Communicating Reproductive Rights to Marginalised Girls and Teenage Mothers at Risk of HIV Infection in Rural Zimbabwe

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Abstract

Access to information and resources are critical factors in ensuring that young girls are empowered to handle reproductive health issues. This is especially significant in the context of teenage Landa mothers' phenomenon, which has a generic relationship with the problem of HIV infection in rural Zimbabwe. The UN Population Fund (2013) indicates that 92% of sexually active women between the ages of 15 and 19 in largely rural Zimbabwe are in a relationship or engage in sexual intercourse regardless of being uninformed about their reproductive rights. It is this paper's position that uninformed girls and women pose a risk unto themselves and their children, which impacts on the fight against new HIV infections. We argue that reproductive health information is central to the prevention of HIV infection and AIDS related deaths. This paper critically appraises existing communication strategies in the dissemination of reproductive health information in rural, marginalised areas; discussing gaps, weaknesses and possible future directions in reaching vulnerable girls and women in the periphery. Young girls have limited access to information, medical services, support and resources that can empower them to prevent unplanned teenage pregnancies and attendant risks like HIV due to common preconceptions about the taboos of teaching 'young' people about 'adult' issues in a culture-conscious society.

Keywords: health communication, teenagers, girls, information, resources, culture, HIV, mass media

Introduction and Background

The media in Zimbabwe is awash with success stories of reproductive health and HIV and AIDS programming in the country (UNAIDS 2015). However, we argue that this programming is concentrated in the metropoles, with the latest youth initiative, Students and Youth Working on Reproductive Health Team (SAYWHAT) that was founded in 2003, focusing solely on higher and tertiary education institutions of Zimbabwe. All these institutions are located in urban areas. Clearly, there is need for more deliberate and more rigorous programming that takes into consideration girls and teenage mothers at risk of HIV infection in the rural parts of Zimbabwe. The rural girl (and teenage mother), seems to be excluded from this programming. Even the few programmes that are taken to the peripheries of Zimbabwe, for example the National Behaviour Change Programme rolled out starting 2006, are designed from an urban perspective.

This paper argues that for any reproductive health and HIV programming to be successful and to have impact on the majority of Zimbabwean girls and teenagers, it should have, as its central driving force, a deliberate and targeted health communication framework. This emanates from the reality that access to information and resources by the youth is the critical tool that can allow young girls and teenage mothers to deal with reproductive health issues and dilemmas they are faced with. In a significant number of cases, adolescent girls are prematurely catapulted into motherhood, and therefore, adulthood. Further, they often find themselves dealing with more than just motherhood as they have to contend with life threatening and debilitating health and wellness issues like Sexually Transmitted Infections (STIs) including HIV.

Youth sexual and reproductive health and HIV and AIDS have been topical issues in Zimbabwe from the past three decades to date as government and non-governmental organisations have spent millions of dollars in reproductive health and HIV and AIDS programming. Programming for the twin health challenges has often been integrated in some of the cases and mostly separated. For instance, the government of Zimbabwe has two huge parastatals; the Zimbabwe National Family Planning Council (ZNFPC) and the National Aids Council (NAC) that solely attend to reproductive health and HIV and AIDS respectively. This paper calls to attention the centralisation of communication in the implementation of all programmes relating to these two

potential threats to wellness and prosperity. The study proposes the Health Belief Model (Becker 1974), for the achievement of sustainable health intervention among girls and teenage mothers in rural Zimbabwe. The Health belief Model proposes that a person's behaviour can be predicted based on how vulnerable the individual considers themselves to be.

Health communication concerns itself with the communication strategies sought and used by individuals in a society in an attempt to maintain healthy lifestyles and contend with health and wellness related issues in all spheres (Rosenburg 1996). Health communication, therefore, places communication at the centre of the strategies that groups and individual members of a community can use to help make decisions that enhance and promote health and wellness (Jackson & Duffy 1988; Piotrow *et al.*, 1997). Over the last few decades, health communication has been proved to be critical to both individual-based and community-centred disease prevention and health promotion interventions (Finegan & Viswanath 1990).

In Zimbabwe, health communication still needs to be promoted as programming is still not taking into consideration the communication variable of health interventions. Mass media is still hardly utilised as a tool for health communication as indications on the ground are that the reproductive health issues are hardly covered. The reproductive health story, which seems to be separated from other health issues like HIV and AIDS in the news, is sparse and infrequent in the Zimbabwean mass media. Where it appears, it is often a recital of statistical issues relating to teenage mothers, early sexual intercourse among girls in school and several other figures often lifted annually off the Zimbabwe Demographic Health Surveys (ZDHS).

