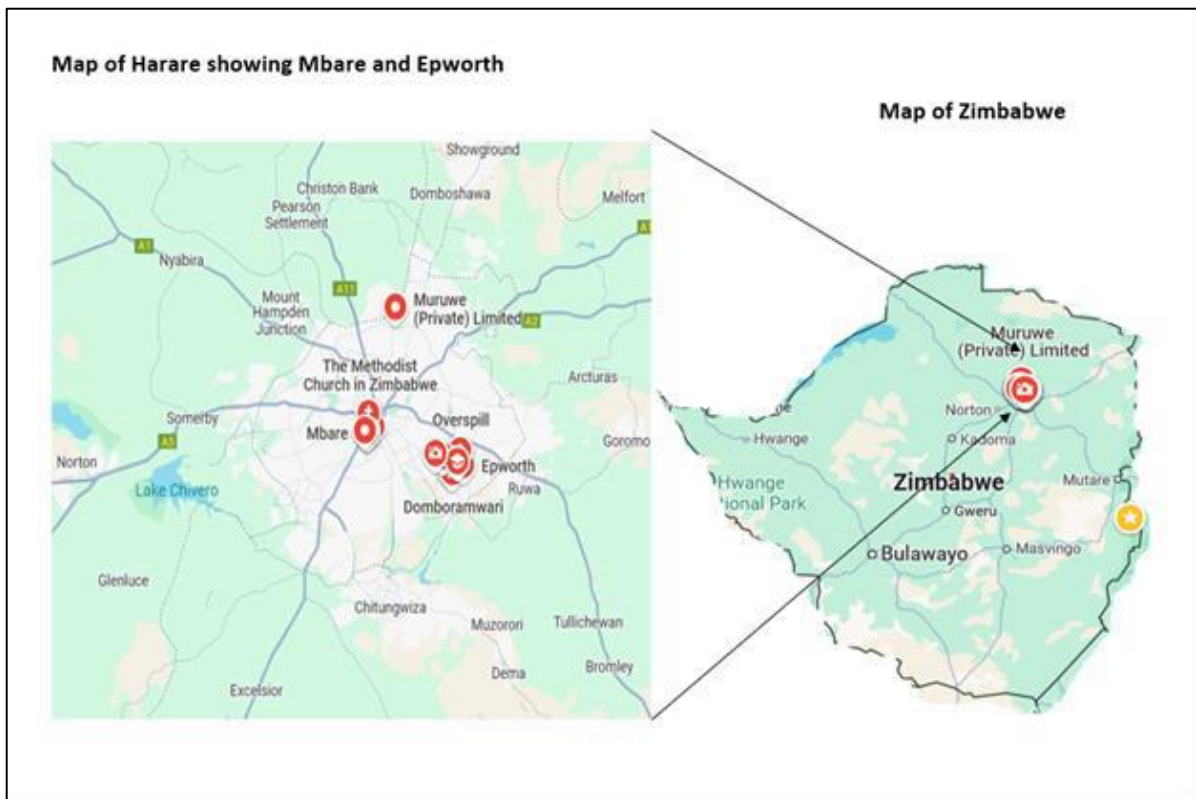
Epworth faces poverty, low literacy, and high unemployment, contributing to its negative reputation as a source of crime, sex work, and informal trade. While serious security incidents are rare, petty crime is common, and caution is advised.

³ This part is adapted from the Mbare project document 2024.

⁴ <https://zimbabwe.opendataforafrica.org/anjlpct/2022-population-housing-census>

⁵ <https://zimbabwe.opendataforafrica.org/anjlpct/2022-population-housing-census>

⁶ [Informal settlements leave communities vulnerable -Newsday Zimbabwe](#)



1.1.3 Health Situation

In 2015, MSF and the University of Zimbabwe's Centre for Applied Social Sciences conducted a Knowledge, Attitudes, and Perceptions (KAP) survey, highlighting the need for adolescent-friendly health services in Mbare and surrounding areas.

In Zimbabwe, adolescents (10–19 years) make up 22.3% of the population, with nearly half under 24 years old. Half of the population marries and has their first child before age 22.⁷ Among 15–19-year-olds, 33% of girls have had sexual intercourse, while 72.1% of boys have not.⁸ Additionally, 45% of married girls aged 15–19 have experienced partner violence, and nearly 25% have given birth or are pregnant with their first child.⁹

School attendance is low, with 36% of adolescents not attending or having left school (2017).¹⁰ Since the COVID-19 pandemic began, school dropouts have risen due to economic hardships and high fees. According to *NewsDay* (March 31, 2022), dropout numbers have reached 20,000 since 2020.

1.1.4 MSF services

The Mbare project provides comprehensive health care services to young people (10–24 years old) in Mbare, Epworth and the surrounding areas. If the focus started on SRH services, the scope of the project has increased over time to meet more needs of the adolescents and young people (AYP) population and fill some of the many gaps faced by the AYP. The activities are provided in three facilities and in the communities.

⁷ DHS 2015 Zimbabwe <https://dhsprogram.com/pubs/pdf/FR322/FR322.pdf>

⁸ Ibid.

⁹ <https://www.afro.who.int/sites/default/files/2019-08/8%20Zimbabwe%20AH18052018.pdf>

¹⁰ ICDS Zimbabwe https://www.zimstat.co.zw/wpcontent/uploads/publications/Population/population/ICDS_2017.pdf

The MSF **Mbare Adolescents Friendly Clinic** is a “*fully medicalized*” facility attached to the Mbare Polyclinic, run by the City of Harare. MSF delivers comprehensive sexual and reproductive health services for young adults through a multidisciplinary team and with Volunteer Peer Educators (VPE) ensuring the first contact with beneficiaries. Medical consultations consist of general outpatient consultations, vaccination, contraception, sexually transmitted infection care (STI), HIV and TB management including pre- and post-exposure prophylaxis, mental health, social support including support for antenatal care registration. Beneficiaries are also assisted when they need referral to secondary level of care. MSF offers services everyday including weekends and public holidays.

The **Matapi Youth Hub** is a peer-led and ‘less medicalized’ set-up. It serves as a safe social interaction space for young people where they can access internet, group sessions, health education, screening and testing for HIV through Volunteer Peer Educators and Community Health Mobilizers (CHM). The site is also served by a nurse from the MSF Mbare Adolescents Friendly Clinic from Monday to Friday. In case of need, the team refers patients either to Mbare Adolescents Friendly Clinic or to other stakeholders and partners.

The **Epworth Youth Centre** is peer-led and ‘non medicalized’. It is used as a social interaction space for young people where they can access internet, group sessions, health education, screening and testing for HIV through VPE, CHM and Health Promotion Officer. In case of need, the team refers patients to the Mbare Adolescents Friendly Clinic and to partners.

To bring the services closer to the young people and make them more accessible, the project has an outreach clinic model with VPE going to the community proposing key basic medical services (emergency contraceptive pill (ECP), HIV test and linkage to care, pregnancy test & linkage to care, condoms (male & female) distribution and menstrual hygiene commodities distribution). There are also VPE ensuring health promotion talks at each facility and in the community. They are key actors of the project to make the bridge between the community and the health service centres. The VPE are aged 18 to 24 years old and have been trained in all medical aspects offered in MSF project, including in Psychological First Aid (PFA), allowing them to identify mental health needs and refer those who need it to the clinic.

On top of the peer-led strategy, MSF Mbare project is re-enforcing community engagement through a collaborative and inclusive approach, bringing empowerment to beneficiaries and strengthening feedback mechanisms, ultimately encouraging meaningful participation from beneficiaries in decision-making. Concretely, the initiatives are a Patient Charter, a Community Feedback Mechanism and an Adolescents advisory Board.

1.1.5 Justification

There is growing concern about substance use among adolescents and young people in Zimbabwe, particularly in Harare. However, there is a lack of data to fully understand the extent of the problem and its impact on AYP health, especially in relation to sexual and reproductive health. Zimbabwe’s approach to drug use remains restrictive and coercive, with a strong emphasis on abstinence. Harm reduction services are not yet in place.

Despite these challenges, both areas benefit from active MSF-supported health facilities, which provide a practical and accessible platform for assessing and addressing the needs of AYP related to drug use.

Given the growing concern around substance use among adolescents and young people in Zimbabwe, the lack of data on its extent and impact, particularly on access to sexual and reproductive health services, MSF commissioned an anthropological assessment to explore the factors and determinants linked to drug use affecting SRH access for AYP (10–24 years old) in Mbare and Epworth, Zimbabwe.

1.2 Objectives

1.2.1 General objective

To assess and understand how the use of drugs (excluding tobacco) by adolescents and young people (10-24 years old) in Mbare and Epworth influences their sexual risk behaviours, health-seeking behaviours and access to sexual and reproductive health services.

1.2.2 Specific objectives and questions

The use of drugs by AYP in Mbare and Epworth

Understanding the daily lives, patterns of behaviour and profile analysis of active users:

- ◆ Knowledge of age, background, job, family etc.
- ◆ Knowledge of type of drug used, type of use, methods, mixing, conditions for use, context of use, frequency of use, etc
- ◆ How their drug use is intertwined with sex
- ◆ How AYP using drugs perceive their health needs
- ◆ How their drug use is perceived
- ◆ On the impact of drug use on risk behaviours, HSB and access to SRH services.

Challenges reaching SRH services

Knowledge about the challenges and aids in reaching SRH services:

- ◆ What factors influence the risk behaviour of AYP who use drugs in relation to sex?
- ◆ What factors influence the health seeking behaviour of AYP who use drugs?
- ◆ What factors influence access to SRH services by AYP who use drugs?
- ◆ What can motivate AYP using drugs to seek SRH services?
- ◆ What are (perceived and experienced) barriers for AYP using drugs to access SRH services?
- ◆ Which challenges exist in treatment (contraceptives, PrEP, PEP, MH, HIV, etc)?
- ◆ Why do previous patients become lost to follow up

AYP using drugs perspectives of MSF services in facility and in community/outreach services

- ◆ Which in facility and community/outreach activities are offered, and which are used by AYP using drugs?
- ◆ Which other activities are requested by AYP using drugs?
- ◆ How is the notion of harm reduction perceived by AYP using drugs?
- ◆ How can we best reach AYP using drugs?

2 Methods

2.1 Assessment setting

The assessment was conducted in the MSF Mbare project in Zimbabwe operated by the Belgium section of MSF.

2.2 Assessment design

A qualitative assessment design was used to gain multiple perspectives of male and female young people and adolescents; in- and out-of-school AYP, young people selling sex (YPSS), young people who use drugs (YPWUD), teen-mums and pregnant teenagers, VPE, CHM, teachers, healthcare workers (HCW), MSF and MoHCC and key populations on the complex factors and key drivers of drug and substance use, engagement in risky sexual behaviours, perception of contraceptives, other protective measures like PreP, PEP, ECP, etc. reasons and key drivers of teenage pregnancies and abuse and sexual violence towards adolescents and young people and their vulnerabilities. (Pope & Mays, 2006). The methods used for data collection were face-to-face in-depth individual interviews (IDIs), paired interviews (PI), focus- and group discussions (FGDs and GDs), informal discussions and observations and transect walks through the communities. For this assessment, we applied the methodologies in a sequenced way, starting with IDIs and FGDs, followed by observations, transect walks, and visits to specific locations such as the Matapi flats, 'bases', and 'touch lines'.¹¹

A methodological triangulation of findings was undertaken to enhance the interpretation of data, in-depth individual interviews were combined with focus group discussions, observations transect walks and visit to specific locations, reports and scientific literature. Triangulation enables an accurate representation of reality through use of multiple methods or perspectives for data collection (Patton, 2002). The choice of methodology encouraged rich text and reflective narratives from the main participants to answer the assessment question.

¹¹ A 'base' is where drug users and dealers gather, consume and sell drugs. A touchline is a street-level spot where sex work takes place.

2.3 Assessment population

The assessment population was a composition of different groups of respondents (Table 1) looking at a diversity of age, gender, level of education, in- and out-of-school adolescents, pregnant and lactating adolescents, young people selling sex, young people who use drugs, VPE and CHM, extrapolated in Table 1.

Table 1: Characteristics of assessment participants:

Background	Total (n=162)	%
YPWUD	35	21%
YPSS	31	19%
Pregnant and lactating AYP	11	7%
Adolescents in-school	28	17%
Kids	4	2,5%
APLWHIV	8	5%
Key population (LGBTQIA+ and streetkids)	8	5%
Teacher	1	1%
VPE, CHM	23	14%
HCW (MoHCC, MSF and other CBOs)	13	8%
Age groups, years	Total (n=162)	%
10-14	6	4%
15-19	78	48%
20-24	61	38%
25-45	15	9%
≥46	2	1%
Education	Total (n=162)	%
Primary school	10	6%
Secondary school	140	86%
University/College	12	8%
Gender	Total (n=162)	%
Male	69	42%
Female	87	54%
Diverse	6	4%
Marital status	Total (n=162)	%
Single	102	62%
Partner	42	26%
Married	12 ¹²	8%
Divorced or separated	5	3%
Widowed	1	1%

¹² Non from the AYP were married. Most said they were single or had a boy- or a girlfriend.

2.3.1 Selection and recruitment of participants

Purposeful sampling was applied for the interviews with all the participants in general; AYP using drugs and substances and/or selling sex were chosen with the help of the translators, the peer educators¹³ and the community health mobilisers working in the different project locations. In-school adolescents were chosen by teachers in the respective schools we visited after we had introduced the purpose of our visit. One teacher was interviewed after we had talked to the students. Teen-mums and pregnant teenagers were selected with the help of the staff who engage with them, either at the clinic in Mbare or at Matapi Youth Hub and at the youth centre in Epworth. Members of the key population groups were met with the help of PE that were linked to them. HCW were directly approached by the PI. The sample size was not determined in advance as we followed the information saturation principle (Green & Thorogood, 2018). In all, we did 54 interviews, 20 IDIs, five PIs, 29 FGDs complemented by informal talks and observations. In the last week we mainly engaged in transect walks in Epworth, Mbare and visited the Matapi flats. As a result, we were able to talk a total of 162 individuals.

2.4 Assessment process and data collection

The data collection process took place in three phases:

Phase I was a preparatory phase, which lasted three months and focused on literature search and preparing the assessment.

Phase II started on the 26th of March 2025 with a field stay of seven weeks for data collection including qualitative IDIs, observations, and FGDs. The assessment team consisted of the primary investigator (PI), a female and male assessment assistant who also acted as an interpreter and a male and a female transcriber. The PI together with the interpreters and Mbare project team members organised the interviews.

In **phase III**, data collection was completed. The recordings and notes from the interviews were transcribed electronically, coded manually and with Nvivo©11, and analysed, resulting in a final report.

2.4.1 Observations and transect walks

Observations were carried out by the PI as part of the data collection. Participant observation is a crucial qualitative method as it gives account to what people say and what they actually do (Coffey & Atkinson, 1996). Observations were not carried out explicitly but were partially informal observations during the interviews at the different project sites in Mbare and Epworth, in the communities, at Mbare clinic and waiting area, and during the transect walks through the communities of Mbare, Matapi and Epworth (Rojas, Nomedji, & West, 2021). In Matapi the team was able to visit the Matapi flats and walk through some of the blocks looking at the general living conditions, sanitary facilities, water points, and bathing places. Uninhabited flats or spaces within the different blocks are sometimes used as 'bases' which were likewise recognized. The team was able to visit a 'base' where crystal meth is sold and consumed. We first asked interview participants if we could come with them, which was initially rejected with great determination. After some attempts and asking back to the 'Jazzman'¹⁴ of the base the team was finally accepted to visit and observe drug preparation, sharing and consumption (Fig 1+2).

¹³ We will use in the following PE instead of VPE.

¹⁴ **Jazzman** is commonly used to describe individuals who sell and distribute crystal methamphetamine, locally known as 'mutoriro', 'guka', or 'dombo', within informal drug networks.



Fig 1: Vaporizing Crystal Meth using the glass inner coil of an energy-saving bulb Fig 2: Smoking Crystal Meth

2.5 Data management and analysis

This assessment used an applied medical anthropological approach to generate insight and understanding of adolescents and young people and healthcare providers on how they perceive, and experience drug and substance use in relation to access to sexual and reproductive health. The aim was for MSF to take these perceptions into account for future programming and interventions. The analysis and interpretation of data was drawn on the various experiences, factors and drivers as the key determinants for drug and substance use and access to SRH services.

Data analysis was conducted manually by the PI as well as using NVivo©11 qualitative data analysis software. All interview transcripts were imported into NVivo after translation and transcription, where they were then coded. A coding framework was developed based on themes emerging during the interviews, as well as themes pre-identified by the assessment team. Emergent categories and themes were identified based on meticulous and systematic reading and coding of the transcripts. Codes and sub-codes were refined during the analysis. Data coding and analysis began whilst data collection was ongoing, to allow for the refining of questions and the in-depth exploration of certain themes if required. The analysis involved a thematic content analysis by Mayring (Mayring, 2010).

Continuous reflection on data was part of the creative process of analysis and necessary for contextualising and linking of findings with theory. To work with principles of good practice, the assessment process was clearly described in the report; validity of data is therefore ensured by presenting a ‘thick’ description¹⁵ (Geertz, 1973) of the assessment context and by also presenting deviant cases if they occur.

A methodological triangulation was applied. The content and emerging themes of the individual IDIs were combined with FGDs, observations, transect walks and a literature review (Brikci, 2007). Various data types (IDIs, FGDs, and observations) that were used for triangulation were harmonized by coherent translation, transcription, and coding, and therefore integrated into a cohesive analysis.

2.6 Limitations

The interviewees clearly associated the assessment team with MSF, potentially resulting in response bias. To mitigate this potential bias, the team provided a thorough explanation of the principal investigator's and her assistants' roles, their neutrality, and strict assurance of anonymity and confidentiality.

Working with an interpreter can be limiting, as the quality of interpretation depends on the interpreter's soft and hard skills. This limitation was mitigated in working with former peer educators as interpreters who knew the project and its objectives and topics in depth.

¹⁵ Originating from Geertz (1973), a “thick” description of human behaviour is one that not just explains the behaviour but its context as well, such that the behaviour becomes meaningful to an outsider.

During the transect walks the team and mainly the PI tried to visit some bases where Marihuana was sold. However, the team was turned away in saying that there are no drugs available or they have been sold out that day by fear of being denounced or reported to the police.

Finally, the presence of the PI at the field site and her background (gender, cultural and professional background, age, social status, origin, etc.) may influence the qualitative data obtained. Therefore, the PI took a critical stance towards her position in gathering data and analysing findings, with special attention paid to discussing the results and recommendations with the project team. Approaches to interview settings and questioning were discussed with the assessment team, who were encouraged to advise the PI in terms of being direct or rather indirect in asking certain questions to certain groups or individuals.

3 Ethical considerations

All participants who agreed to take part in this assessment were duly informed of the aims of this anthropological assessment and gave their oral consent. Informed consent was given verbally by all those interviewed for the assessment. The confidentiality of the participants was respected, and the data obtained during the interviews were anonymized without including any personal identifiers.

3.1 Informed consent

Informed consent was required by all respondents of the assessment. Oral informed consent was obtained in all cases. Informed consent was sought at the beginning of any individual IDI, paired interviews, GD or FGD and visits to hot spots (bases, touchlines, etc.). The assessment team explained the purpose of the assessment and its aim. Any questions from a potential interviewee were answered and clarified by the PI or translator. Assurance that non-participation in this assessment would not impact their future care, treatment provision, or work in the case of healthcare staff was ensured.

It was guaranteed that participant confidentiality would be respected. All data obtained through IDIs were anonymised and stored on password-protected computers, without the inclusion of personal identifiers such as names (Richards & Schwartz, 2002). Verbatim quotations in dissemination materials like this report are designated by the interview number, age, sex, and category of participant (e.g. I36, FGD, males using drugs, 15-19y, etc.). For confidentiality reasons, we refrain from specifically mentioning CHM and include them under the broader category of HCW. Additionally, we have chosen not to indicate the ages of interviewed HCW to further protect their anonymity. All the interviews were audio-recorded, and notes were taken after the respondents gave permission. Each respondent was assured of the confidentiality and privacy of the interview and informed that s/he was free to stop at any time or refuse to answer any questions, although, this did not happen in any of the interviews. Some drug-using participants occasionally expressed discomfort with the duration of the interview, saying they had been sitting long enough. The team then aimed to conclude the conversation as promptly and respectfully as possible. During FGDs, participants were asked not to use their real names but to choose a pseudonym, most often a colour, to ensure anonymity.

4 Results

This report provides an analysis of the perceptions, experiences, and understandings of people living in Mbare and Epworth, Harare, regarding drug and substance use, its connections to sexual and reproductive health, and how it influences access to SRH services. The report specifically examines the key drivers and influencing factors of drug and substance use among adolescents and young people.

The results section addresses key questions such as why drugs and substances are used; which substances are most commonly used; who takes what; how they are consumed; and how individuals afford and access them. It also explores the factors influencing the sexual risk behaviours of adolescents and young people who use drugs, as well as the challenges they face in accessing healthcare. Furthermore, the section presents perspectives on the specific health needs of adolescents and their perceptions of the services provided by MSF. These perspectives are complemented by the experiences and observations of peer educators and community health mobilisers. Additionally, the section includes the views of healthcare workers (MoHCC, MSF and other NGOs) to provide a comprehensive overview of the results.

Given that the collected data is analysed from the perspectives of the various individuals interviewed, the results are presented according to these distinct viewpoints. The findings are supported by direct quotations to give voice to those who participated in assessment.

A large majority of adolescents and young people expressed the difficulties they face in managing life as teenagers, whether in school, out of school, or unemployed. Many young people shared experiences of idleness, lack of engagement, and limited access to job opportunities, which contribute to their vulnerabilities.

It is important to note that many of the healthcare workers interviewed are also parents. Thus, they have a twofold way regarding the challenges adolescents face regarding STIs, other SRH needs, and teenage pregnancies, as both healthcare providers and caregivers.

From the various respondent groups, we received a wide range of suggestions and recommendations for improving the situation of adolescents and young people. These proposals address areas within the current project and programme scope, and, where necessary, point to potential collaborations with other community-based organizations.

These contributions will serve as the foundation for Chapter 5 the recommendations, in line with our objective to develop them collaboratively, based on the voices and insights of the people we work with.

After one week of conducting interviews with individuals from the different respondent groups, it became evident that socio-economic and financial challenges complemented with idleness and availability of drugs were among the main issues faced by adolescents and young people. These hardships have led many AYP to turn to drug and substance use as a coping mechanism, while girls and young women often engage in transactional sex as a means of survival.

Participants also highlighted the stigma and discrimination surrounding drug use, STIs and teenage pregnancy, which often compels affected individuals to keep their experiences hidden or not to seek help.

In the upcoming results section, we refer to young people who use drugs (YPWUD) and young people selling sex (YPSS) as broad analytical categories. However, it is important to acknowledge that these roles often overlap; in particular, many of the females and males engaged in sex work are also involved in drug use. This intersection is significant and will be reflected where relevant in the analysis, while still maintaining clarity in how different patterns and experiences are described.

For quotes, we will indicate the interview number and the interviewee's designation such as YPWUD, YPSS, teen-mums, PE, teacher, HCW, etc. followed by the age for IDIs except for HCWs.

4.1 Framing the context

Before presenting the detailed results, this section provides a contextual overview of the environments, conditions, and everyday realities that shape the lives of adolescents and young people in Mbare and Epworth. These high-density suburbs of Harare are characterized by socio-economic deprivation, overcrowding, informal housing, and limited access to social services. In these settings, daily life for many AYP is marked by unemployment, interrupted schooling, exposure to violence, and a lack of structured opportunities for income or recreation.

