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*Corresponding author: Nigel Mxolisi Landa, Nehanda Centre for Gender and Cultural Studies, Julius Nyerere, School of Social Sciences, Great Zimbabwe University, Masvingo, Zimbabwe
E-mail: nlanda@gzu.ac.zw

Reviewing editor:
Udo Schumacher, University Medical Center Hamburg-Eppendorf, Germany

Additional information is available at the end of the article

EPIDEMIOLOGY | RESEARCH ARTICLE

Exploring discourses of sexual and reproductive health taboos/silences among youth in Zimbabwe

Nigel Mxolisi Landa^{1*} and Kundai Fushai²

Abstract: This study explores discourses of Sexual Reproductive Health (SRH) among the youth of Zimbabwe's small town known as Mupandawana, Gutu. The youth of Mupandawana like many youths of other areas of Zimbabwe, Africa and the world over deal with multiple complex SRH issues which largely emanate from unsafe sexual practises. These practices lead to numerous SRH issues, such as: early and unplanned pregnancies, Sexually Transmitted Infections (STIs), HIV and AIDS, and unsafe abortions among others. While it is a fact that the past two decades of Zimbabwe's socio-economic and political stunted development trajectory have had a negative bearing on many social institutions in the country, it would be too simplistic to rely on this account alone. The primary findings in this article drawn from semi-structured interviews indicate that there are some underlying philosophical and cultural issues which call for a paradigm shift in the way in which SRH policy is developed, formulated and implemented, and that the youths also have to play an active role in demystifying some SRH taboos. The article incorporated tenets of the Empowerment Framework to explain some scenarios and also to assist in future policymaking of SRH, and to help/empower the youths to take charge of their SRH.

ABOUT THE AUTHORS

Nigel Mxolisi Landa Nigel is a full-time lecturer at the Nehanda Centre for Gender and Cultural Studies, Great Zimbabwe University. Nigel's key research interests lie in Gender, Sexual and Reproductive Health, Migration as well as Social Policy. Currently, Nigel is working on an independent project on the lived experiences of the so-called "illegal immigrants" and gender discourses among Zimbabwean women in South Africa.

Kundai Fushai Kundai is a graduate from the University of Zimbabwe and Great Zimbabwe University, Nehanda Centre for Gender and Cultural Studies. She earned qualifications in Politics and Administration as well Gender and Policy Studies. Her research interests lie in Public Policy and Development Projects related to Gender and people in marginalised communities. Currently, Kundai is working on her PhD proposal.

PUBLIC INTEREST STATEMENT

It is a universal attribute of many societies that certain subjects are not discussed freely. These are referred to as taboos. African cultures in general have constructed a number of these barriers around issues which are sexual in nature. It is the submission of this research that these taboos have adverse effects on the Sexual Reproductive Health (SRH) of young people. This is particularly true as discovered in Zimbabwe where young people face a plethora of life-changing as well as life-threatening SRH challenges such as unsafe abortions, sexually transmitted infections including HIV and AIDS. There is evidence from this study that governments and non-government organisations should play active roles in engaging young people in the formulation of SRH policies. Governments of developing countries can contribute positively to the decrease in SRH problems by incorporating empowerment models in terms of employment and opportunities creation for young people.

Subjects: African Studies; Cultural Studies; Gender Studies – Soc Sci; Sociology & Social Policy; The Body; Behavioral Sciences

Keywords: empowerment; sexual reproductive health; youth; Zimbabwe

1. Introduction and background

Attempts to study a subject which is regarded as a “silent” or taboo in any society is not an easy task. A taboo for Gao (2013) is any subject which is prohibited or evokes avoidance by society as it is perceived as harmful to its members. The harm is viewed relatively as arising from its potential to cause anxiety, embarrassment or shame to individuals. Gao (2013) went on to argue that most societies construct taboos around subjects such as body functions, sex, erections, income among a host of other subjects regarded as sensitive and that euphemisms can be used to negotiate the presentation of these taboos. In explaining why sex is such a big taboo in most societies, Heflick (2011) argued that sex reminds us of our animal nature and raises debates about the challenges of morality. Cultural anthropologists such as Goldenberg, Pyszczynski, McCoy, Greenberg, and Solomon (1999) opined that the act of procreation which is a physical act is a direct threat to the idea that human beings are spiritual beings and as such would pose the question “why would spiritual beings emerge from a physical act?” Talking about taboo subjects is not comfortable for many people, especially when the sociological layer of age is added to the issue. The youth who constitute by far the largest demographic group in the world are not surprisingly affected the most by Sexual Reproductive Health (SRH) issues.

