

# MIDLANDS STATE UNIVERSITY



FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF POLITICS AND PUBLIC MANAGEMENT

## **Gender relations and Reproductive Health in Zimbabwe: An assessment of cervical cancer among teenage mothers in Hurungwe Ward 13**

BY

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*A Research submitted to Midlands State University, Department of Social Sciences in partial fulfilment of the requirements of the requirements of Bachelor of Science (Honours) Degree in Politics and Public Management*

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## **DEDICATION**

This thesis is dedicated to my parents Mr E. Marisa and Mrs J. Marisa who have believed in me throughout my educational journey. They have been very supportive and always reminded me that patience and perseverance overcome the greatest difficulties.

I also dedicate this piece of hard work to: Tawanda Marisa, Sibongile Marisa, Tendai Marisa, Sheron Marisa, Romeo Moyo, Tichaona Marisa, Sharon Nyakatsapa, Emmanuel Mbewe and Carol Teguru.

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## **LIST OF ABBREVIATIONS**

HPV	Human Papilloma Virus
VIAAC	Visual Inspection with Acetic Acid and Cervicography
HIV	Human Immune Deficiency Syndrome
NGO	Non Governmental Organisation
STI	Sexually Transmitted Infection
POA	Program of Action
ICPD	International Conference on Population Development
ASRHR	Adolescent Sexual Reproductive Health

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## **ABSTRACT**

*Gender is one of the most important factors to consider in designing, managing and delivering reproductive health services. Yet gender may also be the least understood characteristic in terms of how women's and men's health needs differ and how those differences can be addressed. Adolescent mothers have been seen to be victims of gender disparities and as a result they have faced unprecedented health challenges such as STI infections and teenage pregnancies just to mention a few. This study sought to identify the extent to which gender relations have influenced the attainment of better reproductive health services for these adolescent mothers. The research was based on the case study of teenage mothers in Hurungwe district and how gender relations affected their attainment of reproductive health services with particular attention being paid to cervical cancer. Through a sample of fifty respondents who were identified through snowball sampling and purposive sampling, the research highlighted various issues of concern which included the existence of a high rate of child marriages in the area under study, the role played by religion in infringing the rights of the girl child as well as the issue of the centralisation of facilities which offer cervical cancer screening services. After analysing the findings, various recommendations were laid down and these include the strong participation of stakeholders in information dissemination and ensuring that cervical cancer screening facilities are easily accessible to the populace*



# **CHAPTER 1**

## **1.1 INTRODUCTION**

This Chapter will give a brief background of the topic under study as well as the problem that the researcher seeks to address. The possible threats and predicaments that the researcher might face during the research are also going to be highlighted in this chapter. It will also include the research objectives and research questions that will assist the researcher to come up with possible solutions of addressing the problem. The chapter will close up with the ethical considerations that the researcher has to observe throughout the research.

## **1.2 BACKGROUND**

Reproductive health implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. One interpretation of this implies that men and women ought to be informed of and to have access to appropriate health care services of sexual, reproductive medicine and implementation of health education programs to stress the importance of women to go safely through pregnancy and childbirth could provide couples with the best chance of having a healthy infant. Individuals do face inequalities in reproductive health services. Inequalities vary based on socioeconomic status, education level, age, ethnicity, religion, and resources available in their environment. It is possible for example, that low income individuals lack the resources for appropriate health services and the knowledge to know what is appropriate for maintaining reproductive health. The World Health Organisation assessed in 2008 that "Reproductive and sexual ill-health accounts for 20% of the global burden of ill-health for women, and 14% for men." The concept of reproductive health arose in the 1980s with a growing movement away from population control and demographic targets towards a more holistic approach to women's health. It can be noted that the programme of action (POA) of the International Conference on Population and Development (ICPD) in Cairo in 1994 was the first among international development frameworks to address issues related to sexuality, sexual and reproductive health, and reproductive rights. It was until then that the concept gained international acceptance and was heralded as a turning point for women's health. The POA defined sexual health as dealing

with the enhancement of life and personal relations, not merely counselling and care related to reproduction and sexually transmitted diseases.

Zimbabwe's population is relatively young with over 62% below 24 years according to the Inter-Censual Demographic Survey 2008 report. Young people face unprecedented health challenges such as Sexually Transmitted Infections including HIV, high levels of teenage pregnancies, unsafe abortions and limited access to sexual and reproductive health information. The 2012 ZDHS reported a high rate of teenage pregnancies (21%), for the 15 to 19 age group. The adolescents fertility rate is higher in rural (120 per 1000 girls) than in urban areas (70 per 1000 girls). These statistics demonstrate young people's limited access to family planning, ASRHR, Information, health education and communication. Dearth of youth-friendly sex and reproductive health education has contributed to an increase in early sexual debut and pregnancy. Early pregnancy and early sexual debut has immensely contributed to propensity to cervical cancer. While Zimbabwe has powerful tools in the health sector such as skilled attendance at delivery; emergency obstetric and newborn care, it's a mystery why even with such endowments Zimbabwe has failed to jump start credible reproductive health outcomes, particularly to curtail cervical cancer. However, these interventions are not available to the adolescent mothers and their new born babies who desperately need them. In addition, culture, traditions, and beliefs prevent these young mothers and their new born babies from seeking and receiving life-saving care after giving birth especially in areas such as the one under study. Taken together, these limitations leave poor young women—who have the greatest geographical and financial challenges to adhere to treatment—putting themselves and their babies at the highest risk of poor reproductive health outcomes. Young women are particularly vulnerable because they are less likely to be informed about how to prevent cervical cancer, early pregnancies, sexually transmitted infections and HIV infection. Sexual relationships between adolescent girls and men 5 to 10 years older are all too common. These relationships increase girls' risk of pregnancy, HIV infection and other STIs or susceptibility to cervical cancer because they are based on unequal power relations, with the older man in control, making it hard for the girl to negotiate for safe sex.

### **1.3 STATEMENT OF THE PROBLEM**

While health care programs have done wonders in transforming the lives of many women and societies around the world, its impact on Zimbabwean adolescent mothers does not warrant a special mention in development. Given the influx of investments in Visual Inspection with Acetic Acid and Cervicography (VIAAC) in Zimbabwe, one cannot stop wondering why specific changes in attitude, behavior, skills or knowledge in cervical cancer are obscure, the depth and extent of poverty and reproductive health problems is still escalating between and among women and girls of ward 13 of Hurungwe in particular and generally in Zimbabwe.

A range of barriers have prevented women in Zimbabwe from accessing let alone enjoying the outcomes in cervical cancer investment. The question now becomes what role or roles has gender relations played to prime the attainment of better cervical cancer and other reproductive health outcomes for young women and adolescent mothers in Hurungwe and Zimbabwe. To launch a successful initiative, it will be helpful to redefine the problem for which health care is seen as a solution to. This could be done by focussing more on problems of gender and poverty in Zimbabwe.

### **1.4 OBJECTIVES**

1. To evaluate the level of young people's understanding of reproductive health issues and to increase their access to information on adolescent sexual and reproductive health and human rights.
2. To examine the characteristics of gender relations in Zimbabwe and their impact towards health performance, access, awareness and understanding using a pro women approach.
3. To give recommendations on what can be done to increase young people's knowledge on reproductive health issues
4. To understand and increase access to comprehensive gender sensitive information and youth-friendly reproductive health services, cervical cancer services and education for adolescent lactating mothers.

## **1.5 RESEARCH QUESTIONS**

5. What role or roles have gender relations played in the development and impact of reproductive health outcomes in Zimbabwe?
6. What effects do gender relations have to ordinary young women and adolescent mothers' reproductive health, growth, diversification and development?
7. What is the attitude of the community in relation to women reproductive health care performance, awareness, understanding, services, access, usage and retention and their associated problems?
8. Is there a correlation between gender relations and sustainability of women's reproductive health outcomes and how does each impact on the other?

## **1.6 LIMITATIONS**

Some of the limitations that the researcher might face include difficulties in accessing health statistics from health facilities and others facilities which offer screening services. In addition, due to traditional and religious beliefs which invoke fear in the target group the researcher may find it cumbersome to easily identify them since they will be in fear of opening up. Also there are issues of distance which can pose as a problem to the research in the sense that since it is a rural set up some of the residential areas are not close together as compared to those in an urban set up.

## **1.7 DELIMITATIONS**

This study will be focusing on the activities and developments of women and girls reproductive health in ward 13 in Hurungwe in relation to services obtainable from the health sector in Zimbabwe. The research's catchment area is mainly Hurungwe's prominent gender roles defined community where distinct gender relations are concentrated. Face to face interviews and self administered questionnaires will be distributed in the area. The research could have spanned across growth points in the communal areas but due to time and budgetary constraints, it will be limited to ward 13, Hurungwe. However, health outcomes for women are basically the same and hence the responses can be representative of the community despite the geographical differences. Theoretically, the research will gather primary data from women in ward 13 and their strategic stakeholders and partners such as ministry of health personnel in the ward, gender and community development cadres in the

ward, women producer groups and NGO working with the groups and council officials. Secondary data will be gathered from these but not limited to the same.

## **1.8 ETHICAL CONSIDERATIONS**

A number of ethical constraints are to be considered as ethical standards require the researcher not to put the participant in a compromising position. The researcher may not expose their identity especially on sensitive issues which may cause risk or harm so it is important to first assure the participants that identifying information will not be made to anyone involved.

## **1.9 CHAPTER BREAKDOWN**

### **Chapter 1: Introduction**

This first chapter comprises of the background of the study which give a brief background of how gender relations have had an effect on reproductive health issues. It also highlights some stats on the number of women and girls who have been victims of unfavourable reproductive health issues such as cervical cancer and whether or not these figures have changed over the years.

After the background is the statement of the problem which is written following the common format of writing a problem statement, which answers questions such as; what is the problem? who is affected? and why is it a problem among others. Henceforth this section brings out the problem which is why specific changes in attitude, behavior, skills or knowledge in cervical cancer are obscure and the depth and extent of poverty and reproductive health problems is still escalating between and among women and girls of ward 13 of Hurungwe and generally in Zimbabwe despite the fact that a lot of investment has been done in Visual Inspection and Acidic Cervicography (VIAAC).

This chapter also brings out the research objectives that this research seeks to achieve. It also includes the questions that this research seeks to address. Moreover the chapter highlights the limitations which are the possible risks and threats that this research might pose and also the delimitations which are the positives posed by the research. Lastly, the chapter highlights the ethical considerations that the researcher has to observe throughout the research.

**Chapter 2: Conceptual and theoretical framework**

Chapter 2 explores all that has been written by other scholars pertaining to the topic being researched. The chapter drills through the various arguments that have been brought to the table by other scholars and in the process bringing out the deficiencies of the literature that the research intends to fill. This research shows that a lot has been done in developing countries in the bid to deal with reproductive issues such as cervical cancer among young women such as information dissemination as well as the setting up of VIACC services. However, the role played by gender relations in causing cervical cancer and other reproductive health problems as well as hindering the attainment of services has not been much highlighted. The chapter goes on to look at the Theoretical and Conceptual framework of the research which requires the researcher to discuss the various theories and concepts that explain, investigate, examine, support or refute the argument of the research.

**Chapter 3: Research Methodology**

The third chapter answers the questions of how the research will be conducted. It addresses various questions which include the research design to be used, the target population, the sampling techniques to be used which will determine who will be part of the research as well as the methods and tools of data collection

**Chapter 4: Data Presentation and Analysis**

The fourth chapter, the researcher presents the findings of the research after conducting field work. The data is presented and analyzed to enable the researcher to move to the next Chapter where they suggest recommendations and draw conclusions about the study.