Literature Review

The Zimbabwean Context

The total population of Zimbabwe was 12 973 808 in 2012. Females were 6 738 877 and males were 6 234 931. The proportion of the male and female population was 48% and 52% respectively (Zimbabwe Population Census 2012). A total of 48 percent of the female population was in the age group of 15 to 49, years which forms the reproductive group. Zimbabwe has a broad base population pyramid indicating that the population of Zimbabwe in 2011 was youthful (42% under 15 years). In the same year, girls aged between 10 and 24 years constituted 33% of the population. This is the age group under

study in this paper. The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), Article 14 states the need for State Parties to take into account the particular problems faced by rural women and the significant roles which rural women play in the economic survival of their families, including work in the informal sector. State Parties are also obliged to take all appropriate measures to address issues of rural development and access to basic services such as health, family planning, education and access to credit for rural women. The 2011 statistics revealed that 68.6 % of the population resided in the rural areas while the remainder, 31.4 % resided in urban areas. A total of 52% of the population living in rural areas were females. Rural women constituted 36% of the total population (Zimbabwe National Statistics Agency 2012).

Zimbabwe is one nation that is still steeped in conservative customs that govern relations between parents and children (Kambarami 2006). It is not surprising, therefore, to find a home in which parents have never discussed sexual and reproductive health issues with their teenage children. Subjects such as sexuality, safe sex, contraception, dual protection from Sexually Transmitted Infections (STIs) and unwanted pregnancy are still perceived as specifically tabooed, especially in rural areas where there are conservative cultural and religious beliefs, norms and values. While countries signed agreements at the 1994 International Conference on Population and Development (ICPD) to protect and promote adolescent reproductive health education, information and care; Zimbabwe is one nation in which adolescents, particularly girls, are treated as if they were children who are not in a position to access information on sexuality, reproductive health rights or dual protection (Centre for Reproductive Law and Policy-CRLP 1998). Dual protection information deals with knowledge of simultaneous prevention of STI transmission; and prevention of unwanted pregnancy (CRLP 1998).

The Zimbabwe Population Clock indicates that the current population sits at 15,937,973 with the female population constituting 50.7% with 8,076,444 females. Males constitute 49.3% with 7,861,530 males (United Nations Department for Economic and Social Affairs 2016). Following the 2011 and 2012 official statistics trends, it therefore follows that while the population is experiencing effects of the shrinking government resources directed towards health and education; and the reduced interventions from Non-governmental organisations; the adolescent population in need of education and health intervention has continued to grow hence the need to

interrogate efforts to improve health knowledge and health seeking behaviours that mitigate teenage pregnancies and transmission of HIV.

According to a comprehensive report published by the CRLP in 1998; the bulk of the challenges that adolescent girls and boys face emanates from their parents' and their government's state of denial. Both rural and urban parents in Zimbabwe share a common belief that adolescents are too young to indulge in sex. Their ideal expectation of abstinence till marriage engenders resistance in preparing for the inevitable; which is early sexual debut. As reported in the Zimbabwe Demographic Health Survey of (2010-2011), 33 percent of women aged between 20 and 49 were married before reaching 18 years of age; 22 percent of the Zimbabwean women had their first sexual intercourse forced against their will and 30 percent of Zimbabwean women had experienced sexual violence since the age of 15. What worsens the risk of girls being violated sexually in Zimbabwe is that 'the girl child is more likely to drop out of school, to work in the farms and not to go to school at all than the boy child in Zimbabwean homes' (Zhou & Landa 2013; 402). Zhou and Landa (2013) observe that while such practices as wife inheritance, forced marriage and appeasing of avenging spirits by offering a girl as compensation have decreased significantly over the years, there are still isolated cases of such occurrences in Zimbabwe.

The Zimbabwe Multi-Indicator Cluster Survey (Mics) of 2014 indicates that girls in rural areas enter marriage before the age of 15 to spouses 10 years older than them. Furthermore, 24.5% girls aged between 15 and 19 were already married or in a sexual union, compared to 1.7% of boys in the same age group. This further positions girls and teenage mothers at more a risk of contracting HIV than their male counterparts. This study argues that while girls are more at risk than their male counterparts, rural girls are in an even worse position as compared to their urban counterparts. It was the purpose of this study, therefore, to explore ways in which health communication can be brought into reproductive health programming to mitigate these risks.