In this article, the term youth is conceptualised around the World Health Organisation’s (WHO) categorisation of youth as individuals who lie between the ages of 10–24 years (WHO, 2011). This is an age category which is viewed as being among the most productive as the individual would be in a fairly good physical and cognitive state to earn a living through active participation in the economic market (Skirbekk, 2003). Unfortunately, studies also demonstrate that this age group is at a high risk for sexual health. In 2011, WHO reported that the majority of people become sexually active during adolescence and that the use of protection and contraceptives is very low among young people. The WHO (2011) report went further to state that over 100 million cases of sexually transmitted infections (STIs) were recorded among young people, as well as more than 2.5 million unsafe abortions which were recorded for adolescents. In 2009, WHO (2011) reported that there were over 890,000 new infections among the young people particularly among the young women which contributed to the 5 million young people living with HIV. HIV/AIDS in the same WHO (2011) report was identified as one of the five causes of death in the youth age group. Data from UNAIDS (2015) indicated that young people who are HIV infected are aged between 15 and 24 years and constituted up to 34% global population, and similarly in the sub-Saharan Africa 34% as well. Many factors have been identified as contributing towards this precarious scenario presented above, in the case of Zimbabwe, research continues to point towards the ill-capacitated health delivery system which has been hit by nearly two decades of economic slump.

2. The “crisis years” and Zimbabwe’s health delivery system

Zimbabwe’s development trajectory after the country gained independence from British colonial rule was heralded as a success story which other African countries could emulate; (Mandaza 1986; Raftopoulos, 2006). The perceptions of the success of Zimbabwe were comparable to how many people viewed the success of Asian countries, such as Singapore and Malaysia. Here was a country rebuilding its economy who youth together with nationalists had emerged out of a bitter bush war but were (re-)building their country. This ushered in many clinics, and trained nurses and doctors who provided medical needs especially in the rural areas which had an acute shortage of facilities due to the imbalances of the colonial government. Due to a number of political factors in nature which this article is not to focus on, the economy took a battering and adversely the impacts were felt in sectors such as health. Meldrum (2008) reported that by 2008 the country was battling one

of the world's highest rates of infection of HIV/AIDS, which was estimated to be killing more than 3,000 people each week.

3. SRH policies in Zimbabwe and beyond: A snapshot

Despite the devastating effects of Zimbabwe's economic melt-down, a number of SRH-related policies have been crafted in an attempt to address the debilitating effects of SRH challenges among the youths. For instance, the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III) 2015–2018 is one example of the concerted efforts by the government to provide smart investment in areas which include young people. Its envisioned impact is to have improved well-being and healthy lives of all groups of people free from new HIV infections. The Sexual and Reproductive Health Strategy for the Southern African Development Community region (SADC) (2006–2015) was a proposal towards a holistic and integrated approach to the provision of SRH services. Youth were one of the actors who were provided with specific attention. According to the strategy, youth SRH is identified as one of the key priority areas of the SADC SRH Strategy. The National Reproductive Health Behaviour Change Communication Strategy (2006–2010) provides guidance to stakeholders on their contributions to sexual and reproductive behavioural change promotion and reducing incidence of unsafe abortions. In addition to this, the Maputo Plan of Action on SRHR (Sexual Reproductive Health Rights) (2007–2010) placed emphasis on needs to legalise abortion and ensure safe abortion services for all women and girls to the fullest extent of the law. The plan of action, to which most Southern African countries' SRH policies are aligned, advanced the positioning of youth friendly services as a key strategy for youth well-being and reducing incidence of unsafe abortions.