Within this context, drug and substance use, sexual and reproductive health risks, and limited access to healthcare for AYP do not occur in isolation but are deeply intertwined with economic hardship, social marginalization, and survival strategies. Adolescents and young people, whether they have dropped out of school or completed their education, often remain unemployed, idle, and without realistic prospects for the future. This persistent lack of direction or purpose heightens their vulnerability and makes it easier to turn to drug use as a form of coping or escape with stress and boredom; for others, transactional sex becomes a means of survival in the absence of viable alternatives. In many cases, drug use and transactional sex are closely intertwined. As one participant put it, *“I live in the present moment.”* He explained that when using drugs, he stops thinking about painful past experiences, such as heartbreak, family separation, or personal loss, and no longer worries about the future, like finding a job or building a relationship.

These intersecting vulnerabilities shape not only how AYP navigate their lives, but also how they relate to health systems, services, and harm-reduction interventions. To understand the voices and behaviours described in the results, it is essential to first become familiar with key local terms and expressions used in relation to drug use and sex work.

4.1.1 Understanding local terminology

Coded conversations: How youth talk about drugs

Young people engaging in drug use often develop their own coded language and slang as a way to communicate discreetly among peers and avoid detection by adults. As one participant explained, *“they want to create a language of their own so they can recognize and speak to one another with ease.”* This evolving slang is deliberately designed to be unintelligible to parents and outsiders. For example, terms like *‘buwe’* or *‘stones’* refer to crystal meth, while everyday words are repurposed, such as *‘pot’*, which in this context means the energy saver bulb used to smoke the drug. A phrase like *“I’m going to cook my pot”* may sound harmless to parents, but within peer groups, it clearly signals crystal meth preparation and use.

“They communicate among each other using their own language saying “I am going to cook my pot” meaning “I am going to burn my energy saver bulb to prepare crystal meth”, and the parents are tricked into believing that their child wants to cook.” I6, IDI PE, 23y

The following terms and expressions reflect the language and lived realities of those we interviewed and are essential for interpreting the findings that follow. In particular, the terms *‘base’* and *‘touchline’* hold specific meanings within the street economies and informal social systems of Mbare and Epworth.

Base

In Zimbabwean urban slang, a *‘base’* refers to a semi-permanent gathering spot where people, especially young men and drug users, congregate often to use, sell, or buy drugs like weed, crystal meth and others. A base is typically an informal, often hidden location such as a backyard, an abandoned house, a corner, a room or a flat (Matapi flats), or an empty space in an uninhibited building.

It may also function as a social spot where users rest, sleep, or pass time, especially and mostly when disengaged from school or work. Bases usually have names like *'Jexus Corner'*, *'Golden Corner'*, *'Gul'*, *'Jabuna'*, etc.

The metaphorical comparison of a base can be thought of like a home dugout or a kind of 'headquarters' where the group regroups, plans, or waits. It's not a place of movement, like the touchline, but of belonging, hierarchy, and informal control, often under the influence of a local 'Jazzman' or dealer. The choice of which base to go to was said to be flexible and mood-dependent rather than fixed. Participants explained that they do not always go to the same place, but make spontaneous decisions depending on how they feel on a given day, emphasising the fluid and impulsive nature that is shaped by personal preference, peer influence or simply convenience:

"That day you just feel that this day, let's go to this one, then you go there." I52, PI YPWUD, 23-24

In summary:

- A 'base' is a fixed location where drug users and/or dealers gather.
- It can be a makeshift shelter, abandoned building, corner, or open space.
- At the base, people may buy, sell, and use drugs.
- It is often a social hub as well, a place for rest, interaction, and sometimes sleeping.
- Some bases are controlled by specific individuals or gangs and may involve informal rules or hierarchies.

We were told that when people stay in those bases for longer, navigating their drug use, risky sexual interactions happen among various people staying there overnight but also stealing and petty crime mainly in bases of crystal meth use.

We were told that longer stays in drug bases, particularly those associated with crystal meth use, often lead to risky sexual interactions among individuals staying there overnight. In addition to these sexual risks, petty crime and theft were frequently mentioned as common occurrences within these spaces. The environment of the base, marked by intensive and heavy drug use, under a consciousness clouded by drugs, creates conditions where boundaries are blurred, and individuals engage in high-risk behaviours that increase their vulnerability and the likelihood of harm.

Jazzman and plugs

A Jazzman is typically the person who controls or runs a 'base'. They often have influence or authority over users frequenting the base and may enforce informal rules. The term is part of local slang and reflects the underground, often violent, dynamics of the drug scene, particularly in relation to crystal meth. Under the Jazzman functions the so-called plug, they are younger, 17-19 years old and are sent by the Jazzman to sell drugs.

Touchline

The colloquial use of the term 'touchline' in areas like Epworth and Mbare, refers to a location where female sex workers wait to be approached by potential clients. The term draws a metaphor from football (soccer), where the touchline is the boundary line on the sides of the pitch. Players waiting to be substituted often stand near this line, ready to enter the game.¹⁶ Similarly, sex workers standing along the 'touchline' are perceived as being 'on the sidelines', waiting to be 'called into play' by clients.

In summary:

- A 'touch line' refers to a street-level spot where sex work takes place.
- It's usually near roadsides, nightspots, or known hotspots, where sex workers wait for clients.

¹⁶ Explanation given during an informal discussion with peer educators.

- The term comes from the idea of being ‘on the line’ or ‘edge’, visible and ready for negotiation.
- For many AYP especially those who use drugs, the touch line is both a source of income and a space of exposure to risk, including violence, exploitation, and unsafe sex.

Young people selling sex: Terminology and self-identification

In the context of this assessment, terminology around sex work varied significantly between participants and observers. Girls and young women who engage in sex work were commonly referred to as ‘night walkers’ or ‘sisters’ by community members, while Mbare project staff generally used the term females selling sex.

“We are “*vafambi vemadeko*” directly translated to night walkers, meaning sex workers.” I28, FGD YPSS, 18-37y

In many interviews, however, participants themselves did not name the practice explicitly, often referring to it indirectly as “*when I was doing this*” or “*when I started with this*”. However, it was also referred to ‘the job’, ‘doing this job’, or saying ‘that thing’, or ‘standing in the road’:

“I was now staying at the lodges, and I would do that thing of standing in the road [selling sex].” I54, FGD YPWUD, 22y

“She goes to the hotspots, if you want that same job, it’s your choice” I28, FGD YPSS, 18-37y

While male respondents frequently used the term ‘prostitutes’, it became evident that the girls and young women involved did not identify with stigmatizing labels such as prostitute or commercial sex worker. Out of respect for participants’ voices and self-perceptions, this report aligns with their preferred and implicit terminology, using ‘selling their body’, ‘selling sex’ or ‘engaging in transactional sex’ where appropriate and context sensitive.

4.2 Drug and substance use

Adolescents and young people are particularly vulnerable, with early adolescence (ages 10–14) representing a period of rapid physical, emotional, social, and cognitive change. These developmental shifts strongly influence adolescents’ thinking, behaviour, and decision-making. (Ahmed, Bittencourt-Hewitt, & Sebastian, 2015). Large segments of adolescents in the sub-Saharan African region are growing up in environments where poverty, unemployment, rapid urbanization, limited educational opportunities, and social instability pose challenges to growth and development (Fox & Gandhi, 2021). Growing up in an environment marked by high unemployment or limited to informal work, combined with exposure to drug and substance use, parents who drink heavily, or households where drugs are sold, often creates harmful and unstable conditions. Being raised by a stepmother or stepfather can further complicate family dynamics, all of which shape and influence a young person’s development in profoundly challenging ways (Shinde et al., 2023). Nearly all adolescents and young people we had interviewed spoke in one way or another about their life challenges related to family relationships, lost partners or a ‘broken heart’:

“I was now 18, and it was a while since we had started dating, then I told him that I was pregnant and he asked whose pregnancy it is and I told him, yours, he denied it. I was so heartbroken because I loved him so much, then my friend said you can’t be crying and feeling heartbroken for only one person whilst he doesn’t love you anymore, let’s do what I’m doing [sex work]. Then I joined her.” I1, FGD YPSS, 18-19y

When discussing drug and substance use in the communities assessed, it became clear that consumption patterns are closely tied to affordability. As many participants explained during interviews, people typically buy what they can afford at any given time.

While there are fixed prices for certain drug quantities, some of them might be pre-packaged, these packs are frequently shared or split among users. For example, one person might contribute USD 1, another 50 cents, and together they purchase a shared portion of alcohol or drugs. This collective pooling of resources is a common strategy, particularly among adolescents and young people and those with limited income. Once the shared supply is consumed, individuals usually set out to find money again, often through informal or small-scale work, such as touting (soliciting passengers for minibuses) or working as a 'jagger' (transporting goods for a fee with a manual cart Fig 11).



Fig 11: 'Jagger' with a manual cart

4.2.1 Drugs and substances used, and associated costs

Referring to the interviews, commonly used drugs and substances among adolescents and young people in the areas of Mbare and Epworth include:

- Marijuana, Ganja cakes and biscuits, Ganja tee, Skunk (strong street weed), Malawi (weed)
- Cough Syrup: Broncleer, Benylin, Histalix, Salterpyn
- Musombodia (illicit, cheap and very strong alcohol made of ethanol and emblems powder)
- Mangemba (Diazepam)
- Kambwa (alcohol): Locally produced intoxicants, often made from various household
- Pills: Valium, Benzodiazepine, crushed and/or mixed with alcohol
- Crystal Methamphetamine or Crystal Meth
- Diapers jelly boiled and the extract drunk
- Powder from Plasma TVs
- Glue and Solvents

This list is not exhaustive and reflects only the substances identified within the specific area where the assessment was conducted. It is possible that other drugs are known and consumed, often in various mixed forms, that were not mentioned during our conversations. However, the most commonly reported and significant substances include **marijuana**, **cough syrups**, and **crystal methamphetamine**, along with **various forms of alcohol**, mostly illicit and locally brewed.

Marijuana

Marijuana most referred to as *mbanje*, *weed* or *skunk* was reported to be the most widely used drug. It is not only readily available but also easily accessible and cheap throughout Mbare and Epworth. A small plastic bag of cannabis (Fig 4) sold in the areas of Mbare and Epworth, are reportedly sold for around USD 1.

Description of typical street-level Marijuana packaging:

- Packaging: Small, transparent plastic bags, often referred to locally as 'twisties' or 'bank bags'."
- Contents: Approximately 1 gram of cannabis, known locally as *mbanje*
- Price: Generally sold for USD 1 per bag.
- **Appearance:** The cannabis is usually in the form of dried buds or crushed plant material.



Fig 3: Sachet with weed and a half cigarette, called skunk to be rolled into a joint



Fig 4: 1 Sachet of skunk for USD 1

The picture (Fig 3) shows a small part of weed (in the left corner) and a small piece of cigarette. When the weed is mixed with the cigarette it is called *skunk*. We were told that what is shown in the picture is not for sale but is what the person who prepares the weed will keep for himself to smoke on his own. A full plastic with weed, like the one in the picture (Fig 4) would cost USD 1 and can make up to 4-6 joints depending on how much the person laces into the joint. Therefore 1 joint would cost a maximum of USD 0.25 according to our respondents. Participants also spoke about different types of marijuana, particularly referring to 'skunk' and 'malawi'. *Malawi* was described as a higher-quality type of weed, valued for being naturally cultivated in open fields, unlike other variants perceived to be grown in more artificial or manipulated conditions. In contrast, *skunk* was mentioned as a stronger, more potent variety, sometimes associated with enhanced psychoactive effects due to hybridization or chemical alteration.

"'Skunk'[weed] is different from marijuana in the sense that they are both planted in the same way but when 'skunk' is about to get ripe, they add some chemicals." I48, FGD YPWUD, 20-25y

Marijuana was also consumed in alternative forms such as Ganja cakes, biscuits, and Ganja-infused tea.

Cough Syrup

Cough syrup is also commonly referred to as 'bronco' or 'ngomwa'. The term *bronco* originates from the brand name BronCleer, a codeine-based cough syrup. It has become so popular that many people now use *bronco* as a general term for any cough syrup, even though it specifically refers to BronCleer in some contexts. Commonly used syrups such as BronCleer, Benylin, Histalix, and Salterpyn all contain the opioid codeine and alcohol, contributing to their high potential for addiction.



Fig 5: BronCleer and Benylin Cough Syrup



Fig 6: Empty carton boxes of Benylin Cough Syrup

Cough Syrup is widely used in both areas Mbare and Epworth and has been a significant public health concern in Zimbabwe for over a decade. While it has been described as an ‘epidemic’ by various media outlets and health experts there is no official record of the Zimbabwean government declaring it a national epidemic.¹⁷ The use of codeine-based cough syrups among Zimbabwean youth has been well-documented. Reports indicate that these syrups are often smuggled into the country and sold illicitly, contributing to widespread addiction issues (Hlahla et al., 2024; Marandure, Mhizha, Wilson, & Nhunzvi, 2023; Mugari, 2024; Mukwenha et al., 2022; Muswerakuenda, Mundagowa, Madziwa, & Mukora-Mutseyekwa, 2023). Efforts have been made by authorities, such as the Medicines Control Authority of Zimbabwe (MCAZ), to curb this problem by revoking licenses of pharmaceutical dealers involved in the illegal distribution of these substances.¹⁸

The various cough syrups do slightly differ in prices. The most used is Benylin also referred to as BN¹⁹, with a price of USD 6.50-11.50 for a bottle of 150ml (Fig 5); a bottle of BronClever, called BC by some, would cost USD 6-10, Salterpyn can be bought for USD 7-10 and Histalix USD 5-8.

Cough Syrup	Estimated Price in USD	
Benylin (150ml)	USD 6.50 – 11.50	Price depends on formulation and availability; sold both in pharmacies and informally.
BronClever (100ml)	USD 6.00 – 10.00	Often smuggled; sold illegally. Known for strong codeine-alcohol content.
Salterpyn (100ml)	USD 7.00 – 10.00	Not officially registered in Zimbabwe; found on the black market.
Histalix (150ml)	USD 5.00 – 8.00	Locally available; frequently used. Sales have led to regulatory crackdowns.

These prices are approximate and can fluctuate based on availability, demand, and enforcement activities.

As mentioned in the introduction, individuals using substances often buy what they can afford, leading to shared purchases or smaller, portioned quantities of drugs and alcohol. This practice is also reflected in the way cough syrup is consumed. A common example shared during interviews is the use of what is locally referred to as a ‘bale’, a small plastic container made from bottle preforms, the same tubes used in the beverage industry to manufacture PET bottles (Fig 10).



Fig 10: Bottle preforms used to measure cough syrup.

Respondents explained that a ‘bale’ is filled with BronClever or Benylin mixed with Whisky and sells for approximately USD 2.50. This quantity represents about a quarter of a full bottle of BronClever. Rather than purchasing an entire bottle, which may be unaffordable, users consume one bale at a time, sometimes returning for another if they manage to gather more money. This further illustrates how economic limitations shape consumption patterns, especially among adolescents and young adults in low-income settings.

¹⁷ <https://www.facebook.com/watch/?v=1040691324136008> accessed 30th June 2025

¹⁸ https://zimadvocate.com/2023/10/04/zimbabwe-tackles-cough-syrup-abuse/?utm_source=chatgpt.com accessed 30th June 2025.

¹⁹ We were told that drug users develop their own coded language to conceal conversations about drug use.

Musombodia and other forms of alcohol consumption

Musombodia is an illicit homemade alcoholic beverage made from ethanol and other substances. *Musombodia* or *musombo* also known as *kambwa* (small dog in Shona) is typically produced by diluting industrial-grade ethanol or methanol with water, often incorporating various additives to enhance potency or mimic the appearance of commercial spirits. Some of the added additives include:

- Brownish colouring agents
- Sugar
- Cleaning detergents
- Bicarbonate of soda
- Thinners
- Rat poison
- Anti-retroviral drugs

The bottles in which these alcohols are sold are cleverly disguised as popular brands of Whisky (Fig 8), Gin, Two Keys, Bootleg (Fig 16) and Vodka. These illicit concoctions, known by street names such as '*musombodia*' or '*musombo*', '*kachasu*', or '*tumbwa*', are created by blending ethanol or methanol with a brownish colouring. Illegal distillers further dilute the mixture with water to lower the alcohol content, packaging the resulting liquid in bottles that mimic legitimate spirits, complete with imitation labels for well-known brands.²⁰



Fig 7: Small bottles of *Kambucha*



Fig 8: Small bottle of *musombodia/kambwa*



Fig 9: *Nyathi* beer

When asked about the substances he uses, a participant explained by detailing which ones he started with:

“Black label [brown bottles] and scud beer [sorghum beer]. I also got to a point of drinking '*saints*' [local beverage, sometimes referred to as *musombodia*, which is sometimes referred to as *GD6*, derived from Toyota Hilux GD6]²¹ and I also drank this type of substance packed in a green bottle called '*tembeya*', which was recently banned from the market by the responsible authorities and up to now, I still drink heavily.” I10, YPWUD, 21-23y

Kambucha and *tembeya* (distinct fermented beverages made as a drink that can contain alcohol) would cost USD 1 all other varieties would cost USD 0.50. A small bottle (Fig 8) of *musombodia* costs 0.50 cents, it is the cheapest alcohol. *Nyathi* beer (Fig 9) and *Scud beer* are local beers made of sorghum. They are sold in bottles of 1,25L and cost USD 1 but contain less alcohol than *musombodia*.

“*Nyathi* is a good stuff, its food and drink, because I feel so much energy whenever I take this beer [Nyathi]. If I smoke weed before I drank this full bottle, I will vomit, and even if I take only a sip, I will vomit too. I must take this full bottle of Nyathi until its finished, before I take weed, so that I won't vomit.” I10, FGD YPWUD, 21-23y

²⁰ [Illicit and Prescription Drug Addiction - Jacaranda Sanctuary](#) accessed 30th June 2025.

²¹ The alcohol is so strong that it was given the name of GD6 referring to the Toyota Hilux GD6, known for its power and durability.

Musombodia is also be mixed with *Milkit* (a milkshake) or *Yogie* (a type of yoghurt) and people would say they drink *Amarula*. Such a mixture would cost USD 1; a *Milkit* costs 0.50 cents and *musombo* costs USD 0.50.

In a FGD with young men who use drugs, some participants explained that the type of alcohol consumed is often dictated by affordability, but over time, habits may form regardless of one’s financial situation. One interviewee shared that even though premium whiskies such as Two Keys or Hennessy are desirable, financial constraints often lead people to opt for cheaper, illicit alternatives. A common example is *kambwa*, a low-cost, illicit alcohol. The participant reflected that once the habit of drinking *kambwa* is established out of necessity, it can become routine, even when money is no longer a barrier:

“Sometimes you don’t have the money to buy Two Keys [whisky alcohol] or Hennessy [whisky] and you can only afford to buy ‘*kambwa*’. So, you will end up adopting to a behaviour of drinking ‘*kambwa*’, even when you have USD 500, you will still drink ‘*kambwa*’.” I48, FGD YPWUD, 21-25y

Pills and other psychiatric drugs

Certain prescription medications intended for mental health treatment are being used as recreational drugs. These substances are often sold illicitly on the streets under various local names. The street prices for these medications are relatively low, making them accessible to many individuals. These medications are often consumed in combination with other substances, such as alcohol or marijuana, to enhance their psychoactive effects.

In the interviews conducted with adolescents and young people, pills were frequently mentioned. However, it was not always easy to determine exactly which type of pills they were referring to. Some participants spoke of “*pills given to mentally ill people*,” others described them by colour, such as ‘the blue pills’ without specifying names. Among the pills most commonly named were *maragado*, *mangemba*, *buttons*, and *blue pills*. These terms refer to concoctions made by mixing prescription medications such as chlorpromazine (an antipsychotic) and diazepam (a benzodiazepine) with water.

“People are drinking *maragado* pills and when they drink, they will feel a little bit relaxed in the brains and they won’t be overthinking, they will just be thinking about things that are happening at that moment. For instance, when a person takes *maragado*, they may start to see themselves as *Chivhayo* [a prominent Zimbabwean businessman known for his wealth and being flashy].” I42, FGD in-schoolboys, 19-21y

Street Name	Actual Medication	Typical Price	Street
Maragado/Mangemba	Diazepam (Valium)	Approximately USD 0.10 per pill	A benzodiazepine used to treat anxiety; used for its sedative effects.
Buttons	Various, blue-coloured pills	Varies	Generic term for blue-coloured pills; specific substances can vary.
Molly	Promethazine	No information	Promethazine is used as a sedative and as an antihistamine for allergic reactions.

It was further explained that *maragado* pills are often cheap or even available for free. In some cases, adolescents and young people access these medications because a family member, often an older relative, got prescribed them for mental health treatment.

As one participant shared:

"For *maragado*, you can sometimes get them for free because my grandfather was mentally challenged. These pills stayed at our place. When he would go out of his mind, he'd be given a lot of these pills. So, if you like taking them and you see them lying around at home, you'll just take and use them." I42, FGD in-schoolboys, 19-21y

Another female participant explained about her use of Valium:

"I started taking drugs and loitering in the streets ... and then I came back, and I started taking '*mangemba*' [Valium], those tablets for mentally challenged people. ... they would make me drunk, that's what I wanted, what I coveted, that life of being high always and there will be no one who would have shouted at me or who have done me wrong." I54, YPWUD, 24-28y

During a focus group discussion, one participant explained the so-called "buttons" and other medications, describing them primarily by their colour.

"They also add those pills called '*buttons*'. Some are blue, white and some are green in colour. These are pills given to mental patients, tested and medically proved for psychiatric patients, that can't stay calm, so they need pills to sleep and stay calm." I20, FGD male youth, 16-19y

Another pill mentioned during interviews was called *molly*, which, according to participants, functions similarly to codeine-based cough syrup due to its calming and sedative effects.²² It was described as a codeine-containing pill that some young people use to 'calm down' or enhance the effects of other substances. One participant explained that *molly* is sometimes crushed and taken orally, while in more extreme cases, it is dissolved in water and injected. This method of use highlights the risks associated with polydrug use and unsafe administration practices.

"It's like codeine pills, you get tired, it's like a promethazine. Some guys will crush, and some will take it like that. Some use an injection They crush the pills, mix it with a little bit of water, then they draw the liquid into the injection, and they will inject themselves. Sometimes people take those pills because '*mbanje*' [marijuana] is not getting them high enough." I48, FGD YPWUD, 20-25y

Crystal Methamphetamine

Crystal meth is usually referred to in the local language as *crystal*, *mutoriro*, *dombo*, *guka* or *bulb* which is '*bhaubhu*' in Shona, and *Rock Nation*. Crystal meth (Fig 12) has gained great popularity among young people in and around Epworth and Mbare.

While some interview participants mentioned that crystal meth has been used by older individuals in the past, others highlighted a shift in this pattern.

"For '*dombo*', if I am the one who wants to buy it [18y old], they can sell to me, but if it's a younger person, he will be stopped, and he can be chased away; 13, 12 and 14 years old will be stopped, they will be told "*you are very young for the thing that you want*"." I20, FGD male youth, 16-19y

According to one respondent, the drug is now predominantly consumed by adolescents and young people under the age of 19. The participant noted that:

"Crystal meth is mostly taken by the '*Ama2k*' [young people born from 2000 to date]. ... These days, most of the people using crystal meth are not elderly people but young people from the ages of 19 years and below. These young people are taking more than enough of this drug and going mad because of drug use." I6, IDI PE, 23y

This reflects a concerning trend in which crystal meth use is increasingly concentrated among very young individuals. However, during a visit to one of the crystal meth bases, we were told that younger people were not allowed to enter. When we arrived at the location, the door always remained locked.