The government of Zimbabwe has, as recently as 2016, actively reacted to the abuse of girls and women. The Constitutional Court of Zimbabwe banned the marriage of children under the age of 18, striking off the Section 22 (1) of the Marriages Act (Chapter 5:11) which allowed children of 16 years to marry. The court upheld Section 78 (1) of the Constitution that sets 18 years as the minimum age of marriage and declared that any law to the contrary was unconstitutional. This reconciliation of the Marriages Act with

the constitution has been seen as the first step towards stopping the abuse of women, which has an impact on the reproductive health.

A qualitative formative audience research conducted by Jana *et al.* (2012) explored the challenges faced by youths in accessing credible sexual and reproductive health information in nine countries namely Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. The findings of the regional study revealed that youths face a plethora of challenges that range from client-health worker communication dynamics to unfriendly government policies all exacerbated by a media exhibiting double standards. Jana *et al.* (2012) engaged in their study from a prevention and human rights paradigm. While the study makes a critical contribution to intervention frameworks with regards to youth sexual and reproductive health, it does not address the immediate crisis of teenage/adolescent mothers in rural or marginalised communities. To state that girls in rural areas of the global south are a forgotten and disadvantaged group is axiomatic. It is therefore fundamental to explore how sexual and reproductive health information can be communicated to them in-order to minimize the risk of early and unwanted pregnancies and HIV as intended in this paper.

Ngwenya (2015) recently engaged in a case study exploring Filabusi youths access to sexual and reproductive health information in rural Zimbabwe. The study obtained data through focus group discussions and in-depth interviews to ascertain existing knowledge, behaviours and gaps. Findings demonstrated that youths did not have adequate access to health information that could sufficiently inform sexual and reproductive health behaviour. Ngwenya (2015) further established that sexual issues are not sufficiently dealt with in schools or in the home. This study is essentially relevant to the discourses of youth sexual and reproductive health as it focuses on youths in the margins. However, there is a yawning gap in which the organic relationship between lack of or inadequate health information and adolescent mothers is left unexplored. This paper therefore, seeks to interrogate the nagging questions that drive the teenage mothers' phenomenon all drawing from the communication of credible health information.

Theoretical Framework

This paper adapts Becker's (1974) socio-psychological Health Belief Model to

provide a framework for sustainable reproductive health and HIV programming in rural Zimbabwe. The framework manipulates effective communication strategies for development of sustainable programming premised on access to information by rural communities. We propose that collective individual preventive health actions, where individuals are aware of benefits of and barriers to taking a preventive action, contribute towards an effective communication strategy that can be utilised for the creation of sustainable reproductive health programming and for sustainable public health programming in general. It locates communication, which involves awareness campaigns, educational drills and mass communication, at the centre of efforts of sustainable programming and health consciousness. It has been found that failure by individuals to comply with health and wellness actions is mostly to do with communication. An effective communication strategy functions to help change mindsets to focus on prevention as opposed to mitigation, which is very costly both in terms of resources and where human life is concerned.

The Health Belief Model is premised on several variables. However, two of the variables are closely related to this study and these are; 'risk (perceived susceptibility) and the seriousness of consequences (severity)' (Corcoran 2007). Of course, 'an individual's perception of the benefits of and barriers to taking and preventive health action to prevent disease or illness' (Rosenburg 1996), which is another variable, is subsumed in the two dimensions stated above. We argue, in this paper, that for an individual to know what risks they are exposed to and for them to estimate the severity of the consequences of their behaviour, access to information is critical. These risks are central to reproductive health and HIV and AIDS as wellness issues. Communication, we argue, should take centre stage in any intervention relating to the two health issues of sexual and reproductive health and HIV. It is only through access to information that one can be able to weigh the cost and benefits of a certain behaviour pattern (Naidoo & Willis 2000).

The Health Belief Model of health communication is very relevant to this study in that it places mass media at the centre of communication strategies that are effective in getting advocacy messages to the communities and in packaging the messages in a comprehensible manner. However, the effectiveness of mass media as a communication tool in health or any other issues rests on the nature of the mass media a country has in the first place before we infuse health messages into it.

The potency of mass media lies in the allure that it holds for adole-

scents. The sample age group that we are focusing on comprises of persons who are transitioning from childhood to adulthood. Their fancy is captured by the 21st century digitized world of technology. With digital technology infiltrating even rural Zimbabwe, and with print newspapers having online versions, it is important for the media to exploit this opportunity to highlight the reproductive health story, the HIV story and the adolescent mother's story in order to reach various stakeholders, particularly the adolescents themselves. There is also need to utilise the social media, inclusive of such platforms as WhatsApp, facebook and sms. These have penetrated rural Zimbabwe in an unprecedented rate.