There is need for what Varga (2001) termed a “youth friendly approach” in policy and planning which will take into account the diverse influences of youth SRH. Moreover, the significant “gender gap” in research on sexual decision-making and negotiation presents a threat to the efforts to achieving positive SRH outcomes. According to the Zimbabwe National Adolescent Sexual and Reproductive Health Strategy (2010–2015), young people also lack comprehensive knowledge on SRH issues and services, with little knowledge more skewed towards child abuse and HIV and AIDS. Adolescents have little-to-no information of legal and policy provisions in place to protect their sexual and reproductive health rights. Young people from Mupandawana are particularly affected by this lack of information. Participants showed no knowledge of policies that relate to their SRH. In the Zimbabwean culture, traditionally, it was the role of aunts and uncles to educate young boys and girls as they grew into puberty. However, this practice has been eroded by modern practices such as formal schooling, migration and access to television, radio and print media. An assessment by the Ministry of Health and Child Welfare (MOHCW) in 2008 revealed that the involvement of parents or guardians in the provision of SRH information to young people was very low and only noted in the management of sexual abuse cases.

The SADC Reproductive Health Strategy recognises the role of parents when it highlights some of the transitional problems faced by youths, which include lack of parental guidance, eroded community norms and lack of access to health services. The Adolescent Sexual and Reproductive Health (ASRH) strategy identifies parent and community participation in SRH interventions. The strategy highlights the need for a multi-sectoral and participatory approach that also recognises the participation of youth of both sexes at all levels of SRHR programming. One of the strategies in the policy is that adolescent reproductive health programmes should be implemented through a wide variety of sectors in consultation with parents. It states that parents must continue to be given the responsibility for their children's behaviour patterns. The Inter-Agency Working Group (2007) notes that adults influence young people's access to SRH information and services, as well as their ability to make healthy decisions. The government developed the Life Skills, Sexuality, HIV & AIDS Strategic Plan (Ministry of Primary & Secondary Education 2013), and the ASRH Strategy, to respond to adolescent SRHR needs. Although the legal age of consent in Zimbabwe is 16 years, the National Family Planning Guidelines stipulate that all adolescents who are sexually active should be offered a contraceptive method of their choice. One participant, however, opined that service

providers tend to deny adolescents and unmarried youth access to contraception due to their own personal prejudices and biases about adolescent sexuality, opting instead to place emphasis on conveying messages of abstinence.

One of the SRH problems that was highlighted by young women was unwanted pregnancy and the unavailability of safe abortion services. In terms of abortion, the Zimbabwean context is not one that allows free abortion services to every woman who wants one. Despite being signatory to the Maputo Plan of Action which calls for allowing abortion in states parties,

Zimbabwe's constitution appears to take a strong anti-abortion stance. The provisions of the Termination of pregnancy Act and the Criminal Law codification Act clearly set limited conditions under which abortion can be conducted and any abortion done outside that is punishable. However, despite the fact that abortion is illegal, findings reveal that young women in Mupandawana still continue to have unsafe abortions. Youth SRH is identified as a one of the key priority areas in regional and national health and gender policies. Policies and laws, according to Thompson de-Boor and Shand (2013), significantly define and sustain gender norms by outlining what is considered to be officially acceptable.

Owing to their national impact, policies have a great capability to lead large scale improvements in youth SRH. Zimbabwe has good policies; however, when it comes to practical implementation, little evidence exists unless there is a case raised by civil society organizations (CSOs) or media, for example, on child marriages, age of consent and unintended pregnancies. There is evidence of disharmony of the laws at the moment. Public Health policies need to be aligned and linked; in other words, policymakers have to move away from silo programming—which means grouping whole broad policies without any specific targeted minute entities. Providing young people with SRH information and services is key to dealing away with SRH silences affecting youth and to enabling them to make well-informed choices about their sexual and reproductive health.

While all these policies exist on paper and promise a better solution/alternative for SRH challenges afflicting youths, there are existing gaps which need to be plugged. For instance, some youths who were interviewed indicated that gender-specific matters within youth SRH do not often receive adequate attention. This can be seen by the concern that, for example, where there are policy guidelines, their implementation can be obstructed by lack of capacity or resources. In addition, most policies have a problem of bunching different categories of youths together assuming that they are a homogeneous group; for example, the National Adolescent Sexual and Reproductive Health fails to set clear stipulations on youth who face different circumstances, for example, those living with HIV, disabilities and those who are forced into prostitution. The inability to recognise the multiple positionalities of youths hampers implementation of government and regional, as well as international SRH policies.