**Chapter 5: Summary, Recommendations and Conclusions**

This chapter gives a summary of the results of the research, suggests recommendations of addressing the issue under research and draws conclusions about the phenomena under study

## **CHAPTER TWO**

### **CONCEPTUAL AND THEORETICAL FRAMEWORK**

#### **2.1 LITERATURE REVIEW**

##### **2.1.1 Introduction**

This chapter provides the literature review which summarises part of the existing research on gender relations and reproductive health in Zimbabwe. Attempts have been made to peruse related literature from previous studies on the same subject that were conducted by different researchers in developed and developing countries. In this chapter, various theories and models and are going to be discussed and also other issues such as cultural practices, child marriages among others and their relevance to reproductive health and cervical cancer in particular are going to be dwelt upon. The chapter is going to include also how cervical cancer is affecting teenage mothers and women in other continents and countries and the recommendations they have come up with.

#### **2.2 AN OVERVIEW OF GENDER RELATIONS AND REPRODUCTIVE HEALTH**

##### **2.2.1 Gender Relations and HIV/AIDS**

In sub-Saharan Africa the overall proportion of women living with HIV/AIDS is still rising and is now at 59%. However, when looking globally at young people, the proportion of women among the newly HIV-infected, as well as of people living with HIV/AIDS, is much higher. It can be noted that young women are the most affected. According to the recent World Bank report (2005) it was estimated that in sub-Saharan Africa, there are nearly 10 million young men and women aged between 15 and 24, living with HIV/AIDS, of which more than 75 per cent of these are women, reflecting a worldwide feminization of the epidemic. A similar message emerged from South Africa stating that youth prevention programmes were failing and HIV infection in girls aged between 15 and 24 had jumped from 5% to 17% in just three years (Cullinan 2005). In some cases it can be noted that infection rates are higher among young women than among young men due to various factors, many related to the social vulnerability of young women. This may lead to young women also infecting same-age men. On the contrary higher male HIV prevalence reflects men's and women's different lifestyles. Men are more likely to indulge in temporary same-sex encounters, buy sex and have more occasional heterosexual contacts as compared to

women. Due to cultural and social practices, it is not taboo when a man has many sexual partners but it is a different story for the women hence they become the victims of circumstances. In both cases, the trend is linked to patriarchal male behaviour.

Gender issues have become increasingly prominent in national and international work, and particularly as a development issue. It is now widely accepted that preventing HIV/AIDS is linked with improving gender relations. While much evidence has been gathered on the linkages, action and especially results are still lagging behind. People in one or several of four high-risk groups namely prostitutes, injecting drug users, men who have sex with men, or persons with sexually transmitted infections are most likely to be infected. It can be noted that gender relations has a part to play in all these aspects

Prostitution is an effect not only of poverty but also of gender inequality, and it reflects the exposed situation of many women. They are often the sole providers for their families and children. Other factors such as low education, unemployment and unequal rights to ply a trade for instance to open a business, sign a contract or own land can also contribute to prostitution, which can take many different forms including so-called transactional sex. In various parts of sub-Saharan Africa, prostitution has been a major route for the spread of HIV. Women and girls indulging in prostitution are also very prone to cervical cancer infection. In addition sharing of needles and syringes is a very efficient way of spreading HIV. It is also in some cases linked to prostitution, that is women and men financing their drug use by prostituting themselves and/or beginning to take drugs when becoming a prostitute. It can be noted that HIV positive women and girls are at a high risk of contracting cervical cancer.

There is also the issue of same sex relationships among men. These are clearly also a gender issue. Many of these men also live in heterosexual relationships, and neglecting them as a group risks contributing to the "bridging effect" that is HIV spreading from this population to women and thereby into the general population. However these cases are not much common in African countries as compared to European and other countries not in Africa. This is due to the fact that in most African countries this practice is still considered illegal. Moreover persons with STIs constitute a high-risk group for HIV, as STIs greatly increases the transmission of the virus, especially if it is linked to any of the above populations, or where HIV is common. Dealing effectively with STIs in any stage of the epidemic is a very effective



way to reduce the spread of HIV. One way to do this is to integrate such services with other health programmes such as family planning and maternal health programmes.

In a mature epidemic, there are factors and conditions that will influence the evolution, all of which have significant gender dimensions and these include sexual patterns. In most parts of sub-Saharan Africa sexuality is, to a larger extent, influenced by male dominance, as often evidenced by large age differences between partners for instance in the case of child marriages which are happening all around African countries. This appears to be one of several major determinants of HIV spread in many countries in this region. It cannot be disputed that when, with whom and how to have sex is largely determined by men for instance the use of condoms is determined by men in most cases. If a man does not want to use a condom during intercourse, the woman is expected to oblige despite the risks that may come with such an act.

Furthermore there is also the issue of widespread alcohol and other drug use. Widespread alcohol and drug use commonly among men play a major role to the unsafe sexual and injecting patterns that are encountered in many countries. Also, gender-based violence is a prominent feature of gender inequality, which is intimately linked to the risk of HIV transmission. These factors mostly affect women in those situations. In addition, practicing HIV/AIDS home-based care should not be ignored. This entails that care for family members suffering from HIV/AIDS complications largely is the responsibility of women and girls, who thereby tend to lose opportunities for schooling or income generating activities. This can augment their exposure to discrimination and poverty, adding to already existing gender inequity, and in turn an increased risk of exposure to HIV infection.

From the above mentioned issues, it can be noted that cervical cancer can also be caused by the same gender related factors that cause HIV transmission. Prostitution, having numerous sexual partners, drug and alcohol abuse among all the other factors leads to cervical cancer as well.

### **2.2.2 Gender Relations and STIs**

In both developed and developing countries, the increasing incidence and prevalence of STIs among adolescents present a serious challenge to their health and well-being. The four most

prevalent STIs are trichomoniasis, chlamydial infections, gonorrhoea as well as syphilis. The majority of these infections occur in developing countries, at a higher prevalence and incidence compared to developed countries. Several African studies indicate that risk of STI contraction is increased when the sexual partner is older. Also, a more sexually experienced partner may also expose an individual to a wider spectrum of infection, particularly gonorrhoea, trichomoniasis, genital ulcer disease and HIV. However it can be noted that there is high STI prevalence in developing countries due to factors such as child marriages which have proved to be of high prevalence in these areas as well as religious practices which allow marriage of young and many wives. Also due to the patriarchal society which exist in most African countries it is difficult for women to question their husbands when they have multiple sexual partners and also in the cases of child marriages the young girls will not be in a position to negotiate for safer sexual practices such as using protection hence they become more susceptible to STIs. Therefore it can be noted that due to unhealthy gender relations such as that of women oppression and child marriages, teenage mothers are more prone to STI contraction.

In addition it can be noted that the main impetus for treating STIs has been the HIV epidemic, which has affected as many as 25% of sexually active girls in some sub-Saharan African countries. However, even in countries where HIV infection is at low prevalence, STIs are associated with other serious issues in the non-pregnant and/or pregnant teenager, such as ectopic pregnancy. In general STIs appear to pose a much greater problem in pregnant adolescents than in older pregnant women who are more sexually experienced and more likely to be involved in a stable monogamous sexual relationship at the time of conception. Adolescents have miscarriages more often than do older women – a difference which may be partly attributed to STI. The younger the individual, the greater the likelihood that any given infection is a primary infection, which in non immune women will cause greater morbidity. Gonorrhoea and syphilis are serious infections of pregnancy. Sexually active adolescents place themselves at risk of an STI when they engage in unprotected sex. The context in which adolescents become sexually active very much influences how they deal with sexual relationships, the extent to which they are able to protect themselves and how they perceive the unwanted outcomes of sex. However it can be noted that most of these teenage mothers do not have the opportunity to negotiate for safe sex with their male counterparts due to age differences.

### **2.2.3 Gender Relations and Reproductive Health**

The health status of persons is often affected by whether you are male or female, as well as the gender stereotypes that are prevalent in any particular society. In many African societies, women are expected to stay at home take care of children, the elderly and the frail, as well as cook and clean. Men, on the contrary, are expected to earn money and be responsible for the financial well-being of their families. Therefore this means that in these societies, women may have fewer educational opportunities and men may have less opportunity to spend time with their children. Societies give different values and different status to these gender roles. In most societies, the types of activities that are carried out by men are valued more than those done by women. Though women's work is critical to the functioning of society, it is seldom adequately valued. If women are healthy and empowered to make decisions about their bodies, they will be more economically empowered and they will be able to gain more social power. Thus it can be noted that appropriate health care and gender equality is strongly related, just as gender inequality is linked to disease and neglect. However in African societies, due to the fact that women are confined to doing household chores and are hardly educated, they do not have that voice to speak out. As a result they have accepted oppression and consider it as their way of living. This then brings their reproductive health to a critical stage since they continue allowing male dominance to hinder them from accessing health services.

## **2.3 CASE STUDIES**

### **2.3.1 Cervical Cancer in Zimbabwe**

Many of the cancer cases in the Zimbabwe are HIV related. Zimbabwe is among the top twenty two countries in the world in terms of the burden of HIV hence the country is facing a huge cancer challenge. Priority areas to be considered include prevention, early detection as well as care and support. The focus should be on high-impact, low-cost interventions such as vaccination against Human Papilloma virus (HPV) which causes the cancer and cervical cancer screening using visual inspection of the Cervix (VIAAC). These are the most appropriate measures for resource-constrained countries such as Zimbabwe. Furthermore, as most cancers present at an advanced stage, it is important to scale up early detection. Equally important, is making treatment and care available and accessible to all patients, as opposed to the current situation whereby services are mainly centralized there by making it difficult for

some of the clients to access the services. According to World Health Organization (WHO) projections, the majority of people with cancer worldwide live in developing countries such as Zimbabwe. These countries are facing a growing double burden of both infectious and non-communicable diseases such as cancer and this is causing enormous pressure on already overstretched health systems. Zimbabwe, a low-income developing country in southern Africa, has a population of 15.76 million, with a life expectancy of 49 years. In Zimbabwe, cancer is a major cause of morbidity and mortality, over 5,000 new diagnoses and over 1,500 cancer deaths per year have been recorded. The most common cancers in the country are cervical cancer and Kaposi sarcoma; these are also the leading causes of cancer mortality. Analysis of data derived from the National Cancer Registry showed that 60% of cancers were HIV associated. Unfortunately, in Zimbabwe, like other resource limited countries, the majority of cancers present at an advanced stage and this makes the situation more cumbersome. Low survival rates are therefore chiefly a consequence of limited access to early detection and treatment.

A number of recommendations to deal with cancer in the country have been put forward and these include a national cancer plan which should underpin the priorities for cancer control. Also, Zimbabwe has a draft Cancer Prevention and Control Strategy, which outlines priorities for cancer prevention and control. In addition, a concerted effort by various stakeholders planned a feasible, cost-effective, appropriate, evidence-based and sustainable cancer prevention and control strategy. The aim of the strategy includes reducing cancer incidence, mortality as well as morbidity. According to the WHO, it can be noted that 30–40% of cancers are preventable. For resource-constrained environments such as Zimbabwe, prevention would be the most cost-effective intervention with the greatest public health potential. Zimbabwe has to formulate a national cancer prevention communication strategy. Additionally, access to cancer screening services should be improved through increased availability of cost-effective screening services and information dissemination. Screening by Visual Inspection with Acetic Acid and Cervicography (VIAAC) has been introduced at tertiary and at some secondary centers. This has been selected as the screening method for Zimbabwe due to the fact that it places less demand on the limited numbers of available pathologists, provides immediate results, the simplicity of the procedure and the potential for immediate treatment of lesions and its cost-effectiveness for both the woman and the health system. Plans are on-going to make VIAAC available for primary care and all other levels as

well. 18% of the sexually active women in the country were affected with cervical cancer in 2010 and of these 18%, 15% died of cervical cancer.