Methodology

The paper is a qualitative study. It employed critical discourse analysis (CDA) in the assessment of the frequency and depth of newspaper articles focusing on reproductive health, teenage pregnancy, teenage motherhood and HIV and AIDS in Zimbabwe. CDA as a methodology focuses on text as social practice in social contexts. It exposes how social inequality is initiated and reproduced in society (van Dijk 1993) and shows hidden causes of the status quo (Fairclough & Wodak 1997). Articles were drawn from the online versions of five newspapers in Zimbabwe in the period spanning from 2013 to 2016. A total of ten (10) newspaper articles drawn from The Sunday Mail, The Zimbabwean, Newsday and the Daily News were analysed.

Data was also drawn from in-depth interviews with a total of 120 teenagers drawn from two rural districts in the Midlands Province of Zimbabwe; Kwekwe rural and Gokwe South rural. These were female (80) and male (40). These ranged between the ages of 13 and 19. A total of 20 of the 80 female participants were either mothers, married or both at the time data was collected. A further 20 participants were drawn from elderly parents from the two selected districts. These were over the age of 30 and were not necessarily couples. While the study targeted specific age groups, the selection of the actual participants was done randomly. The two districts, Kwekwe and Gokwe South were purposively selected for their unique characteristics of being mining and farming communities respectively. These two activities (mining and farming) had been observed to bear an influence on the kind of lives families in these communities generally led. Furthermore, the school, home and church as institutions of all kinds of education and information

dissemination were assumed to be threatened by the hand-to-mouth lifestyle of farmers and miners suffocated by their precarious socio-economic realities. The lack of robust home and school pillars therefore leads to the examination of what the mass media has to offer as a mainstream source of information.

Discussion of Findings

Analysis of data relating to demographic profiling indicates that a total of six (30%) of the 20 elderly parents who participated in this study reported that they had been married before the age of 16. The legal age at which people in Zimbabwe are expected t o get married is 18. Further, data shows that a significant number of these participants had fallen pregnant before they were married, suggesting that pregnancy could have contributed to their getting married early.

It can also be deduced from the data that only seven (35%) of the 20 teenagers, who were either married, mothers or both at the time data was collected, had attained the age of 18 then. The rest ranged between 14 and 17 years of age. Also, only 2 (5%) of the 40 male teenage participants were parents and none of them were married at the time they were interviewed. Further, one of the two male participants who were parents at the time of the study was still going to a formal school while none of the teenage mothers in the sample were in any formal school. This could suggest that once they get pregnant or get married, it is difficult for girls to continue going to school. Even returning to school after delivering the baby seems not to be much of an option to the girl child while boys can continue going to school even when they become husbands and/or fathers.

Of the 20 female married teenage participants only one had been staying in an urban setting and only returned to her rural home after getting pregnant. The rest had been staying at their rural homes and had gone to schools in their rural homes since birth. This means the majority of the female teenage participants had a purely rural background.

Of greater interest in the data collection was the issue of access to information relating to reproductive health. Data indicates that there is a lot of HIV and AIDS education, especially in schools but little of reproductive health education anywhere in rural communities in Zimbabwe. There was even lesser of education relating to reproductive health and HIV and AIDS in the home. Parents find it a lot easier to talk to their children about anything except

reproductive health and HIV and AIDS, which are still tabooed issues in some parts of rural Zimbabwe. Talk of reproductive issues in the home front is unheard of. One participant said:

> *Hazvitaurwe kumba izvozo. Ndingataure izvozvo nababa vangu here?* (That is not a subject to be discussed at home. How can I discuss that [reproductive health and HIV and AIDS] with my father?)

This emphasises the reality on the ground; where subjects such as reproductive health and HIV and AIDS are tabooed subjects in such places as the home and the church. In line with the Health Belief Model, the particular participant above does not see the benefits of a discussion of such issues between parents and children. Cultural barriers and religious beliefs render sex a dirty and prohibited subject in the home. This leaves girl children at the mercy of just the school and the would-be abuser or violator. These findings relate to findings by Rimgheim and Gribble (2010) who established that with the exception of Senegal, reproductive health information was scarce among teenagers in African countries.