4. Research site and data collection

Mpandawana is a town and the largest service centre in Gutu—which is the third largest District of Masvingo located in the southern area of Zimbabwe. Saunyama (2014) opined that in the early years of independent Zimbabwe's economic planning, Mpandawana was designated as a "growth point". Mpandawana is estimated to have a population numbering up to 30,000 people (Saunyama, 2014). Under these circumstances outlined above, it is important to point out that the level of trust in as far as opening up to speak to "strangers" who include researchers is low as matters that relate to sex are perceived as a private and a taboo issue. McIlwaine and Datta (2004) note that conducting research with young people is fraught with practical and ethical challenges. Approaching issues of SRH involves careful consideration of how to address people and how to show respect for existing social value. We therefore sought for ethical clearance from the Great Zimbabwe University and we were granted. The youths who later became participants in the study were engaged after informed consent was granted. This involved is important in studies on SRH; thus, the researcher observed this ethic by seeking for consent from key informants, as well as the

participants in the focus group discussions. Consent was sought from all respondents before interviewing them. First, a written guide was read out to the participants who clearly stipulated their rights to privacy, and confidentiality and that research findings were going to be used solely for research/academic purposes. Therefore, real names were concealed in the findings and events or contexts which implicate someone or inadvertently reveal their identity were edited so that there confidentiality was maintained.

Ontologically, the article adopted a subjective interpretation reality of the social world and this led to the choice of the qualitative research methodology. It was particularly important to have this methodology as it allowed the research participants to express their lived realities in the most “valid” of situations. Therefore, the bulk of what is presented as findings indicates primary data which were collected using semi-structured interviews with youths that lasted anything between 15 and 45 min. The findings were then analysed in a thematic manner and discussed in the context of broader discourses around SRH, policymaking, youth empowerment and notions of social constructivism.

5. Findings

It is an unwritten norm in Mupandawana as most other areas of Zimbabwe that young unmarried people are not expected to be sexually active. This stems partly from an inherited Christian conservative belief which was ushered in by the British colonial Victorian Ideology (Adams, 2006; Blommestein, 2011; Mate, 2002; McEwan, 1996). This culture permeated into other social building blocks of colonial Zimbabwe, such as health delivery system, religion, the economy, politics, law and education. Unpacking the local discourses of indigenous inhabitants of Zimbabweans was one of the excesses of the colonial system. This is one of the reasons why in our opinion SRH problems which young men and women face are often kept silent for fear of victimisation by their families and communities. In relation to the challenges of norms constructed around “no sex before marriage”, young people in Mupandawana felt that they could not trust the health service providers with their might recognise them and unethically tell their parents/guardians or in other cases they feared meeting their peers at the facilities who might spread the news. Norms of virginity especially among young girls fostered the culture of silence when it came to issues of SRH (Arnfred, 2004; Bhatasara, Chevo, & Changadeya, 2013; Chikovore, 2004). This means that such cultural norms that are upheld in this society exert great pressure on young women to maintain their virginity, however, if they fail that is when they try by all means possible to hide their SRH problems.

6. Early pregnancies and conservative culture

In terms of pregnancies, young women expressed concern over the perception that young women lie about the responsibility for pregnancies. Young women aged 16–18 years who were still in school noted that this problem often leads to unsafe abortions since they are afraid of being castigated by society. Participants noted that notions of proof paternity can be used as a battle by young men to deny responsibility for impregnating young women. In a bid to deny responsibility, young women argued that they have heard of instances where young men deny a pregnancy saying she had other sexual partners/boyfriends or that she was not a virgin when he slept with her. Based on such realities, community might discriminate the young women and start pointing fingers at her and in the words of one participant;

so it is better to silently have an abortion and protect yourself and your family’s reputation.

This then explains why girls and young women end up going for unsafe means of terminating the pregnancies, some of which may have long-term negative effects on their reproductive systems. Youth also expressed concern that even if they wanted to have a proper procedure of abortion, no clinic would accept that; thus, they were left with no option but to go to those who do it using other means. One of the interviewed people who is a nurse expressed great concern over the problem of unsafe abortions and their toll on the SRH of young women. He noted that some of

the girls who have unsafe abortions end up coming to the clinic for medical treatment after having encountered problems in their processes and this was noted to be a great threat to the health and well-being of the young girls. One of the respondents observed that there has been an increase in teenage pregnancies in Mupandawana over the past three years. Mutenga (2014) noted that the rise in pregnancies among young women can be attributed to the idea that society could have abdicated its responsibility in “correctly socialising these young people”.

