Customary Marriages and Young Women's Sexual and Reproductive Health Rights in Makwarela (South Africa) And Concession (Zimbabwe)

by

Gwatimba Leah

Student No: 11605759

Thesis submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy in Gender Studies

Institute of Gender and Youth Studies

School of Human and Social Sciences

University of Venda

South Africa

Promoter: Dr N.R. Raselekoane

Co-Promoter: Prof A.O Nwafor

2020

DECLARATION

I, Leah Gwatimba (11605759), hereby declare that this thesis for the degree of Doctor of Philosophy in Gender Studies at the University of Venda titled Customary Marriages And Young Women's Sexual And Reproductive Health Rights In Makwarela (South Africa) And Concession (Zimbabwe), hereby submitted by me, has not been submitted previously for any degree at this or any other university, and is entirely my work. All reference material contained therein has been duly acknowledged.

Leah Gwatimba 17 May 2021

Signature Date

ABSTRACT

Patriarchy continues to place limitations on women's rights in many societies. This is manifested by the unequal gender power relations between sexes, which also adversely impact women's sexual and reproductive health rights. The well-being and health of women are compromised by society's indifference to women's sexual and reproductive health rights. Using the key human rights principles of non-discrimination and gender equality, this study aims to promote women's rights and emancipation, through the abolition of primordial cultural practices in customary marriages which infringe on the rights and dignity of young women. This study interrogated, compared, and analysed the effects of customary marriages on women's sexual and reproductive health rights and gender equality in Makwarela (South Africa) and Concession (Zimbabwe). A mixed method approach was used, where both quantitative and qualitative data were collected and analysed. The qualitative results assisted in the development of a survey instrument for the quantitative phase of the study. Data were collected from young women aged between 18 and 40 years who are engaged in customary marriages and men in customary marriages who are aged between 20 and 45 years. The collected data were purposively sampled for the qualitative study using a semi-structured interview. The quantitative phase surveyed 802 participants (i.e. 401 from each country) who were selected randomly. Data were analysed using narrative analysis and the Statistical Package for Social Sciences (SPSS). The study found that payment of roora/mamalo affects the power dynamics in the family which subordinates women to men and makes it difficult for women to assert their sexual and reproductive health rights. The study reveals that there are various challenges that women face in their customary marriages which impede the enjoyment of their sexual and reproductive health rights. The study exposed challenges like the effects of dry sex, being unable to practise safe sex, and widowhood rites of being celibate. The study also found that relationship control factors make it difficult for wives to refuse sexual advances from their husbands as well as to negotiate for condom use. The study also put forward the intervention strategies that can be used for the promotion and protection of sexual and reproductive health rights of women. The study recommends that the Multi-level Approach to Strengthen, Protect, and Promote Sexual and Reproductive Rights of Women be adopted to facilitate women's enjoyment of their sexual and reproductive health rights in its entirety.

Keywords: Customary marriages, Gender equality, Human rights, Sexual and reproductive health rights, Women's rights

ACKNOWLEDGEMENTS

Utmost gratitude goes to my Lord and Saviour, the author of my life, Master Jesus lover of my soul. Thank you for partnering with me, without You I could never manage to do anything meaningful in my life. When my back was against the wall throughout this journey you made the wall crumble. You allowed me to become what you had in mind and hence you created in me a clean heart that I was able to recognise that everywhere I go was holy ground, it was holy because you were with me. I stand in awe because of your grace. You remind me each day that you are still the One.

This academic journey would not have been possible without the unwavering support and guidance of my promoters. Dr. N.R Raselekoane, thank you very much for volunteering to supervise me for my master's degree because this is where it all started. Thank you for believing in me, mentoring, and supporting my thoughts throughout this whole journey. The long office hours finally paid off. Not forgetting my co-promoter Prof. A.O Nwafor, I approached you with my research interests and you never hesitated to work with me. Your input in this study was invaluable, thank you.

To my family: Mom, Lynne Gwatimba, Michelle Gwatimba, Chido Gwatimba, Isheanesu Gwatimba, and Prince Gwatimba, I am forever indebted to you guys. Your support throughout all my academic endeavours was overwhelming. At times you would not understand what I want to do but you always trusted me to make the best decisions for myself. Thank you for allowing me to be the best version of myself.

I would also like to acknowledge my friends, Dr. Flora Takayindisa and Dr. Leoba Nyathi. You guys saw it all the procrastination and the frustrations of this journey. I will sadly miss the "working lunches" and the mischief in the library cubicles which bought sanity to all our journeys. Thank you and I wish you all the best with your future endeavours. To my friend Nyasha Charlotte Matsa, thank you for always being there throughout you were one friend that almost knew when to call and talk to me when I needed a good laugh to make this journey better.

I would like to thank my dear friend Dr. Rachel Chinyakata. You have been one amazing friend for the past nine years. I got a roommate in freshman year not knowing I am also gaining a motivator and a sister I would walk this journey with. Thank you for encouraging me to push myself beyond limits.

My deepest acknowledgement goes to European Union Intra Africa Academic Mobility Scheme for awarding me a year-long opportunity to be a research fellow at the University of Ghana.