²² Internationally *molly* is recognized as a street name for MDMA (3,4-methylenedioxymethamphetamine), also known as ecstasy, however participants use the name *molly* for another drug.

Crystal meth is typically consumed through inhalation, following a specific process that has become common among people who use drugs. The process of preparing the drug for use is referred to as *kubika*, a Shona term that translates to ‘cooking’.

In earlier years, during the time of Soul Jah Love, a popular Zimbabwean musician known for his own drug use, the preparation was often done by the *Jazzman*, a local term for drug lords or experienced dealers. However, due to increased police raids and arrests, many ‘*ghetto youths*’, like participants call them, have started buying and preparing crystal meth themselves.

The preparation involves a repurposed C-shaped energy saver bulb:

- The bulb is cleaned and modified by removing the cap to leave only the curved glass tube (Fig 13).
- One end of the bulb is attached to a pen barrel or plastic tube, sealed to allow inhalation (Fig 14). The other end is left open to insert the crystal meth.
- The base of the bulb is then heated so the crystal meth evaporates (Fig 14).
- The vapour condenses on the inside of the glass and is reheated and inhaled as smoke (Fig 15).



Fig 13: Cleaning the bulb



Fig 14: Bulb with attached pen barrel heating crystal meth

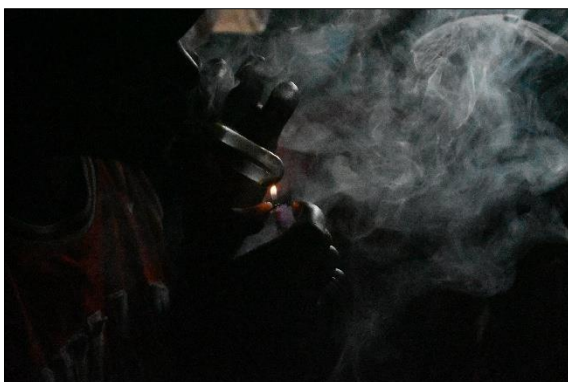


Fig 15: Inhaling crystal meth ...

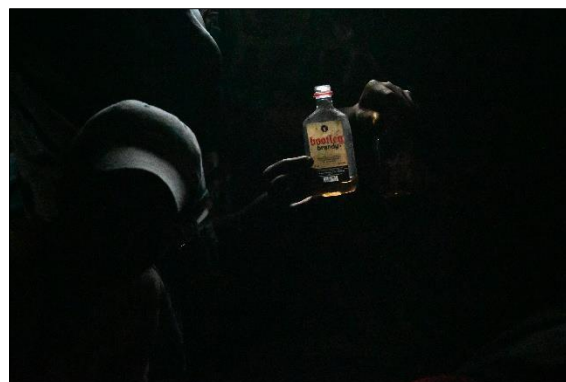


Fig 16: ... and drinking *musombodia* together.

This method allows the user to inhale the fumes directly, a process known to intensify the drug’s psychoactive effects. However, participants noted that not all crystal meth is prepared properly. Poorly ‘cooked’ meth is referred to as *mbodza* and is believed to be one of the main reasons why young people who use drugs lose touch with reality or experience episodes of psychosis. In addition to *mbodza*, participants also mentioned the emergence of fake meth, which resembles coarse salt and is suspected of contributing to the growing mental health crisis among young people.

The costs for crystal meth do not vary but as said earlier the amount that is bought depends on what the person can afford.

One gram of crystal meth would cost USD 8. One plastic pack in the size of Fig 12 contains 0.5g and costs USD 4. Some users might smoke 0.25g for USD 2 which would give 4 puffs, shared among two people, which comes to two puffs per person.



Fig 12: The pack shows 0.5g of crystal meth for USD 4.

Diapers' Jelly

In addition to the widespread use of weed, cough syrup, *musombodia*, pills and crystal meth, several participants described the increasingly innovative and hazardous methods used by adolescents and young people to get high. One such method involves the use of disposable diapers. In some cases, the gel-like substance from the inner lining of used or new diapers is extracted, boiled or cooked, and then they drink the resulting liquid. In another account, it was reported that diapers are burned directly, and the fumes are inhaled as an alternative way to induce intoxication.

One teacher shared how information about drug use practices often emerges informally through conversations with students. She recalled how some students explained the unexpected link between street vendors and substance use:

“I get that information from our learners, they are saying ahh ma’am when you see those people selling pampers in the streets, it’s not for the babies, is for those people who are taking drugs.” I15, IDI teacher, 50y

In numerous interviews and FGDs, respondents described the use of diapers, both new and used ones as a method of substance use. The absorbent gel inside the diaper is extracted, cooked, and the resulting liquid is then consumed.

“The pamper would already been used, yes, it would have urine. Those who don’t have money use such type of drugs. With regards to some of the jelly that I was talking about, you pour alcohol in a glass of water and put the jelly inside then leave it for a while whilst you do some errands. So, the jelly will suck all the alcohol, and you then eat the jelly once you are done with your errands. ... We find them [diapers] at home, because there are a lot of children at home, so we just take the used ones with urine and extract the jelly then we boil in a pot and drink the water. ... If there are no children at home, they look around for diapers, in the streets and other places. ... They look for pampers from their neighbors and friends. They know each other, and they [the users] give each other tasks to say, “*you are the one bringing the pamper today*” and to another on a different occasion “*you are the one, bring the pamper today.*”” I20, FGD male youth, 16-19y

Powder from Plasma TV

In a similar vein, some participants also mentioned the powder extracted from inside television plasma screens, which is burned and inhaled in an effort to produce a high. However, the belief that a powder extracted from plasma televisions can be used as a drug is a myth and has been thoroughly debunked by scientific investigations.

Experts have confirmed that the white powder found in plasma screens is magnesium oxide, a harmless compound commonly used in antacids and lacking any psychoactive properties.

“We have that bulb that is being called energy saver, it’s also being used as a drug, or TV [Television] plasma. TVs that no longer work, there is a part behind it if you open some powder will come out, that will be used as drugs.” I43, FGD in-schoolgirls, 18-21y

Glue and Solvents

Another commonly mentioned substance used by adolescents and young people is industrial glue, which is typically inhaled to induce a rapid high. As described by one participant, the process involves placing the glue into small plastic sachets, often repurposed from sour milk containers (approximately 500 millilitres in size). The person then inhales the fumes directly from the sachet, resulting in an immediate intoxicating effect. Participants noted that frequent use of glue often leads to signs of mental disturbance, highlighting the serious neurological risks associated with inhalant abuse. In this FGD, the participant referred to the fact that glue is widely available and sold without any restrictions in local markets, despite its well-known use as a drug among young people and its harmful effects:

“Glue is sold the same way as tomatoes because no one is aware that glue can be used as a drug. When a person buys it, people will just assume that he wants to use it to repair a bicycle, shoes or use it for something else. People are using glue as a drug because it produces heat. If we look at glue, it’s made from ethane, ethanol is also used, methane and methanol also. All of these are used to make glue. So, people are just taking it and use it, but after using it, if you take a closer look, you will see that when you go into town wearing a wig, they can grab it from your head. They know the difference between wig attached to the hair and the one which is not attached. Being intoxicated, they will quickly go and sell the wig to buy glue again.” I50, FGD in-schoolboys and girls, 16-21y

Inhalants like glue are used mainly among street-involved youth.

“Mostly ‘*zvigunduru*’ [people living in the streets], these are the people who use glue mostly because firstly, glue is cheap. Also, it is sold everywhere, it’s not seen as a drug.” I42, FGD in-schoolboys, 19-21y

However, one of the participants who uses or used crystal meth compared glue with crystal meth and explained:

“They used to take glue, that was the most prominent but nowadays, there is crystal meth. Crystal meth can make you do strange things; it can make isolate yourself from people. Glue would make them look like crazy people, they could even grab people’s food forcefully, among other things. Glue was worse to them, but crystal meth made them better, they now know how to bath and dress properly. So, you can see that those people who stay at that house are more hygienic. So, I don’t know if it’s helping us or they are affecting us, you can see what these drugs do us. It also depends on the source of the drug, where you got it, from *Dhama* [one of the most famous drug lords] or from the ‘*Gaza*’ [drug base].” I36, IDI female PE, 24y

In a FGD with peer educators it was explained to the question why people living in the street would take drugs:

“For the people living in the streets, they want to adjust to living in the streets, so if you are not sniffing glue, you don’t belong to the streets, you can’t survive, you won’t survive.” I46, FGD PE, 20-22y

4.2.2 Why do young people start to use drugs

When going into this topic, we need to ask the question: What does the drug or substance give to the person that he or she starts engaging in drug and substance use, or why does the person continue using it? Drug and substance use is not only triggered by emotional distress or addiction; for some, though this is a smaller group, it is also driven by recreational motives or social experimentation.

Interviews revealed a range of reasons why young people, especially those in their teenage years, begin using drugs. These include lack of occupation and job opportunities, peer pressure, you want to fit in and curiosity, the desire to imitate others in their surroundings, life circumstances and the situation young people live in, etc. Over time, patterns of use often shift, influenced by age, changing social context, and personal experiences. For those who are no longer in school, a major driver of continued drug use is the lack of occupation, educational engagement, or job opportunities, factors that contribute to idleness and reinforce vulnerability to substance use. With the ongoing absence of clear direction or purpose in their lives, young people become increasingly vulnerable, making it more likely for them to turn to drug use as a way of coping with stress, unstructured daily life, or just to escape their reality.

According to the interviews the main driver behind drug use stems from deep socio-economic hopelessness and structural exclusion, which leave many out-of-school or after finishing school young people disconnected from opportunity and vulnerable to using substances as a means of coping. The second main driver is the 'situation' individuals find themselves in. Psychological and emotional hardship at home, be it within the family, the partner, the social environment, where many young people are referred to the 'ghetto youth' (young people from a poor community). Participants reported various experiences such as parental abandonment, drug and alcohol use within the family, abuse from family members or stepparents and/or the death of a parent or both parents. Some participants are orphans because of the HIV/AIDS crisis two decades ago, at a time when antiretroviral therapies were not yet widely available. For in-schoolboys and girls, drug use was often described as a way to boost energy and enhance academic performance like to study harder, focus during exams, and achieve better results. It was also used for social reasons: to show off, impress others, overcome shyness in front of teachers, and gain admiration from peers. Some students used drugs to feel more confident, to be liked, and to position themselves as leaders within a 'cool' and respected clique.

The following list summarises the wide range of reasons and drivers mentioned by participants for why adolescents and young people begin using drugs and substances. These factors span structural, emotional, social, and behavioural influences, and often intersect. Each part is underpinned with quotes from the interviews.

Structural and economic drivers

- Lack of occupation
- Nothing to do, idleness (makes me start to use drugs and brings me back to drug use)
- School drop-out
- Not finding a job after finishing school
- Hopelessness, no prospects for the future
- Lack of finances for education
- Availability and affordability of drugs

"On people who are taking drugs, we are saying we have other scholars who have dropped out of school because their parents might have failed to pay for their school fees or other problems. So, they will not have other things to do in their communities, and they will be taking drugs because they have nothing to do, no employment." I23, FGD in-schoolboys, 16y

"In this community when people do not have things to do there will be too much drama. ... If a person is staying at his home and has nothing to do, he can start to do unmeaningful things, doing drugs, going to clubs and all because you don't have anything to do." I39, IDI KP, 21y

"It's because of the economy or the way that the country is, these adolescences are just idle, and they are not doing anything whilst the drugs are accessible, they are cheap and readily accessible in the community. Even if you go outside this clinic here in Matapi, it won't take you three minutes to locate people who are selling drugs, and they are cheap." I12, IDI HCW

“Well, you can see that... If your family does not provide for your education, you may view drugs as a good thing because you are unemployed. Even being unemployed can lead to drug use because you may begin to wonder, "I am not getting a job, so what am I doing here at the house? It is better that I take drugs than to remain idle".” I18, FGD PLWHIV, 18-24y

“The first thing that is leading young people to take drugs is the issue of unemployment. Also, lack of financial support to continue with education is also leading young people to take drugs because we are spending much of our time sitting being idle in the neighbourhood and we end up influencing each other to take drugs. I22, FGD PE, 20-23y

“I start to think that if I leave them [drugs], but without something to occupy me I won't be doing anything because I will spent the day idle and sober, so if I get drunk that thought of looking for a job or thinking that I am supposed to look for a job or about where my life is going I won't have that. But if I find something to do, I will leave drugs and I will be spending much of our time at work.” I31, FGD YPWUD, 15-20y

“With taking drugs number one is, the community we live, the community influences you to take drugs. Number two, nowadays, you cannot avoid taking drugs whilst you wake up in the morning and see drugs being sold next door, and you can also wake up and see your brother holding ‘mogo’ [cigarette], you will end up thinking that's the normal lifestyle and you need drugs to survive. That's what leads other people to take drugs. It's because of the place they live in and it's also because of unemployment; people are spending most of their time doing nothing.” I48, FGD YPWUDS, 21-25y

Emotional and psychological coping

- Escapism
- To isolate myself
- Depression relief
- Managing stress
- Loneliness
- Not thinking too much
- To bear life

“People who smoke ‘mbanje’ say “we don't think too much, we are not concerned about a lot of things”. Let's say for example, a woman may be facing marital problems, and she would say that she doesn't think too much, and she won't feel stressed after taking weed. That is what I know.” I34, FGD teen mums, 15-19y

“Some they can take it as a stress reliever that drug. According to the background and the treatments he/she might be getting from home, so she/he will be seeing that I need a drug. And he/she will be always spending time ‘aka sticker’ [being numb from drugs] it will be good for him/her because he/she won't be thinking too much. So, it will be a stress reliever.” I43, FGD in-schoolgirls, 18-21y

“Let's say there is no breadwinner in the family, people get stressed, and the poverty will lead people to use drugs and to steal also. After stealing, they will only think of drugs.” I46, FGD PE, 20-22y

“When you talk about young people who are involved, they are not left out here, the girl child. They are also involved in taking drugs, especially those who are in the vulnerable groups like sex workers and teen mothers. They are also involved in the sense that they really need a way to cope up with the stress. Give an example of a young person who just got impregnated and someone is refusing to take responsibility. And they just thought taking drugs is a way to solve that challenge.” I51, PI CBO, 21-24y

“So that's when she introduced me and said, this is to relief stress, so that you won't think too much, come lets smoke ‘mbanje’ [weed] and drink ‘bronco’ [BronClear].” I54, FGD YPWUD, 22-28y

Family and home environment

- Family situation: not having parents, death of parents, abuse at home, bullying from parents, other children, or teachers

- Living with a stepparent
- Environment at home: father is a drug lord, guardians or parents use drugs
- Self-medication as a solution to family problems

“When I asked her why she is taking drugs, she responded, “It’s better for me to take drugs than to be stressed out all the time because I stay with my stepmother who abuses me, so even if I try to tell my father, he doesn’t believe me saying that I am the one giving my stepmother problems because she is not my real mother and he would say a lot of negative things about me.” That is how she got into drug use.” I18, FGD PLWHIV, 18-24y

“I think because of the environment you will be staying with your father and mother, then they take drugs and things that makes them drunk. Then you will take them because you will imitate what they will be doing, or their behaviour will not be good. You will end up doing that.” I23, IDI in-schoolboy, 16y

“What I used to do, my father is a drug dealer, I would see him drinking cough syrup, and I would imitate him and drink also. I would feel that BronClear and Benylin tastes sweet, and when I go to school, I would not understand what the teacher would be saying. Sometimes, someone would ask me why and how I did not feel anything after being beaten 10 strokes in school, and I would tell the person which drugs to take. So, you can end up forming a group of drug users through influencing each other. Sometimes I would bring some drugs for them, and sometimes we would influence each other to use our pocket money meant to buy food and use it to buy drugs.” I34, FGD teen mums, 15-18y

“One of the students here has a father who sells drugs, the father is a drug lord. So, he steals from his father and brings it to school to influence other students.” I14, IDI in-schoolboy, 18y

“Let’s talk about what abuse means, you are going to school and staying at a house living with two boys and you will be the third one, the stepmother will be the owner of the house, and the stepmother would prepare a bag for her own children with some things needed by a child when going to school, and you might not be given such things. When you get to school, you would also see other children with their stuff. This can cause someone to take drugs because you will be searching for somewhere you can fit, and with people who likes you. I don’t want to lie to you, people who use drugs have one love, they love everyone, even without a source of income.” I48, FGD YPWUD, 20-25y

Social influence and experimentation

- Experimentation
- Peer pressure, friends' influence
- Taking drugs because a friend takes them
- Witnessing others and imitating them
- Social media influence, imitating stars
- Watching videos/films where drug use is portrayed as ‘cool’
- Adopting foreign cultures (e.g., Jamaica, Canada)

“Peer pressure is a contributing factor, and the other thing I have noticed here in Mbare is the so -called role models, its either they are using drugs, or they are selling drugs. I think people are making a lot of money by pushing or selling drugs. They are leaving Mbare, and they are buying cars. They may still be selling drugs here in Mbare, but they have relocated to better suburbs, and they are buying cars, coming back looking flashy and these young people are seeing and admiring them.” I12, IDI HCW

“What also happens in taking drugs is that you can take drugs for someone else. In the sense that you can do something that he likes because you like that person.” I48, FGD YPWUDS, 20-25y

“At school, during form 4 student adapt to such things because he would be exposed to a lot of things. So, when he starts doing drugs in school, the form 3 student will also be watching, and it goes down to form 1 and even grade 7 students are also taking drugs. So, it’s no longer that much of a big deal if you see a grade 5 doing drugs too.” I48, FGD YPWUDS, 20-25y

“Also, music is another contributing factor. Music pushes the intake of drugs. We have people who sing about it. We have people who sing praising crystal meth, we have people that sing praising BronClear. So, at times when you listen to such kind of music, yeah, they influence you into it.” I12, IDI HCW

“As a top fan of Saintfloew [a famous local musician], who is into drug use, I can end up engaging into drug through imitating him. So, these are some of the reasons why young people are being engaged into drug use without knowing the end results.” I22, FGD PE, 20-23y

Recreational, performance and image-related use

- Recreational purposes
- To be cool
- To boost energy (for sex, jobs, or performing)
- To do a good job
- To pass school, gain energy to study, stay awake
- To boost self-esteem or confidence (especially for artists or those involved in sex work)
- To avoid feeling ashamed during sex work
- To have the courage to do or bear sex work
- To be able to face the risks of sex work

“These drugs helped me because I was no longer thinking about the person who dumped me, I was now focusing on my baby that I was carrying. They [drugs] were giving me the ‘ginger’ so that when I was at my work I would focus on the work because I knew I was doing this for my baby.” I1, FGD YPSS, 15-19y

“I once came across a group of young people who take drugs, and they mentioned the issue of loneliness. So, they said there are times when you fail to find someone who motivates you, someone to play with or to share advice with. So, taking drugs will boost confidence, makes you feel high and comfortable to blend with others.” I22, FGD PE, 20-23y

“We just hear others saying, if I take drugs, I feel so much power such that I can go somewhere, and when I get there, I can be given a job to do, and they give me power. Others they say, they gave me energy. For, *dombo* [crystal meth], you will hear others saying, I have been affected by ‘*para*’ [the urge to take more drugs, craving] and you will ask, ah ‘*para*’? And you will ask what is ‘*para*’? I want drugs, I don’t have drugs in my body.” I31, FGD YPWUD, 15-20y

“Drugs are always available at the parties that we attend, *mbanje* [weed] will be available so we take drugs for pleasure and to feel happy. Even in school, we used to take *mbanje* whilst attending school because we were told that smoking ‘*mbanje*’ makes you intelligent.” I20, FGD male youth, 16-19y

“As for me I think it’s because the girls won’t be able to work in a sober state. They take drugs so that they don’t think too much and to get into the mood to work.” I28, FGD YPSS, 18-23y

“Experiment, they would just want to see how it feels [taking drugs], then wanting to be given attention by other school children. Like in the classroom, that situation when you are the one who smokes and you are being known by people if a person says something you will be threatening him/her, and the whole classroom will be saying the ‘boss’.” I43, FGD in-schoolgirls, 18-21y

We would have loved to include many more quotes, as these reflect just a small sample of the reasons participants shared for why young people begin using drugs and substances. Alongside these accounts, we also heard moving reflections from adolescents and young people about the dreams they once held like becoming a teacher, a mechanic, working with trains (though railways no longer function in Zimbabwe), or pursuing careers as architects, musicians, or professional athletes. However, for many, the lack of opportunity and structural barriers made it difficult to realise those aspirations, leaving them with deep frustration and despair.

“I had my own dreams whilst growing up, I don’t know if they have ended or started yet. Because I am still young and there is still time, right? I wanted to become an electrical train engineer, fixing trains in Zimbabwe, we no longer have trains. So, I used to see trains as fascinating. I don’t know if the dream has started or ended.” I48 FGD YPWUD, 20-25y

4.2.3 Different ages, different patterns

When examining drug use patterns, a clear distinction emerges between older, and/or out-of-school youth and the younger generation of school-going adolescents or those who recently finished school. In this context, 'finishing school' refers to completing Form 4, either with or without the final exam. Many of these young people were unable to continue to A-Level due to financial constraints rather than personal choice. Others dropped out of school entirely for the same reason. However, even reaching A-Level does not necessarily protect young people from falling into drug use, particularly when their outlook remains shaped by hopelessness and a lack of future opportunities.

"They just finished 'O' Level [ordinary level], they did well in 'O' Level they can't pursue.... they will be at their homes, you don't have money to do these professional courses, you don't have money to pursue your education. So, what else can they do, they will venture into sex work, they will venture into drug abuse doing all sorts of things because there is no employment in Zimbabwe." I29, IDI CBO, 39y

The term 'older generation' in this context generally refers to individuals above the age of 20. Many within this group are already in an advanced stage of drug and substance use, with crystal meth and *musombodia* being among the most commonly consumed substances. In the case of the homemade alcohol *musombodia*, participants consistently noted that it is primarily older men who drink it. These older men are often referred to as 'jaggers'. Jaggers, typically aged 20 to 30 years and above, are part of the older segment of the adolescent and young adult population. They are often involved in informal labour, such as transporting goods for market vendors using wheelbarrows or manual carts (Fig11). This group is frequently associated with the use of strong illicit substances like *musombodia* and crystal meth, reflecting more entrenched patterns of drug use.

"*Musombo* is there but it's not common within our ages [15-19y]. *Musombo* is mostly taken by '*madhara*' [older men], those who are a bit older. So, mostly we don't meet such people, as for us, we usually meet people who are into drugs because most people who are taking drugs are within our ages, our generation. So *musombo* is drunk by older men especially men who will use manual carts at the vegetable marketplace, and even in the neighbourhood also." I34, FGD teen mums, 15-19

When asked about the presence of *musombo* in school settings, one participant clarified that these substances are not typically consumed by children, stating that "*they are normally used by adults.*" Although the strength of *musombo* was noted, the participant suggested that the lack of interest among teenagers was more about preference than potency.

Regarding crystal meth, the same participant explained that it is not commonly used within schools either, indicating that such substances are more often associated with out-of-school environments or older youth.