She summed up her perspective with a proverb that says “it takes a village to raise a child”. It seems that some participants were in agreement with this stance which interrogates the role of “macro-institutions” such as the family and community in socialising the young. Contrary to this perspective, the youths argued that one of the main reasons for the silences around SRH is related to the overbearing role of community on them.

The fear of victimisation emerging from accounts by youths of unethical health professionals was related with the surge in clandestine consultation of unregistered traditional herbalists who, in some instances, might not have adequate knowledge of medical issues even from a traditional medicine perspective. This culture of silence created by social institutions such as clinics has resulted in many cases of youths dealing with serious SRH challenges in silence. Young women in particular opined that health workers are judgemental when it comes to assisting them when they are seeking SRH services and products. An ASRH assessment commissioned by the MOHCW in 2008 in five of Zimbabwe’s ten provinces revealed that there is generally a limited appreciation of ASRH issues, especially at lower levels of care.

Health institutions face a number of challenges, which include limited skills in dealing with youth SRH issues among service providers. Health workers and other service provider need to be sensitive and have appropriate skills to competently deal with adolescent SRH issues. They need skills to be able to treat young people with respect and gender equality. The study also revealed that poverty especially exacerbated by the surging food insecurity leads to several SRH problems among youth, including silence on SRH issues affecting them. According to Zwicker & Ringheim (2004), poor SRH among youth is a poverty issue.

7. The scourge of HIV and youth SRH

Youths have some knowledge about HIV and pregnancy prevention, although this knowledge is sometimes muddled by some misconceptions, especially about condom use and contraceptives (Alemu, Mariam, Belay, & Davey, 2007). There is also evidence that youth risk perception is high, though this is not matched by their sexual behaviour that is often characterised by unsafe sex including intergenerational and transactional sex. A participant who works with youths noted that young people living with HIV are starting to be sexually active. These young people, both male and female, mostly do not have adequate information on preventing reinfection with other strains of HIV. Findings from document search revealed that HIV-positive young people often suffer from family pressure to reproduce and have children before they die. Examples were pointed in an area in Mupandawana known as Hwiru of young mothers whose health were deteriorated since giving birth. There were some indications that there is an inherent gap between ways of prevention and actual preventive practices. It was noted that most young people were having unprotected sex justifying the act noting that one cannot wear a condom when breaking a girl’s virginity.

Some participants reported the need for accurate information about sexual activity. Main sources of information that were brought out include the media, peers and a few acknowledged acquiring some of the knowledge from school. Most youths, especially the male youth noted that the mobile evening clinics being operated by Doctors with Border (MSF) have been of great help to them. Some noted that it is difficult for them to ask for money for treatment of STIs from parents; thus, the mobile clinics were very handy. However, concern was expressed that the clinics were not always accessible as the young people had to give excuses for leaving their homes in the evening. The youths alluded to some factors that dissuade them from accessing SRH services from clinics in the town. Stigma faced by young people from health personnel when they go to enquire about

reproductive health issues or seek treatment was reported as a huge factor that repels youth from accessing SRH services.

From discussions with young people complained of judgmental and discouraging remarks coming from nurses, one participant opined that nurses ganged up on her and scolded her for having been sexually active at sixteen. Among the many causes of teenage pregnancies is the lack of accurate information on puberty, which leaves young people dependent on uninformed peer sources or unguided internet searches. An interview with an officer from a local NGO revealed that dependence on peers for information is dangerous because peer influence affects decision-making on sexuality. The article also discovered that there is a need for accurate information on sexual activities and protection measures, such as how to use condoms properly and the dangers of relying on the morning after pill.