Hence forth it can be noted that cervical cancer might be cumbersome to eradicate due to the fact there is always a missing link in one way or the other. In Europe they have all the necessary equipment but they have poor information dissemination strategies. If they manage to send information to a large number of women and girls on the importance of accessing cervical cancer services even when they do not feel sick this might help in ensuring that everyone is screened and treated if need be. In African countries however, the case is the opposite. There is no equipment, there are limited resources and cancer screening points are not easily accessible. However they have tried to disseminate information to as many people as possible for instance in Zimbabwe there are behaviour change programs where by behaviour change facilitators educate the teenage mothers and women in rural and remote areas on cervical cancer issues and encourage them to go for screening. Though the teenage mothers and women may be willing to access these services it can be noted that due to poverty and lack of financial resources they might fail to travel to a town which offers the services from their place of residence. Hence it cannot be disputed that it is of paramount importance that screening facilities be located in various parts of the county for easy accessibility.

### **2.3.2 Cervical Cancer in Europe**

The case of cervical cancer in Europe is different from that in Africa. Whilst most African countries are finding it difficult to find ways of dealing with cervical cancer due to resource constraints, Europe has all the necessary means of preventing and dealing with cervical cancer. It has been clearly established that population based organised cervical cancer screening programmes can prevent up to eighty percent of the cases. In addition, in Europe there are two vaccines that are highly effective in preventing infection with two of the most common carcinogenic types of the Human Papilloma Virus and that could substantially reduce cervical cancer rates if deployed in population based programs that provide equitable coverage of the target population. Henceforth it can be noted that cervical cancer in Europe is neither a matter of further research nor is it a matter of resource constraints but rather a matter of the implementation of these public health programmes. There is also the European Cervical Cancer Association (ECCA) which is responsible for raising awareness of cervical

cancer and the means by which it can be prevented as well as to promote the implementation and the uptake of population based organised prevention programs equitably across the continent. Despite all these aspects mentioned above, cervical cancer remains a serious public health problem in Europe. From the standpoint of Europe as a whole, sixty thousand women develop cervical cancer and thirty thousand die from it every year while the number of women living with cervical cancer at any one point in time in Europe exceeds one hundred and seventy-five thousand.

### **2.3.3 Cervical Cancer in Sub Sahara Africa**

The burden of cervical cancer is quite low in developed countries of the world. It can be noted that the situation is quite the reverse in developing countries where it constitutes a major health problem. While the incidence seems to be decreasing in the former, it is on the increase in the latter. This is quite disturbing considering the fact that cervical cancer is preventable and curable at low cost with currently available methods. Sub Sahara Africa is the region with the highest incidence of cervical cancer in the world with affiliated high mortality affecting women at their prime. There are no screening programs for early detection of precancerous lesions within the countries of Sub Sahara Africa due to lack of resources. Most screening activities are done as pilot or research projects which are discontinued on completion hence they help only a few. South Africa is the only country in the region with a national cytology based screening program since 2001 but then coverage remains poor and the impact on invasive cervical cancer is still unknown (Louie et al. 2009).

The inception of HIV/AIDS epidemic that is highest in the sub region has elevated the problem of cervical cancer to a serious level. To compound the problem is the widespread lack of resources that is associated with the region. In sub-Saharan Africa cervical cancer accounts for 22.2% of all cancers in women and it is also the most common cause of cancer death among those women (Parkin et al., 2003). Women in sub-Saharan Africa lose more years to cervical cancer than to any other type of cancer due to the fact that they only get to know of its existence when it would have reached the advanced stage. Unfortunately, it mainly affects them at a time of life when they are critical to the social and economic stability of their families (Parkin et al., 2002). The true incidence of cervical cancer in many African countries is unknown due to gross under-reporting. Only very few countries have functional cancer

registries and recordkeeping is minimal or non-existent in many countries in the sub-Saharan region

### **2.3.4 Cervical Cancer in West Africa: The case of Nigeria**

Cancer has emerged as the major health problem globally with an estimated ten million incidences and six million cancer mortalities annually (Parkin, 2000). The projection shows that by 2030, 70% of all new cases will be found in developing countries (Boyle and Levin, 2008). The reason being population growth and increased life expectancy as well as high poverty levels. Only in Nigeria, more than ten thousand cancer deaths and about two hundred and fifty thousand incidences are recorded every year (Ferlay et al., 2010). In Nigeria, it was depicted that breast cancer is the most common cancer in females, followed by Cervical Cancer. Therefore it can be noted that cervical cancer is not the major type of cancer affecting the women and girls in Nigeria. Be that as it may be, it is still a cause for concern. Larynx and Kaposi sarcoma are found to be the least common cancer for both males and females in the Nigerian population. Some guidelines to aid the design of cancer control programs in Nigeria and border countries were brought to the table and these include public awareness on the importance of lifestyle and dietary modification as a component of health campaigns in decreasing cancer incidence. Also, there is need for development of regional oncology centres affiliated to tertiary health facilities for cancer treatment as well as further research. It was noted that it is of great importance that current cancer registries in Nigeria and border countries should also be organized into well-structured networks of population-based cancer registry systems coordinated by a national cancer registry.

## **2.4 FACTORS AFFECTING REPRODUCTIVE HEALTH**

### **2.4.1 Child Marriages and Reproductive Health**

Child Marriage can be defined as any marriage of a child younger than eighteen years old. Child marriage continues to be a challenge in the world especially in southern Asia and Africa. Though it affects both sexes, girls are the most affected as they are the majority of the victims. Child marriage causes untold suffering to the victims in the sense that it curtails the child's education, affects the general health, and puts the affected in a disadvantaged position in many ways than one. It can be noted that in India, almost half (44.5%) of women aged 20-

24 years got married before they reach eighteen years (Sinha,2009). Furthermore, girls in India grow up with the normative expectation of marriage within a socially determined social frame. In Latin America and the Caribbean, 29% of young women were married by age of 18 whilst in Southern Asia 48% that is nearly 10 million of young women were married before the age of 18. In Africa, 42% were married before they turned 18 (UNICEF, 2005). In Ethiopia and other West African Countries, some girls get married as early as 7 years and in Bangladesh, 45% of young women between 25 and 29 were married between the age of 10 and 14 (UNICEF, 2001). Some of the reasons behind this child marriage include bride wealth, creation of cement alliances, and status of women in the community as well as poverty just to mention a few.

It can be noted that child marriage causes untold suffering to the victims. It results in loss of development opportunities, limited life options and most importantly, poor health. Some of the health risks that come with child marriage include maternal mortality, sexually transmitted diseases, cervical cancer among others (International Center for Research on Women, 2007: UNICEF, 2001). According to the United Nations World Population Fund (UNFPA), in Africa, 60% of women and girls give birth without a skilled medical professional present. In most cases this is due to lack of finances to access proper health services and ignorance. Worldwide, 70,000 girls aged between 15-19 years die each year during pregnancy and child birth (UNICEF, 2005). This shows that the health of the girl child is adversely affected due to child marriage. The young girl is expected to go through the same process that the older women go through. They are not given special treatment though they will be very vulnerable. According to World Health Organisation 2012 report, every day, approximately 800 women die from preventable causes related to pregnancy and childbirth of which 99% are from developing countries. Maternal mortality is higher in women living in rural areas and among poorer communities and especially young adolescents. In assessing this fact critically, gender relations play a huge part as far as these child marriages and deaths are concerned in the sense that culture entrenches the fact that men have high status as compared to women. This coupled with vulnerability in terms of economic empowerment and decision making skills exposes the married children even more. Child marriage exposes the young girls to risk of contracting various diseases such as HIV and other sexually transmitted diseases. A study in Kenya showed that married girls had a 50% higher likelihood of contracting HIV infection than unmarried girls. The risk was even higher in Zambia at 59%. In Uganda, the prevalence



rate for girls 18-19 years was higher for married at 89% whilst unmarried girls were at 69% (Kelly *et al.*, 2003). The study noted that the age difference between the men and their wives was a noteworthy cause of this infection. Due to age differences, the husbands were likely to have had numerous sex partners. Those women who marry early and young remain vulnerable and powerless given the fact that there's a great difference in age between them and their spouses hence they cannot negotiate for safer sex practices and they cannot access health services without consent from their husbands. In addition they cannot ask their husbands to take an HIV test nor can they abstain from intercourse. For example, in Samburu traditions, it is believed that girls are the property of the community and therefore they are not enrolled in schools. The community believes that girls have no need for education because all their needs are catered for by their fathers and husbands of which the opposite happens to be true. Additionally, married girls are not economically empowered, they have poor access to health care and it cannot be disputed that their husbands have had multiple sexual partners. This among others has led to increase in cervical cancer among these young mothers. In Mali, cervical cancer has an incidence rate of 24.4% per 100,000 and is the second cause of death in the country. In Morocco, studies show that child marriage contributes to cervical cancer (Chaonki, 1998). It can be noted that in most communities, marriage is not seen to be complete without children. The married girls therefore are under pressure to consummate the marriage by giving birth of which child bearing poses a lot of health challenges to the married girls since their bodies will not be yet prepared for such business. During delivery young mothers are at a higher risk as compared to older mothers. Studies have depicted that married girls are more likely to die from childbirth due to various reasons such as postpartum haemorrhage, HIV Infection, malaria and even obstructed labour. The girls' pelvis is too small to deliver a fetus and without a caesarean section, the neonate dies and the mother is likely to die as well and is only fortunate if she survives. Many times obstructed labour leads to fistulas and more than two million adolescences are living with Fistulas. Unless the fistula is repaired surgically, the girls are bound to face a lot of challenges, face stigma and some are even sent back to their parents. Getting this surgery is next to impossible since the young girls do not have any financial power. Henceforth from the above discussion it can be noted that child marriages play a bigger part in the contraction of cervical cancer by teenage mothers in Africa and in some cases the girls are not even teenagers.

#### **2.4.2 Cultural and Religious Practices and their effects on Reproductive Health**

Reproductive health problems are caused by various factors and among those factors is the issue of cultural and religious practices. Though this applies more in African and developing countries it does not nullify the fact that these practices are also present even in developed countries. It can be noted that these factors are also linked to gender relations. Some of the cultural and religious factors that have an effect on reproductive health include polygamy, wife abuse and the fact that men have various sexual partners outside their marriage among other things. Due to the patriarchal setups in most developing countries especially in Africa, men's dominance is very distinct. Women in Africa and Zimbabwe in particular have not yet reached a level of equality and are still being dominated by their male partners. Women's subordination can be directly linked to the increasing number of women becoming infected with various illnesses such as HIV/AIDS and cervical cancer, especially within the African cultural context. It can be noted that culture plays a vital role in determining the level of health of the individual, the family and the community. This is particularly relevant in the context of Africa, where the values of extended family and community significantly control the behaviour of the individual. The behaviour of the individual in relation to family and community is one major cultural factor that has implications for sexual behaviour. Ngubane J (2010) states that in Africa, and according to African culture, men are permitted to have more sex partners than women, and often free to engage in commercial sex. As a result women become more susceptible to illnesses such as HIV/AIDS and Cervical Cancer among various STIs due to the unfaithfulness of their spouses. The issue of polygamy in African Society has proved to be one of the major causes of reproductive health problems amongst women. Due to the fact that women are subordinates of men they do not have a say on what and what not the men should do. Hence men can marry as many wives as they wish and can engage in sexual relations with as many women as they wish. One concrete example is that of King Mswati who chooses a new wife every time there is reed dance.