Among teenagers and younger adolescents (15-19), a distinct drug use pattern emerges. Depending on whether they are still in school or have already dropped out, subtle differences in usage can be observed. For those still attending school, marijuana appears to be the most commonly used substance, often combined with alcohol and, at times, cough syrup. Participants described how drugs are smuggled into the school environment, often hidden in creative ways, such as inside lunch boxes, sandwiched between slices of bread, or alcohol concealed in water bottles. Others mentioned hiding drugs in their shoes, under school ties or within school uniforms, allowing students to use or distribute substances discreetly during the school day.

"In schools the drugs are there but school children try by all means for the teachers not to find out. Like in class, people could drop '*mbanje*', you could just see that small pack being dropped on the floor, and no one would admit that this is mine. Even '*bronco*', a person can just put it in a juice bottle which is tinted, and you could think, that a person is taking juice, yet he is taking '*bronco*'. ... With this pen you take out the lead and fill it with *mbanje*. When they pass by the gate you just say it's my pen and you get inside the classroom." I43, FGD in-schoolgirls, 18-21y

Another school going adolescent explained how they used BronCleer to boost them during learning and studying time:

“What I used to take its ‘*ngo’ma*’ also known as ‘*bronco*’. As young people, we used to drink it for the sake of studying. I had a friend of mine, so we used to buy dragon [energy drink] and then we put ‘*bronco*’ inside, and we used to study that much, and we even had the potential of going insane because we could even study from 10pm to 6am.” I42, in-schoolboys 19-21

However, in one discussion with a mixed group of schoolboys and girls, participants emphasized that *musombodia* is also consumed by students:

“*Musombo* trends a lot in a boarding school more than in the community. *Musombo* comes to school in juice bottles, and it will be concentrated. The school child will be knowing that he has his bottle drink filled with concentrated *musombo*, he will just take the juice bottle and dilute. After he dilutes it, he can come and offer me to drink and tell me that it is an expensive beer which is more concentrated. Noone would know that it is *musombo*. when the alcohol is finished, we can give the juice bottle to a day scholar so that he can buy more alcohol and bring to school the next day” I50, FGD in-schoolboys and girls, 16-21y

In the school premises, marijuana is smoked in hidden places, that can be under a tree outside the school compound or sometimes in the toilets or in a corner. In a FGD with schoolgirls, participants shared their experiences with classmates who use drugs, noting that such behaviour disrupts daily school life. They also expressed feeling personally affected, highlighting a sense of disturbance and frustration over the loss of learning opportunities:

“They [drug users] are there, from our own class, to the extent that if a teacher gets in the classroom and starts writing on the board, they will start producing disrespecting sounds and say go away, have you checked the time table, or when the teacher is writing on the board they start to make noise, for example today they started playing their radio in the classroom but they were reprimanded. There are about five boys who do drugs, they stay in a corner and if you walk to that corner, you will definitely pick the smell of drugs. ... During our lessons, someone can just shout, madam, can you go now because we are tired, yet you will still want to continue with the lesson. The madam continues writing on the chalk board then they will start to throw things on her. They will take a paper, squeeze it and throw it on her, so the madam will not continue she will just walk away. She will be back only after two weeks. Especially in our class, almost the whole of this term we haven’t learnt anything” I13, FGD in-schoolgirls, 17y

Among younger adolescents (15-19) who are out of school, drug use typically involves marijuana, cough syrup, and alcohol. Marijuana is often the entry point and the substance many begin with. However, over time, and as patterns of use and dependency develop, some young people progress to stronger substances, with a number eventually turning to crystal meth. As mentioned earlier, even though crystal meth is heavily ‘demonised’, it has nonetheless become a very popular drug among adolescents and young people today. One participant recounted how his drug use began during his school years, starting with marijuana and later progressing to cough syrup:

“I use ‘*mbanje*’ and ‘*bronco*’. I started when I was in form 1 and I was 15, by then I was still going to school. So, I just met some people who were interested in getting high and I could always see older people blowing up some smoke and I could say this is good. So, we started taking ‘*mbanje*’ and getting high, and we could link up with others who knew where to buy. Everything was going on well, we could laugh on our own in the classroom. And the girls were saying our boyfriends get high and we love them the way they are because they have ‘*swag*’ [stylish confidence]. Then we started buying ‘*bronco*’ and taking it, because all we wanted was to get high. Then we started sleeping in the classroom and we could not concentrate. So, my parents discovered it and said that we can no longer continue paying school fees for this child. Then I was now addicted, and I loved it, then I started stealing money from my mother to buy those things because I was no longer going to school.” I3, FGD YPWUD, 15-19y

4.2.4 Effects of the different drugs (desired and unwanted)

This section explores how adolescents and young people themselves describe the physical, emotional, and behavioural effects of the substances they use. Participants shared personal experiences of both desired effects, such as feeling energised, calm, or confident and unwanted effects, including drowsiness, hallucinations, social withdrawal and addiction. While some substances like BronClear were said to produce a numbing effect and induce a sense of peace or detachment, others like crystal meth were described as powerful stimulants that heighten energy levels and activity. In one interview participants described how they spend their day and what they take at which time to have the 'effects' from drugs they are aspiring for.

In a FGD with school-going girls, participants reflected on the broader behavioural and societal impacts of drug use among adolescents and young people in their communities. They highlighted how substance use not only affects the individual but also contributes to a visible deterioration of social norms and public safety. The girls spoke about an increase in criminal behaviour, including theft, assault, and even rape, which they linked to the desperation that comes with addiction and the constant need for money to purchase drugs. They explained how young people under the influence often lose self-control and may engage in violent or reckless acts. In their view, the cravings associated with drug use can override ethical or legal boundaries, leading to an environment where community members no longer feel safe, and social trust is undermined. These insights show how adolescents themselves are aware of the wider implications of drug use, not only on health, but on the fabric of society. As one participant put it:

"Number one, we have rape cases, then number two, we have high crime rates, number three, prostitution, number four, people are committing suicide because of this issue of drugs, number five, robbery, you will end up feeling like killing people, robbing them so that you will get money to go and buy drugs." I43 FGD in-schoolgirls, 18-21y

In relation to both the effects of drug use and the reasons for starting, many respondents spoke about the moment they realised they had become addicted. This recognition often came with a strong urge to take the substance again, either because the body began to demand it, or because they wanted to relive the positive sensations they had experienced before, such as relief from stress, emotional numbness, or a temporary escape from reality. For some, addiction was described as a gradual process, while others recalled specific points when they could no longer go without the drug.

"For me my life started going down when I started to use drugs. You will realise that the money that I have used if I had started a small business I would be on another level. But it is also difficult to stop, because you will be craving for that happy mood. Sometimes, going to church helps us, because its not advisable to go to church when you are high, God will punish you. So, we wish everyday was a church day so that we will stop this." I3, FGD YPWUD, 15-19y

"When I take drugs, I feel good but when I am not high, I feel like I am sick, headache, nose bleeding..., so I am used to drugs because if I take them, I will be fit." I3, FGD YPWUD, 15-19y

"Sometimes you will realize that this type of confusion "I'm not high but ummh I am being more confused when I am sober" so it's better for me to be high than being sober. There is this level of addiction, when you start taking them, you will be like, when you are done eating and bathing you will want to go and look for them [drugs], when you are that high you will be happy and as you feel a bit low you will need to take them and feel high again." I5, FGD YPWUD, 15-19y

The same group of participants also expressed a conscious decision not to move on to stronger drugs, as they had observed the negative effects, addiction and mental health consequences in others:

"What I was experiencing with marijuana is the only experience that I want. There are other strong stuff drugs that are there, but we don't want to be involved with those ones because we have realized that when we started taking weed, we have done wrong already so continuing with other stronger drugs is not good, so we continue quitting. And I think when taking those stronger ones, those who take it, what they will be doing after is not good." I5, FGD YPWUD, 18-19y

Marijuana

In relation to marijuana, participants often emphasised its widespread use and ease of access, describing it as the entry point for many young people, particularly those still in school. While its use was often portrayed as recreational and peer influence, many respondents also spoke about the physical and psychological effects, including hallucinations and episodes of confusion or altered cognition. These accounts suggest that despite its relative social acceptability compared to other substances, marijuana use can still lead to notable psychological and emotional effects for adolescents and young people.

One interviewee described the different phases a person can go through when using drugs, noting that individuals often move from one substance to another over time. He explained that the person becomes 'stable' when the effect of the drug on the body kicks in, meaning that they are no longer experimenting but are in a stable phase of 'being high'. Referring to the fact that people often move from one substance to another over time, he described this progression as part of a broader pattern where initial use, often starting with marijuana, gradually leads to the use of stronger or more addictive substances such as cough syrup or crystal meth, depending on availability, tolerance and social influence as well as personal circumstances:

'Mbanje' and 'skank' makes you go crazy immediately, to an extent that you can go crazy whilst hallucinating, hearing like there are some people talking. It is more dangerous than crystal meth. Crystal meth can help me to gain focus depending on what I want to do. So, these drugs go stage by stage, for instance you can say "I no longer get high from 'mbanje', so let me go to another stage of cough syrup, maybe I can get high from using it". It depends on how you handle yourself also. The drugs themselves make you go through these different stages; they put you through the first stage, pulls you out and put you into another stage until you become 'stable' [not being experimental]. So, when you start using crystal meth, you go wild then you will go back to being stable when the drug first enters your system, that is why it's called 'hard trip drug'." I36, IDI PE, 24y

Marijuana has been described as having both negative and positive effects. Some participants mentioned that it can cause anxiety, loss of appetite and reduced interest in relationships, especially with women. At the same time, others emphasised its stress-relieving properties, saying that it can boost self-confidence and provide a sense of energy or focus, whether for schoolwork or, as in the case of some young women involved in sex work, as a means of coping with the demands of their environment:

*"When we are conducting our work, sometimes we take six or eight girls, and they will provide their 'quotation' [list of demands] specifying what they need to be able to perform on the stage. Some can say they need four or five black label bottles [beer in 750ml brown glass bottles], and some will request for 'mbanje' [marijuana] and 'bronco' [cough syrup]. ... I understand that they don't prefer to perform in a sober state, they prefer to be a bit intoxicated. This is how they boost their self-confidence. ... Most of them would give an excuse of not coming to work because they failed to find *mbanje*, they don't work when they are not intoxicated."* I28, FGD KP, 18-37y²³

"Sometimes people take drugs [marijuana] to boost their confidence in what they will be doing. For instance, in a classroom, there are some students who are shy to go to the board, or even if they are asked by the teacher to stand up and say the answer, they might feel shy to answer. So, that's when they now take drugs which will give them confidence." I50, FGD in-schoolgirls and boys, 16-21y

*"On the first day I started using drugs, I was at home resting with a friend of my brother. He asked me why I was stressed and then offered if I wanted to take two puffs of *mbanje* to relieve the stress. So, smoking *mbanje* made me feel so high and distracted that I forgot about the problems that were*

²³ The person who was 37 is a male, working with female sex workers who would be engaged at their events to attract male guests and clients.

causing me concern. From that point on, I became accustomed to the idea that I would simply take *mbanje* anytime I felt stressed.” I6, IDI PE, 23y

When it came to the negative effects participants mentioned:

“People suffer anxiety with marijuana, and some they suffer also illusions with marijuana.” I19, FGD PLWHIV, 20-25y

“If one takes *mbanje* they will lose appetite with food, you will be focusing on what is happening that moment, and if you are at work, you will work a lot, but if you stop taking ‘*mbanje*’, you will feel pain. That’s how people get addicted.” I42, FGD in-schoolboys, 19-21y

“If you use *mbanje* for a longtime you end up losing feelings for women. You will not be interested in women.” I20, FGD male youth, 16-19y

Musombodia

Regarding *musombodia*, participants described seeing individuals who consume it lying on the streets, having lost significant weight, showing signs of mental instability, and experiencing hallucinations. Many emphasized that this illicit alcohol not only destroys the body but also has a profound and damaging effect on the mind.

“If you take *musombo* for long, your lips will turn red, and you will lose weight. It won’t be understandable. It destroys the body.” I20, FGD male youth, 16-19y

“It makes one behave in a strange way, let’s say one might get drunk because they have an argument or a fight with someone, or you owe me some money and I can’t confront you in a sober state, I will go and drink even 5 bottles and come to you whilst I am very drunk. ... You might not even get to the place where someone owes you your money because you will be falling because of alcohol influence. It makes one very drunk even if you drink it undiluted, you can start behaving strangely. Just 1 bottle, and you won’t even get to where you will be going. That type of alcohol can make you feel like you want to beat someone, but you might just fall as you get to the person you want to fight. You will be powerless.” I50, FGD in-schoolboys and girls, 16-21y

In a FGD with three young men aged between 15 and 19, each using a nickname inspired by a colour, they discussed various drugs and the effects they had observed, both personally and among their peers:

“Green: You can just start to hallucinate, maybe three days hallucinating without saying anything meaningful.

Blue: For example, *ganja* cake, you can go for three days sleeping, and you will be high.

Red: Even *dombo*, you can have maybe three days sleeping.

Blue: That is when you will hear that a person has died, because three days ... the person is not waking up, that *ganja* is very dangerous, it’s not good.

Red: Even *dombo*, you can take *dombo* during the afternoon, you won’t sleep, you will spend the whole night walking. When you sleep that is when you will sleep for three days.

Green: Even *musombo* your mouth will get damaged, if you take *musombo*.

Red: If you start to take *dombo* you start to lose weight to the extent that you can be left with your head only. With ‘*dombo*’ you can kill yourself.” I41, FGD YPWUD, 15-19y

Pills

Participants described the effects of pills such as Diazepam, which are sometimes crushed, mixed with water, and injected directly into the bloodstream. One participant explained the impact using the imagery of a robot, highlighting the extreme numbness and lack of movement experienced after taking the drug. Others described this state as ‘*kustika*’, a local term referring to a feeling of being completely numb, detached, or unresponsive. As one young person put it, “*Kustika is like blocking all the noises around you and blocking what you don’t want to think about.*” This reflects the emotional and psychological escape that many users seek, shutting out pain, stress, and intrusive thoughts.

“They [diazepam pills] are given to mental patients, yes, they usually use those types of pills. Usually, they crush it and add it into water, dissolve it until the water turns blue. Then they take the water and inject themselves. You get high, and you will be feeling like a robot. ... People will be seeing you like a robot. Internally, you will be feeling good.” I48, FGD YPWUD, 20-25

Crystal meth

Crystal meth was frequently mentioned during the interviews, standing out as one of the most impactful and concerning substances discussed by adolescents and young people. Its effects were described as both physically stimulating and mentally destabilising. Crystal meth usually goes with alcohol as emphasized by many participants leading to a reinforcing cycle of dependence and risk of harm. One participant highlighted how the use of crystal meth and alcohol are often intertwined, explaining that once someone begins using one, the other tends to follow:

“I started taking alcohol when I was taking *dombo* [crystal meth]. Because it goes hand in hand, if you take *dombo*, you now want alcohol, if you take alcohol, you now want *dombo*.” I52, PI YPWUD, 23-24y

“So, ‘*mutoriro*’ [crystal meth], when a person takes crystal meth, the effects, they start experiencing is illusions. It’s like someone is following them and they are just vindictive for no reason. They will think like they have power to fight but they don’t have power to fight. Also, some of the effects, they are not interested in girls all they want is that crystal meth, its very addictive.” I19, PLWHIV, 20-25y

Some participants highlighted its energising and empowering properties, saying it helped them stay awake, feel strong, or boost their confidence, particularly in sexual performance. Others stated they used it only occasionally or recreationally, such as during weekends or before specific events, suggesting a perceived sense of control over their usage. This perception was particularly striking, given that crystal meth is globally recognised as a highly addictive and harmful drug, with long-term use leading to severe mental health issues, including paranoia, aggression, and psychosis. The contradiction between its known risks and how some participants downplayed their own use points to a potential lack of awareness about its addictive nature or a form of denial or rationalisation that often accompanies early stages of dependency:

“I don’t use it every day, I don’t use it all the time. It’s not a drug that you have to use every day, but I think you just use it once in a week or twice per week, because if you use it every day, you will start losing weight and sometimes having a headache, and sometimes in the night you will start seeing things that do not exist.” I11, FGD KP, 19-21y

“For *dombo* [crystal meth], it is obvious that it gives power, energy. For *bronco* it is obvious that one will be sleepy after taking it, he will have no energy. So, *dombo* users can smoke till sunrise, they can spend the whole night taking it.” I42, FGD in-schoolboys, 19-21y

In a FGD with young people who use drugs, participants spoke about the damaging effects of crystal meth on the skin, noting that users often spend many hours confined in a room or ‘base’ smoking. This prolonged exposure combined with dehydration and lack of sleep was said to lead to skin deterioration:

“*Dombo* produces smoke, so if that smoke is blown to you, it damages people’s skins. The smoke is supposed to be blown away by wind, they will be in an enclosed base. So, the smoke stays in there, no windows are opened because of the fear of being arrested. So, people will be surviving in the smoke, and a person can spend three days without going out, he will be inside there. So, imagine when he goes out on the 7th day coming from a single room without a toilet.” I48, FGD YPWUD, 20-25y

Participants repeatedly described the link between drug use and an increase in theft and petty crime, particularly among users of crystal meth, marijuana or BronClever. They emphasised how quickly addiction can develop, often after just one or two experiences, and how this addiction drives young people to desperate acts to fund their next high. One participant vividly presented this pattern:

“Those people, if someone tastes *dombo* for the first time, he might get addicted when he takes it for the second time and he might start stealing money at home, stealing clothes on clothesline, shoes or

steal anything that they can find. So, they will sell the stolen items and buy *dombo* and get high from smoking it. ... Most of the people who use these drugs are thieves. So, drugs influence a person to steal and to break windows and selling all the household property, even if in his mothers' house, they just grab whatever they see. They pick things when the mother is not around and sell and they also start going crazy, and their lives will be destroyed from there." I40, IDI YPWUD, 15y

Some participants described their relationship with crystal meth as one that gradually led to a state of 'slavery'. Initially, the drug was often offered for free, particularly by a local Jazzman or dealer, making it easily accessible to curious or vulnerable youth. But once dependency set in, the dynamic would shift dramatically. Participants explained that after becoming addicted, they found themselves in a position of helplessness and dependency, no longer using the drug by choice, but out of urgent physical and psychological need. In this state, they felt they were at the mercy of the person supplying the drug, having to find ways, like exchanging sex, to secure their next dose. This account where this tactic was called '*rugu style*', highlights the exploitative dynamics that can emerge in drug-using networks, particularly when young people lack economic means or family support, especially the teen mums the quote is referring to. The initial 'gift' of drugs becomes a trap, drawing users into cycles of control, manipulation, and powerlessness:

"Effects of crystal meth include giving the suppliers of crystal meth an 'advantage' of being able to control you and doing as they please with you. ... Those 'leaders' [drug lords], do as they please with us until we realise that this is wrong, then we will decide to be 'normal' again [refraining from using that drug] and choose not to play with such people. ... It's like '*rugu*' [rogue], they call it '*rugu style*'. You know what thieves do, they train you to use drugs by offering you for free and when they realise that you are addicted and not able to afford, they stop giving you. So you end up depending on them as seeing them as your only friends. That is how you start working for them, you become their slave. That's the slavery I mentioned because you can get married [symbolically to the drug lord], made to do all the house chores and have sex with you, make you do hustles without even caring for you. For women, this suits 'M1' [mother of one child] better. 'M1' mothers have mastered this game. Every 'M1' who takes '*dombo*' does sexual intercourses with different people, especially the younger ones, the teen mums." I36, IDI PE, 24y

Cough syrup numbing the body and mind

Cough syrups containing codeine, an opioid, such as BronCleer, Benylin, Salterpyn or Histalix, are frequently consumed by adolescents and young people because of their sedative and numbing effects. These syrups, originally intended to treat respiratory illnesses, are consumed in large quantities to induce a state of emotional disconnection, physical heaviness and detachment from one's surroundings. Users often describe the experience as one in which thoughts are blanked out, emotional pain is muted and one no longer reacts to external stimuli known locally as '*kustika*'. A condition where an individual appears to be in a state of stupor (deep unresponsiveness) with paralysis or weakness of voluntary muscles. This can manifest as locked-in syndrome, where the person is conscious but unable to move or communicate verbally except for eye movements.

"BronCleer makes you numb, less interactive with people, BronCleer makes me antisocial." I31, FGD YPWUD, 15-20y

"People overdose those things, and they end up '*vango sticker*' [being numb] and not doing anything." I19, FGD PLWHIV, 20-25y

"I take *bronco* [BronCleer] and when I take BronCleer I will be just seated and I will be silent, others will be talking and making noise, but I will be silent. I don't want to get cross with people, I don't want to fight. ... When I am in that mood of not wanting to talk to anyone, I take BronCleer. When I am in that happy mood and wanting to laugh, that's when I take beer." I3, FGD YPWUD, 15-19y

In a focus group discussion with seven young women involved in sex work, they shared a range of motivations for using BronCleer. For many, the syrup provides a way to emotionally disconnect, avoid overthinking, reduce anxiety, or simply mute their reactions to overwhelming situations. It serves as a tool to avoid conflict, violence, or fear, especially when facing intimidating or disrespectful clients.

Others described its role in boosting energy and confidence, to get the 'ginger', allowing them to perform their work or retaliate if treated unfairly. These testimonies reflect how BronClever is used not just as a drug, but as a coping mechanism and form of psychological armour in their harsh everyday reality.

"You just feel lazy to talk, avoiding to talk or think too much. You won't like noise. ... Or to avoid violence with people, and avoiding noise, so when you hear people making noise you then isolate yourself. ... It will allow you to do the work with more power, so we use drugs so that we will have the zeal to do our work, you will feel more power. ... Plus sometimes the people we meet won't be fit for us so when you are under the influence of drugs you will not be in a state to think that I cannot have sex with this disgusting person. ... We use BronClever because we do not want to be traumatised, men like giant men come to us so I wouldn't want to be afraid, that is my reason. ... Other reasons why we are using drugs, most of them [clients] are taking advantage of us for example he can underestimate my body, after sleeping with me he might not want to give me the money, so if I take the drugs together with my friend, we will be ready for retaliation. We gang up against him and start to beat him using pots, so BronClever gives us more power and energy." I1, FGD YPSS, 15-19y

A frequently mentioned physical side effect of taking BronClever was 'dry mouth', also referred to 'airlock', a feeling often experienced by users due to the syrup's ingredients and its sedative effect on the body. To counteract this side effect, many feel the urge to drink alcohol:

"We take alcohol whilst smoking. Sometimes we take black label beer and pour it into Salterpyn [cough syrup], or sometimes when we smoke *skunk* [a mixture of weed and cigarettes crushed together], we take alcohol also. That is how I quench my 'dry mouth'. I2, FGD YPSS, 20-23y

"If you are a drug user, you will be eating a lot, sometimes you can fail to get something to eat whilst you are intoxicated, this will affect your throat, you will experience 'airlock' [dry mouth], people who uses 'bronco', they can end up spitting out sputum with blood." I34, FGD teen mums, 15-19y

"People who are into drugs always talk about 'airlock' where they will experience sore throat, loss of voice, and feeling dizzy when they have not smoked weed. Dizziness is the most common sign of addiction to weed." I6, IDI PE, 23y

4.2.5 Perception of young people using drugs and substances

Understanding how drug and substance use is viewed by others offers important insight into the social dynamics and stigma surrounding young users. In the interviews, participants shared how family members react to relatives using drugs, how users themselves perceive their own condition, how communities and neighbours label or treat those who use, and how students view their peers, especially girls, who take drugs. Parents' reflections on their children's drug use also shed light on the emotional and moral tensions within households.