To my friends that I made in Ghana, Timi Ebiede and Essi Kwebga you guys made my stay warm and pleasant, I wish you all the best. My friend Dr. Monde Mabuku you made my stay in Ghana joyful. Thank you for taking the time to assist me with the quantitative part of this study, I am forever grateful.

DEDICATION

To Mom and Dad

Conditio sine qua non

Thank you for loving me unconditionally, thank you for a home that was full of love.

Dad, I am told I take after you a lot and kind of stubborn in a way. I hope I have made you so proud. I think I have done well for myself; your little girl will be a doctor of philosophy and not a doctor of medicine.

Mom, thank you for instilling in me important values such as hard work, determination, and prayer. With all these, I grew up and never had problems that came with being a teenager and growing up. I saw what the power of prayer does in a person's life through you and I vowed to continue walking towards God each day.

I would have wanted you to cheer me on the day I get this degree and see you smile because I know I would have made you proud. I would have loved for you to meet my teachers for this kind of school and hear how I was doing in school and thank them. For this kind of school and what I studied for they are no longer called teachers but they are called promoters, they are very educated men, mom, and dad. I know you do not understand what I was studying but I will explain it to you further when we meet.

This Ph.D. is for you, we did it. I love you; I miss you, forever in my heart. Till we meet again.

Rugotwe rwenyu

Tati

Contents

LIST OF FIGURES

LIST OF TABLES

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CTOPA	Choice of Termination of Pregnancy Act
HIV	Human Immune Virus
ICCPR	International Covenant on Civil and Political Rights
ICESR	International Covenant on Economic Social and Cultural Rights
ICPD	International Conference on Population Development
MDG	Millennium Development Goals
RBA	Rights-Based Approach
SA	South Africa
SADC	Southern Africa Development Committee
SDG	Sustainable Development Goals
SDH	Social Determinants of Health
UDHR	Universal Declaration of Human Rights
WHO	World Health Organisation
ZIM	Zimbabwe

CHAPTER 1 INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 Introduction and background of the study

Human rights are indivisible, inalienable, and universal. They apply to all people, at all times and places (Moriarty & Massa, 2012). All individuals have equal rights without any differences. This warrants the indebtedness of human worth. Women's rights continue to be overlooked globally. Women are more vulnerable to abuse, injustice, and discrimination despite copious existing protective legal measures available for women to address the issue of gender inequality.

The dawn of the United Nations culminated on the issue of equality between men and women being one of the fundamental human rights. Adopted in 1945, the United Nations Charter espouses the dignity and worth of the human being and equal rights for all genders. This is specifically stated in article 1 of the charter which articulates that, the rationale of the United Nations is to advocate for the respect of human rights and fundamental freedom stripped of any difference based on sex, race, language, or religion. Dersnah (2012) is in support of the United Nations charter's principle of equality and inclusion of all since this is the only way to ensure that women can enjoy their fundamental rights like men.

The Universal Declaration of Human Rights (UDHR), promotes the equal entitlements of men and women to such rights. The UHDR acts as the basis for many international constitutions and it entitles individuals to non-discrimination of any kind (Report of online discussion, 2010). This, therefore, means that this instrument emphasizes a wide range of human rights from family relationships to violence against women and even non-discrimination in employment.

The International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic Social and Cultural Rights (ICESR), and the UDHR make up the International Bill of Rights. ICCPR and IESCR, bear specific provisions on the equality of public and political rights. ICESR legally requires states to respect and protect women's rights. ICESR also expresses an understanding of gender equality that can serve as a vision for those with the desire to advance women's issues in challenging contexts (United Nations Women, 2015).

The Millennium Development Goals' (MDGs) statement highlights that, if development is not engendered it is endangered (Sustainable Development Solutions Network, 2015). MDG goal 3, focused on gender equality and the empowerment of women. It aims to eliminate gender disparities as well as increase women's economic independence. However, the United Nations Industrial Development (2008), articulates that it is not practical to achieve this goal without first eliminating the differences between sexes in terms of capacities, access to resources, and opportunities. With these in mind, it can be said that gender inequality hampers the well-being of individuals and impedes productive ability. It also inhibits growth and poverty reduction. Sexual and reproductive health rights have a close link with MDG 5 (to reduce maternal mortality) and goal 6 (to halt the spread of HIV). In September 2015, the Sustainable Development Goals (SDGs), were put in place to chart the path towards sustainable development. SDG goal 5, builds on the target set by MDG goal 3. The aim of goal 5 is to promote socio-political transformation for the empowerment of women at the global and local levels (Sustainable Development Solutions Network, 2015). The specific goals that relate to this study are goals 3.7 (ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes), 5.1 (End all forms of discrimination against all women and girls everywhere); 5.3 (Eliminate all harmful practices) and finally 10.3 (Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies, and practices and promoting appropriate legislation, policies).

The preamble of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), specifically explains that, although there are instruments in place, women are still unable to exercise their rights to the fullest. The convention clarifies the nature and the meaning of any discrimination based on sex and sets out the position and duties of states to purge discrimination and achieve equality (United Nations Human Rights, 2014). Article 2 of CEDAW points out that state parties express disapproval of discrimination against women, and they agree to make use of available means of eliminating discrimination against women (Stark, 2013). The line of reasoning is that states must aim to eradicate all forms of social, political, cultural, and traditional discrimination, which perpetuate labelling through gender, yet create a society that aids the promotion and recognition of women's rights. CEDAW is seen to be providing a much-anticipated link to human rights (Hodson, 2014).