In addition it can be noted that men are deeply skeptical and resistant to gender equality and women have internalized many of the norms that sustain their subordinate position relative to men. Some men also think that gender equality benefits primarily the rich populace which is practically not so true. There are other cultural issues that pose as a threat to the relations between men and women such as the issue of son preference. The preference for sons over

daughters is strong in many societies. There are instances in some countries, for example China and India, where this can lead to selective abortion of female foetuses. In many societies, daughters are treated differently from sons. Daughters may be given less food, denied education opportunities, not taken to health services when they are ill, or trafficked for work, sexual exploitation or marriage. Due to this kind of treatment these girl children may end up opting for marriage as soon as they get a chance thus child marriages. Also due to the desire of having a son, most women end up having too many children in the bid of obtaining a male child and this has a n effect on their economic and financial status which may lead to issues of gender based violence. On the issue of bride price as a cultural practice In some cultures, for example in parts of the Middle East and South Asia, a man must buy a bride. In most cases, the bride-price is highest when the groom's family can be sure of the prospective bride's purity. This means that a girl's family will guard her behaviour fiercely to ensure that she does not 'damage' her purity. She may be prevented from having any contact with members of the opposite sex outside her immediate family, or forbidden to move outside the family home. The practice also suggests that women are property which can be bought and 'owned' by their husbands. Henceforth this gives the husband some kind of authority over the wife which leads to him dominating his wife and in some casing abusing her.

Furthermore, though women in Africa have gained substantial rights and opportunities this has not yet adequately dealt with inequalities which are still very prevalent among the genders. African culture continues to promote patriarchy in more than one way and this perpetuates the subordination of women. One major issue surrounding women in Africa is the problem of violence. Abuse against women and children is still very common and feeds into the culture and tradition of male dominance. Due to the fact that women are still refused rights and are seen as inferior to men, they are more likely to be mistreated at the work-place, in the community and at a personal level. Women have always been viewed as the property of men, first of their fathers and then, when they get married, of their husbands. This is encouraging male supremacy and also increases and encourages violence against women. This violence against women pushes them to live inside some kind of a shell in which they cannot express their views as far as decisions on their sexual health are concerned. It is not only cultural practices that have an effect on reproductive health issues but religious practices as well. Various religions have different rules and regulations which guide the relations between men and women. An example can be given of the Apostolic sect in Zimbabwe which

allows the men to marry as many wives as they wish and also the wives are supposed to be young mostly teenagers. Though the government has tried to hinder such practices, it can be noted that the girls who have been married at such young ages have suffered various reproductive health calamities. Also due to poverty and fear of being condemned by their society, families of these young girls who are married off to the older men do not report such cases.

## **2.5 LEGISLATION**

### **2.5.1 Convention on the Elimination of all forms of Discrimination Against Women 1979**

This is regarded as the first international treaty recognizing the rights of women. It stressed on two concepts; equality between sexes as the primary objective and the elimination of all forms of discrimination as the penultimate goal. Zimbabwe ratified the convention in 1991 and in accordance with Article 4; it was mandated to ‘adopt temporary special measures aimed at accelerating de facto equality between men and women’

### **2.5.2 The National Gender Policy 2013- 2017**

The national gender policy has brought to light various factors that advocate for the betterment of the relations between men and women and that are meant to ensure that the rights of women are not infringed. It states that The Bill of Rights in Chapter 4 of the new Constitution recognises that men and women have a right to equal treatment, including right to equal opportunities in political, economic, cultural and social spheres. It accords to women the right to custody and guardianship, and makes void all laws, customs, cultural practices and traditions that infringe on the rights of women and girls. Certain sections are further elaborated to ensure certainty in the application of these rights.

The gender policy goes on to highlight gender based violence issues where it states that More women (and young girls), than men suffer more from various forms of violence as shown by the following statistics from the Zimbabwe Demographic Health Survey (ZDHS, 2010/11):

- In 60% of the cases, the victims are women and girls.
- About 43.4% of the women population experienced physical and/or sexual violence.

- 51.3% of girls aged 19 years and below have their first sexual experience forced against their will.

Economic disempowerment, unemployment, orphan hood, cultural practices and the code of silence are factors that continue to hinder efforts to eliminate GBV in Zimbabwe.

Apart from the above mentioned, the national gender policy goes on to state that Health and HIV and AIDS service delivery is a key concern for women because they play an important role in parental and health care. A poor health, HIV and AIDS delivery system will impact negatively more on women than men hence Zimbabwe has made efforts to address the issues related to gender in the health sector with the aim of ensuring that women's health needs are met.

## **2.6 THEORETICAL FRAMEWORK**

Various theories and models have been suggested to explain health behaviour. This research will focus on two that is the theory of reasoned action and the health belief model.

### **2.6.1 Theory of Reasoned Action**

The theory of reasoned action was designed to explain not just health behaviour but all willful behaviours. The theory is based on the assumption that most behaviours of social relevance are under willful control (Ajzen 1980). According to this theory, a person's belief to perform a specific behaviour is a function of two factors that is positive or negative attitude towards the behaviour and the influence of the social environment. The attitude towards behaviour is determined by the person's belief that a given outcome will occur if he or she performs the behaviour and by the evaluation of that outcome. The social subjective norm is determined by a person's normative belief about what important or significant others think she or he should do and by the individual's motivation to comply with those other people's wishes or desires (Miller 2005).

Attitudes are a function of beliefs in this theory. If a person believes that performing a given behaviour will lead to positive outcomes then he or she will hold a favourable attitude towards performing that behaviour. However, if he or she believes that performing the behaviour will lead to mostly negative outcomes, they will hold an unfavourable attitude.

These beliefs that form the foundation of a person's attitude towards the behaviour are referred to as behavioural beliefs. An example can be given of a woman from a polygamous marriage or a patriarchal society who feels she needs to go for cervical cancer screening. Through the theory of reasoned action this woman in question will be in fear of what the other wives will think about her character or about her decision and will also be in fear of her husband's reaction and her husband's family's reaction in the event that the tests come out positive. Due to the existence of the subjection of women in patriarchal societies, a woman in this scenario will not be able to speak out that the cancer was transmitted to her by her husband rather in actual sense she will be blamed for being immoral. Hence at the end of the day, if it is a polygamous marriage, there will be a ninety-nine percent chance that the other wives will be infected as well.

### **2.6.2 The Health Belief Model**

The Health Belief Model is the most commonly used theory in health education and health promotion. It was developed in the 1950s as a way to explain why medical screening programs particularly for tuberculosis were not very successful (Hochbaum 1958). The underlying concept of the original Health Belief Model is that health behaviour is determined by personal beliefs or perception about a disease and the strategies available to decrease its incidence. Personal perception is influenced by a whole range of intrapersonal aspects affecting health behaviour. There are four perceptions that serve as the main constructs of the model and these are perceived seriousness, perceived susceptibility, perceived benefits as well as perceived barriers. Each of these perceptions individually or in combination can be used to elucidate health behaviour.

#### **i. Perceived Seriousness**

Perceived seriousness speaks to an individual's belief about the seriousness or severity of a disease. While the perception of seriousness is often based on medical information or knowledge, it may also come from beliefs a person has about the difficulties a disease would create or the effects it would have on his or her life. However, it can be noted that with the young married girls or with the teenage mothers, perceived seriousness might be found not existing in their vocabulary because of immaturity and/or illiteracy. Hence they might not be aware of the dangers a disease such as cervical cancer can pose for them until it has reached critical stages.

#### ii. Perceived Susceptibility

Personal risk or susceptibility is one of the most powerful perceptions in prompting people to adopt healthier behaviours. The greater the perceived risk is, the greater the likelihood of engaging in behaviours to reduce that risk. This is what prompts sexually active persons to go for circumcision, use of condoms in an effort to decrease susceptibility to HIV infection.

#### iii. Perceived Benefits

Perceived benefits is when a person's opinion of the value or usefulness of a new behaviour in decreasing the risk of developing a disease. People tend to adopt healthier behaviours when they believe the new behaviour will decrease their chances of developing a disease. For example someone might stop indulging in unprotected sex due to the fact that they would be aware that it may lead to illnesses such as STIs. Another example can be that of a woman who will consider going for cervical cancer screening due to the knowledge of the benefits of early detection of the cancer.

#### iv. Perceived Barriers

Perceived barriers involve an individual's own evaluation of the obstacles in the way of him or her adopting a new behaviour of all of the constructs hence perceived barriers are the most significant in determining behaviour change. In order for a new behaviour to be adopted, a person needs to believe the benefits of the new behaviour outweigh the consequences of continuing the old behaviour. For instance one can realise that having one sexual partner is healthier than having multiple partners as this exposes them to the risk of sexually related illnesses.

Henceforth it can be noted that these theories are significant in enabling one to have a healthier life in the sense that if this kind of information is disseminated to the target group, they can have a better understanding of the benefits of positive thinking and behaviour change.

## **2.7 Summary**

Over and above, the chapter gave an in-depth insight on issues of gender relations and reproductive health not only in Zimbabwe but in other areas as well so as to identify more gaps in knowledge that this research intends to fill. The chapter also highlighted how teenage

mothers in other parts of the world are affected by cervical cancer and other reproductive health problem due to the nature of gender relations existing in those areas.



## **CHAPTER3**

### **METHODOLOGY**

#### **3.1 INTRODUCTION**

The following chapter encompasses the methods employed by the researcher to gather data pertaining to gender relations and reproductive health in the area under study. This chapter also outlines and justifies the different methods, techniques and instruments the researcher used to collect information about the subject matter and gives information on the target population as well. Data collection methods which were used include primary and secondary sources as well as interviews and observations. The research tools include both qualitative and quantitative methods.

#### **3.2 RESEARCH DESIGN**

Kvale (1996) states that research design is the blueprint for the amassing of data required to meet the objectives of the study. It encompasses all tools that the researcher employed to gather information. Research design also aims at justifying the use of certain research mechanisms ahead of those that were not used. It can be noted that the integrity of the research conclusions rest on the relevance and consistency of the methods used in data collection and analysis. The research design of this investigation is both qualitative and quantitative in nature in order to get broad spectrum of data required for the realization of the objectives of this research.

The researcher used both these methods of collecting data due to the fact qualitative data allows for a holistic and in depth understanding of data whilst quantitative data methods conceptualizes reality in terms variables and relationships between them. Some of the information that is depicted from using qualitative methods cannot be obtained through use of quantitative methods since the later is less flexible. As a result the researcher r saw it fit to use both methods.

##### **3.2.1 Qualitative**

Qualitative research is based on collecting actual descriptive and self-explanatory data (Grbich 2007). Qualitative research thus gives off information that is already in its 'real' state and does not need further explanations. Qualitative research aims for in-depth and holistic

understanding in an attempt to do justice to the complexity of social life. The qualitative approach is therefore more flexible as compared to the quantitative approach. The qualitative research methods are more flexible than quantitative methods; therefore they can be used in a wider range of situations and purposes. High flexibility implies that the methods are well suited for studying naturally occurring real life situations. Henceforth the researcher used qualitative methods due to the fact that they give data which is more precise and qualitative methods offer room for clarifications.

### **3.2.2 Quantitative**

According to Labaree(2009) this involves gathering raw numerical data. Sapford and Abbot(1996) explain that the quantitative approach conceptualises reality in terms of variables and the relationships among them. It is based on measurement therefore pre-structures the data, research questions, conceptual framework and design. The researcher used quantitative approach because quantitative studies are based on well developed and codified methods for data analysis. Procedures for the analysis of quantitative data are well developed and codified therefore bring objectivity to the research in the sense that they increase the chances that the results of the analysis depend on the researcher doing the analysis. Certain types of important questions can be systematically answered, opening the way to useful knowledge.