A total of 93 (76%) of the 120 teenage participants indicated that they had never been engaged in reproductive health and HIV and AIDS discussions with their parents beyond being told; '*ukaita nhumbu onotsvaga kokugara kwako wega*' (if you get pregnant you will have to move out of my house). Sometimes they are told; '*ungathola igcikwane ngelakho wedwa*' (if you contract HIV it will be your own problem). A total of 17 (14%) of the teenage participants had regularly had discussions about reproductive health, HIV and AIDS with their parents. The remaining 10% had discussed reproductive health, HIV and AIDS with their parents but not enough for the discussions to be described as productive and informative.

Data generally indicates that most of the parents also did not believe in open discussions about reproductive health and HIV and AIDS with their children. A total of only three (15%) parents said they had regularly sat their children down to discuss issues relating to reproductive health proactively; without relating to any specific incident. A further six (30%) claimed they had talked to their children about reproductive health issues only after certain incidents relating to their children misbehaving, which was reactive. One participant (5%) said she did not have children old enough to discuss reproductive health issues with as her first born was only four (4) years old.

The remaining 10 said they had never discussed reproductive health issues with their children at any point. The majority of parents (50%), therefore did not discuss reproductive health related issues with their children. The picture being painted here is that there is need for government and HIV programming partners to reinforce programming that encourages open discussion of reproductive health issues in the home.

A survey of newspapers indicated that the reproductive health story is infrequent and a critical discourse analysis of the sample articles when they appear the few times revealed that the reproductive health story is often just statistical as opposed to critical and educational. The stories are also often mere reports of whatever research findings academics and organisations would have established. This way, the reproductive health story is communicating to academics and programmers and not to the poor girl in the rural areas in Zimbabwe. These findings are not different from findings of a Zambian study by Radu and Gribble (2012), which established that the coverage of reproductive health issues was both low and poor as focus was on national and international issues and not on localised contexts.

The first sample story that was analysed was taken off the Sunday News of 5 July in 2015. The article is entitled; *Teenage pregnancies soar*. An analysis of the story reveals that the reporter is just presenting the facts and figures emanating from some research findings, comments of politicians, gender activists and experts. In one paragraph we read that a development analyst, Enock Musara said:

> The rural environment is not friendly to the girl child. It leaves her vulnerable. For example if in a family there is a boy and a girl and parents are struggling to send both to school, parents often decide to send the boy to school while the girl stays at home. That redundancy will leave her vulnerable to abuse as on most occasions marriage appears to her as her only escape route from her family's poverty.

In a typical hard news story fashion, the story does not have a message for the ordinary people. It does not even address programme implementers as it offers no suggestions on what then needs to be done, either by programmers, the girls themselves or their parents.

Another story, taken off the Newsday (of 30 May 2016) and is entitled

'Teenage pregnancies still high in rural areas', is also not communicating to the teenage pregnancy candidates. It is very statistical in nature and is a report on research findings of a survey. The statistics are given as early as the lead (introduction), which reads:

> CASES of teenage pregnancies have remained high in the rural areas, with one in 10 adolescent girls giving birth each year, despite massive awareness campaigns against child marriages, latest statistics from the Zimbabwe Demographic Health Survey (ZDHS) 2015 have indicated.

Subsequent paragraphs are also purely statistical. Focus is entirely on giving statistics as exemplified by the following excerpts:

> In 2010, 28% of adolescent girls from rural areas were already mothers compared to 16,4% of their counterparts in urban centres.
>
> For 2015, the percentage for the urban adolescent dropped to 10,3%, but for the rural adolescent girls, it was still high at 27,2%.

The question a critical discourse analyst would then ask after reading such a story is; so what? The approach needed therefore would be one that focuses on reaching out to the affected, vulnerable girls in a bid to provide credible information that will halt the teenage mothers' phenomenon as well as transmission of HIV. Mass media in all its forms presents a neutral and competent ally in breaking cultural and religious barriers through encouraging and improving parents and adolescent girls' communication on sexual and reproductive health issues.

Conclusions and Recommendations

Some parts of Zimbabwe remain preoccupied and obedient to traditional perceptions of girls and women as subservient to patriarchal rule despite advances in the global urban culture of empowering women that other parts of the country are adopting. In a society where it is not yet universally accepted that women's rights are human rights, it is important to think of alternative and creative ways of advancing women's reproductive health issues. Recognizing the power and effect of advocacy communication, the explored possibilities

that communication should play a central role in health programming in rural Zimbabwe can be implemented in areas located in the margins. Essentially, failure for girls and women to recognize their rights impacts negatively on them, their families, as well as their communities.