"They [my brother and uncle] know [that I am taking drugs]. They refer to us as idiots because we take drugs. They say we are mentally ill. But we are not mad. If we were mentally ill, we would have been beating them." I52, PI YPWUD, 24-25y

"You can perceive a person [who use drugs] as one suffering mentally because of the state he might be in. People who are religious might think that the person has been bewitched because a person might walk in the street without clothes." ... Most of them when they take drugs, they can cause domestic violence, or most of them can rape even their mothers. ... Those who take drugs at my hood, their family is a family of drug gangsters, so they go to gangster corners and sell drugs. ... Some, they shout at their mothers and are involved in domestic violence. ... People who take drugs will end up stealing, cell phones, television and money in the house and then go and buy drugs." I8, FGD in-schoolgirls, 15-16y

"After using drugs, some people will end up arguing, insulting, and using vulgar language with those they should respect, which ruins relationships with neighbors. Therefore, maintaining positive relationships with your neighbors will be challenging." I20, FGD male youth, 16-19y

“Most people who are using *dombo* [crystal meth] are thieves because they are walking during the night when people are sleeping. Also, people who are smoking *dombo*, they are people whom I can say, they don’t have anything to do, so they end up taking anything from the house and sell so that they can buy *dombo*. They will start looking for money after they get high from *dombo*. They smoke *dombo* to gain the guts to even break down people’s doors.” I42, FGD school boys, 19-21

“White: The picture of people [who take drugs] that I will have is of people ‘*vanenge vaka sticker*’ [who will be numb] like what we once said, they will be just sleeping in the road, they won’t have any energy, talking nonsense, sometimes he might not even have the energy to talk.

Blue: Yeah on crystal meth, you are seen as a mad man.

Black: Sometimes the community view them as thieves. They don’t want to be associated; they don’t want their kids to be associated with those types of people. They are seen like people with no future, people who were not good in school, but some of these people are geniuses. If you take their certificates, you will see that this guy is a genius, you understand, but the community will view them as people with no future who deserve to be locked in jails.” I19 FGD PLHIV, 20-25y

“If you are a girl taking drugs, I can say, it’s a sign that you are now a ‘*hure*’ [sex worker]. You won’t hesitate to have sex with anyone.” I50, FGD in-schoolboys and girls, 16-21y

“They [parents] are heartbroken because they do not like it, they end up accepting it. ... Sometimes the other parent uses drugs and if he sees you doing drugs at an earlier age, he will be heartbroken, no parent wants to see his child taking drugs” I48, FGD YPWUDS, 21-25y

“Those who take *dombo*, let’s say it’s during the night they might be carrying a knife. They are always carrying dangerous weapons. Then if they are into smoking things like *mbanje*, they are always confused, and whenever you try to engage them into a conversation, you won’t understand each other. If you say something, they respond with something else off the topic. *Dombo* users always think about hurting others. In our neighbourhood, we don’t walk past midday because of him. He will be moving around carrying a very big knife which can be twisted.” I18, FGD PLWHIV, 18-24y

4.3 Transactional sex as a means of survival

In this section, we use ‘transactional sex as a means of survival’ to describe situations where young women engage in sex primarily to meet their basic needs within limited alternatives and under economic and social pressure. Transactional sex refers to sexual relationships in which sex is exchanged for money and/or material benefits. Within the scope of this report, it is defined as non-marital, non-commercial sexual relationships that are motivated by the implicit expectation that sex will be exchanged for financial or other forms of material support.

The meaning and motivations for transactional sex vary from one individual to another. For many, the exchange is driven by the need to fulfil basic needs such as food, care for their children, shelter or access to drugs.

“... here, in this area [Mbare], sex work goes hand in hand with drugs, in most cases. Because in the community, people tend to frown upon that [sex work], taking drugs is a way of removing shame.” I43, FGD in-schoolgirls, 18-21y

In some cases, young people turn to transactional sex as a survival strategy when they have no family support or stable living conditions. The following quote illustrates this: an 18-year-old girl recounts how the death of her parents and the rejection by extended family left her with no choice but to fend for herself. This situation not only led her to start using drugs and engage in selling sex, but also forced her to drop out of school at a young age:

“When I started this work [selling sex], I was young [14 years], so when my parents died, my relatives rejected me, saying we have big families too; so I then saw that this is the easiest way for me to get money through this work; that is when I stopped going to school.” I1, FGD YPSS, 15-19y

This example is representative of so many other situations in which young people are trying to find their own way.

Layers of survival: class and context in sex work

In an interview with a healthcare worker from an organisation supporting key populations, it was highlighted that sex work is not limited to young people from disadvantaged areas in Harare. Even young women who have completed their education and cannot find work may turn to sex work as a means of survival. These girls work in so-called Massage Parlours in Harare's city centre where they often stay from Monday to Saturday and only return home on Sundays. While some of these establishments offer legitimate massage services, others operate as fronts for sex work, and the term Massage Parlour has increasingly become a euphemism for a brothel.

This phenomenon highlights the broader impact of Zimbabwe's precarious economic situation, which affects even well-educated young women. Many of them live and work in these Massage Parlours, while telling their families they are employed as nurse aides or caregivers for sick patients.

“We have different types of sex workers, they classify themselves into high and low... there are those who do sex work at a low minimum cost and those that target the big guys in town, the ministers and the businessmen. They have a house [Massage Parlour] where they are accommodated and these big guys they go there. They dress in a sexy way and model, and a client will choose the type of girl he wants, and whether he wants one or two.” I29, IDI HCW

This illustrates the stark contrast between different tiers of sex work in Harare. At Massage Parlours, considered to be ‘high class’, clients pay significantly higher prices, with rates for short-time services starting at USD 20 with protection and rising to USD 50 without protection, USD 100-200 for an experienced sex worker and full night service and as much as USD 400 for specific acts like first-time sex, oral and anal sex.

In more disadvantaged areas, the different ‘classes’ or levels within the sex work landscape take on very distinct and contrasting forms. Girls and young women in places such as Mbare and Epworth are often engaged in what is commonly referred to as ‘lower class sex work’. This work is usually informal, takes place in public or semi-public spaces such as bushes, cars or cheap accommodation, e.g. a group of young women rents a flat or a ‘space’ in a room together (Fig 17+18) and is characterised by extremely low prices. For example, one space in the room in Fig 18 costs USD 5\$ a day. The economic hardship and lack of opportunities in these densely populated suburbs contribute to the vulnerability of those involved, who accept any form of transaction in order to survive.

“And then we have the low-class sex worker, those from Mbare, Epworth, Hopely. They just do this business anywhere even in the bush, in the car or wherever they are. They can do it in these cheap lodgings where they can charge USD 3, even USD 1 for a short time, so that is for these guys from the high-density suburbs.” I29, IDI HCW



Fig 17: Rented and shared flat in Matapi flats

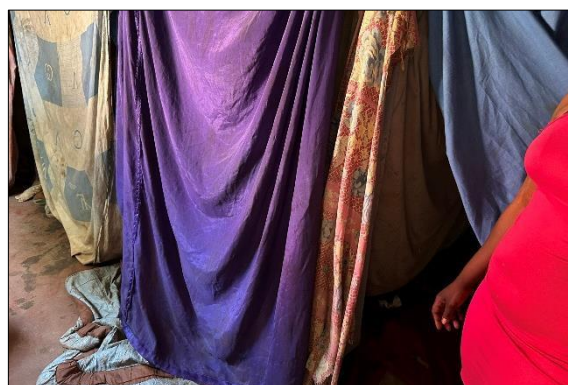


Fig 18: Four spaces separated with curtains in a room

4.3.1 Causes and drivers of transactional sex work

Influenced by peers but driven by need

In the interviews, many female respondents shared that they began engaging in transactional sex during their teenage years, often influenced by peers who appeared to earn quick money through this practice. Curiosity and peer encouragement led some to try it themselves, usually accompanied by a friend. While most girls and young women in Mbare engage in sex work within their immediate surroundings, both in and around the Matapi flats or at Joburg Lines, a known area within the Mbare community, those in Epworth are either found at local 'touchlines' across different quarters of the area, while others travel to clubs in the central business district (CBD) in search of clients who are more likely to pay well. These young girls who go to the clubs stated that they prefer older men between 30 and 40 years of age, as they perceive them to be more respectful and willing to pay.

"Clients are mostly around 40 years, because we fear to go with the younger ones due to stories that we hear from our friends being abused by clients. Elderly men are better than young ones, in terms of security issues." I2, FGD YPSS, 20-23y

In contrast, younger men were often associated with abuse or non-payment. As previously mentioned in chapter 4.2.4 on drug effects, several young women explained how drug use gave them the courage to confront or retaliate against clients who refused to pay, often acting together with friends.

The following participants' stories and quotes show different but often interlinked paths to transactional sex. Many began in their teens, influenced by peers, financial hardship, family breakdown or the need to support their children. What begins as a response to immediate needs or peer influence often becomes a means of survival and, in some cases, a long-term coping strategy. The following quotes illustrate this personal trajectory and the circumstances that shaped it:

"I started when I was 18 years old [now 19]. I failed to financially support my child. I had no source of income. I started to go to beerhalls selling sex as my friend was also in the same business. I admired how my friend would make money out of selling sex and perceived that she was living a better life, so I joined." I4, FGD YPSS, 15-19y

"I was 15 years old [now 18] when I was staying with my mother and siblings. With my friends, we discussed how we could manage and improve our lives, then later we encouraged each other to start selling sex. This was caused by the issue of dropping out of school." I4, FGD YPSS, 15-19y

"I would see others and go wherever they were going, since I had nothing to do and lacked money and by then I was 17 years old [now 21]. Then I was just seeing others going there [touchline], and this other day I just said let me go there and I started doing it too." I7, FGD YPSS, 20-21y

"I began[at the age of 15 years now 21] because I would see people doing it and it was fascinating, like I saw one person and she said if you go to nightclubs you will find something, so we went to nightclubs and we would find older men who would say, I will have you for today and I will give you a few dollars. I ended up finding it interesting and I was enjoying it even up to now. So, we exchange areas where we can go, like where there are gigs and where there is more money we go. With these people I was not friends, I was just asking for ideas on how to raise money then they said, why are you so dull girl right now money is so easy to find, then they took me and taught me to wear revealing clothes so that I can find some clients and then they taught me to do some seducing actions and even pretending to be drunk even when you are not, so that you can get some clients." I7, FGD YPSS, 20-21y

Prices and charges for sex – time and services

As already mentioned, prices for transactional sex vary considerably depending on the context: who is offering the service, the location, the time and the client's ability to pay. Teenagers and young women who are new to sex work often charge less, especially in the early stages when feelings of shame, hesitation and lack of trust are still strong.

Many in this group report that they use drugs or substances to cope with the nature of the work, especially when dealing with clients who are perceived as difficult, such as drunk, smelly or unkempt men. At this initial stage, they often lack the negotiating skills to set prices or insist on the use of condoms, making them more vulnerable to exploitation and health risks.

In Mbare, particularly around the Matapi flats, young women reported charging:

- USD 2–3 for short-time sex for the age range of 15-19 years
- USD 5-10 for short time sex for the age range of 20-24 years or more experienced ones
- USD 7–10 for a full night for the younger ones
- USD 15-20 for a full night for the older or more experienced ones
- USD 1-3 for lodge accommodation (if required).²⁴

Some participants who use drugs and have children to care for explained that their daily financial needs could reach as much as USD 25–30:

“I need USD 25. That is what I want but I might not get that, yes for food and other stuff, USD 25 is what I need.” I1, FGD YPSS, 15-19y

Additional services such as oral or anal sex were said to range from USD 30–40. In some interviews, prices were reported to go as low as USD 0.50, especially for girls newly arriving in a community or not yet established in the sex work networks:

“These girls sell them out at a price of USD 0.50.” I2, FGD YPSS, 20-23y

“Sometimes the money that they are charging per night, is also not reasonable. Because they are young, they are vulnerable, so, I can just say “I can give you USD 0.50” which is worth nothing, it cannot buy bread, it cannot buy anything, but because you are desperate, or because you are chased away from home. Some of them even go to the ‘touchlines’ when they are pregnant.” I21, GD CBO

Price fluctuations were often related to time of night and perceived wealth of the client:

“Personally, I have fixed rates that I charge. If you come to me around 07:00pm I will charge you USD 25, but at midnight or 01:00am, I will charge USD 10 or 15 because it won’t be busy anymore.” I7, FGD YPSS, 20-21y

“For short time it depends on the place; when I go to better places, I charge USD 5 then at other places I just charge USD 4 or 3.” I7, FGD YPSS, 20-21y

“When I go to a club or bar, I charge from USD 5 or any amount which is affordable to the client for a short time. For the night, I judge from his looks; if he looks rich, I charge more, from USD 15 per night or 10. From 09:00pm to 05:00am, I will charge USD 20.” I7, FGD YPSS, 20- 21y

In Epworth, respondents reported relatively fixed pricing systems:

“Short time costs USD 3.00, and for a night service it starts from USD 15 upwards. We don’t accept sex without condoms, even at a higher price.” I4, FGD YPSS, 15-19y

“Short time I charge USD 5, and for night service USD 20 and above.” I4, FGD YPSS, 15-19y

“At first I was still new to the business [12 years old], and not fully aware of the standard prices, so I would be given USD 10 per night. But now [16 years old], I am fully aware and charge USD 15 per night. For short time I charge USD 5 or 4.” I4, FGD YPSS, 15-19y

Notably, this same respondent explained how she balances sex work with attending school, using her earnings to pay school fees:

“I attend school first then later go for sex work which starts at night. Normally, I go for sex work on Wednesdays till Sunday after coming from school.” I4, FGD YPSS, 15-19y

According to this participant, a school term costs USD 95, and she pays in instalments. To put this into perspective, two morning-after pills cost USD 5, highlighting the economic challenges and reproductive health costs that young girls face.

²⁴ The prices were gathered through interviews and are based on participants’ accounts; we do not claim they are absolute.

Across both locations, adolescent girls newer to the practice tend to charge less and lack power in negotiation, while older or more experienced individuals adjust prices more strategically. Pricing is influenced not only by duration and service type but also by the client's perceived income and the sex worker's level of agency, confidence or familiarity with the work.

Paying for drugs

The intersection of drug and substance use and transactional or exploitative sexual encounters was a recurring theme in several discussions. One participant explained how the drug itself diminished his sexual desire while under its influence but nonetheless engaged in sexual activity when sober. He described how, in the absence of a girlfriend, he and others would go to areas known for sex work, such as Joburg Lines, where interactions could range in cost from USD 1 to 5 or sometimes occur for free. When asked how sex could be obtained without payment, he responded:

“If I give her that crystal meth, and I gave her that USD 2, I can go for the whole day, whole night. We exchange, if you don't have money, you can just give her a drug.” I52, PIYPWUD, 23-24y

This exchange illustrates the transactional nature of sex involving crystal meth, where the drug itself becomes a form of currency. It also reflects the power dynamics and blurred lines between consent, coercion, and survival, particularly in environments shaped by poverty, addiction, and limited options. The quote sheds light on how drug dependency and economic vulnerability fuel exploitative exchanges, often reinforcing cycles of risk and harm for both parties involved.

Young women involved in sex work said that they need up to 30 USD per day to maintain their cough syrup consumption. One participant explained that she only uses Benylin, which she considers more tolerable than other brands. At prices between USD 8 and 10 per bottle, she takes one bottle in the morning, one in the afternoon and one in the evening. To afford this, she sets aside money from her earnings from sex work and explains that Benylin is a non-negotiable priority in her daily routine. Sometimes, she added, clients buy the syrup for her, and they take it together before having sex.

“I take three bottles a day. I only take Benylin, others [cough syrup] don't go well with me. I take one in the morning, one in the afternoon, and another one in the evening. I use the money that I earn from sex work. I prioritize Benylin, I cannot do without it, so I set aside a budget specifically for Benylin. Sometimes clients buy it for me, and we drink it together before sex.” I2, FGD YPSS, 20-23y

Quick money and support: boyfriends and sugar daddies as a means to meet basic needs

In situations where daily survival is uncertain, many adolescent girls and young women seek relationships that offer them material support in exchange for companionship or sexual favours. While these interactions are by definition transactional, in the local context they are often referred to as having a 'boyfriends', a term that has a different meaning than in many Western settings. As participants described, a boyfriend can mean having someone to provide them with money for basic items such as menstrual pads, new hairstyles or clothing, needs that cannot be met in any other way due to economic hardship.

The following quote illustrates how these pressures and perceptions shape young women's choices and justifications.

“You see when you are a girl, you might be very broke, yet you are on your menses and you don't have any pad, what will you do, there is no way you will walk wearing a cloth, what if it falls? ... They will tell you, you have been plaited this *magodi*²⁵, have a boyfriend so that he will give you money for new hairstyles.” I33, FGD teen mums, 14-19y

²⁵ *Magodi* in Shona refers to a traditional African hairstyle, made by twisting or braiding natural hair into small, tight curls or coils or with synthetic fibres like wool. It is a simple and often inexpensive style, worn by young girls and associated with rural or lower-income settings in Zimbabwe.

Importantly, these relationships are not always based on emotional attachment or mutual care, but rather on necessity and expectation. Culturally, however, they are still referred to as relationships, and the line between a 'boyfriend' and a transactional partner is often blurred. In some cases, a pregnant girl's family may refer to the one who impregnated her as her 'husband' and expect her to move in with him, not because a formal relationship has been established, but to avoid the shame and stigma of an unmarried teenage pregnancy. This dynamic has also been reflected by the Zimbabwean writer Petina Gappah, in *The Book of Memory*, highlighting how deeply such social expectations are embedded: "*Her maths teacher raped her when she was thirteen. Her teacher paid a fine for the crime. When she was sixteen, her family forced Sinfree to marry her rapist so that she did not have the shame of the rape following her all life*" (Gappah, 2021).

In contrast, sugar daddies were less often referred to as 'boyfriends' but rather described for what they are – older, wealthier men who often have cars, money, and are already married with families. These men are primarily interested in having sexual relations with young girls, not in forming romantic relationships. However, during a FGD with school-going girls aged 17, participants unanimously agreed that if one of them had a sugar daddy, she would be seen as superior. Having a sugar daddy was perceived as a symbol of prestige and elevated social status among peers.

"Girls love and get attracted by rich people. So, most of the sugar daddies have cars and they are very rich. So that is why girls are engaging with sugar daddies. For money, maybe to buy clothes, to have a new hair style, phones, like iPhone and also, for prestige reasons. ... Let's say the three of us here are into sugar daddies, and your sugar daddy is richer than ours, you will be superior to us." I24, FGD in-schoolgirls, 17y

Some young women shared how relationships with those 'sugar daddies' begin in everyday public spaces, particularly in the streets. These men might approach them directly, offering money not food or drinks, which the girls decline due to safety concerns. Sugar daddies provide money, and the girl is expected to provide sex, a clear transaction, understood and accepted by both parties. However, the sugar daddy would typically begin by slowly seducing the girl, being nice, generous, and attentive. What starts as a seemingly caring or supportive relationship gradually transforms. Initially, the man may not ask for anything in return, but over time, once trust has been established or money has been spent, he begins to demand sex.

"He won't start by asking for sex, he will first provide for all your desires, then later in the middle of the relationship, he will start to ask for sex. When you have spent his money, then he will later ask for what he wants. He doesn't start by treating you roughly, he will start as a nice person, listening to all your concerns then later they will change." I16, PI teen mums, 17y

A young boy from the KP community described how being in a relationship with a teacher made him feel like he was 'glowing', not only emotionally, but also through improved appearance and lifestyle, marked by financial support, better clothing, and small acts of care like being brought fruit to his hostel:

"I started glowing when I was in school, and even my dressing at school changed, it was different from the previous. Also, this teacher used to give me money. Sometimes I would make demands soon after sex saying, "I want this and that" and he would provide everything I request for. Even fruits, he used to buy me fruits and bring them to the hostels." I30, IDI KP, 22y

4.3.2 Navigating harm and vulnerability in survival sex

Young women engaging in survival or transactional sex face numerous layers of harm and vulnerability, both immediate and long-term. Many participants described being drawn into sex work due to poverty, lack of family support, or the loss of parents, with some starting during their teenage years. Unprotected sex was identified as a key vulnerability, often leading to teenage pregnancy, as illustrated by the experience of this young mother:

“In selling your body, you can meet a person offering a lot of money for unprotected sex, being intoxicated and in need for money, you will do ‘it’ [unprotected sex].” I34, FGD teen mums, 15-19y

For those who are also mothers, the situation can become even more precarious. It was reported that some would give their child cough syrup to make them sleep while they leave to do sex work at night but also sometimes during the day, emphasizing the regular compromises made in the face of economic desperation.

“Salterpyn is just like ‘bronco’ [cough syrup]. Some would overdose their babies, so that the child can sleep for long whilst they go to clubs. So, the child can sleep continuously for the whole day without waking up. ... Especially women who are into sex work. They overdose their children with Salterpyn, so that they won’t wake up crying.” I34, FGD teen mums, 15-19y

In other cases, sex work is not only used to meet immediate needs but also as a cover for opportunistic or criminal acts, influenced by drug use and the need for money.

“I have heard about a certain girl who took drugs in a bar where drugs are not allowed, I don’t know how she did it. She would keep an eye on people with money whilst pretending to be a sex worker. She would get a client, probably a wealthy person and inform some guys about where they will be going, so that the guys can follow them and steal from this person before they even have sex.” I50, FGD in-school boys and girls, 16-21y

Drug dependency often becomes part of this coping mechanism. Substances such as cough syrup, crystal meth, alcohol and marijuana are used to dull emotional pain, overcome fear, or find the strength to deal with clients, especially those who are drunk, abusive, or force risky sexual practices. The constant need for drugs increases financial insecurity and entanglement in sex work, a vicious circle that is difficult to break.

Participants also reported facing unsafe working conditions, such as being forced into unprotected sex, having condoms removed or torn without consent, or being coerced into anal or oral sex, which they acknowledged to be more dangerous. These practices not only increase the risk of STIs and HIV but also leave them vulnerable to physical injury and emotional trauma. There were also instances where clients would refuse to pay or become violent. Others described experiencing beatings, emotional abuse, and rape.

“Then there are also some other external effects like the risk of getting murdered whilst under the influence of drugs and obviously that person will get raped.” I50, FGD in-schoolboys and girls, 16-21y

And when pregnancies occur, especially for teenagers, parents may respond with rejection or insist that the girl move in with the man who impregnated her, often to preserve family honour and avoid stigma. In such contexts, sex becomes a currency of survival, with girls navigating a reality where the need for money often outweighs the ability to negotiate safety, respect, or agency.

From a public health perspective, transactional sex has been found to considerably increase the risk of unplanned pregnancies, HIV and STIs, and can also result in other undesirable sexual and reproductive health outcomes, such as intimate partner violence and sexual coercion.