### **3.3 TARGET POPULATION**

According to Kotler and Armstrong (1996) population is the universe or the number of people to be involved in the study from which the researcher can draw a target population for a research. Population can be defined as any collection of social interactions, events, individuals and organizations that is divided into target and accessible population. Of the 2018 females in Ward 13, approximately 403 of the females are teenage mothers. The sample was selected from this total. The table below shows statistics on the population of the district.

**Table 3.3.1: target population**

Total ( <b>n</b> ) of married females in the district	102 803
Total number of Ward 13 residents	3542
Total number of females in Ward 13	2018
Target population	403

**Source: ZimStat 2014**

Out of the overall population of the teenage mothers in Hurungwe District, the researcher targeted only fifty respondents through the use of sampling methods which are going to be discussed at length below. Apart from the teenage mothers, the researcher also got to obtain information from key informants who included personnel which works at organisations which deal with gender issues as well as those that offer cervical cancer screening.

### **3.4 SAMPLING**

Creswell (2004) defines sampling as the process of selecting participants for a study from a total population. A sample is easy to manage and is economic in terms of time and financial resources. Sampling is defined by Merriam (1998) as the selection of a research site, time, people and events in a field research. There are two basic methods of sampling namely non probability sampling and probability sampling. Non probability sampling is whereby observations are not selected randomly and probability sampling is whereby observations are selected on a purely random basis from the population. The table below shows the sample used by the researcher.

**Table 3.4.1: sample used**

Target population	403
Sample selected	50
Sample used successfully	50

**Source: ZimStat 2014, Raw data**

#### **3.4.1 Purposive Sampling**

Purposive sampling was used by the researcher during the research. Purposive sampling was used in the research as it targeted a specific population sample from which the researcher intended to derive information from. The method was largely geared towards targeting people who had information about the subject matter to achieve the objectives of the study. Moreover it gave the researcher the discretion to select the respondents that she deemed useful to the research which would be through key informant interviews such as Family AIDS Caring Trust, an organisation in Chinhoyi which offers cervical cancer screening services to the populace of Hurungwe District.

### **3.4.2 Snowball Sampling**

The method was used by the researcher to complement purposive sampling as respondents would have to suggest additional persons, thereby increasing the pool of information. According to Kumar (2005), snowball sampling is a process of selecting a sample using networks. Since the method is very instrumental if the researcher knows little about the group, it was useful to the researcher as it helped her get referrals and contacts of the other teenage mothers who had accessed cervical cancer services. The method was also useful in studying communication, patterns, decision making or diffusion knowledge amongst the teenage mothers of Hurungwe Ward 13.

## **3.5 SOURCES OF DATA**

Data for the research was collected from primary and secondary sources.

### **3.5.1 Secondary Data**

The researcher also made use of secondary sources in gathering information on the subject matter. This data is very important to the research as it gives the researcher explanations which are absent in primary data. Secondary data compliments primary data. In this regard the researcher used secondary data in the form of:

- Internet
- Journal articles
- Dissertations
- Reports from health facilities

### **3.5.2 Primary Data**

According to Kumar (2005), the three main methods in primary sources are observation, interviews and questionnaires. Primary data provides the information that is first hand for a particular project, hence more reliable with research problems and objectives. Primary data is data that is in its natural form and thus is largely accurate. For the research to have factual conclusions accurate data is needed and this is the reason why primary data was used as the major data source for the research.

## **3.6 DATA COLLECTION INSTRUMENTS**

### **3.6.1 Questionnaires**

A questionnaire consists simply of a list of pre-set questions. Blaxter, Huges and Tight (2000) bring out that in a questionnaire the same questions are usually given to respondents in the same order so that the information can be collected from every member of the sample. Questionnaires may be administered in a number of ways for example as structured interviews, postal questionnaires, internet questionnaires or as group questionnaires. The researcher used questionnaires due to the fact that through questionnaires, data can be analysed more scientifically and objectively than qualitative data. Also, data can be considered more reliable than qualitative data since each individual response answers precisely the same questions in the same order, all responding to the same stimuli. Questionnaires also ensure high reliability since figures produced can be checked by other researchers. The researcher also used questionnaires because questionnaires research can generally use larger samples than qualitative methods.

However on the contrary questionnaires have their cons which include the fact that respondents may lie. In addition there is no room for flexibility hence some responses might prove to be substandard since the respondents will not be able to elucidate further thus there is no room for probing or clarifications.

### **3.6.2 Interviews**

Face to face interviews with gender experts and other key informants were conducted. The focus was to gather information on what these professionals thought about gender relations and reproductive health as well as cervical cancer issues in the district. Interviews with such experts was picked as a data collection tool as information derived thereof is principally relevant and accurate since these professionals have studied gender issues profoundly.

The researcher also used interviews as a method of data collection due to the fact that they enable the researcher to explore further in cases where interviewees may want to hide information or give a vague answer. In addition, interviews have flexibility and adaptability since they permit much greater depth. The face to face interaction helps to maintain good rapport since the interviewer has to establish friendly communicative skills and this helps to

promote friendly working relationships. Interviews also provide immediate feedback and the interviewer can readjust. However, it can be noted that in some cases, some people may give answers they think the interviewer expects them to give. To overcome this challenge, the interviewer avoided some leading questions. The most common and major disadvantage of interviews is that some of the scheduled interviewees declined the interview requests.

### **3.7 ETHICAL CONSIDERATIONS**

Respondents were assured that the information obtained was going to be used for academic purposes. Participation in the study was on a voluntary basis among the selected respondents. The health service provider and FACT were assured that the information obtained would be used for academic purposes and would be considered highly confidential. They were further assured that none of the information obtained would be used to identify any individuals or groups other than for study purposes

### **3.8 SUMMARY**

This chapter presented the processes that researcher undertook to collect, analyze and present the data. The research instruments and methods were stated and justified and these included the use of questionnaires and interviews. Sampling techniques were also highlighted and for this research purposive sampling and snowball sampling were used. The next chapter will detail the presentation and analysis of the research outcomes.

## **CHAPTER FOUR**

### **PRESENTATION OF DATA AND ANALYSIS**

#### **4.1 INTRODUCTION**

This chapter is a report of the findings and results following the study that was done in Ward 13 of Hurungwe District in Mashonaland West. In this Chapter as well, the researcher focused on presenting the data collected and also highlighting the analysis of the data. The researcher gave attention to the responses obtained from interviews, questionnaires as well as the researcher's interpretation of the observations. The findings were critically analysed to bring out how gender relations have an effect on reproductive health issues. The findings will be presented using a number of data presentation techniques which include pie charts, bar graphs line graphs, pictures among others.

#### **4.2 DATA COLLECTION PROCESS**

The data collection was done using instruments discussed in the previous chapter, that is, interviews, questionnaires and observations. The data was collected from the teenage mothers in Ward 13 of Hurungwe district who were located through snowball sampling and also from personnel from health service providers which carter for the district residents.

#### **4.3 RESPONSE RATE**

The response rate offers the research weight as it determines the quality and genuineness of the ultimate findings of the study. It can be noted that a high response rate is essential if one is to come up with proper well represented discoveries and a lower response rate will inevitably compromise the authenticity of the findings. The response rate in this instance was high. The respondents were willing to react to the topic under research. Response rate for focus group discussions stood at 50%, key informants interviews at 40% and responses to questionnaires were the most successful and these stood at 100%. The table below shows the response rate for the administered questionnaires.

**Table 4.3.1: Questionnaire response rate**

<b>Respondents</b>	<b>Questionnaires administered</b>	<b>Successfully responded questionnaires</b>	<b>Unsuccessfully responded questionnaires</b>	<b>Response rate</b>
<b>Teenage mothers</b>	50	50	0	100%

Source: primary data

Responses to questionnaires reached 100% due to the sampling method that was used by the researcher. The researcher targeted a total of 50 respondents and through snowball and purposive sampling the researcher managed to meet that target. The table above shows that the response rate for the questionnaires administered stood at above 60% which is commendable. Saunders (2003) states that, a response rate of 60% is generally a representation of the population. Key informant interviews were relatively successful however the glitch was caused by the busy schedules of these key informants.

**Table 4.3.2: Interview response rate**

<b>Respondents</b>	<b>Scheduled interviews</b>	<b>Successfully Conducted interviews</b>	<b>Unsuccessful interviews</b>	<b>Response rate</b>
<b>Key Informants</b>	10	4	6	40%

Source: primary data

10 interviews were scheduled to be conducted with personnel from health facilities in Chinhoyi. However only 4 interviews were conducted and the other 6 failed because some of the key informants had left town for field work and others claimed sitting for an interview was a waste of time since they had lots of work to do.

**Table 4.3.3: Focus Group Discussion response rate**

<b>Focus Group Discussions</b>	<b>Scheduled discussions</b>	<b>Successfully Conducted</b>	<b>Unsuccessfully conducted</b>	<b>Response rate</b>
	4	2	2	50%

Source: primary data



As for the focus group discussions the response rate was relatively low due to time constraints and also due to the fact that some of the targeted respondents were not willing to participate.

#### 4.4 CHARACTERISTICS OF RESPONDENTS

The table below gives a brief description of the characteristics of respondents. All of the respondents were females. Of all the respondents who participated in this study, 80% were married, 2% were widowed and 18% were single. 24% of the respondents were aged below sixteen years whilst 76% of the respondents were aged between 17 and 19. Education wise it can be noted that only 16% of the respondents managed to complete their secondary level whilst 20% of the respondents commenced but failed to complete their secondary level. A total of 26% of the respondents managed to complete their primary level whilst 24% did not complete their primary education. 12% of the respondents never went to school. From the above statistics it can be noted that the level of education is generally low. All of the respondents had accessed cervical cancer screening services. 26% of the respondents are self employed which shows some element of women empowerment however the number of unemployed respondents is 38% which is relatively a high percentage.

**Table 4.4.1: Characteristics of Respondents**

<b>Variable</b>	<b>Category</b>	<b>Number</b>	<b>Percentage</b>
<b>Age</b>	16 years and below	12	24
	17-19 years old	38	76
<b>Total (n)</b>		<b>50</b>	<b>100</b>
<b>Marital Status</b>	Married	40	80
	Widowed	1	2
	Single	9	18
<b>Total (n)</b>		<b>50</b>	<b>100</b>
<b>Level of education</b>	Incomplete Primary	12	24
	Completed Primary	13	26
	Incomplete Secondary	10	20
	Completed Secondary	8	16
	Never went to school	6	12

	Other	1	2
<b>Total (n)</b>		<b>50</b>	<b>100</b>
<b>Employment</b>	Unemployed	19	38
	Permanent	0	0
	Temporary	2	4
	Self employed	11	22
	Housewife	16	32
	Student	2	4
<b>Total (n)</b>		<b>50</b>	<b>100</b>

**Source: primary data**

#### **4.5 Gender relations and their impact towards health performance**

The health status of persons is often affected by whether or not you are male or female as well as the gender stereotypes that are prevalent in any particular society. It can be noted that appropriate health care and gender equality is strongly related just as gender inequality is linked to disease and neglect. The study found out that 50% of the teenage mothers did not make the decision to get married on their own rather the decision was made either by their parents or their spouse's family. Only 32% of the respondents made the decision to get married by themselves or jointly with their spouse. It can also be noted that the social subjective norm was one of the causes why the parents made these decisions and why the adolescents did not refute them. Miller (2005) alludes that the social subjective norm is determined by a person's normative belief about what important or significant others think she or he should do and by the individual's motivation to comply with those other people's wishes or desires. Administered questionnaires highlighted the following information.