8. The impact on of economic hardships on youths and SRH issues

Poor youth are more vulnerable to sexual exploitation, as they may resort to transactional sex to support themselves. Food insecurity has been linked to high-risk sexual behaviour in

Zimbabwe and this study found this to be true in the case of Mupandawana. There exists a nexus between poor sexual and reproductive health of youth and poverty (Wilson et al., 2009). Economic development of a country or region can be negatively impacted by low levels of young people's SRH and vice versa. Poverty is largely associated with early sexual initiation among girls, but not among boys; therefore, young girls are more vulnerable to HIV/AIDS and other SRH problems and this is aggravated by pove; Chikovore et al 2013). In discussing how sexuality is constructed in societies, it can be noted that the relations between men and women are constantly affected by changes in economic and social conditions. Poverty can therefore lead to the development of a culture of silence on the part of the young girls who have to endure the unpleasant situations they find themselves in. Knowledge of prevention methods among young people has a strong positive association with education and wealth. This means that for those uneducated young people, risk-taking behaviours are high and also there is no knowledge of where and how to access SRH services. The consequence is that silence will be maintained.

Most married young people in Mupandawana revealed that they were not able to go beyond the third form of secondary school (around 15 years old at this point) because there was not enough money for them to continue with school. The participants noted that staying at home also became a burden; thus, they opted to get married to men who mostly travelled to South Africa and had petty jobs that were enough to support their new families. Most girls however revealed that they came face to face with reality when they got married, sometimes the men did not come back for months and the young women had to rely on food handouts from CARE and OXFAM. This means that the burden of poverty has become worse for them because they now have children to take care of. In other cases where the men are there, young women find themselves with limited independence and freedom, and are not able to negotiate safe sexual relations, contraceptive use and childbearing.

The problem of poverty in Gutu has also driven many young girls from areas surrounding Mupandawana, such as Chitsa and Bhasera, to the night clubs of Mupandawana in search of money to survive. Most of these girls end up being prostitutes. The issue of teenage prostitution in the town's night clubs has become popular among older men who then go after the cheap services of these young girls. Poverty is a vicious cycle in which the girl child will be indebted to take care of her siblings if they have been orphaned, ending up resorting to prostitution.

Interviews with some key informants revealed that most of the teenage prostitutes are orphans who see this as their only means of survival. This then puts them in vulnerable positions such that when they suffer sexual abuse at the hands of their clients, they keep silent. One young woman identified in the local state-run press—the Sunday Mail—as Princess is quoted saying that she left school when she was only in form two and she was an orphan. According to her, poverty and

hunger led her into prostitution. The study found out that poverty is one of the causes of SRH silences.

This article discovered that reproductive health silences are a public burden mainly in low resource and income settings. Young women living with poverty lack information about specific health services such as contraception and their SRHR, and this has great consequences on their health. Poverty leads to the inability to negotiate for safer sex. One reason for inability to negotiate was cited as fear of losing sources of income and survival; this is similar to what was found in Chiredzi by Chikovore. Young women, especially the teenage prostitutes, noted that they could not negotiate for safer sex with their older participants because they feared losing the clients, or were scared of being violently assaulted by the clients. In addition, providing livelihood skills is an integral component of adolescents' development and poverty reduction. Livelihood skills will also reduce vulnerability to risks, such as abuse, poverty and exposure to sexually transmitted diseases.

The practice of gender-based violence is widely prevalent and socially silenced in many African small towns. Some married young women in the study revealed that there are large age differences between them and their husbands, and in most cases when they find that their husbands have been unfaithful, they try to deny them sex. This then becomes a problem because the husbands often end up being violent. The participants went further to name one woman whose husband always beats her because she asks him to use a condom; according to them, rumour has it that the man is also HIV positive. From this case, it can be noted that gender-based violence (GBV) restricts a woman's decision-making capabilities and her freedom of choice, curtailing her rights to access critical SRH information and services. Gender-based violence is a major cause of silences on SRH issues for young women in Mupandawana.

In an interview with a key informant from MSF, the respondent noted that patriarchal gender constructions contribute to gender based violence, Women who suffer from this phenomenon are socially and culturally expected to keep quiet lest they be accused of being unable to keep their marital life secret. Studies by several scholars also reveal that GBV has important implications for SRH and sexual behaviour of young women ; Chikovore, Makusha & Ritcher 2013; Dunkle et al 2004). GBV is therefore a major contributory factor to the SRH silences affecting youth in Mupandawana. Moreover, the youths noted that they even notice that these young women who are subject to violence have many children indicating problems in their ability to use birth control. An example of a twenty-two-year-old woman who already had 3 children was given.