“Girls of my age [17 years] are most prone to get teenage pregnancies. For instance, my friend can tell me that she has a sugar daddy who is financially supporting her with everything she desires and having no boyfriend or anyone to offer me financial support at that time, I may feel jealousy, and go look for my own sugar daddy, only to end up getting pregnant from him. The sugar daddy eill refuse to take responsibility of the pregnancy because he has a family already. These are the reason why girls of my age are falling pregnant.” I16, PI teen mums, 17y

Similarly, the question of having protected sexual intercourse or sugar daddies not using a condom additionally increased the harm and risks related to transactional sex:

“These sugar daddies will not use protection or condom, because they will tell you that “I am giving you my money, you had no money, so you should do what I want”.” I16, PI teen mums, 17y

Unintended pregnancies: a consequence of risk and vulnerability

One of the significant consequences of transactional or survival sex is teenage and unwanted pregnancies. Whether arising from unprotected sex with a boyfriend, a sugar daddy, or a client during sex work, often done to earn money for drugs or basic survival, many young girls find themselves pregnant while still in their teenage years. These pregnancies are rarely planned and often unfold in situations where girls have little power to negotiate condom use. In some cases, girls become pregnant because of abuse or coercion within the family, including by stepfathers, uncles, or other guardians. Such abuse often goes unreported due to stigma, fear, or lack of protection. These pregnancies add yet another layer of vulnerability, forcing many young women to drop out of school, face rejection by family members, or be pressured into relationships with the perpetrators to avoid social shame. For many, this marks the beginning of an even more precarious life trajectory and sometimes a second pregnancy follows like this young woman recounts:

“My father went to stay in South Africa and my mother failed to cater for my tuition fees for schooling therefore I did not manage to finish my education and then I got impregnated and my mother began abusing me, saying “go to your husband” but I refused to go there. By then I was 18 and I started living with a certain girl who took care of me until I gave birth; when I gave birth, I went back to my mother’s house and I repeated the same mistake [got pregnant again], you know a female child continues to repeat the same mischievous deeds and mistakes. I didn’t see the mistreatment I had received from the former mistake, and I was given another baby [got pregnant] again. My mother refused to accept me again and then I decided it was better for me to do sex work so that I take care of my family [children]. I started doing sex work and I was able to take care of my family until now [for 5 years] and my children are going to school through my work and my kids know that I go to work, and I instruct them to lock the door and then open for me when I come back from work.” I2, FGD YPSS, 20-23y

“I was now 18, and it was a while since we had started dating [three years ago], then I told him that I was pregnant and he asked who’s pregnancy it is and I told him, yours, and he denied it. So, when he denied it, I was so heartbroken because I loved him so much, then my friend said that you can’t be crying and feeling heartbroken for only one person whilst he doesn’t love you anymore, let’s do what I’m doing. Then I joined her [in sex work]. I1, FGD YPSS, 18-19y

“Personally, I felt ashamed, I started blaming myself that I wish I had not done it. They would say Hazel is now having a pregnancy without a father [meaning husband]. They will be saying she was impregnated, and she was dumped. At first, I never felt bad but when I went there [to the man’s house], I was so confident thinking that I am going to a person who is going to accept his pregnancy but when he denied it, that is when I regretted what I did.” I17, IDI teen mum, 16y

A professional from a community-based organisation working in SRH highlighted how cultural stigma and family reputation often dictate how teenage pregnancies are handled:

“Culture plays a pivotal role, because culturally our parents, they think that if a girl gets pregnant she should just go to the what [who made her pregnant]...so, they are afraid of what the community will say, what my friends will say if this girl gives birth in this house, so they say it’s better for me to chase this girl away before the people start even noticing the pregnancy.” I21, GD CBO

Trapped in a cycle: coping and dependency

The quotes below illustrate how young women describe their reliance on drugs as a way to cope with the emotional and physical demands of sex work, often framing it as necessary to endure the reality they face. In one of our first interviews with girls and young women involved in sex work, we came to understand this harsh dynamic: they take drugs to endure the demands of sex work, and later, the resulting addiction pushes them to continue doing sex work in order to afford those same drugs.

“We take drugs, personally I take drugs and alcohol because this is risky, so engaging into sex work without taking anything to alter our minds, it won’t be possible. We must be high on drugs all the time.” I2, FGD YPSS, 20-23y

“I use drugs to act impulsively, as sex work is not a decent job. We are stranded, and we are looking for money. Imagine when sleeping with five different people per day, so, taking the cough syrup helps us to get high and feel better... [breaks with emotions].” I2, FGD YPSS, 20-23y

As illustrated earlier, participants of this FGD stated that they need up to USD 30 per day to meet their drug-related needs.

Unpaid and unsafe: facing abuse with impunity

Girls and young women involved in transactional sex face not only the emotional and physical burdens of the job, but also the daily threat of being exploited by clients who refuse to pay, become violent, or rob them of their earnings. Despite having informal agreements, many clients break these without consequence. Reporting such abuse is rarely an option; Prostitution and sex work is forbidden in Zimbabwe as a result sex workers are often dismissed or shamed by police and community members alike. The following quotes illustrate the frustration, vulnerability, and sense of injustice that comes with being unprotected in such encounters:

“The risks that we encounter are, one, tearing of condoms and two we do our did and you haven’t given me money, and when you are done you now refuse to pay, on that one we can end up confiscating even your clothes, of course I won’t be alone, I will tell my colleagues so that they help me so that he will pay.” I7, FGD YPSS, 20-21y

“Other clients you agree on USD 3 for 5 minutes and they sleep with you and give you nothing. Some might even hit you, so it varies in this journey we have embarked on. You might be abused and who would you report to? No one, because no one wants prostitutes.” I2, FGD YPSS, 20-23y

“Some men take you, knowing you have placed money in your bra, he hits and abuse you and rob you the money you had worked for, and he doesn’t pay for sex. You can’t even report to the police because they don’t want prostitutes there, that is the problem we are facing.” I2, FGD YPSS, 20-23y

Risking infection: unprotected sex and intentional harm

During the interviews, we came across a local phenomenon: the simple and short term ‘sick’ is commonly used to designate STIs, including HIV. Participants described a range of situations where their health was intentionally or carelessly endangered by clients, either through condom refusal, condom tampering, or coerced unprotected sex. These encounters show the high vulnerability of girls and young women to infection and the critical consequences of working in an environment where their own safety is regularly compromised.

“We might fell ‘sick’ [sexually transmitted infection]. We risk STIs, other men want to pass on HIV, even if he uses a condom, he makes a whole into the condom.” I1, FGD YPSS, 18-19y

“Those who don’t like to use protection are older men, I believe they are already infected because there is no way an HIV negative person can get into a club and hire a sex worker and refuse to use protection, what kind of bravery is that it shows that he will be having his own illnesses already. So, I don’t like those people.” I7, FGD YPSS, 20-21y

“Others they will then contract diseases like AIDS because when they try to look for money to buy drugs, they will go to the ‘touchline’, that is when they will meet other people who have disease like AIDS or HIV.” I9, FGD in-schoolgirls, 15-16y

“Sex work is very risky. A client can say I don’t like to use a condom then I will tell him, if you don’t want to use a condom you can go, then maybe he has been attracted to me already and he will say let’s do it, I will use it, then during the act he will tear it because of his cruelty.” I7, FGD YPSS, 20-21y

Money forces you to take the risk

Despite knowing the dangers, many young women described how the urgent need for money compels them to engage in risky sexual practices such as unprotected, oral, or anal sex. Higher payments are often offered for these acts, and the economic pressure leaves little room for refusal. Some participants shared that access to healthcare services, such as PrEP or post-exposure treatment, offers a sense of safety and justification for taking such risks. The quotes below illustrate how financial necessity can override personal safety considerations.

“There is another risk, the man will say “if you eat my penis, I will pay more money”, so I will take the risk. And when I eat his penis, I come here [MSF] so that these peer educators give us something to prevent STIs. ... We will be so happy that we went from USD 7 to 30, because you rarely find people like those ones.” I1, FGD YPSS, 18-19y

“Sometimes the price will force you to take a risk, a person can say “I want to have sex without protection and I will give you USD 30” and because you want the money you take the risk because we know that we are using PrEP to prevent HIV.” I1, FGD YPSS, 18-19y

“Doris, I want to tell you something, we take these risks because we know that MSF will help us with some medication, so that is why we take the risks because we know that we will get the medication for free. We get PrEP, and if you can tell the doctor your story that yesterday I had unprotected sex, she will give you pills and help and tell you what to do.” I1, FGD YPSS, 18-19y

All that has been shared so far about navigating harm and vulnerabilities in transactional or survival sex paints a picture of extreme hardship and risk. Despite the harsh living conditions and daily challenges they face, the girls and young women demonstrate strong solidarity and support for one another. This resilience and mutual care are encouraging to witness and can serve as a powerful foundation for how we, as MSF, engage with them, building on their existing networks of support to shape more inclusive and effective interventions.

“Claude, let me tell you, among us we share our daily experiences. So if one of us tells me something, I’ll definitely remind her that we need to go to the clinic. We encourage each other, and we help each other” I1, FGD YPSS, 18-19y

4.4 Living on the edge: the impact of drugs on SRH choices

4.4.1 Navigating health in the shadow of substance use

Building on earlier insights into the realities of drug use, transactional sex, and survival strategies among adolescents and young people, this chapter explores how these interlinked experiences affect their sexual and reproductive health. Substance use not only drives risky sexual behaviour but also creates direct and indirect barriers to accessing critical SRH services. As explored in previous chapters, from engaging in unprotected sex for higher pay, to staying in drug-use ‘bases’ where consent and safety are compromised, to the experience of unwanted pregnancies and HIV and STIs, young people’s health is put at serious risk. Moreover, the stigma of both drug use and sex work compounds challenges in seeking care, sometimes limiting access to essential services such as contraception, HIV testing, PEP, PrEP, and psychosocial support. This chapter addresses what influences risk behaviours and access to services, the motivating and deterring factors for care-seeking, and the challenges healthcare providers face in supporting AYP in these contexts.

4.4.2 Drivers of risk: how drugs influence SRH decisions

This section explores how drug use, especially substances like crystal meth, cough syrup, and alcohol, shapes risky sexual behaviour. It examines the principles and dynamics of drug bases, peer influence, and impaired judgment, showing how these factors lower inhibition and reduce the likelihood of using protection.

For many adolescents and young people, drug use significantly shapes their sexual and reproductive health choices. Substances such as crystal meth, cough syrup, alcohol, and marijuana alter risk perception, reduce inhibitions, and fuel decisions that lead to unsafe sex, especially in settings like drug 'bases' where people sleep over and share partners. Young women under the influence of substances describe engaging in unprotected sex, anal or oral sex, or sleeping with multiple partners. Crystal meth, for example, is often linked to heightened energy and prolonged sexual encounters, while cough syrup creates a numbing effect that distances users from the emotional and physical discomfort of sex work.

"I want to add on what was mentioned earlier about the drug [crystal meth] which makes a person lose sleep for the whole night; a person will have sex with someone from the evening till the next morning." I50, FGD in-schoolboys and girls, 16-21y

Encounters under the influence of drugs often lead to multiple and anonymous partners, low condom use and coercive or transnational sex, which increases the risk of HIV, STIs and unwanted pregnancies. Many young women report not knowing who the father of their child is:

"You see, when the girls spend let's say three weeks in that base, sleeping there, doing sex. Changing people, changing men. So in the end she gets pregnant, and she doesn't know who the father is." I35, IDI PE, 22y

Furthermore, the stigma surrounding unwanted pregnancy among schoolgirls mirrors similar findings from my fieldwork in Uganda in 2024 (Burtscher & Masiingya, 2024). In a focus group discussion with teen mums, participants described the social consequences of attending school while pregnant:

"It's disturbing [being pregnant at school] because you will not get friends, because some will be avoiding you ... if you befriend their kids, they say you will be teaching them to be mischief. Others will laugh, so you will be just staying at home alone. You will be looked down upon by other students at school. ... Boys can be shy to be said that he has a baby." I33, FGD teen mums, 14-19y

Young people described engaging in frequent, unprotected sex in group settings as a common aspect of their drug use routines. In these contexts, health takes a backseat to momentary survival, altered judgment, and addiction.

"For example, I can take drugs and get high to a point of losing consciousness then someone uses that as an advantage to have sex with me. I will not recognize the person I had sex with because of the influence of drugs. That person can have a disease [STIs] and I can get infected." I50, FGD in-schoolboys and girls, 16-21y

In a paired interview, a young person described the serious health risks associated with drug use and its intersection with access to sexual and reproductive health. HIV was one of the most frequently mentioned concerns, referred to as "this virus of ours". They explained how many young people claim to use condoms but take risks, often due to the influence of drugs. "*That's why our generation is dying young,*" they said, pointing to the way alcohol and drug use interfere with consistent treatment. Even when antiretroviral therapy or TB medication is available, those who use drugs may forget or neglect to take their pills while intoxicated, a pattern of defaulting that contributes to preventable deaths. Some even mix their medication with alcohol or drugs, further undermining their health. As the participant said, "*They end up meeting God*".

4.4.3 Barriers to care: why AYP struggle to access SRH services

This part outlines the challenges adolescents and young people face in accessing SRH services. It includes stigma from health workers, fear of being judged, lack of confidentiality, and the emotional burden of shame, especially for those involved in drug use or survival sex. While the majority of the respondents who use drugs are aware of their health needs, self-stigma, and structural and social barriers often hinder them accessing SRH services. Young people shared experiences of feeling ashamed, being judged, refused treatment, or humiliated when asking for sanitary pads, seeking contraception, PEP, PrEP, or STI treatment.

“It’s like someone who is suffering from STIs when they seek help; for some, it’s already too late because they are ashamed, they will think that I am sleeping with everyone. So, shame also plays a role, they procrastinate.” I19, PLWHIV, 19-25y

One group of young men aged 19 to 21 spoke openly about the emotional barriers boys face when seeking care for sexually transmitted infections. They described the shame associated with exposing intimate health issues, particularly in the presence of female healthcare workers. This discomfort, compounded by fear of embarrassment and the intimate nature of STI examinations, often deters them from seeking the treatment they need.

“They can shout your name to everyone: “this person is the one suffering from an STI!” whilst everyone will be sitting there, imagine if it was you. ... It’s difficult to walk into a reception at the clinic and to see a female healthcare provider and to tell her that “I have been infected with an STI”, but if I find a guy like him [peer], I can easily tell him “my guy, things are not okay” then upon asking me what the problem is, I can tell him that I have an STI. ... An STI cannot be treated without firstly accessing the type of STI. It will be difficult for me to remove my pants whilst a woman is looking at me. You may go to the clinic with your foreskin closed because of an STI. ... I heard that they use a stick or something like a small spoon, then they will insert it deep inside the penis...they will take the discharge and run some tests to see which type of an STI it is. So, if you arrive at the clinic and you need that kind of treatment, my friend, it will be difficult, that is why I said you won’t feel comfortable.” I42 FGD in-schoolboys, 19-21y

Governmental health facilities are not always youth-friendly, and service providers may lack sensitivity towards young drug users or those involved in sex work. Mistrust of health workers, fear of being reported to parents or police, and stigma, both internalized and from the community, discourage many from seeking help until it's too late. Sometimes it might be related to services we do not provide as this healthcare worker pointed out:

“For those of them who are into the drugs, no, they are not coming. I think maybe it’s because we don’t have something which can entertain them in this facility. Because it seems we are limited with other resources [empowerment].” I32, IDI HCW

In Epworth, participants repeatedly pointed out that the clinic’s proximity to the police station discouraged young people who use drugs, particularly those using crystal meth, from accessing the facility.

“These crystal meth users may fall ill and would want to go for treatment, but they do not like to come to the clinic because they don’t want to be known that they take crystal meth. They are constantly thinking negatively and believe that everyone is against them, for instance when I visited one of the hotspots to mobilise them for this study, one of them made a fearfully comment: “We will meet in the prison transport vehicle heading to the prison”. Additionally, they were concerned that the Epworth Youth Centre is close to a police station.” I22, FGD PE, 20-23y

Participants often spoke about death when discussing the realities of drug and substance use. Accessing health services was described as particularly challenging due to multiple barriers, such as the physical distance to the clinics, the fear of losing time and income, lack of money for transport, and rigid clinic opening hours. These challenges are especially pronounced for those who use drugs at night and sleep during the day, making it even harder to seek care within conventional health service schedules.

“Others have died because it is [drug use] deadly. You start by procrastinating without knowing that you are damaging yourself. Like the one [STI] for the stomach, you will die. People will just be giving themselves strength [enduring the ill health condition]. They take, but they will not drink it, it will be thrown under the bed. Because all the pills are painful.” I52, PI YPWUD, 23-24y

Fear of being recognized, nepotism, concerns about confidentiality, lack of youth-friendly spaces, and misinformation further prevent AYP from accessing condoms, hygiene products, HIV testing, PrEP, contraception, or STI treatment. For school-going adolescents, time constraints and fear of parental discovery serve as additional deterrents. For those involved in sex work, especially in the evenings or overnight, clinic hours do not match their schedules, and mobile lifestyles interrupt follow-up care.

“When they go to clinics it’s because they will be accompanied by their relatives, he can’t go alone. ... Going to the clinic for them is difficult they are afraid that if they go and they find out that I have drugs in my body I will get arrested, so they are afraid of going to the clinic.” I8, FGD in-schoolboys 15-16y

“Okay, excuse me on that, there is favouritism and ignorance by the female service providers here. For instance, I can ask if the doctor is available, and they might ignore, but later, they will come inviting us to come and attend support groups. Also, sometimes we may come here to access WIFI, but they ignore us when we request for WIFI tokens and prefer to give WIFI token to someone they like or is close to them.” I10, FGD YPWUD, 21-23y

Some girls pointed out that they feel ashamed walking home with a pack of sanitary pads out of fear to be seen by their boyfriends:

“Others are shy to come; they just take some ‘cloths’ [instead of sanitary pads]. If we tell them that go and take some pads at the clinic they say, its humiliating. I don’t know what makes them feel shy. Maybe they are shy to be seen by their boyfriends holding pads. And they are afraid that the boyfriend knows that she has her periods.” I53, FGD YPSS, 14-15y

Others reported facing discrimination and stigma due to their involvement in sex work, for example, being recognised as someone who sells sex and subsequently denied access to basic items like sanitary pads:

“Personally, I am currently menstruating, so, I came here yesterday, and I met a certain girl whom I asked for sanitary pads, and she replied to me that they are out of stock. As I walked out, some other girls came in and walked out with sanitary pads. ... They will prefer to assist someone else who is not from our group [sex workers]. Sometimes we can tell the peer educators: “I am a sex worker” and they will tell you: “sanitary pads are out of stock”, but when you walk out of the gate, you will meet someone holding sanitary pads.” I2, FGD YPSS, 20-23y

In a discussion with two young men who use crystal meth they talked about people living with HIV who would not take the drugs because they would forget it:

“No those [PLWHIV] won’t be taking drugs; [ARV] treatment is always there but they will be drunk so they will end up defaulting and they will meet God [dying]. Defaulting is killing a lot of people. When they get drunk, they forgot to take pills.” I52, PI YPWUD, 23-24y

Others highlighted a more general hesitation among people who use drugs to seek medical care, noting that health concerns are often dismissed or downplayed, particularly when individuals are under the influence. Illnesses and symptoms are frequently minimized or ignored, delaying care and increasing vulnerability to more serious health outcomes:

“They don’t really acknowledge medical stuff as something very important. They just say: “Ah, I’ve got a small pimple, I don’t go. I am not feeling well, ah, I will be better soon. Especially when they’re under the influence, they tend to just take everything lightly and pass it: I’ll get better, I’ll get better .” I35, IDI PE, 22y

4.4.4 Turning points: what motivates SRH service-seeking

In this section we will highlight moments that trigger AYP to seek care, like STI symptoms, unplanned pregnancy or with the encouragement of peer educators. The importance of free, youth-friendly services and trust in healthcare providers and MSF as an international organisation that has been present in the country for many years also comes through as a major driver.

Despite the barriers, many AYP using drugs do seek health services, especially when peer support and non-judgmental spaces are available. Access to free PrEP or emergency contraception is seen as a lifeline, especially for young women engaged in survival sex. Peer educators and outreach services often play a key role, providing both information and encouragement. Some young people described a strong desire to protect themselves or their future fertility, citing fear of HIV or repeated unwanted pregnancies as motivation. For others, it is the solidarity within their peer networks, reminding each other to visit clinics or accompany one another, that makes accessing services more manageable.

Most of the participants were happy with the MSF services and some were enthusiastic and expressed their gratitude in an excited way:

“I come every day for condoms and masks, because I work too hard, I am a servant of the community. The services here are very good, 2000% good. They treat me well, well well...I frequently come here, services are 3 000 % good!” I52, PI YPWUD, 23-24y

Some young people also described the MSF space as more than a health facility, a safe and welcoming environment that offers brief relief from the pressures of daily life, including drug use:

“We just come here to access TV, watching soccer and films especially when there is no electricity at home, you even forget about drugs, but as you get out of this premise, you will feel that something is missing here.” I3, FGD YPWUD, 15-19y

In addition to providing a sense of comfort and regularity, some participants emphasized the value of receiving respectful, youth-friendly information and care from MSF staff:

“Nothing hinders us [to come], we don’t want to lie, because the nurse helps us. She helps us telling us that we are still young so if we want to have sex, we must use condoms so that we can protect our health. So sometimes if I see that my body is developing some rash I just come and ask the nurse.” I3, FGD YPWUD, 15-19y

Several young mothers highlighted the support they received for pregnancy-related care, describing MSF services as accessible and welcoming:

“We have received a lot, we came and registered for our pregnancies here, we were helped by registering for ante-natal care. We can come here and get treated and it was for free. I33, FGD teen mums, 14-19y

4.4.5 Systemic gaps: challenges in SRH treatment and continuity of care

This final part discusses treatment-related obstacles such as maintaining adherence to HIV treatment, PrEP/PEP, difficulties in managing long-term contraception, or follow-up failures due to unstable living conditions and drug dependency.

Once engaged, remaining in care presents another set of challenges. Drug dependency disrupts routines and can interfere with regular use of contraception or PrEP. Some young women shared how they forget pills, miss appointments, or stop treatments altogether when overwhelmed by addiction or trauma.

“On that one [PeP] we procrastinate because you will be tired; for example on Saturdays when you are back from the night club, the whole night you will be up, then you are back home, and you want to rush to the clinic. Sometimes you might get to the clinic, and you will be told that we don’t have PeP kindly go to Edith Opperman Clinic, after walking to Edith then they will say that they don’t have,

so that is when you feel tired, and the time is already gone then you go back home and sleep.” I11, FGD KP, 19-21y

“Some of them they think it’s cool, some of them they think it’s just a minor problem I will take care of it. So, the more you procrastinate you are just delaying on time because you don’t know the damage which is already done because you are not seeing what is happening in your system. So, they keep on procrastinating saying ah I will go later.” I19, FGD PLWHIV boys, 20-25y

Health workers also noted that treating infections or offering long-term methods like injectables or implants can be difficult when girls return to violent homes, stay in unstable accommodation, or rely on sex work for survival. AYP in bases may disappear for days, and without sustained outreach, many fall through the cracks. The intersection of addiction, violence, and marginalization creates a fragile context where consistent and dignified care is hard to maintain.

4.5 Key population

This chapter will explore the lived realities of young people from key populations in Mbare and Epworth, focusing on LGBTQIA+ individuals, especially young people identifying as gay, lesbian, or transgender. Drawing on quotes from interviews and FGDs, it highlights the challenges they face, including discrimination, rejection, substance use, survival sex, and systemic health care barriers.

Rejection, stigma and drug use

Discrimination and rejection begin early and often come from within the family. Participants recounted experiences of being labelled as ‘satanic’ by their parents and subjected to exorcism rituals involving pastors, prophets, or traditional healers. Such rejection frequently leads to forced homelessness and independence at a young age:

“I work for myself, I pay rent for myself, this community is my family. [...] It is hard to find a job if you are gay, it’s very hard. It’s hard even to go for a social outing if you are gay.” I11, FGD KP, 19-21y

In a hostile environment, fear and misinformation often lead parents to discourage their children from associating with peers perceived as different. LGBTQIA+ youth are especially vulnerable to this form of indirect discrimination. A participant shared how this rejection is felt in daily life:

“Many parents are no longer comfortable to see me associating with their children, because they think that I am attracted sexually to their children. Many of my friends are still going to school so their parents don’t see me as a good person. The parents say don’t play with this one you will be taught sex work, she is a *‘ngochani’* [gay]. You will be given so many derogatory names, and personally my parents never accepted who I am.” I11, FGD KP, 19-21y

Facing constant marginalization, young people from key populations often find themselves isolated, misunderstood, and pushed to the edges of their communities. This rejection does not only come from people in the public sphere but also from within their own families and social networks. Such persistent social stigma and exclusion can have profound psychological consequences, particularly for adolescents still forming their identity and place in the world. For many, drug use becomes a way to dull the pain of non-acceptance, to find temporary relief from internalized shame, or to gather the strength to face a hostile environment.