**Table4.5.1 :Marriage Decision making**

<b>Variable</b>	<b>Category</b>	<b>Number</b>	<b>Percentage</b>
<b>Marriage decision made by:</b>	Myself	2	5
	My spouse and myself	14	34
	My spouse only	0	0
	My spouse's family	9	22
	My parents	16	39
<b>Total (n)</b>		<b>41</b>	<b>100</b>

**Source:primary data**

The table above shows that 39% of the respondents had their marriage decision determined by their parents whilst 22% had theirs made by their spouse's family. Only 34% of the respondents managed to make the decision jointly with their spouses and 5% of the respondents made the decision to get married by themselves. The above statistics show a certain anomaly in gender relations as it can be noted that 50% of the teenage mothers were not given an opportunity to make the marriage decision by themselves rather it was dictated to them. The mean age for the spouses of these teenage mothers is 31 years thereby showing that the minimum age difference between these mothers and their spouses stood at 12 years. Due to this major age difference, the young mothers barely have a platform to voice their concerns as far as reproductive health matters are concerned. Also it proves to be cumbersome for them to negotiate for safer sexual practices with their spouses.

The researcher also managed to draw information from the respondents qualitatively through focus group discussions. From the discussions, one of the respondents mentioned the following,

*'Ndakangonzimumwemusinamhai,*

*waakutoendanemurumeuyundiyeavemurumewakonekutiakangaavasiirachibagenemari.* (One day my mother informed me that I had to go with a certain man to his house as his wife because he had left them money and maize). The above statement by the respondent shows that she did not have a say in that issue but rather had to agree to what her parents had decided. This brings to the table issues of poverty as it can be noted that due to the desperation for money and food they had to send their daughter off for marriage. The discussions also brought out issues of religious affiliation as most of the respondents highlighted that due to their religions they were obliged to agree to marriage proposals from older man. One of the respondents highlighted that she was a member of the Apostolic sect and that the man who married her had been directed to her by God.

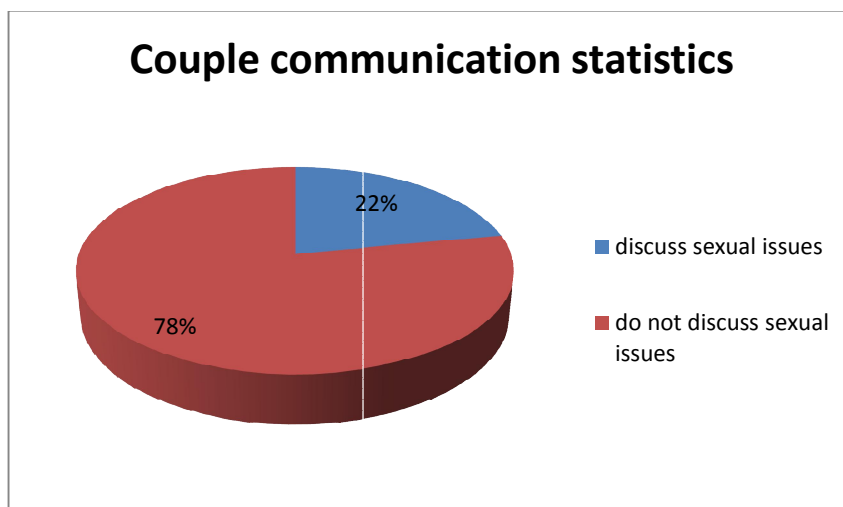
*'VakangotivakaoneswanaMwarikutindinindaivemukadziwavo,*  
*hapanamarambirondakabvandoenda.* Henceforth it can be noted that various means were used to push these young girls into marriage against their will.

#### **4.6 Couple communication on reproductive health issues**

From the administered questionnaires and the focus groups, the researcher noted that these couples do not discuss issues pertaining to sex mainly because of the age differences that

exist between them. In addition, George & Jaswal (1995) highlight that endeavouring to discuss these issues sometimes led to domestic violence for instance in some settings, women have reported that bringing up the issue of condom use can result in violence. As a result the adolescents succumb to whatever their spouses desire there by putting them at risk of contracting various reproductive health illnesses. The figure below clearly illustrates the information. 78% of the respondents did not discuss sexual issues with their spouses whilst the remaining 22% discussed those issues. However, of that 22%, only 12% of the respondents had their views considered whilst 10% of the respondents had their views neglected.

**Fig 1: Couple communication rates on Reproductive health issues**



**Source:primary data**

From the focus group discussions, the researcher noted that most of the respondents were part of polygamous marriages in which they were either the last wives or had one or two wives after them. One of the respondents after being asked whether her views were considered mentioned that her husband mandated her to do what he wanted and if she refused he would go to the other wives. *“Eh zvichemozvanguzvinonzwikwanani, vakatondiudzakuti kana ndisingadikuitazvavanodandinongoregedzavanoendakunanamaiguru.”* The above statement shows that the respondent was in a polygamous marriage which made it even more difficult for her to be selective since her husband would just go to the other wives. It also shows the existence of fear to lose a partner despite the age differences. As a result she had to

compromise her needs so as to maintain that cordial relationship between her and her husband.

These relations that exist between the respondents and their families as well as between the respondents and their spouses show that there is a gap which needs to be addressed. The gap which shows absence of adequate information and knowledge as far as issues of reproductive health are concerned. It can be noted that the populace in this district is still practicing patriarchal tendencies where by the young girls are sent off for marriage to older men and they do not have a say. Another cause of this practice is due to religious beliefs of the people in the district. The level of these child marriages in the area under study is quite alarming. The respondents were some of the few teenage mothers who managed to access cervical cancer services. Due to ignorance and lack of reproductive health knowledge caused by dropping out of school due to marriage and in some cases poverty, other teenage mothers in the area have not yet been able to access those services. Hence from this study, it can be noted that gender relations in Zimbabwe are more anti-women than pro-women. As a result they pose as a negative element in health performance, access and awareness.

#### **4.7 Multiple sexual partners and reproductive health**

Reproductive health is also affected by issues such as having multiple sexual partners. One of the leading causes of cervical cancer among these teenage mothers is the fact their spouses due to age have been involved with various sexual partners before moving on to the young girls. As a result there is a high chance of them having contracted and distributed the Human Papilloma Virus which causes cervical cancer. NgubaneJ(2010) states that in Africa, and according to African culture, men are permitted to have more sex partners than women and often free to engage in commercial sex. As a result women become more susceptible to illnesses. However, on the contrary, the study brought out that it is not only the husbands that had multiple sexual partners but the teenage mothers as well. These issues were brought out in the focus group discussions. A total of 17 respondents have had multiple sexual partners at one point in their lives giving a total of 34% and 33 respondents that is 66% have not been involved in multi-partner sexual encounters.

The researcher managed to draw reasons for having multiple sexual partners from the respondents during focus group discussions. Half of the single teenage mothers that is 9 respondents had multiple sexual partners. Their reasons were that since they were not married

they did not find it necessary to get tied down to one sexual partner as a result they got involved with many partners. Such a reason shows the absence of reproductive health knowledge. The other 8 respondents were married and their reasons included the desire for affluence. One of the respondents clearly stressed out that she was in a polygamous marriage and her husband did not take proper care of her. As a result she would get involved with other men for money and other luxuries. This again shows the absence of reproductive health knowledge as the respondent is clearly unaware of the dangers that come with multiple sexual partners such as contraction of STIs. Other issues that the discussion managed to bring to light include the fact that there was poor communication between the spouses as far as sexual issues were concerned as a result these teenage mothers would get involved with someone who attended to their needs and respected their views. Another respondent highlighted that the only reason why she had multiple sexual partners was because she wanted to be sexually involved with a younger man.

#### **4.8 Teenage mothers’ understanding of reproductive health issues.**

One of the objectives of the study was to evaluate the level of young people’s understanding of reproductive health issues with teenage mothers being the case study. Amongst these reproductive health issues are issues of family planning and cervical cancer screening. The researcher managed to derive the total number of teenage mothers who used contraceptives and those who did not through the administered questionnaires. The researcher also managed to obtain the reasons for not using the contraceptives from the respondents. 64% of the respondents highlighted that they did not use any family planning method whilst 36% of the respondents highlighted that they used some method of family planning. The table below shows the total number of teenage mothers who use contraceptives and those who do not.

**Table 4.8.1 :Teenage Mothers’use of contraceptives**

	<b>Total number</b>	<b>Percentage</b>
<b>Teenage mothers who use contraceptives</b>	18	36
<b>Teenage mothers who don’t use contraceptives</b>	32	64
<b>Total</b>	50	100

**Source: primary data**

The table above shows that a total of 64% of the respondents did not use any contraceptives whilst only 34% used contraceptives. The respondents did not desist from using contraceptives willingly. It can be noted from the administered questionnaires that there are various reasons why they did not use any contraceptives. The respondents had more than one reason for not using contraceptives. Pulerwitz et al. 2006 states that in many parts of the world, dominating women by pushing them to have unprotected sex is considered an acceptable way of asserting male power and demonstrating manhood and male rights over women. Most of the teenage mothers had their husbands disapproving the use of contraceptives for religious reasons. This goes back to the issue of the Apostolic sect religion that is dominant in the district which prohibits the use of western or rather modern medication. By virtue of that, contraceptives are regarded as medication so the young mothers are prohibited from using them.

Also it can be noted that it is not only due to the fact that the husbands disagree rather it is also because of lack of knowledge on where to find the contraceptives and how to use them. Most of the teenage mothers who highlighted that they did not know where to buy contraceptives did not know how to use the contraceptives as well. Hence this brings to light the lack of understanding of reproductive health issues among these young mothers mainly due to ignorance and fear. The researcher also found out that poverty plays a part as well as far as the usage of contraceptives is concerned. Due to lack of money the teenage mothers cannot access these contraceptives and requesting the money from their spouses is out of the question. The table below gives statistics on the reasons why these teenage mothers did not use any contraceptives.

**Table 4.8.2: Factors leading to the non usage of contraceptives**

<b>Variable</b>	<b>Category</b>	<b>Number of Respondents</b>	<b>Percentage</b>
<b>Reasons for not using contraceptives</b>	To have a child	2	3
	Cannot afford contraceptives	2	3
	Husband disapproves	21	33
	Do not know where to buy contraceptives	10	16

	Do not know how to use contraceptives	14	22
	Religious purposes	15	23

**Source:primary data**

33% of the respondents were prohibited by their husbands to use contraceptives. This brings out that disparity in gender relations that was mentioned earlier. The study goes on to show that 23% of the respondents did not use contraceptives due to religious reasons. A total of 22% of the respondents highlighted that they did not know how to use the contraceptives. This shows the absence of access to information and also lack of understanding of reproductive health issues. These are some of the reasons why most of the teenage mothers in the district have failed to access let alone enjoy the outcomes in cervical cancer investment and the researcher noted that gender relations have emerged as a barrier to the attainment of better reproductive health outcomes.