Despite CEDAW's immense protective affirmation of women's rights, it failed to specify other injustices which include some harmful practices faced by women in the African continent. This resulted in the African Union adopting Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, known as the Maputo Protocol. This protocol reaffirms the principle of promoting gender equality. The protocol recognizes the important role that women play in the conservation of African values, based on the important egalitarian principles of equality, dignity, justice, freedom, and democracy. However, women are still victims of harmful practices across the African continent, which must be eradicated. Article 45 (1) (b) of the African Charter, puts forward principles aimed at addressing legal problems that have women's rights at the core, for African countries to base their legislation towards fulfilling women's rights and the mandate stated in the African Charter (Duggard, 2007 and Mujuzi, 2008). In this ambit, the charter seeks to promote measures that protect human rights without being hampered by traditional separation of the categories of rights. The charter has translated into regional policies to national-level policies and legislation to address gender inequality.

The Southern Africa Development Community (SADC) Protocol on Gender and Development was founded on an approach based on individual rights. This approach requires the mainstreaming of human rights in a developmental approach. This entails embracing human rights in all the policies and programmes of governments. Munalula (2011), postulates that the protocol reiterates the legacy of the African Union and extends an invitation to member states to promulgate the issues that were previously not mentioned, such as sexual and reproductive health rights. This is one of the areas that were overshadowed by African customary practices. Thus, it challenges patriarchal customs and values of decision making structures (Forere & Stone, 2009). The Gender Protocol places an obligation on member states within Southern Africa, to enshrine the equality of sexes in their constitutions because it is superior to any other constitution, such as religious law and customary law.

In South Africa, during the apartheid era, the Abortion and Sterilisation Act 2 of 1975 legalized abortion with certain conditions under the control of professionals. Within that Act, abortion was permissible where there existed fostering circumstances, for example, in cases of rape or incest. Black women's choices were not important, as the apartheid regime made it clear that, offering abortion to 'promiscuous' black women would be a waste of state resources (Klausen, 2010). Abortion was, therefore, exclusive to the white race and the black women were viewed as inferior citizens.

After democracy in 1994, the Reproductive Rights Alliance, worked with women in the African National Congress (ANC) and the government to secure progressive reproductive rights frameworks in the final constitution and abortion law reform. Advocates of women's rights called for equality which encompassed reproductive freedom as a constitutional right, to be embodied in the constitution (Albertyn, 2015). The Constitution of 1996 in section 12(2) guarantees the 'right to bodily and psychological integrity', including 'the right to make decisions concerning reproduction' and to 'security in and control over their body' and the right of access to reproductive health care services in section 27 which must be read together with section 9 which is the equality clause. Sections 9 (2) and (3) specifically state the equality clause and advocate for non-discrimination. The adoption of the constitution in 1996 was a milestone in terms of addressing inequalities between men and women. The constitution reaffirms an agenda of reinforcing the national, regional, and international framework for the promotion of human rights.

The result of these efforts was the Choice of Termination of Pregnancy Act 92 of 1996 (CTOPA). This Act is advancing both women's rights and the rights of the foetus. Pickles (2012) posits that CTOPA reinforces constitutional rights such as the right to life, privacy, bodily integrity, dignity, psychological integrity, equality, and access to information that are grouped within the ambit of sexual and reproductive health rights. This, therefore, equips women with substantive protection awarded to them by the constitution despite their age. According to Albertyn (2016), the Act visualizes abortion as an important right of every woman to decide whether to have a safe abortion, and this service is seen as a vital part in asserting the universally acceptable health care services in which the state is obliged to provide for an environment that respects women's choices. It can, therefore, be understood that access to safe termination of pregnancy services aid the reproductive health of women by reducing maternal mortality.

In 1998, the South African Population Policy departed from the previous position of focusing exclusively on population control and ventured into the empowerment of women through the inclusion of men in health-related matters. This was done by imparting knowledge on contraception to both men and women. Contraception was usually shrouded in obscurity, but the National Framework and Guidelines for the Contraception Services in 2001, made a bold statement that family planning is aimed at increasing women's choices and access to health care services (Lalthapersad-Pillay, 2015). It should be understood that access to

contraceptives has a two-pronged aim (Department of Health, 2011); reduction in child and maternal mortality and to address high rates of unwanted teenage pregnancies.

In Zimbabwe, the Termination of Pregnancy Act 29 of 1977 permits abortion in limited circumstances. It is only permissible where the pregnancy poses a threat to the woman's life, where there is a risk of the child being born with physical or mental impairment, or where the pregnancy is a result of rape or incest to mention a few. However, permission should be granted by a superintendent of the given institution and performed by a medical practitioner. The restrictions placed on abortion compel women to undergo unsafe abortions, which in some cases result in the death of young women since most abortions are performed by unskilled and unprofessional personnel (Mulenga, 2010; Chin'ombe, 2014). Section 60 (1) of the Criminal Law Act 2004, criminalizes abortion. This means that women's rights over bodily integrity and dignity are constrained by the Act.