This is phenomenon is as a result of the social construction of acceptable behaviours of women in the society. These norms have strong implications on women's ability to speak up and get help in stopping gender based violence. Participants in this study also alluded to the fact that gender-based violence (GBV) is one of the causes of sexual and reproductive health silences and has great negative implications on female sexual and reproductive health. GBV is defined as an act that results in or is likely to result in sexual or mental harm or suffering to women including threats or such acts as coercion or arbitrary deprivation of liberty, whether occurring in private or public life (UN Declaration on the Elimination of Violence against Women 1993, adopted from UNFPA).

Findings from the study signify that young women endure domestic violence in silence.

UNFPA notes that violence experienced by women takes place within the "privacy" of their homes and has contributed to a culture of silence as regards the health consequences of the young women and girls. This silence is fostered by the perception of violence against women as being a family issue and not to be discussed in public. This has dented a major gap in public health policymaking. In terms of sexual coercion, the culture of silence existing in Mupandawana makes it difficult for response to be made to the needs of young women and girls. Findings in this study show similarities with studies conducted in other parts of Africa who found out that many women in too many countries speak the same language of silence. Young women, more than young men, may choose to remain silent for the fact that they fear what might happen if they talk, rather for

lack of a channel through which they can express their SRH needs. This phenomenon can be explained in the context of cultural challenges which foster silences by prescribing that young people, especially women, do not need SRH assistance. Policies, Guidelines and Strategies focusing on Youth SRH Findings on this section mostly come from desk review and key informant interviews. Constitutionally, the provisions are there to protect young people's SRHR, but practically there is silence on that. Section 76 of the Constitution on the Right to Health Care states that, "every citizen and permanent resident of Zimbabwe has the right to have access to basic healthcare services, including reproductive healthcare services". It is this supreme law of the country that guides public health policymaking in Zimbabwe.

9. Conclusion

One of the reasons why policies and strategies are failing to address the needs of the youth is that they are not involved at the grassroots/consultative level in the policy formulation. There is exclusion of youth in policymaking. Government should therefore prioritise the up-scaling of programmes that are related to youth SRH whenever such policies are tabled for promulgation. Youth should be included in the drafting of solutions to their problems. This is also important in ensuring that the country realises the sustainable development goals. The study recommends that government should include youth in reforming legal frameworks and reducing discrimination and stigmatisation. Government and relevant stakeholders should ensure that youth know their rights. The research recommends involvement of the community and youth in coming up with action plans for implementation since these increase the sense of ownership and increase sustainability of the programmes.

Gender Responsive Budgeting: The budget is the most important policy tool of government because it determines the successful implementation of all other policies. For youth SRH to be fully addressed there is need for government to prioritise gender-responsive budgeting and set guidelines for every institution to follow in relation to gender responsive budgeting. A gender responsive budget ensures that the needs of individuals from different social groups (sex, age, location) are addressed in policies. In the context of youth SRH, gender-responsive budgeting is an essential aspect and is important if we are to ensure that youth SRH is improved. This researcher therefore recommends that government sets up legislation that promotes gender-responsive budgeting in every institutional programme that targets youth sexual and reproductive health.

All the stakeholders involved in the implementation of SRH policies and strategies should have basic understanding of gender issues; thus, they should be trained. Health workers should be trained to improve their knowledge on how to address the SRH needs of young people. The community must also be trained on how to make youth feel free in expressing their sexuality without fear of judgement. There is need for context-specific toolkits to be developed so they can be used to train community members. The study further recommends that youth be trained in advocacy so that they can be able to advocate for their own needs and influence policymaking.

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Author details

Nigel Mxolisi Landa¹
E-mail: nlanda@gzu.ac.zw
Kundai Fushai²
E-mail: kundaifushai@gmail.com

¹ Nehanda Centre for Gender and Cultural Studies, Julius Nyerere, School of Social Sciences, Great Zimbabwe University, Masvingo, Zimbabwe.

² Gender and Policy Studies, Nehanda Center for Gender and Cultural Studies, Julius Nyerere, School of Social Sciences, Great Zimbabwe University, Masvingo, Zimbabwe.

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Wider Research Issues

This study has wider policy implications especially if one analyses the SDGs- GOAL 1: No Poverty; GOAL: 3 on Good

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