Moving on, it is important to note who made the decision on the contraceptive method for the teenage mothers who used contraceptives. The study shows that of the 18 teenage mothers who used contraceptives, 9 of them made the decision to use contraceptives by themselves without consulting their spouses, 8 of them made the decision jointly with their spouses and only 1 of them had their husband decide on the contraceptive method. 50% of the respondents made the decision to use contraceptive methods by themselves. Various reasons for this decision were identified by the researcher from the administered questionnaires. One of the respondents pointed out that she did not inform her husband that she had decided to use contraceptive methods due to the fact that he wanted to have lots of children whilst she only wanted a few. *“babavaidavanavakawanda. Pandakaita wechi3 ndakangandisingachadivamwesakandakabvunzavakomavanguvakandiudzanezvemapiritsi.”* (My husband wanted many children. When I had my third child I no longer wanted more so I asked my sister for advice and she told me about the birth control pills).

33% of the respondents who made the decision to use contraceptives on their own were single teenage mothers hence they had that freedom of choice. The study also shows that there is also the existence of favourable gender relations as evidenced by the 44% of the respondents who made the decision of contraceptives jointly with their husbands. Though this is a very small number it shows that it is possible for men to consider women’s view in marriages as far as reproductive health issues are concerned. The study goes on to bring to



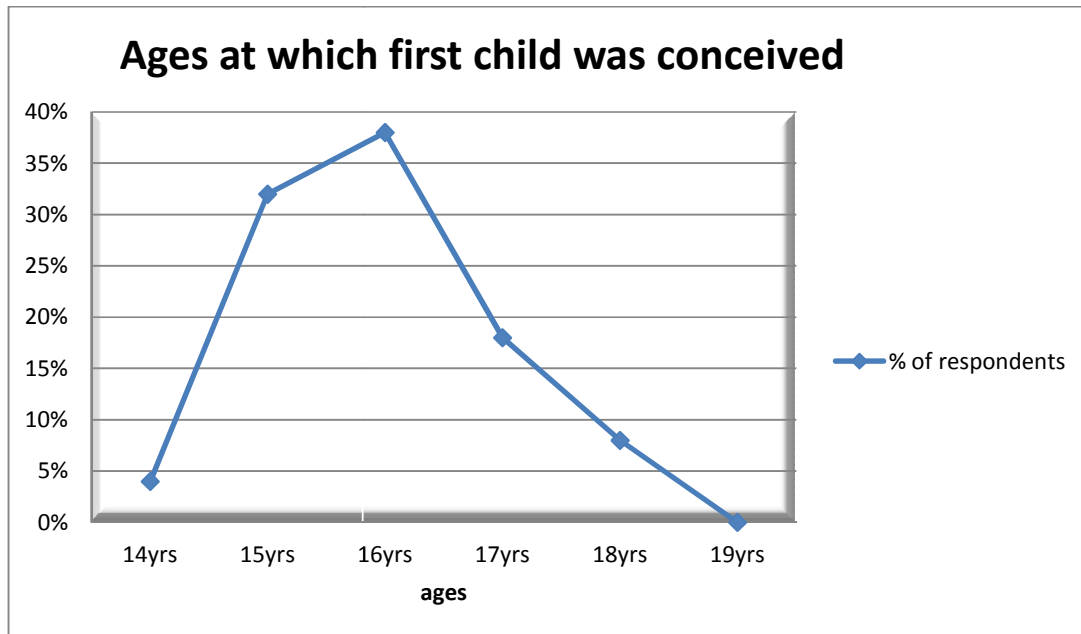
light that the families of either spouse did not have a say in this issue. Other family members had a say in the decision to get married but in the issue of the use of contraceptives it can be noted that they were not involved.

Furthermore, from the focus group discussions conducted the researcher managed to obtain what prompted the respondents to go for cervical cancer screening. 46% of the respondents accessed cervical cancer services after being educated by Behaviour Change Facilitators in the district. Behaviour Change Facilitators are trained persons who move around residential areas disseminating information on reproductive health issues such as HIV testing, Cervical Cancer Screening, STI screening, Gender based violence just to mention a few. Hence after being tutored on the importance of getting screened, 46% of the respondents went for cervical cancer screening. 24% of the respondents accessed cervical cancer because they had been involved with multiple sexual partners and after hearing about the cancer is spread they decided to access the services. The remaining 30% went for screening due to various reasons; some of them just went because their friends and relatives were going. They did not really know why it was important to get screened. Others went because cervical cancer screening was the talk of the town and others ended up getting screened after going to the health facilities to get treated for other illnesses. The study shows that this 30% has quite a low understanding of reproductive health issues and this is a gap that needs to be covered.

#### **4.9 Gender sensitive information, reproductive health education and human rights.**

The National Gender Policy has brought to light various factors that advocate for the betterment of the relations between men and women and that are meant to ensure that the rights of women and girls are not infringed. It states that the Bill of Rights in Chapter 4 of the new Constitution recognises that men and women have a right to equal treatment, including the right to equal opportunities in political, economic, cultural and social spheres. However, from this study it can be noted that these equal opportunities are not being recognised as evidence by the child marriages happening in the area under study. Child marriages cause untold suffering to the victims in the sense that it curtails the child's education, affects general health and puts the affected in a disadvantaged position in many ways than one. The study brought out that 70% of the respondents failed to complete secondary school, 12% never went to school and only 16% of the respondents managed to complete secondary school. The graph below shows the ages at which the teenage mothers had their first babies.

**Fig 2: Ages at which first child was conceived**



The graph shows that the highest number of the respondents conceived their first child at 16 years. A relatively high number of respondents conceived their first child at age 15. None of the teenage mothers had their first child at 19. These statistics nullify the whole idea of the right to equal opportunities in political, economic, cultural and social spheres in the sense that by having a child at 14, the young girl's future is already in shambles since she now has to work to sustain her child and also she gets to drop out of school which makes it close to impossible for her to venture into the economic or social spheres. Henceforth it is important that these young girls get education on their human rights so that they can know when their rights are being infringed. For instance the right to education for these girl children is being infringed.

Moving on, it is also important that these young girls and young mothers be educated on reproductive health issues as it can be noted from what was mentioned above that 24% of the respondents went for cervical cancer screening due to the fact that they had been involved with multiple sexual partners. This alone shows that they lack knowledge of the risks that

come with having multiple sexual partners such as STI contraction, HIV as well as cervical cancer. Henceforth it is important that organisations which focus on health matters and wellness continue to disseminate information on reproductive health so that the young mothers and other girls can get educated.

#### **4.10 Poverty and Cervical Cancer**

Despite the fact that gender relations play a vital role in hindering the attainment of reproductive health services the study also managed to bring out that poverty is also a risk factor for cervical cancer. The researcher noted that even though the teenage mothers managed to access the services the process was cumbersome for them. Due to the fact that cervical cancer screening facilities are centralised, for instance, Hurungwe district populace attain their cervical cancer services in Chinhoyi. Hence forth due to financial constraints the teenage mothers find it difficult to acquire money for travelling expenses. If the case was vice versa, there could have been a higher chance of this group of people accessing cervical cancer services. Richards(2008) highlights that women living in deprived areas are nearly twice as likely to be diagnosed with cervical cancer than their affluent counterparts. Henceforth it can be noted that most of the teenage mothers acquire cervical cancer services when the cancer is already in its later stages which becomes even more difficult since at those stages they will have to pay for some of the services.

The issue of poverty is not only about finances to travel but also incorporates issues such as diet and other needs. Food items such as fruits and vegetables are recommended to reduce susceptibility to cervical cancer. However these are tertiary issues to the teenage mothers since they are more focused on taking care of their children and saving their marriages. It is also due to poverty that these young girls are married off at a tender age. Marriage enables their families to obtain some income through bride price.

#### **4.11 Interviews with key informants**

Interviews were also conducted as a data collection means. Interviews take a number of forms depending upon how they are structured. Haralambos and Holborn (1991) state that, a completely structured interview is simply a questionnaire administered by an interviewer who is not allowed to deviate in any way from the questions provided.” The interviewer simply reads out the questions to the respondent. Keyton (2001) says, “Unstructured interview takes the form of a conversation where the interviewer has no predetermined questions.” Most

interviews fall somewhere between these two extremes-semi-structured interviews. In this study the researcher used unstructured interviews. The interviews were directed to the personnel at health facilities in Chinhoyi which is the town in which the people from Hurungwe district go to access their health services. Interviews were targeting personnel at the General Hospital and at Family AIDS Caring Trust a local NGO which offers cervical cancer screening services.

The researcher managed to interview Mr Mbudzi an officer at Family AIDS Caring Trust responsible for the Orphans and Vulnerable Children Department for Hurungwe District who highlighted that every single term there are school dropouts due to marriages in the schools around the district under study. He also mentioned that though the program aims at eradicating poverty in schools by establishing project which generate income for the schools so that the children can get all the necessary equipment that they need to learn, poverty at home is one of the push factors that drive parents to send the young girls for marriage.

Another interviewee was Mr Tafira, a New Start counsellor who pointed out that before anyone is screened for cervical cancer they are first tested for HIV. He highlighted that most of the HIV positive patients are usually cervical cancer positive as well. He also mentioned that they receive a relatively large number of teenagers seeking cervical cancer screening services.

The researcher managed to interview one of the nurses responsible for cervical cancer screening. She mentioned that when she discusses with the young mothers who come for screening, most of them point out that they decided to get screened without the knowledge of their spouses as they would get into trouble if the spouses found out hence they could never inform them of the outcome.

#### **4.12 Other factors hindering easy attainment of cervical cancer services and other reproductive health services**

The research managed to bring to light that it is not only gender relations that cause problematic access to reproductive health services. Even though organisations have endeavoured to disseminate information to the people all over the country it can be noted that poverty and lack of financial resources hinder the teenage mothers from easily accessing the services. The other issue is of the centralisation of health facilities in the country and also a limited number of facilities that offer cervical cancer services. In this case, the researcher

found out that Hurungwe district despite having more than 30 health facilities it had no facility that offered cervical cancer services as a result the populace travelled to Chinhoyi, the capital of Mashonaland West to obtain these services at the hospital and at Family AIDS Caring Trust where it is done for free. In addition the research also brought out that there is a huge problem as far as knowledge on reproductive health issues is concerned. The teenage mothers did not possess knowledge on reproductive health issues. They had no idea on family planning issues or the dangers that came with having multiple sexual partners. Henceforth it is of paramount importance that information be disseminated to them.

#### **4.13 Conclusion**

The chapter focused on the research findings that were gathered and the information that they produced pertaining to gender relations and reproductive health. The information or data obtained was illustrated and explained with the aid of graphs, pie charts among others. The research findings were based on the research objectives which included examining the characteristics of gender relations and their impact towards health performance just to mention one. From this chapter it can be noted that gender relations have played a very diminutive role in priming the attainment of better cervical cancer and other reproductive health outcomes. Various problems and gaps were also identified and solutions to these as well as recommendations are going to be given in the next chapter.

## **CHAPTER 5**

### **CONCLUSIONS AND RECOMMENDATIONS**

#### **5.1 Introduction**

The aim of this chapter is to give an overview of the whole research focusing on critical areas which shaped the research. It seeks to summarize the previous chapters and give relevant recommendations. The chapter also aims to answer the research questions and to meet the objectives of the study.

#### **5.2 Summary**

The research was based on a case study of cervical cancer among teenage mothers in Hurungwe District Ward 13 in regards to how gender relations affect reproductive health. The research was deductive in approach; thus it sought to validate a theory by providing empirical data on the role that gender relations have played to prime the attainment of cervical cancer services and other reproductive health outcomes for teenage mothers in the area under study. The research was also explanatory in nature as the researcher used qualitative methods in the bid to explain the ‘why’ questions about the reasons behind the early marriages and the non-communication of sexual issues between the teenage mothers and their spouses regardless of how much early child marriages have been condemned at local, national, regional as well as international levels. Furthermore, the research was conducted using a pro-women approach thereby making it feminist in nature.