The National Adolescent Sexual and Reproductive Health Strategy 2010-2015 had a principal aim to develop and disseminate guidelines on the misconception that, adolescents younger than eighteen need consent to receive contraception. According to the National Adolescent Sexual and Reproductive Health Strategy (2010-2015), young people do not possess adequate knowledge on sexual and reproductive health rights and they also lack knowledge on sexual health issues and services with little distorted knowledge on child abuse and HIV/AIDS (Biriwasha, 2012). Therefore, young women with little or no knowledge of provisions on sexual and reproductive health rights cannot assert their sexual and reproductive health rights.

It is to be noted that Section 80 (3) of the Zimbabwean Constitution of 2013, states that, all laws, customs, traditions, and cultural practices that violate the rights of women guaranteed by the constitution are void ab initio. Section 76 of the constitution of Zimbabwe advocates for the right to health including sexual and reproductive health rights. Thus, any laws, customs, or government policies that restrict the reproductive rights of women are inconsistent with the constitution.

The constitution of South Africa is a sound framework for the generation of the transformational agenda in enforcing the promotion of human rights. Sections 30 and 31 of

the South African constitution guarantees the religious and cultural rights of everyone to be exercised under the Bill of Rights. In 2004, the Commission on the Promotion and Protection of the Rights of Cultural, Religious and Linguistic Communities was set up. The mandate of the commission is to promote and further respect cultural, religious, and linguistic rights.

In Zimbabwe, women live under a combination of customary laws, general laws, and families who make their laws. Section 63 of the Zimbabwean constitution states that every individual has the right to participate in the cultural rights of their choice, but, in some cases limited where they infringe with other people's human rights. The South African and Zimbabwean patriarchal practices formulate and propagate gender inequality which strips women of any control over their sexuality, because African cultures have strongholds, even over religion.

Marriage is a union between two people under civil laws or religious laws. Marriage is an important instrument in forging societal relationships. Zimbabwean constitution, Amendment 20 of 2013, defines marriage as an agreement between a man and a woman who has attained the majority age (18). In Zimbabwe, the Customary Marriages Act of 1951, does not make provisions for the minimum age of marriage.

Customary marriages involve the payment of bridewealth, known as *lobola* in many South African communities and *roora* in Zimbabwe. Tfwala (2008), states that bridewealth is regarded as the main social means, wherein reproductive powers are transferred from the bride's family to the groom. Hence, women are seen as property that can be bought. Olabisi, Aransiola, and Osezu (2006) assert that the payment of bridewealth renders women as objects bought to satisfy the urges of their husbands. This is how women are also stripped of control over their sexual and reproductive health rights. Customary marriages in Zimbabwe and South Africa, also allows men to practice polygamy. It is difficult to have control over sexual behaviour in this kind of marriage therefore risks of contracting sexually transmitted diseases are heightened.

In patriarchal societies, some cultural practices within the customary marriages are to some extent harmful to young women, because, they promote discriminatory practices and beliefs about the inferior role and position of women in society. These practices and beliefs hinder young women from asserting their sexual and reproductive health rights. All this hinders the

growth and development of women. These cultural practices often have a detrimental effect on women's sexual and reproductive health. Although cultural practices such as virginity testing and female genital mutilation are conducted to prepare young women for marriage, they have far-reaching implications on their health and well-being. Such cultural practices also pose threats to young women's ability to exercise their rights. Therefore, these cultural practices serve to fuel inequalities based on gender. The above mentioned cultural practices will be discussed in seriatim, and this includes how they affect young women's sexual and reproductive health rights.

There are various ways in which women are left without the ability to exercise their sexual choices. Placing restrictions on the ability of women to access sexual and reproductive services such as abortion services hinders the progress on the health and well-being of women. This is one of the many areas that women have been facing challenges to assert their rights. This serves to signify that the reproductive choices of women need to be awarded particular emphasis. When women are in a position where they cannot exercise their own sexual choices it creates problems such as maternal mortality and morbidity. International instruments that have already been discussed in this study seek to promote the health and well-being of women. Regardless of the copious legal instruments under both soft and hard law, the assertion of women's sexual and reproductive choices is still fraught especially within the circles of traditional and customary norms. Norms in societies and families place women in a precarious position by dictating navigation within their sexual and reproductive health.

There is a need for research to analyse customary marriages and young women's sexual and reproductive health rights as a result of patriarchy coupled with gender norms and inequality. It is therefore important to analyse customary marriages and young women's sexual and reproductive health rights to understand the situation of young women and their position within an African context and develop interventions that can support and promote gender equality and young women's sexual and reproductive health rights in customary marriages.

1.2 Problem statement

The power that women possess over their bodies, sexual and reproductive health rights has great influence over their lives, their families, and communities. Patriarchal ideology has always made it difficult for women to enjoy their sexual and reproductive health rights.

Patriarchy tends to validate gender inequality through the promotion of cultural practices, norms, and beliefs, which often undermine women and their rights. In customary marriage, there exist some cultural practices which disregard women's rights (Dyani-Mhango, 2016). Customary marriages serve as a validation of patriarchy, which disadvantages women by placing women in an inferior position. It, therefore, promotes inequality between women and men which results in social restriction, lack of financial freedom, and lack of or limited access to education by women (Kruger *et al.,* 2014). This subsequently denies women the freedom to adopt healthy sexual and reproductive behaviours, since they are culturally socialised into believing that they are expected to even sacrifice their sexual and reproductive health rights for the benefit or pleasure of men.