We also propose an advocacy role by the media where women's reproductive rights issues are topicalized, headlined and advanced in both national and community newspapers and radio. In this approach, media such as radio, television, print and electronic news editions, which are key communication vehicles in Zimbabwe, would have to invert their traditions in which male figures are idolized, interviewed and hero-worshipped. Women can then be raised in status and allowed to discuss their reproductive rights issues in public spheres. Such a large scale headlining of women's rights and reproductive health issues by the media is set to change mindsets of not only those men and women with access to the various media but also policy makers and traditional leadership that can lead in favour of the women whose rights are not being recognized. This paper acknowledges the challenges of confronting existing systems of patriarchy in all sections of society where there is authority; and proposes different strategies of exploiting communication trends and media space for the benefit of girls and women is as far as reproductive health is concerned. The study continuously pointed to the fact that reproductive health and HIV and AIDS issues cannot be dealt with separately as these inform each other.

The government of Zimbabwe should address the gap by enacting legal frameworks that protect against discrimination on specified grounds such as gender, age, marital or socio-economic status. More specific would be the creation of public education campaigns and awareness raising activities addressing the cultural taboos surrounding adolescent sexuality. Targeted advocacy with an emphasis on encouraging parents to override taboo and communicate with their children about sexual matters is critical in dealing with the adolescent mothers' dilemma in the face of HIV and AIDS.

The study established that health communication is central to disease and un-wellness prevention in rural Zimbabwe as it increases the community's awareness of potential risks and attendant consequences associated with certain social behaviours. Advocacy centred sexual and reproductive health communication has the potential to alter perceptions and attitudes of individuals and communities towards certain behaviours, norms and social patterns. This consequently fosters a rigorous and deliberate disease prevention

culture and a positive and proactive health seeking behaviour in the rural communities.

References

Center for Reproductive Law and Policy; Child and Law Foundation 1998. State of Denial of Adolescent Reproductive Rights in Zimbabwe.

Fairclough, N. & R. Wodak 1997. Critical Discourse Analysis. In Van Dijk, T. (ed.): *Discourse Studies: A Multidisciplinary Introduction. Discourse as Social Interaction.* London: Sage.

Finnegan, J. Jr & K. Viswanath 1990. Health and Communication: Medical and Public Health Influences on the Research Agenda. In Ray, E.B. & L. Donohew (eds.): *Communication and Health: Systems and Applications.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Jackson, L. & B. Duffy (eds.) 1998. *Health Communication Research.* Westport, CT: Greenwood.

Jana, M., I. Mafa, K. Limwame & A. Shabalala 2012. Challenges to Youths Accessing Sexual and Reproductive Health Information and Services in Southern Africa: A Review of Qualitative Research in Seven Countries. 5th Africa Conference on Sexual Health and Rights 19-22 September 2012, Windhoek, Namibia. Soul City Institute for Health and Development Communication and Regional Partners, Johannesburg, SIDA.

Kambarami, M. 2006. Femininity, Sexuality and Female Subordination in Zimbabwe. Africa Regional Sexuality Resource Centre and Health Systems Trust South Africa and University of Fort Hare. Understanding Human Sexuality Seminar Series: 'Culture, Femininity and Sexuality'.

Ngwenya, S. 2015. *Communication of Reproductive Health Information to the Rural Girl Child in Filabusi, Zimbabwe.* Dar es Salaam: African Health Sciences.

Piotrow, P.T., L. Kincaid, J. Rimon & W. Reinhart 1997. *Health Communication.* Westport, CT: Praeger.

Radu, W. & S. Banjac 2012. *Writing it Right: An Analysis of Zambian Media Coverage of Health Issues.* Open Society Institute.

Ringheim, K. & J. Gribble 2010. *Improving the Reproductive Health of sub-Saharan Africa's Youth: A Route to Achieve the Millennium Development Goals.* Population Reference Bureau.

United Nations Department of Economic and Social Affairs, 2016. Available at: http://countrymeters.info/en/Zimbabwe.

Van Dijk, T.A. 1993. *Elite Discourse and Racism.* London: Sage Publications.

Zhou, S. & N. Landa 2013. Life Narratives Mirroring the Feminisation of HIV and AIDS Trauma: Zimbabwean Perspectives of Coping and Resilience. In Pulla, V., A. Shatte & S. Warren (eds.): *Perspectives on Coping and Resilience.* New Delhi: Authorspress.

Zimbabwe Demographic Health Survey 2010-2011, 2012. Ministry of Health, Zimbabwe.

Zimbabwe National Statistics Agency 2012. Women and Men in Zimbabwe Report.

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