The first chapter introduced the topic under study. A comprehensive background of the study highlighting the factors that prompted the study was also outlined. The background looked at a brief background of reproductive health quandaries among adolescents. It highlighted the existence of health challenges such as sexually transmitted infections including HIV, high levels of teenage pregnancies as well as how early pregnancy and early sexual debut has immensely contributed to propensity to cervical cancer among these adolescents. The background also brought out efforts done by the Program of Action (POA) of the International Conference on Population and Development (ICPD) in Cairo in 1994 which was

the first to address issues related to sexuality, sexual reproductive health and reproductive rights. The statement of the problem was also highlighted in this chapter as well as the research objectives. The chapter also looked at the limitations which are the possible risks and threats of the research as well as the delimitations which are the opportunities that may be posed by the research to the researcher. Lastly the chapter highlighted and explained the ethical considerations that the researcher had to observe, uphold and guarantee throughout the research.

Chapter two unpacked the literature review and explored the theoretical and conceptual framework of the research. This chapter explored all that has been written by the wide scholarship pertaining to the topic under research. Theories included in this study include the theory of reasoned action, and the health belief model. The theoretical and conceptual framework required the researcher to explore the various theories and concepts that explain, investigate, examine, support or refute the argument of the research. The research revealed that a lot has been written on gender equality and how the position of the girl child has to be upheld in society as well as the upholding of the rights of the girl child but none of these has been implemented to full capacity especially in remote areas where the populace may find it cumbersome to access information.

The third chapter looked at the Research Methodology which answered the questions of how the research was conducted practically. It addressed questions such as the research design, the target population; the sampling techniques used which determined who would be part of the research as well as the methods and tools of data collection. The research instruments and methods were stated and justified. Research instruments include questionnaires and interviews. Sampling techniques used were highlighted and these are purposive sampling and snowball sampling.

Chapter four was about Data Presentation and Analysis. In this Chapter, the researcher presented the findings of the research after the field work conducted in Chapter 3. It also gave an in-depth analysis of the findings. The data collected was combined summarized and presented systematically using a combination of graphs, tables and charts and analyzed to enable the researcher to move to the next Chapter where they would give a summary, suggest recommendations and draw conclusions about the study which is the current chapter. The research findings were based on the research objectives which included examining the characteristics of gender relations and their impact towards health performance, access and

awareness and evaluating the level of young people's understanding of reproductive health issues just to mention a few.

### **5.3 Summary of Results**

The research on Gender relations and Reproductive health among teenage mothers in Hurungwerevealed some interesting results. A number of challenges and prospects were revealed in the research and these all went back to the role played by gender relations. It brought out that gender relations are the key that unlocks the door for young mothers to access reproductive health services and information and for them to be fully aware of their human rights and reproductive rights. The research started off by highlighting issues such as the literacy levels of the respondents which showed that 12% of the respondents never attended school, 70% did not complete secondary and only 16% completed secondary. These low literacy level have been due to the disparity in gender relations and partly due to financial constraints. These financial constraints have led to the early marriages and on the other hand early marriages due to the disparity in gender relations have hindered the young girls from finishing their education. It can be noted from the findings that the decision to get married was done in mostly by either the girl's parents or the spouse's family. Since it was noted from the findings that the mean age of the spouses of these teenage mothers is 31 years, the reasons behind the parents sending their girl children off for marriage included financial constraints and religious beliefs. This mean age brought out the fact that it is difficult for the teenage girls to negotiate for safer sexual practices as a result they become susceptible to unprecedented health challenges such as STIs, HIV and cervical cancer.

The research also compounded what was identified in the literature review in regards to child marriages as an aspect of gender relations and how it affected reproductive health. It was noted by the International Centre for Research on Women 2007 that child marriages resulted in loss of development opportunities, limited life options and most importantly poor health. The level of education of these teenage mothers shows that they are already losing on development opportunities and they barely have any other life options rather than staying in their marriages and taking care of children. Moreover, The National Gender Policy has brought to light various factors that advocate for the betterment of the relations between men and women and that are meant to ensure that the rights of women and girls are not infringed. However the research has proved that this is being ignored as the rights of women and girls



are still being infringed in the name of religion and traditional practices. The research brought out that religion is playing a large role in the infringement of the rights of the girl child. Teenage girls in Hurungwe are being married off at a very tender age and the cases are not being reported as the parents and other elders see it fit according to their religion.

The focus group discussions conducted by the researcher brought out various predicaments that the teenage mothers were facing in their relationships with their spouses and their families. One of the main issues that the teenage mothers faced in their marriages was that of poor communication between them and their spouses. The study brought out that the teenage mothers did not have a platform to air out their concerns as far as sexual issues were concerned. This goes back to show that women in Africa and Zimbabwe to be precise have not yet reached a level of equality and are still being dominated by their male partners. The interviews that the researcher conducted with the key informants brought out that there was a large number of school dropouts due to marriage as well as financial constraints in the district. They also mentioned that most of the teenagers that visited the health centres for cancer screening came without the knowledge of their spouses due to fear. Never the less, the research also managed to bring to light other factors hindering the teenage mothers from accessing reproductive health services which include financial constraints and the absence of health facilities in their areas of residence.

#### **5.4 Conclusions**

The subsequent are the conclusions which were drawn by the researcher after an overall scrutiny of the research findings:

- Child marriages despite being prohibited are still rampant in the area under study.
- Information on reproductive health issues has not been fully disseminated to the young girls as well as the parents in the area.
- Religion and traditional practices are being used to infringe the rights of the girl child despite the contents of the National Gender Policy.
- Education of the girl child is being affected by these child marriages hence the literacy levels are relatively low.
- Financial constraints have also stood out as one of the reasons why the children are sent off for marriage at a tender age and also why they are failing to access reproductive health services at health facilities outside the district.

- Women oppression is highly in existence in the area under study as it was noted the teenage mothers do not have a say what so ever as far as their life decisions are concerned.
- Gender relations have played a very distinct role in hindering the attainment of better cervical cancer services and other reproductive health outcomes for young women and adolescent mothers in Hurungwe and Zimbabwe as a whole.
- The teenage mothers are afraid to speak out and air their concerns mostly due to the age differences that exist between them and their spouses. It was noted that the mean age difference between the mothers and their spouses is 31years which is a relatively large number.

## **5.5 Recommendations**

1. Various stakeholders should effectively play their part in ensuring that information on reproductive health and cervical cancer in particular is disseminated to all the young girls in the district and around Zimbabwe. This may be done through forming peer groups where these young girls reside.
2. The stakeholders should also see to it that even the parents and all the other adults in society are educated on the dangers of sending off their children for marriage at a tender age. They should be informed on the health dangers that the children are bound to face because of such acts.
3. The government and other able organisations should endeavour to set up cervical cancer screening stations and facilities that offer all reproductive health services in areas that are easily accessible to the general populace. It can be noted that at the moments, these facilities are centralised.
4. The general public should be encouraged to report child marriage cases without fear whether they are religiously affiliated or not so as to reduce or rather eradicate these child marriages.
5. Reproductive health issues should be taught in depth in schools so as to increase the young people's knowledge.
6. Willing and able organisations should come up with projects that will assist the young girls and adolescent mothers to sustain themselves so that they are not entirely dependent on their dominating spouses.

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Good day, my name is ElinaMarisa. I am a final year Politics and Public Management student at Midlands State University. As part of my studies I am supposed to undertake research in any area of my interest and as such, I am researching on Gender relations and reproductive health in Zimbabwe: an assessment of cervical cancer among teenage mothers in Hurungwe ward 13. You have been identified and selected to participate in this study. I would like to assure you that this study is being done for academic purposes only, therefore the information you will give shall remain confidential. This questionnaire will only take a few minutes of your time and you are free to stop the interview at any time if you feel uncomfortable.

**INTERVIEW TRANSCRIPTS FOR KEY INFORMANTS**

	Date of Interview:	Interviewer:
	Interviewee:	Institution:
	Position	
	Are you familiar with reproductive health issues affecting teenage mothers in Hurungwe Ward 13?	
	Are there any teenage mothers who come for cervical cancer screening ?	
	Do you discuss reproductive health issues with these teenage mothers?	
	What are challenges faced by the teenage mothers in accessing reproductive health services?	

	What do you think should be done in order to make these services easily accessible to the teenage mothers?	
	Are there any programs that are helping in hindering these early marriages in the district?	

*Thank you*

# QUESTIONNAIRE

**Questionnaire on how gender relations pose as a threat to the reproductive health of teenage mothers in Hurungwe especially in regards to cervical cancer.**

This research is on how gender relations affect reproductive health in particular the contraction and treatment of cervical cancer among teenage mothers in Hurungwe Ward 13. Participation in this research is voluntary however your views are very important in assessing the awareness of reproductive health issues in relation to gender relations. Information you provide will be kept strictly confidential and will not be shown to other people, that is any of health providers, family members, friends or neighbours so please be sincere in your responses.

**Thank You For Your Co-operation**

## SECTION I PERSONAL DATA

1. **Place of residence** \_\_\_\_\_

2. **Age** \_\_\_\_\_

3. **Sex**                      Male                       Female

*Please tick the appropriate box*

4. **The highest level of education:**

- Incomplete primary
- Completed primary
- Incomplete secondary
- Completed secondary
- Never went to school
- Other \_\_\_\_\_

5. **Employment:**

- Unemployed
- Permanent
- Temporary
- Self-employed
- House-wife
- Student

6. **Marital status:**

- Single
- Married                      Age of spouse \_\_\_\_\_
- Other \_\_\_\_\_



## SECTION II REPRODUCTIVE HEALTH

1. How old were you when you got married? \_\_\_\_\_ years old

2. The final decision to get married was made by:

- Myself only
- My spouse and myself
- Me and someone else
- My spouse only
- My spouse's family members
- My parents
- Other \_\_\_\_\_

3. How many children do you have?

- 1
- 2
- 3
- 4
- 5
- More than 5

What is the spacing between the children? *(Please indicate their years of birth)*

\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**4. How old were you when you had your first child?**

\_\_\_\_\_ years old

**5. Who was involved in decision-making on family size and/or spacing of children?**

- Husband
- Only self
- Jointly with husband
- Other family members (my mother and father, my in-laws, other relatives, etc.)
- Other \_\_\_\_\_

Please describe in what way.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**6. Have you ever used any contraceptive method or method of preventing a pregnancy?**

- YES                       NO

*If no, go to Q 11.*

*If YES, what contraceptive method do you currently use?*

- Birth control pills
- Injections
- Implants
- Emergency contraception
- Withdrawal
- Condom

- Sterilization/Vasectomy
- Other \_\_\_\_\_

**7. Why don't you use any contraceptive method? Tick all your reasons.**

- I want to have a child
- I cannot afford them
- My husband disapproves
- Don't know how to use the contraceptives
- Don't know where to buy contraceptives
- For religious reasons
- Have health problems
- Other \_\_\_\_\_

**8. Who decides on a contraceptive method in your family?**

- Husband
- Only self
- Jointly with husband
- Other family members (my mother and father, my in-laws, other relatives, etc.)
- Other \_\_\_\_\_

Explain the position of your husband in the decision-making on this issue.

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**9. Have you ever had multiple sexual partners at any point in your life?**

Yes

No

**10. Do you discuss issues pertaining to sex with your spouse?**

Yes

No

If yes are your views considered and explain how

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**11. What prompted you to go for cervical Cancer Screening?**

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**12. What was your spouse's reaction to this?**

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**13. Was the screening helpful to your health and to your relationship with your spouse?**

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**14. Will you encourage other young mothers to go for cervical cancer screening?**

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*The end*

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