1.3 Aim of the study

Using the key human rights principles of non-discrimination and gender equality, the aim of this study is to promote women's rights and emancipation, through the abolition of primordial cultural practices in customary marriages which infringe on the rights and dignity of young women.

1.4 Objectives of the study

The objectives of the study are:

- To determine the relationship between customary marriages and gender equality;
- To explore the effects of customary marriages on young women's sexual and reproductive health rights;
- To identify obstacles to the realisation of young women's sexual and reproductive health rights;
- To investigate sexual relationship power in customary marriages;
- To formulate interventions that can support and promote gender equality and young women's sexual and reproductive health rights in customary marriages.

1.5 Research questions

The main research question derived from this problem is: How does customary marriages impact on young women's sexual and reproductive health rights in Makwarela (South Africa) and Concession (Zimbabwe)?

The sub-questions are:

- What is the relationship between customary marriages and gender equality?
- How do customary marriages affect young women's sexual and reproductive health rights?
- What are the obstacles to the realisation of young women's sexual and reproductive health rights?
- How is the sexual relationship power in customary marriages exercised?
- Which interventions can support and promote gender equality and young women's sexual and reproductive health rights in customary marriages?

1.6 Significance of the study

This study is significant because some of the studies carried out on customary marriages in South Africa and Zimbabwe do not specifically focus on young women's sexual and reproductive health rights. The comparative study of the two countries' respective positions on issues of women's reproductive health rights is crucial because South Africa has successfully promulgated progressive laws on sexual and reproductive health rights while Zimbabwe is yet to do so. Therefore, a knowledge of the legal protections in place will assist in understanding how both countries advance and protect women's sexual and reproductive health rights. The study will also add to the body of knowledge on women's rights and in particular women's sexual and reproductive health rights. The study will also contribute to the existing body of literature in construing the roles that cultural practices play on issues of sexual and reproductive health rights of women. Therefore, the research will address the unknown to provide a rich insight which can be used to form a knowledge base on and for women's sexual and reproductive health rights in customary marriages. Women's rights education is a fundamental right in itself as stated by the UHDR (United Nations Human Rights, 2014). The UHDR articulates that states should strive to educate people about human rights to promote freedom and respect for human rights. Through the provision of knowledge from this study, education on human rights entails one's ability to understand and observe the principles of equality and freedom of all people irrespective of their gender, race, culture, and language.

1.7 Justification for the research

Patriarchal ideology has always created an environment wherein women cannot assert their sexual and reproductive health rights for the mere reason it validates issues such as gender

inequality and the roles of women in the family and society as that of lower-class citizens. This is done through the promotion of some practices performed under the guise of culture and norms which disregard the rights that women also possess.

Women's rights are human rights. Therefore, the principles of inalienability, universality, and interdependence apply to women's rights as well (Bauer and Helie, 2006). Various human rights instruments also advocate for gender equality since they are intended to end inequality and discrimination (Maparyan, 2015). The worth of any human being is defined by one's ability to enjoy all rights based on the fundamental dignity bestowed upon all human beings (Ntlama, 2010).

Rights are indivisible and interdependent; hence, it is impossible to claim rights without knowledge and information about laws, policies, and the right to organise and claim the right (United Nations Women, 2015). Therefore, the state must be in a position to provide individuals with all the necessary information, to ensure opportunities to obtain what they need, and be in a position to provide that which cannot be secured by personal efforts (Braungardt, 2015). This means that depriving one of any of the rights negatively affects the enjoyment of the other rights.

The universality and inalienability of human rights are unquestionable in instances where cultural identity is recognized and taken into consideration (SOAWR, 2011). The United Nations has put in place several instruments that emphasise human rights which should be enjoyed by all people. According to Moriarty and Massa (2012), universality intends to make all nations work together to achieve the inalienability of human rights. This does not mean that the rights are absolute, because they, can be overridden. For instance, some rights contradict with public interests, however, due process should be maintained.

Gender equality is one of the fundamental human rights. Gender equality refers to a situation wherein, men and women have equal conditions for the realization of their potentials to equally contribute and benefit from global development (Kemi and Jenyo, 2016). According to the Australian Government (2016), gender equality is all about equal opportunities which can be hindered by the ongoing discrimination or weakness in laws, policies, and relations in societies that normalise inequality. Therefore, the causes of discrimination must be identified and

eliminated to give both men and women equal chances. Durojaye, Okeke, and Adebanjo (2014) are of the view that mainstreaming gender equality is an important development strategy that can be used to promote the position of women in society.

Hartman *et al.,* (2016), state that, harmful gender norms and practices which promote male dominance over women, culminating in the neglect of human rights. Male dominance has often led to the disregard and undermining of women's rights. This often brings about negative health outcomes for women, since they are denied opportunities to exercise their rights. This is as a result of the patriarchal systems in most societies across the world. Patriarchy is the prime obstacle to women's advancement and development. In patriarchal terms, women are seen as biologically inferior when compared to men. This view allows society to assign different and submissive roles to women. Hence, patriarchal systems in most societies justify male dominance and female inferiority based on their biological make-up (Sultrana, 2010).