One participant powerfully described this emotional tribute and the role that drug use plays in his attempt to cope with daily discrimination:

“The challenges are not being accepted by the community, being discriminated by everyone and sometimes you put yourself in a shadow, thinking about what the community is going to say; if my parents will accept me as who I am, those things keep ringing in our minds. That is why we go to drugs. I want to walk freely in the community, but I can’t because when they see me, they won’t see ‘ME’ as what I am [gay]. If I show myself to the community, I could get hurt, they could say bad things. They call me gay, you are a boy not a girl, ‘*ngochani*’ [shona for gay], so if I hear those words, I feel discriminated and shattered. That’s why I use drugs, so that this will get off my mind, it gives me confidence, so when they say something, I won’t hear it.” I11, FGD KP, 19-21y

Sex work and risky sexual practices

For many adolescent and young people, economic exclusion and a lack of familial or community support leave few alternatives for survival. Faced with rent, food insecurity, and the daily cost of living, compounded by stigma and discrimination, sex work becomes one of the only available means to earn money. However, this form of livelihood comes with serious health and safety risks. In contexts shaped by financial desperation and power imbalances, individuals are often forced to compromise their safety to satisfy client demands, particularly when higher payment is offered for unprotected sex.

Substance use further complicates these dynamics. Sex while under the influence of alcohol or drugs, already explained earlier, is common among those trying to cope with the emotional strain of sex work, makes it even more difficult to negotiate condom use or assess risky situations. The combination of economic vulnerability, coercion, and intoxication places many at heightened risk of HIV, STIs, and other forms of harm, as participants candidly described:

“Most of us are now sex workers, we need money, so they can meet a wealthy person with money, and he might say I want to sleep with you, but I don’t want to use protection. You will just do it and tell yourself that its only once. And, we can have sex whilst we are drunk, and you don’t not have protection, or the condom bursts.” I11, FGD KP, 19-21y

“One can ask, how much are you charging and you will say USD 10 or 15 then he will say alright I need unprotected sex. He will offer you more money maybe USD 40 or 50, you will just do it because that’s what is there.” I11, FGD KP, 19-21y

Despite the risks involved, some participants demonstrated awareness and agency in trying to protect themselves, including using HIV prevention methods like PrEP. However, negotiating prevention with partners was not always straightforward:

“Even when I try to introduce PrEP to the person I am dating and try to convince him to go for HIV testing, he can refuse. When he refuses, I won’t be able to continue with him, I will move on like a WI-FI and find someone else interested. The person I am dating now is okay, we are both on PrEP.” I30, IDI KP, 22y

Yet others rely on informal strategies to navigate risk, especially when formal prevention methods like PrEP or condoms are unavailable or difficult to negotiate. These approaches reflect both resourcefulness and the limitations of access to consistent care:

“It depends on the type of a person that you meet. Sometimes I first look at the health status of that person. I am always having tests kits in my apartment, so if my partner requests for unprotected sex, we first do an HIV test.” I30, IDI KP, 22y

Some participants explained that their only form of protection was accessing free services at the clinic, such as PreP or emergency contraception. However, recent shortages, reportedly linked to funding cuts (e.g., from USAID), have made this increasingly difficult:

“We can do nothing to prevent an infection, that is when we just come here to the clinic and being given PreP or morning after pills. But currently, there is no PreP even the condoms are not available so, yeah, it’s a difficult situation.” I11, FGD KP, 19-21y

Despite these efforts, some find themselves lured into dangerous setups. Key populations face similar risks as their female counterparts when engaging in transactional sex. Many are pushed into sex work by necessity and, like women selling sex, experience non-payment, abuse, or physical violence. However, some described falling into traps that go beyond these common risks:

“We are struggling, we want money, but we will end up getting into bad situations. On social media you can be proposed, and the person can say can we meet, and when you meet the person will beat you. You can arrive there, and some boys will be waiting for you, and they will beat you thoroughly.” I11, FGD KP, 19-21y

Inadequate access to healthcare and mistreatment

Participants explained that when they visit a health centre, they are often discriminated against or treated differently upon being identified as members of the LGBTQIA+ community. Feelings of shame, fear of judgment, and anxiety about being misgendered or mocked can act as powerful deterrents to seeking care. One participant described the discomfort and stigma experienced during a clinic visit:

“We are shy, others feel ashamed to be seen at the clinic at a young age. I went once and I got a bad result. They asked me: “are you a girl or a boy?” I11, FGD KP, 19-21y

Key populations face consistent stigma in the health system. Participants detailed dismissive and even abusive treatment from healthcare workers:

“When people [KP] go to the clinic, maybe you are ‘bottom’²⁶, maybe you got warts at the back, and you tell the nurse, she might shout at you: “what is this, you are the one who is corrupting our kids, why are you doing this, this is satanism.” The nurse can harass you and shout at you, sometimes she can tell you today we are not able to attend you. Another one can feel ashamed and say what if I will be ill-treated, and he will decide not to go.” I11, FGD KP, 19-21y

Neglect and refusal to treat were also reported:

“Yesterday we met a lesbian, she is a sex worker, but when she is looking for money, she can sleep with men. So, she came because she had some warts, and a discharge. Then they told her, and I was hearing it with my own ears: “I don’t want to keep on treating the same illness on the same person”. She then said I think it’s better I move away from here.” I11 FGD KP, 19-21y

²⁶ In the context of homosexuality, particularly among men who have sex with men, the term ‘bottom’ refers to the partner who is receptive during anal sex. This means they are the one being penetrated. It’s a role often contrasted with ‘top’ the penetrating partner. Versatile or ‘vers’ refers to someone who is comfortable in either role.

PE working with key populations often face layered challenges in encouraging their peers to seek care. They act as bridges between the community and the health system, yet when those they support encounter stigma, neglect, or logistical barriers at the clinic, peer educators themselves become stuck in an impossible position. One peer educator from the KP community expressed his frustration about the repeated challenges and emotional strain of his role:

" I have a challenge as a peer educator for the KP community. The nurses are ill treating people, they can just say that there is no treatment, but the treatment will be there. Then that person will be referred to the other clinic and that person will not have money for transport to go there. It will be known that those clients must be given money for transport to get the treatment, but they won't give them the money, they will say that there is no money allocated for that. It will be very difficult for me because tomorrow if you ask me to look for people for the support group, where will I find them since they were ill-treated. Last time I used my own money for transport for those people so that they could come. I am the one who is caught in between because they will need participants for the support group. I am the one who will be stressed about it because that's my work I am supposed to do here at MSF." I11, FGD KP, 19-21y

Seeking safe spaces outside of MSF

While MSF offers youth-friendly services, some members of the key populations expressed a preference for alternative spaces where they feel safer, less judged, and more accepted for who they are. They described a sense of discomfort or exposure when accessing services at MSF supported facilities alongside the general public, particularly in environments that feel heteronormative or potentially hostile:

"We don't come [to Epworth Youth Centre], we just see a lot of people there. Our character makes us fear to go to public places or even at clubs. We usually don't go to crowded places because violence might occur there. We go and enjoy in town. The freest place for us that we usually go is GALZ [Gays and Lesbians of Zimbabwe]²⁷, then sometimes we go to Devoris in Milton Park, then at CeSHHAR [Centre for Sexual Health and HIV/AIDS Research Zimbabwe], which is in town and in Mbare. We have places that we like where we will be covered by a Durawall. So even if you go there wearing a dress and women's high heel shoes, no one will question you." I30, IDI KP, 22y

"We cannot mix with straight people. There are other ladies who pretend to be our friends, but they will talk about us behind our backs, so we cannot mix. So that is why you will see that a lot of LGBTQ, they don't want to come." I39, IDI KP, 21y

These accounts highlight how young people from key populations experience compounded vulnerabilities, due to social rejection, economic marginalization, and limited access to respectful and inclusive healthcare services. Their coping strategies, including drug use and reliance on peer-led support, reflect both resilience and a pressing need for inclusive, non-judgmental care structures. Addressing their needs must go beyond medical care to include psychosocial support, protection from violence, and access to safe and affirming spaces.

²⁷ <https://galz.org/> accessed 10th July 2025

5 Recommendations

The current anthropological assessment took place from March to early May in 2025 and was performed with an anthropology team of 5 people (PI, a female and male assessment assistant and translator, and a female and male transcriber) along with the support of many members of the Mbare project.

The anthropology team applied a holistic approach, incorporating the perspectives of a broad range of stakeholders. We worked closely with individuals who have lived experience such as young people who use drugs, or engage in transactional sex, teenage mothers and pregnant adolescents. Their insights were complemented by those of healthcare workers, Ministry of Health representatives, and MSF staff who engage with adolescents and young people in their daily work. Together, these diverse viewpoints have informed the recommendations presented in the following section.

An adolescent-friendly approach must be both comprehensive and holistic, addressing not only the physical and medical needs related to drug and substance use and its link to SRH, but also the psychosocial and structural challenges that adolescents face in their daily lives. The following recommendations aim to complement the project's existing objectives by providing tailored support for young people as they navigate their complex vulnerabilities of early adulthood and life realities.

The recommendations that follow are numerous, and some may echo points already raised in previous evaluations or outlined in the current health promotion strategy or the Mbare KP engagement strategy. Others may reflect activities that are already being implemented or are well known to the team. Nevertheless, even if certain suggestions appear repetitive, we felt it was important to include all insights that emerged during this assessment. They represent the voices and concerns of participants and reaffirm the relevance of ongoing efforts while highlighting areas where continued attention or reinforcement may be needed.

We do not claim that this is an exhaustive set of recommendations; there may be additional needs or insights that were not captured in this assessment. However, we hope that the suggestions presented here, based on the voices and experiences of those interviewed, will be taken as constructive contributions. We do not pretend to know better, but our intention is to help amplify the perspectives of adolescents and young people who have experienced drug and substance use, transactional sex and the health risks going along with, and to support the creation of an encouraging positive environment by promoting supportive life conditions.

This assessment comes with an outsider perspective. We fully recognise that offering recommendations is easier than implementing them in practice. Therefore, rather than presenting them as final conclusions, we propose organising a comprehensive dialogue/workshop exercise in Mbare. This would allow for joint reflection and discussion of the recommendations with key stakeholders, including MSF and MoHCC healthcare teams, PMR, peer educators, CHM and the health promotion team, as well as adolescents and young people and the anthropology team members. Such a participatory process could help validate findings, adapt suggestions to the local context, and foster collective ownership of future actions.

In the first part of the workshop, the report findings will be presented and discussed for validation with the participants. In the second part, recommendations could be discussed and validated to see which ones are feasible to implement and which ones are most important, as perhaps not all of them can be addressed. In the realm of a participatory approach, some adolescent and young people who participated in the interviews could be reinvited. As a next step, it can be decided which recommendations can be practically implemented, how, by whom, and what would be needed to implement. Which recommendations can be implemented on a structural level, and which ones can be applied by the adolescents themselves? Where is personal engagement needed?

Our recommendations are grounded in the experiences and insights shared by adolescents, young people, peer educators and healthcare providers throughout this assessment. They are informed by the realities observed in Mbare and Epworth and are closely aligned with the scope and objectives of the Mbare ASRH project. Informal discussions and community walks in Epworth and Mbare, including visits to the Matapi flats, direct observation of crystal meth use in a base, conversations with young women selling sex in the Joburg lines, and a visit to the music producer 'Fantan' (Fig 19+20), have also informed the analysis and the formulation of recommendations.



Fig 19: Fantan in his studio



Fig 20: Fantan's music production studio

Since its inception in 2015, the ASRH project in Mbare has grown from a SGBV clinic into a comprehensive, adolescent-friendly programme. It now offers an integrated package of SRH services, including HIV care, mental health, and tuberculosis support at both community and facility levels. These recommendations aim to strengthen and adapt the project in response to the evolving needs of adolescents and young people in the project's catchment areas.

What does the Zimbabwean mindset reveal and how should it guide our response?

Understanding the Zimbabwean mindset means recognizing the powerful role that tradition, religion, and social norms play in shaping attitudes toward adolescence, sexuality, drug use, and health. The expectation of obedience, modesty, and silence, particularly for girls, creates a deeply conservative environment where shame and stigma are used to enforce conformity. In this context, topics like transactional sex, drug use, or teenage pregnancy are not only taboo but often met with harsh judgment or rejection. These social dynamics, compounded by structural barriers such as poverty and lack of youth-friendly services, leave many adolescents and young people navigating risk in isolation. The divide between urban exposure and rural conservatism adds further complexity. As we turn to recommendations, these realities must frame our approach: adolescent friendly interventions must not only deliver services but also challenge stigma, build trust, and meet young people where they are, socially, emotionally, and geographically.

Where do adolescents and young people fit in?

Navigating between tradition and modern pressures, young people in Zimbabwe often find themselves caught between conflicting demands. They are expected to uphold conservative cultural values such as obedience, abstinence and respect for their elders, while at the same time being confronted with economic hardship, the influence of their peers and the urban lifestyle. This tension creates emotional and social strains. Many are well aware of their sexual and reproductive health needs but find it difficult to seek treatment because of shame, fear of judgement or lack of youth-friendly attitudes and services.

The MSF Mbare project has already made great developments, offering essential medical and social services through a range of impactful interventions and activities. These efforts are deeply appreciated and form a strong foundation for continued engagement. The recommendations emerging from this assessment aim to build on this existing work, drawing directly from the voices and experiences of those most affected. By incorporating their insights, we hope to strengthen and refine our strategies to better reach and support the most vulnerable among them.

◆ **Promotion of truly youth-friendly staff**

MSF and collaborating MoHCC staff should undergo refreshed and context-sensitive training in youth-friendly approaches. Numerous accounts throughout this report have illustrated how young people, especially those who use drugs or engage in survival sex, are met with moral judgment, harsh language, or dismissive treatment. Such experiences discourage them from seeking timely care. In several interviews, even healthcare providers themselves acknowledged that they do not feel adequately trained or equipped to handle the complex needs of young people who use drugs. As one HCW openly noted, they often lack both the technical tools and the emotional preparedness to interact with YPWUD in a non-stigmatizing and supportive way:

“It’s not easy especially with substance [YPWUD]. I would say I’m not fully ‘equipped’ to handle the issues of substances.” I 45, IDI HCW

This highlights the need for not only medical refresher courses, but also workshops that foster empathy, self-awareness, and practical skills for engaging with adolescents living in vulnerable conditions. Such a training must go beyond technical skills and actively encourage and positively motivate staff to put themselves in the shoes of the young people they serve, many of whom face daily struggles such as poverty, social rejection, drug dependence, or unwanted pregnancies. Care must be delivered with empathy, confidentiality, and without moral judgment. This is especially crucial for young women involved in transactional sex, adolescents who use drugs, and teenage girls who are pregnant or seeking STI treatment, who often arrive at the clinic already burdened with shame or fear of being scolded.

“With regards to the nurses, can you kindly provide us with nurses that are kind-hearted, who do not concentrate too much on their cell phones before assisting clients.” I2, FGD YPSS, 20-23

For many of these young women, particularly those dealing with teenage pregnancy, the clinic visit comes after having already faced harsh reprimands or rejection from family members, especially parents or older brothers. If healthcare staff replicate this judgmental tone, even unintentionally, it reinforces the young person’s sense of isolation and stigma, making it far less likely they will return for follow-up care or encourage peers to seek help. Creating a supportive and understanding atmosphere is therefore not just a matter of professionalism, it is essential to building trust and improving health outcomes.

To enhance collaboration and motivation among colleagues, and to strengthen networks with other stakeholders, one healthcare provider highlighted the value of recognition and shared learning. Celebrating small successes and creating spaces where staff feel acknowledged can foster a sense of purpose and encourage ongoing commitment to serving vulnerable groups. As the provider reflected:

“I think we need to do more to celebrating our small wheels. Sometimes motivation comes from just realising that I did something good. If the peers see that I did this and it was celebrated, I am motivated to do it better and more often because I know that it is being recognised. Showing out to the world in writing and describing what we are going through will attract some other complementing partners to intervene together.” I47, IDI HCW

In terms of YPWUD and if they would come or not one HCW said: From MSF HCW point of view what should be improved:

“When it comes to access to services, I don't feel that they're not coming. I actually think people are coming but there is a loophole in terms of how we screen. I am not sure whether it's about the service providers or health care providers not being capacitated on knowing that when a client comes how to screen to know whether they use drugs or not.” I37, IDI HCW

◆ **Inclusive targeting: Reaching both girls and boys and their ‘surroundings’**

While the current medical programming at Mbare clinic commendably focuses on SRH services and primarily for teenage pregnancies, there is also a need to increase engagement with adolescent boys and young men in and around the Edith Opperman Clinic. Future programmes should take greater account of gender-specific aspects and develop services that actively involve boys and young men in preventive and curative SRH services, especially in the treatment of sexually transmitted diseases.

“We had a health education session with a group of adolescents, and after the session, the girls asked for reusable pads which we distributed but then the boys asked, “what do we get?” I had a FGD with boys here in Mbare, we were talking about personal hygiene, and they were saying that ‘mini briefs’ [underwear] are expensive and some of us don't even wear them because we can't afford them. I was just thinking that whilst we distribute sanitary pads for the girls, we can also distribute mini briefs for the boys. I12, IDI HCW

Furthermore, strengthening MSF's impact requires expanding beyond the clinic walls and actively engaging families and communities. A more visible presence in the neighbourhoods, where adolescents and young people live and navigate daily challenges, would help build trust and reduce barriers to care. This includes promoting a client-centred and non-judgmental approach grounded in harm reduction principles. To reduce stigma and discrimination effectively, we must leverage the influence of key community figures such as parents, pastors, priests, teachers, and individuals with lived experience who can speak openly and empathetically as role models. Their voices can support programmes that normalise care-seeking and foster a more supportive social environment.

◆ **Expanding safe spaces and harm reduction initiatives**

Adolescents repeatedly expressed the need for safe, welcoming environments where they can spend time without stigma, boredom, or danger. Would it be possible to have a safe space at the Edith Opperman Clinic? A small social corner²⁸ to attract AYP also as a linkage to medical care? The experience with peer clubs or support groups was always reported positively an expansion of such peer clubs, HIV adherence groups, and psychosocial support circles should be prioritized and scaled up above all in a direction of YPWUD. If MSF wants to commit to a harm reduction philosophy that acknowledges the lived realities of adolescents and young people and find ways to reduce the risks rather than deny the behaviours, we should try to approach places where drugs are used and sold, the drug bases. Whether legal or not, these activities are happening, and adolescents need support to navigate them safely. Safe spaces must be designed not only for care provision, but also for community, creativity, and trust-building.

◆ **Empowerment through role models and lived experience**

Adolescents benefit from seeing people like themselves in leadership and mentoring roles. The MSF peer-led program is already a great step, however, some peers do not have lived experience but are engaged because they know the environment.

²⁸ Behind the roofed waiting area at the clinic, there is a small open space where the Friendship Benches are located.

To further promote peer-led initiatives where AYP can identify themselves with, MSF could explore engaging peers that specifically target ‘drug bases’, with the jazzmen and ‘plugs’ and the ‘touchlines’.

MSF should actively seek partnerships with influential figures from the local community, such as musicians, former DJs, or respected youth leaders, who resonate with adolescents and young people. In particular, collaboration with individuals like ‘Fantan’ from Chill Spot Records (Fig 21), a well-known music producer, could create meaningful opportunities for engagement through music and creative expression. Involving such trusted personalities in outreach, health promotion, or even music production initiatives can boost participation, inspire confidence, and provide a sense of purpose and visibility for AYP, especially those affected by drug use or survival sex.



Fig 21: Chill spot records at Matapi flats Block 9 Level B

Using voices from the community, including youth with lived experience of drug use or survival sex, can foster authenticity and trust. Additionally, adolescents need real support to empower themselves. Instead of offering refreshments or symbolic tokens, MSF should consider financial stipends or transport reimbursements, especially for those participating in support groups or peer educator networks as reported by some vulnerable groups:

“We are tired of the type of refreshments that we are getting, we are leaving our jobs here; at least if they could give us the money so we can go and buy food.” I11, FGD KP, 19-21y

◆ Collaboration and integration with broader networks

MSF should not work in isolation. There is an urgent need to continue to connect with other actors involved in SRH services, drug and substance use and social support for AYP services like income generating activities or specific courses. However, any such interventions must be rooted in the real interests and capacities of young people. Integration into broader networks will allow for greater resource sharing, policy influence, and harmonized approaches and above all for a more sustainable intervention in terms of an exit strategy. For example, the CBO MUFARO created by former peer educators, functions as a link between the community and MSF.

“We are former peer educators, we were in the field, we were in the community. So, we know what they want, what they experience, and sometimes they cannot come here straight. They do trust us, we are of the same age, they are our peers, and they are our friends. We are with them most of the time because we were there in the community.” I26, IDI CBO, 26y

Participants noted that MSF is sometimes seen as disconnected from other service providers. Strengthening collaborations with organizations such as CeSHHAR, Young Africa²⁹ and GALZ in particular, which already work closely with vulnerable youth and key populations, would enable a more comprehensive and coordinated response.

◆ **Bridging the gap beyond ANC**

In line with the previous recommendation, MSF should also reflect on how to extend its support beyond the provision of antenatal care. While MSF provides critical ANC services to pregnant adolescents and young women, participants expressed concern about what happens after childbirth. Many young mothers, some of whom were already engaged in sex work, return to it shortly after giving birth, not out of choice but necessity, in order to feed and care for their child. As one healthcare worker reflected:

“It breaks my heart at times, I will say to myself ‘I helped this young person with ante-natal care, but then what did I do next?’” I12, IDI HCW

This gap between clinical intervention and long-term support highlights the urgent need to connect vulnerable populations with community-based organisations or NGOs that offer income-generating activities. However, many of these organisations operate with limited resources and insufficient funding. MSF could play a vital role not only by referring individuals to such programmes but also by actively collaborating with and supporting these partners financially, where feasible. Strengthening these local networks would provide young women with more sustainable alternatives to returning to sex work and help address the broader structural drivers of vulnerability.

◆ **Reinforce and expand information and meaningful activities**

While MSF already offers valuable recreational and educational opportunities at youth centres, adolescents and young people highlighted the need to reinforce, revive, and build upon these existing initiatives. More targeted, engaging, and gender-sensitive activities are needed to better meet their evolving needs, combat idleness, and foster empowerment through information and skill-building.