Patriarchy is rooted in the Biblical story of creation, where Eve is a product of Adam's rib. From this, context, a woman is seen as nothing but just part of a man. Such doctrines relegate women towards subordinate positions, both in church and family. This view promotes the notion of second-class citizenship on women, whose creation was God's last piece of work.

Feminists critique patriarchy in their quest to understand women's realities in society. They posit that the degree of patriarchy in a given society is a reflection of the extent of control men have over women as reproductive beings, and this also shows the amount as well competition there is for higher and powerful positions (Kruger, Fisher and Wright, 2014). Feminists view patriarchy as one of the strategies men use to oppress women. As a result, feminists are a united front against patriarchy, intending to liberate women from subjugation (Ahikire, Musiimenta, and Mwiine, 2015). Feminists oppose social systems which regard men as the source of authority, while women are expected to be submissive objects to men.

Patriarchy is a social system which produced a culture which moulds people into accepting that, even though humans are social beings, men are dominant and women are submissive (Serpa, 2016). This, therefore, means that culture has certain rules that are at some point against the law. This is the case because there are cultural norms that put women at a disadvantage. After all, such cultural norms do not accord women the same status as men.

Nations around the world have their own cultures that connect communities and individuals. Culture helps individuals with an easy way to connect with others who share the same mindset, values, history, and beliefs. Culture is important for both individuals and the communities, because, it contributes to building a person's identity, self-esteem and it also promotes social cohesion. Wadesango, Rembe, and Chabaya (2011) are of the view that every social grouping is characterised by the observance of certain cultural beliefs that guide its members on how to behave or live. Therefore, culture is like a fabric made up of different threads and some of these threads represent customs and practices. In a patriarchal society, these customs and practices are shaped in a way that creates and endorses the dominant position of men and the subservient position of women in society.

Traditional cultural practices reflect the values and convictions that are passed from generation to generation in a community. Every society observes certain cultural practices and norms. However, some of them are beneficial, whereas, others are harmful to specific groups in a society like women. In patriarchal societies, customs and other practices are structured and carried out in a manner that conforms to the prevailing culture which often subjugates women.

According to Ndulo (2011), traditionalists argue that the promotion of traditional customary values supports the promotion of human rights. However, others argue that some customary norms infringe on the rights and dignity of women. Such customary norms are used to justify the treatment of women as inferior beings. Traditional norms are often used in a patriarchal society to project women as an adjunct group of the society, not equals to men (Walker, 2013).

Health and human rights are closely interwoven since health is also a basic right to life and all people are entitled to it. Wesonga *et al*. (2015), posit that the promotion of health practices which are in line with the human rights agenda can be understood if there is a better level of observance of human rights. There is a strong link between gender norms and the influence men have over women's sexual and reproductive health rights. According to the International Planned Parenthood Federation (2015), gender inequality prevents women from reaping the benefits of the evolving world. Therefore, gender inequality must be stamped out to ensure that women realise and assert their sexual and reproductive health rights. Sustainable and meaningful rights-driven development can be made possible through addressing the issues of

gender inequality, which act as a barrier against women who wish to make their own decisions concerning their bodies (Universal Access Project, 2014).

Many international organisations such as the United Nations and World Health Organisation, have set standards against gender inequality. Bangura and Thomas (2015), postulate that, organisations like the World Health Organisation, state that women are entitled to the highest standard of physical health. Although the constitution of South Africa contains specific provisions against discrimination on grounds of sex, gender, race, language, and culture, some cultural and religious practices continue to discriminate against women (Durojaye, *et al.,* 2014). The Gender Policy Framework is one of the key South African national policies which were put in place to advance human rights. The Gender Policy Framework states that equality of treatment entails meeting specific standards and needs for both sexes (Simmons, 2014).

On the other hand, section 3 (1), of the Zimbabwean constitution guarantees equal protection to all citizens regardless of sex, class, and religion. According to Ndoma and Kokera (2016), section 17(1) of the Zimbabwean constitution requires the state to promote gender equality, and this culminated with the Ministry of Affairs, Gender, and Community Development, putting in place the National Gender Policy for the protection and advancement of gender equality.

The literature cited, unequivocally highlights the problem of gender inequality, regarding women exercising their human rights; the very same rights that their male counterparts seem to possess. There are several theories propounded by different scholars, to help explain the problem of gender inequality in society. Since one theory is not enough to interrogate and understand the phenomenon under investigation, it is imperative to use a variety of theories and a framework to get a deeper and clear understanding of individuals and socio-cultural factors that underpin the ability of young women in customary marriages to assert their sexual and reproductive health rights.

This study will be conducted employing a literature review and empirical research. An empirical investigation is conducted in this study using both qualitative and quantitative methods to acquire data that would strengthen the trustworthiness and validity of the research. The study will employ a comparative analysis to first establish experiences within customary marriages and its influences on the sexual and reproductive health rights of women within

these countries. These will be used to demonstrate commonalities and/or differences about sexual and reproductive health rights on customary marriages in South Africa and Zimbabwe. In the end, the commonalities and/ or divergences on sexual and reproductive health rights will help determine the role of customary marriages in promoting or undermining women's sexual and reproductive health rights. This research seeks to analyse customary marriages and young women's sexual and reproductive health rights, most research conducted in this domain focuses on adolescents and sexual and reproductive programmes not the effects of customary marriages. Therefore, a research design is needed that could allow new themes to emerge. The purpose of a two-phase exploratory design is to utilise the results of the first method (qualitative) to assist in informing the second phase (quantitative). Sequential exploratory designs are used when the researcher wants to generalise the findings from the qualitative study with a larger sample gathered using the quantitative study and to explore the phenomena in-depth and measuring its prevalence (Petrosyan, n.d). Of the purposes of a sequential mixed methods design, this study will attempt to achieve the benefits of triangulation, complementarity, completeness, and development. Conducting a study in Makwarela (South Africa) and Concession (Zimbabwe) is important to assess the extent of progress made, particularly on the promotion of women's sexual and reproductive health rights and gender equality in Zimbabwe and South Africa. The rationale for conducting such a study in Zimbabwe and South Africa is that South Africa seems to have extensive protection and enforcement of human rights issues when compared to Zimbabwe.

Using the key human rights principles of non-discrimination and gender equality, this study aims to promote women's rights and emancipation, through the abolition of primordial cultural practices in customary marriages which infringe on the rights and dignity of young women. Three key contributions are expected as a result of conducting this research: (1) a better understanding of customary marriages and young women's sexual and reproductive health rights in Makwarela (South Africa) and Concession (Zimbabwe), (2) a more comprehensive examination of culture, sexual and reproductive health and rights and gender norms in the context of customary marriages than has been done by researchers in that research domain, and (3) pragmatic results that provide with a new lens to view the pursuit of health and human rights for women to promote and protect sexual and reproductive health and rights.

1.8 Definition of key terms and concepts

Customary law

It refers to an indigenous law of ethnic communities in Africa (Ndulo, 2011). This definition will be used in the context of this study.

Customary marriage

It is a marriage conducted under customary law (Recognition of Customary Marriages Act 120 of 1998). In this study, a customary marriage is a marriage conducted according to the customs and traditions of South Africans and Zimbabweans, which forms part of their culture.

Young women

In this study, young women refer to women aged between 18 and 40.

Sexual and reproductive health rights

For this study, this phrase refers to the rights of all people to make choices about their sexuality and reproduction (Tallis, 2012). This includes the right to access health care, respect for bodily integrity, the ability to choose partners, decide to be sexually active or not, have consensual sex, decide when and if to marry or not, whether to have children and pursue a safe sexual life.

1.9 Chapter synopsis

Chapter 1: Introduction and Background. This chapter is an introduction to the topic and it will consist of the introduction, background to the study, statement of the problem, research aim and objectives, and the significance of the study.

Chapter 2: **Theoretical Framework**. This chapter focuses on the theoretical framework of the study. It discussed the feminist theories of radical feminism, liberal feminism, and African feminism. It also discusses the sex role theory, framework for unequal gender power, the theory of social justice, and the social representations theory and how these theories will inform the study.

Chapter 3: **Literature Review**. This chapter will be made up of a literature review on the characteristics of human rights, sexual and reproductive health rights, cultural rights, the position of women within an African context, and the harmful traditional practices imposed on women under the guise of culture. The literature will also explore the issues of patriarchy and the theories that informed the study.

Chapter 4: **Research Methodology**. This chapter will unpack the research methodology, and this will entail the research design, study population, location, sampling techniques, data collection, analysis, and ethical considerations.

Chapter 5: **Qualitative Research Findings**. The chapter covers the presentation of data and analysis of the qualitative phase of the study from the in-depth interviews conducted with young women and men on the effects of customary marriages on young women's sexual and reproductive health rights. In this chapter data from both countries is presented and the results are presented according to the patterns that emerged from the data.

Chapter 6: **Quantitative Results**. This chapter entails a presentation of the findings of the quantitative phase of the study conducted with the young women who were participants in this study. The data from both countries were presented by using tables and graphs on the analysis ran.

Chapter 7: Discussion of the Findings. This chapter discusses the qualitative and quantitative findings of the study. While doing this the chapter will link the findings to previous research findings, to theory, and practice.

Chapter 8: Overview, Contribution, and Recommendations of the Study. This chapter will give an overview of the study, highlight the contribution that this study made, and also make recommendations based on this study findings.

1.10 Conclusion

This chapter introduced the reader to the study. It revealed the problem under investigation, the aim, objectives as well the research questions that this study seeks to answer. This chapter also highlighted the significance of the study and defined the key concepts in the study and finally gave a detailed chapter division of the study.

CHAPTER 2: THEORETICAL FRAMEWORK

2.1 Introduction

This chapter discusses the theoretical framework on which this study is premised. The researcher keeps in mind the advice put forward by Serres (1995:50) that:

> *"…a single theoretical pass key will never suffice to open all doors rather each time you want to unlock a specific problem you must use a specific theoretical key which will be adequate."*

This argument is also corroborated by Raselekoane (2010) who contends that the use of different theories plays a major role in widening the researcher's understanding of what she/ he is reading or investigating. In other words, the use of a variety of theories provides the researcher or reader with different meanings of what is being read or investigated. This means that a researcher or reader who uses different theories to interrogate the text or problem being investigated will always have a much deeper understanding of the phenomenon being researched or text being analysed.