Adolescents and young people repeatedly expressed the need to be occupied and engaged, not only to pass time but to gain skills, confidence, and a sense of purpose. While MSF already offers valuable recreational opportunities at the Matapi youth hub and at Epworth youth centre, such as pool tables, television, and table football (though some facilities are broken or limited), adolescents and young people highlighted the need to expand, diversify and revive these existing initiatives. Girls, in particular, voiced a desire for tailored activities, including beauty-related skills like braiding, cosmetics, and salon work, which symbolically reinforce self-worth and personal care: *“I am worth it, I am beautiful, I value myself”*. Other suggestions included forming more teen mum clubs or engage teen mums that are not yet in clubs, football teams for boys, and interactive spaces for movement and physical activity like Zumba, netball, etc. Forming a dance performance group with various styles like Afrobeats Dance, Zimdancehall-Inspired Moves, Pantsula/Ghetto Dance, Traditional Zimbabwean Dance Fused with Modern Styles, Krump or Hip Hop Freestyle Battles, Street Cyphers or Dance Battles, etc. depending on taste and preference of AYP could be another way of positively engage, empower and physically and psychologically stabilising young people (Gardner, Komesaroff, & Fensham, 2008).

²⁹ <https://youngafrica.org/zimbabwe/> accessed 17th July 2025

Young people also emphasized the importance of learning practical skills that can generate income and offer long-term alternatives to drug use or transactional sex. Proposals ranged from gardening and poultry farming to growing mushroom, sewing, baking, mechanics, and digital skills. Others stressed the importance of supporting young people to go to school or to attend courses which they cannot afford but would help to gain a living.

“If you want to end this issue of young female sex workers and young male sex workers ... we are not educated and we cannot find jobs, so there are some short courses, but we are not able to raise the money. My dream is to be a fashion designer and a make-up artist, but I can’t do those short courses because I don’t have the money.” I11, FGD KP, 19-21y

Importantly, they stressed that programmes should not be imposed, but co-created, young people should be asked directly what they want to learn or do.

◆ **Breaking the cycle of idleness**

Young people who use drugs expressed appreciation for the Matapi youth hub, particularly valuing the health promotion sessions and information provided there. However, while they come to learn and engage, many ultimately return to the same environment and challenges that fuel their vulnerability, highlighting the need for sustained support beyond the facility’s walls.

“Sometimes we come here to attend lessons so that we can stop taking drugs and other health-related topics. After being taught, we go back to the environments we live in and we see someone who is drunk again and is holding the bottle then we will start craving for the drugs again and all the information we have been taught is lost.” I3, FGD YPWUD, 16-19y

As previously highlighted, the demand for health promotion and informational sessions emerged strongly throughout the assessment. Topics such as signs and symptoms of STIs, the use of PrEP, the use of female condoms and menstrual health management (including safe use of menstrual cups) should be integrated into a regular schedule at youth hubs like Matapi and Epworth. Empowering adolescents to learn, move, and grow in safe, supportive spaces is a vital step toward addressing the root causes of idleness, economic hardship, and drug dependency.

“What leads people to continue taking drugs is because they have nothing to do. You will spend the whole day sitting at home, then you meet a person who wants to have a deal with you, and you get USD 1. What else will you think of buying with that dollar besides buying drugs? ... There should be activities that people can do so that they do not take drugs. ... way back, the issue of drugs was low because the grounds were still in a better condition as compared to nowadays, there was activity.” I48, FGD YPWUD, 21-25y

Several limitations related to the Matapi youth hub emerged during the interviews. Participants raised concerns about perceived nepotism and discriminatory practices in accessing SRH services. Some respondents also mentioned the absence of nurses at certain times, although it remains unclear whether nurses are scheduled to be present at the hub on a daily basis.

“Sometimes we come here to access services, let’s say I am on my monthly periods. Personally, I am currently menstruating, so, I came here yesterday, and I met a certain girl whom I asked for sanitary pads, and she replied to me that they are out of stock. As I walked out, some girls came in and walked out with sanitary pads. They look for familiar faces.” I2, FGD YPSS, 20-23y

Others mentioned that sometimes services were not available at the Matapi youth hub, resulting in referrals to Edith Opperman Clinic. While the physical distance between the two facilities is not substantial, several respondents emphasized that the time spent walking and waiting for services posed a significant barrier. For some, especially young women engaged in transactional sex, this time away from their usual locations was seen as a loss of potential income or clients, making them reluctant to follow through with the referral.

“They can refer you to Edith Opperman Clinic but with the work you might have been doing the whole night it might be too far for you, and you will not have the energy to go there. ... sometimes we look for clients along the way so it might take us a bit of time to reach there also.” I1, FGD YPSS, 15-19y

◆ **Provide injectable PrEP services for the most vulnerable groups**

One of the striking findings from this assessment was the strong and informed demand for injectable PrEP among young people selling sex in Mbare. Participants demonstrated clear awareness of PrEP and its preventive potential and specifically expressed preference for long-acting injectable forms, citing the challenges of daily adherence. This interest reflects both health literacy and a proactive attitude towards HIV prevention among this vulnerable group.

“That is what we once told you that we prefer and injection, so yes, sometimes you don’t forget but sometimes to tell you the truth you might forget, even taking PreP you might forget because it is supposed to be taken everyday.” I1, FGD YPSS, 18-19y

While it remains unclear whether PrEP is currently unavailable due to USAID funding cuts or regulatory delays in drug approval, participants’ voices make a compelling case for exploring the introduction of injectable PrEP alongside accessible long-term contraception.

“We want the ‘morning after pills’ [emergency contraception pill], these other kids that you are seeing here have escaped from the condom and are a result of not having morning after pills. Sometimes we can’t find a nurse here and sometimes we need contraceptives like Depo-Provera and Jadelle.” I1, FGD YPSS, 18-19y

◆ **Ensure consistent access to long-term contraceptives**

In both Mbare and Epworth, the demand for long-term contraceptive options, such as injectables, implants, and pills, was clearly expressed, particularly among adolescent girls and young women engaged in transactional sex. In Epworth, where transactional sex was noted as a more prominent concern than drug use, participants highlighted that access to such methods is often limited to specific days or facilities. MSF should not only ensure consistent and reliable access to long-acting contraceptive options but also invest in proactive promotion and information-sharing. Young people need clear, age-appropriate information about the full range of contraceptive methods available, how they work, where they can be accessed, and what to expect when using them. Beyond providing technical knowledge, it is crucial to engage in active sensitisation to address the persistent fears, myths, and misconceptions that often surround contraception, particularly among younger, school-going adolescents. Building trust and understanding through peer education, school outreach, and youth-friendly materials can empower young people to make informed choices about their sexual and reproductive health. Strengthening collaboration with partners like DREAMS may help expand access, but MSF should also assess whether it can sustainably provide these services directly, especially for high-risk groups who may not reach DREAMS or other providers regularly.

“With regards to the issue of unintended pregnancies as a negative factor of drug use, I think we should promote or encourage the accessibility of long-term contraception like implants, pills and injectables. ... MSF is partnering with DREAMS right, and MSF is the one which offers those services, so I think if we could have them as MSF, that would be better. Every day, because they are only accessible once a week.” I22, FGD PE, 20-23y

◆ **Suggestions for Epworth youth hub**

Several young respondents shared concrete suggestions to improve the Epworth Youth Hub. They highlighted the need for better ventilation in the pool table room and called for fairer access, as the space is often dominated by older youth who don’t give others a turn.

A specific complaint was that some peer educators were perceived as monopolizing the snooker table, “as if they came from home carrying the white ball on their heads”, leaving others feeling excluded and frustrated.

“The Peer Educators should stop sabotaging us on the snooker. They act like they came from their houses carrying the snooker or the white ball on their heads. There is corruption on the snooker. If you are not known, you might not play. You can see someone playing more than three times whilst others haven’t played at all.” I20, male youth, 18-19y

There were repeated requests for more inclusive recreational opportunities such as games, dart, a functional gym room with proper equipment, particularly important for boys who expressed a desire to be physically active. Some existing resources, as previously mentioned, like the table football, are broken and need repair. The library was noted as empty, with no books or clear purpose, leaving young people wondering how to use it.

“I think they should add more games some people like playing slug [table football], but the slug is no longer worker. Some clients love chess games. So, you see clients waiting in a queue giving each other chances to play the pool. ... We used to have a dart board. We should conduct tournaments for clients and if we need a much bigger ground, we can use the Epworth Local Board ground then we form clubs with the clients and take them seriously, for instance netball team, volleyball team. This will also increase the total number of young people attending the youth centre because games provide entertainment.” I22, FGD PE, 20-23y

Additionally, there is a shortage of activities tailored to girls.

“Are there enough activities for girls, to attract girls? Do you think the gender balance is okay, because pool and soccer are rather for boys? ... Some young people come here to access the library, only to find empty shelves with a few papers written by MSF. The library should have academic books so that a young person can come and study.” I22, FGD PE, 20-25y

“Soccer, netball and novels in the library, because if we look at the available games, for instance, WIFI, and snooker is played by boys mostly but when MSF started, we were mixed, girls used to come also but, now mostly boys are coming. So, I think if games would be brought back, both girls and boys can access the services because currently most are boys.” I20, male youth, 18-19

Irregular supply of menstrual hygiene products further discourages girls from visiting the youth centre regularly. Reliable and continuous provision of sanitary pads is essential not only for menstrual health but also for maintaining trust and engagement with adolescent girls.

“There is the issue of delivery of the commodities that we use every day here. For example, MHM commodities [Menstrual Hygiene Management] like sanitary wear can run out of stock for a month and then sometimes they are available for this month. This is affecting girls, they are not coming. So, when they are available, we then go and tell them that “sanitary pads are now available, you can come”, that becomes boring.” I22, FGD PE, 20-23y

Token availability was also raised as a problem, with stockouts or access barriers affecting participation. Finally, a separate television space for younger children was suggested to improve inclusivity and reduce conflicts over use.

◆ **Expanding outreach and tailored engagement for YPWUD in Epworth**

In Epworth, there is an urgent need to enhance engagement with YPWUD, particularly those using crystal meth. Many respondents emphasized the importance of structured, skill-based activities, such as welding, painting, catering, hairdressing, and sewing, to provide purpose, empowerment, and pathways out of survival strategies. Linking these adolescents to organisations like Young Africa could help redirect their trajectories toward self-reliance. Teenage pregnancies in this context are closely tied to school dropouts, poverty, and engagement in transactional sex, reinforcing the need for proactive educational outreach.

MSF should consider stronger school-based presence, to students and teachers, to provide accurate information, including SRH topics like menstrual hygiene, contraception, and emergency contraceptive pills, while also addressing the stigma that prevents some girls from returning to school during or after pregnancy.

Respondents stressed that outreach once a month is insufficient. More frequent and targeted community engagement, such as expanding peer educator-led services like HIV self-testing, pregnancy testing, and health education, is needed. For key populations, including sex workers, young people who use drug, and LGBTQIA+ individuals, suggestions included ‘moonlight outreach’ activities between 7–9 PM using mobile setups with tents and Land Cruisers to discreetly offer HIV testing, condoms, and ECP. One peer educator illustrated the challenge of unmet expectations among crystal meth users when trying to mobilise them:

“Some of the clients are ‘*dombo*’ [crystal meth] users... I have mobilized them to come, assuring them that they will receive the service at once, but when they come here and fail to get treatment at once, they end up giving us [PE] negative attitude in the community.” I22, FGD PE, 20-23y

To build trust and avoid backlash, services must be reliable and responsive to the urgent and often chaotic realities of young people navigating drug use and survival in Epworth.

◆ **Involve ambassadors from the bases**

One peer educator described MSF’s work as “creating an ocean, drop by drop”, acknowledging the gradual impact of current efforts while proposing a bold, community-rooted approach to reach young people in drug bases. Rather than trying to pull users away from their environment, he suggested leveraging the influence of individuals already embedded within those spaces, such as ‘plugs’³⁰ to act as harm reduction ambassadors. These individuals, if trained and supported, could gently guide behaviour from within the networks. While not advising complete abstinence, such individuals could reduce risky use and encourage more responsible decisions. Providing stipends and recognizing their peer influence could turn a high-risk setting into an opportunity for outreach, trust-building, and incremental change.

“Right now, we are trying to create an ocean of going drop by drop. Maybe if we could visit the drug-dens [bases], we get two or three ambassadors from there, with a stipend from MSF for doing their work. Like the plugs for example. Get the plugs to act as peer-educators in the drug-dens. And they will not advise the people to stop taking drugs but influence them. They could say, my friend you had three already, I think, for today that’s enough. And tomorrow, they might reduce the intake.” I35, IDI PE, 22y

This participant emphasized on infiltrating the drug bases as a starting point and then go further engaging the plugs and jazzman.

“First, we infiltrate their dens. Maybe as a next step we could give them tasks. Like, can you do this for us? Can you do that for us? Bit by bit. Taking them for one or two trainings, and then giving them maybe T-shirts or IDs, so that they feel important in their own way. And then, they can start preaching our message themselves. Maybe not mainly for drug abusers first but bit by bit we will be slightly going in that direction. Get tested, practise good hygiene, do this, do that.” I35, IDI PE, 22y

³⁰ Plugs sell drugs under the Jazzman. Refer to the chapter 4.1.1

◆ Strengthening community work and the role of peer educators

Peer educators play a vital role in bridging the gap between MSF services and vulnerable youth in the community. However, their outreach work in areas like Mbare and Epworth is not without challenges. Participants emphasized the importance of improving how PEs are known and perceived in their communities. Some respondents mentioned that PEs tend to focus on adolescents who are already receptive to support, while others, those more isolated, staying in bases or/and under the influence of drugs, or dealing with heightened vulnerability, are sometimes left out due to the difficulty or risk involved in reaching them. This points to the need for enhanced training on how to engage harder-to-reach individuals, including strategies for managing resistance or fear and assessing personal safety in unpredictable or intoxicated environments like crystal meth users particularly and bases. Beyond just identifying willing individuals, peer educators should be equipped to understand and navigate the broader barriers young people face, such as shame, denial, or hostility. These concerns are echoed in the following quote, which underscores both the physical and emotional risks PEs face in their community interactions:

“PE should be known in the community, as approaching certain people is difficult and they are afraid; train them how to approach the difficult ones, not the ones who are willing.” I47, IDI HCW

Furthermore, peer educators face significant challenges when attempting to engage young people who use crystal meth, particularly due to the location of the youth centre being close to the police station. This proximity fosters fear among users that seeking support could lead to arrest, especially as the use of crystal meth is criminalized. As one respondent explained, “They once told us that we are mobilizing them to come to the youth centre through PE with a hidden agenda of getting them arrested by the police...”

“Last time I did some errands with Doris, she also realized that the errands we did were difficult. There are some groups of people that Doris wanted to interview like the ‘*dombo*’ users, and honestly speaking, those people are difficult to mobilize. They don’t like to come to this place because it is near a police station. They prefer that we go and see them at their hotspot areas. They once told us that we are mobilizing them to come to the youth centre through a hidden agenda of getting them arrested by the police. I22, FGD PE, 20-23y

Many young people expressed a strong preference for peer-to-peer interaction, particularly when it comes to seeking health information or services. They explained that peers who are embedded in the same social environment, familiar with the daily realities, language, and challenges of “*Ghetto youths*”, can provide not only relatable support but also practical assistance. Trust is more easily established when the peer is someone they already know, have socialised with, or recognise as “one of them.” In such relationships, care and advice are more likely to be accepted and followed.

“You are saying it’s easy for you guys to approach someone of your age who is friendly, someone who networks with ‘*Ghetto youths*’ so that when you fall sick, you can easily approach that person knowing that he is one of you.” I42, FGD school boys, 19-21y

MSF should reinforce community outreach through peer educators already working across all seven wards of Epworth. These educators are best positioned to approach crystal meth users in their own ‘hotspot areas’ where they feel safer and less scrutinized. Given the sensitivity and mistrust involved, outreach must be discreet, community-rooted, and based on relationship-building over time. Strengthening peer-led efforts in these contexts, supported with adequate resources, mobility, and safety protocols, will be key to engaging the most hidden and at-risk adolescents.

◆ **Promote self-care through community distribution and education**

MSF should further invest in promoting self-care options for adolescents and young people, particularly through its existing peer educator and community health mobiliser networks. Building on current practices, such as HIV self-testing, peer-to-peer counselling, and psychological first aid, there is strong potential to expand into community-based self-care solutions. One promising example is the use of Sayana Press, a self-injectable contraceptive. If PE were trained and equipped to provide information and distribute Sayana Press directly within the community, it would help overcome access barriers for adolescents who may be unable to visit clinics. As highlighted, not all young people who need contraception are coming to the health facility, bringing services to them could bridge this critical gap.

“There is a self-injectable contraception called Sayana Press, being an organisation working with PE, I think if they are trained, they could go and offer the service because its self-injectable, they could go to the community and give information on Sayana Press and distribute it to the communities. Doris, do you think everyone who wants contraception is coming to the clinic?” I12, IDI HCW

◆ **Offer discreet identifying materials to reduce stigma and boost confidence**

Support group members, particularly those involved in sex work, expressed the need for neutral MSF-branded t-shirts to wear during community activities. Such clothing would help them blend in, reduce the risk of being identified or followed due to their association with MSF transport, and enhance their self-esteem by signalling formal program participation. A simple t-shirt, not identical to peer educator uniforms, could serve both a protective and empowering function. Additionally, it could help to encourage others to attend support groups. One of the peer educators explained how this request was raised:

“There is an issue raised in the support groups for sex workers that they also require t-shirts, just like the DREAMS program. The group said that people from the community are now aware that there is a car from MSF that comes to pick them up. they suggested that they could have t-shirts that can deceive people from the community that its work related, and people will think that they are conducting a certain program. This won’t give the impression that they are all sex workers. They don’t want people to know that they are into sex working.” I22, FGD PE, 20-23y

6 Conclusion

This assessment explores the lived realities and perceptions of adolescents and young people in Mbare and Epworth, shedding light on how drug and substance use is deeply intertwined with socio-economic hardship, emotional distress, and sexual and reproductive health risks. Substance use among youth is not simply a matter of individual choice or rebellion, it is often a coping mechanism in response to poverty, social exclusion, discrimination, and family breakdown. These challenges are further compounded by stigma, barriers to accessing youth friendly SRH services, and limited opportunities for education or income generation.

The results highlight that young people, especially those who are engaged in transactional sex, use drugs, identify as LGBTQIA+, or have experienced teenage pregnancy, navigate complex transitions with limited support. They are often misunderstood, judged, or silenced by both their communities and the systems meant to serve them. From the shame of seeking STI treatment to the economic pressure of returning to transactional sex after childbirth, the vulnerabilities they face are profound. Yet, their voices also reveal resilience, awareness, and a desire for change: for long-acting contraception, harm reduction, safe spaces, information, peer support, and dignity.

Addressing these interconnected issues requires moving beyond medical care alone. MSF and partners must adopt a holistic, youth-centred approach, one that builds on existing strengths and listens closely to what young people say they need. By supporting meaningful activities, fostering empowerment, engaging credible messengers like PE and CHM, and investing in long-term partnerships, we can help shift the structural conditions that keep youth trapped in cycles of risk. Doing so is not just essential for their health, it is foundational for their future.

If the present moment is where many young people seek refuge, then let us work together to make that moment safer, kinder, and full of possibility.

7 Annex

7.1 References

7.1.1 Articles

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7.1.2 MSF Internal documents and reports

2024: MSF Mbare project document



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2022: Mbare KP engagement strategy



2022 - Mbare_KP
engagement strateg

2022: Mbare MH and drug abuse proposal



Mbare MH and
drug abuse proposa

7.2 Anthropologist's work plan during the field stay

WEEK 1

Wednesday	26 March	Flight Vienna Addis Abeba
Thursday	27 March	Flight Addis Abeba to Harare
Friday	28 March	CST office briefings
Saturday	29 March	Literature reading, preparation
Sunday	30 March	Literature reading, preparation

WEEK 2

Monday	31 March	Preparation work and briefings
Tuesday	1 April	Mbare project visit and assessment preparation with HPAM and PE
Wednesday	2 April	Matapi Youth Hub visit and briefings, meeting with PE, translator and transcriber recruitment
Thursday	3 April	1 FGD YPSS, 2 FGD YPSS, 3 FGD YPWUD
Friday	4 April	4 FGD YPSS, 5 YPWUD
Saturday	5 April	
Sunday	6 April	

WEEK 3

Monday	7 April	6 IDI PE, 7 FGD YPSS
Tuesday	8 April	8 FGD in-schoolboys, 9 FGD in-schoolgirls
Wednesday	9 April	10 FGD YPWUD, 11 FGD KP, 12 IDI CHW
Thursday	10 April	13 IDI in-schoolgirl, 14 IDI in-school boy, 15 IDI head teacher, 16 PI teenage mums, 17 IDI teenage mum,
Friday	11 April	18 FGD YPLWH girls, 19 FGD YPLWH boys
Saturday	12 April	
Sunday	13 April	

WEEK 4

Monday	14 April	20 FGD male youth, 21 GD CBO, 22 FGD PE Epworth
Tuesday	15 April	23 FGD in-schoolboys, 24 FGD in-schoolgirls, 25 FGD kids
Wednesday	16 April	26 IDI CBO, 27 IDI PE, 28 FGD CeSHHAR YPSS, 29 IDI CBO
Thursday	17 April	30 IDI KP, 31 FGD YPWUD, 32 IDI HCW
Friday	18 April	Literature reading
Saturday	19 April	Literature reading
Sunday	20 April	Transcripts reading

WEEK 5

Monday	21 April	OFF
Tuesday	22 April	33 FGD teenage mums, 34 FGD teenage mums, 35 IDI PE, 36 IDI PE, 37 IDI HCW
Wednesday	23 April	Flight to Cape Town, SAMU office meetings 38 PI ADO living in the street, 39 IDI KP, 40 IDI YPWUD
Thursday	24 April	SAMU office meetings 41 FGD YPWUD
Friday	25 April	42 FGD in-schoolboys using drugs, 43 in-schoolgirls using drugs
Saturday	26 April	OFF
Sunday	27 April	Flight from Cape Town to Harare

WEEK 6

Monday	28 April	44 IDI HCW, 45 IDI HCW, 46 FGD PE Mbare Clinic
Tuesday	29 April	47 IDI HCW, 48 FGD YPWUD, 49 IDI HCW
Wednesday	30 April	50 FGD in-schoolboys and girls, 51 PI CBO
Thursday	1 May	OFF

Friday	2 May	52 PI YPWUD, 53 YPSS
Saturday	3 May	
Sunday	4 May	

WEEK 7

Monday	5 May	Transect walk Gaza, Joburg lines, Matapi flats, 54 PI YPWUD
Tuesday	6 May	Transect walk Epworth, touch lines mainly, brothel, bars
Wednesday	7 May	Data validation discussion with assessment team, debriefing Zahra
Thursday	8 May	First findings feedback and debriefing Mbare project PMR Charlotte
Friday	9 May	Flight from Harare to Addis and from Addis to Vienna
Saturday	10 May	Arrival in Vienna

Abbreviations

ADO adolescent, **AYP** Adolescent and young people, **CBO** community-based organisation, **CeSHHAR** Centre for sexual Health and HIV/AIDS research, **CST** country support team, **FGD** Focus Group Discussion, **HCW** healthcare worker, **HP** health promotion, **HPAM** HP activity manager, **IDI** individual in-depth interview, **LGBTQIA+** Lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual or allies, + represents other identities not explicitly listed, such as pansexual, non-binary, genderqueer, two-spirit, and more, **PE** peer educator, **PI** paired interview, **PMR** project medical referent, **YPLWH** Young people living with HIV, **YAADS** Youth advocates against drug and substance, **YPSS** young people selling sex, **YPWUD** young people who use drugs



The Vienna Evaluation Unit

The Vienna Evaluation Unit was established in 2005, aiming to contribute to learning and accountability in MSF through good quality evaluations. The unit manages different types of evaluations, learning exercises and anthropological studies and organises webinars for evaluators. More information as well as electronic version of evaluation and anthropology reports are available at: evaluation.msf.org