Having said this, it was important for the researcher to employ different theories to answer different problems to broaden the researcher's understanding of the phenomenon being investigated. In this study, the researcher used six theories: three feminist theories (radical, liberal, and African feminism), gender theory, the theory of social justice, social representations theory, and one framework (i.e. Framework for unequal power in sexual and reproductive health). Since one theory was not enough to interrogate and understand the phenomenon under investigation, it was imperative to use a variety of theories and a framework to get a deeper and clear understanding of individuals and socio-cultural factors that underpin the ability of young women in customary marriages to assert their sexual and reproductive health rights. All the theories discussed helped to unpack and understand the behaviour of men and women about the issue of sexual and reproductive health. All the theories were relevant in assisting the researcher to choose the relevant research design of this study which is a mixed method as well as designing both qualitative and quantitative data collection instruments.

The discussion of the theoretical framework in this study entails thorough scrutiny of different theories concerning the phenomenon being studied. Theories consist of a set of related concepts that specifically highlight the nature of the relationship between variables. In the view of Mills and Birks (2014), a theory is an explanation that consists of concepts related logically. Green (2014) argues that the main purpose of a theory is to aid in understanding a problem through the description of a phenomenon. In the same vein, Ocholla and Le Roux (2011) state that good theories for social sciences aim at explaining the nature, meaning, and challenges that are unexplained in the universe we live in to use that knowledge to act in a more informed way. Scholars like Green (2014) are even bold enough to state that in social sciences it is almost impossible to study empirically without theories and research methods.

A theoretical framework lays the groundwork from which all knowledge is created for a research study. A theoretical framework is an outline that guides the research through the use of articulate concepts and explanations that are in place to explain relationships (Grant & Osanloo, 2014). Therefore, the theoretical framework acts as a yardstick for the literature review and methodology of the research. Lysaght (2011:572) states that:

> *A researcher's choice of framework is not arbitrary but reflects important beliefs and understandings about the nature of knowledge, how it exists in relation to the observer and the possible roles to be adopted and tools to be employed consequently by the researcher in his or her work.*

According to Ziedler (2007), the nature and the function of the theoretical framework are twofold. Firstly, what is the problem that the researcher is investigating, and secondly why is the approach that the researcher is employing practical in solving the problem? The answers to this question came out of the literature review and research methodology chapters which are critical components of this study. Herek (1995) sets down four components of a theoretical framework. Firstly, it must state specifically the theoretical assumptions upon which the researcher based her methodology on. Secondly, it must depict how the researcher builds upon the existing literature. It must explicitly expound on the theoretical assumption that the researcher is basing her research on and how it allows the researcher to generalize aspects through observation. Lastly, the theoretical framework helps with an all-inclusive explanation as to why the research method being used in the study was chosen and how it assists in answering the research questions. In summation, a theoretical framework should fit the purpose for it to enlighten the research (Ngulube *et al.,* 2015).

The discussion of the theoretical framework in this study covered several theories propounded by different scholars. These theories were applied to explain the problem of gender inequality in society and its role in the sexual and reproductive health rights of young women in customary marriages. The purpose of discussing and using many theories was to device well-corroborated arguments by interrogating the issue of sexual and reproductive health rights concerning women. The vast body of feminist theories is one of the many points of departure in support of women's struggle for gender equality in society. In other words, feminist theories advocate inequality between sexes which is not set up by nature but it is set up by man. The researcher combines the strengths of feminist theories of radical feminism, African feminism, and liberal feminism to interrogate the issue of gender inequality in a customary marriage. The study also drew on the strengths of the theory of social justice, sex role theory, social representations theory as well as the framework for unequal gender power in sexual and reproductive health.

It is necessary to use a variety of theories to unpack and explain issues raised when analysing the phenomenon being investigated in this study. This is essential because the literature used for this study also covered different themes on cultural practices in customary marriages, gender inequality, women's sexual and reproductive health rights, and promotion of social justice for all. The literature surveyed unequivocally highlights the problem of gender inequality when it comes to women exercising their human rights, the very same rights that their male counterparts possess. The use of different theories helped to ensure that no issue raised in this study was left unexplained. Hereunder, follows a discussion of the selected theories which were used to analyse the effects of customary marriages on young women's sexual and reproductive health rights.

2.2 The concept of feminism

Defining feminism remains a daunting task as feminism closely involves rethinking the past, present, and future. Feminists share a mutual understanding of what entails the oppression of women but they hold different views over what women's liberation involves (Ramazanoglu, 2012). Briggs and Pepperell (2009) define feminism as a belief in the equal nature between men and women because most societies bestow men with privileged positions. Therefore, the basis of feminist arguments is that women hold inferior positions in society. Watson (2014) is of the view that feminism is a theoretical project to understand the societal dynamics and social institutions which culminate in women being assigned marginalised positions. On the

other hand, Hooks (2014) posits that feminism is a movement aimed at putting an end to sexism, sexist exploitation, and oppression. This does not imply that feminists hate men but contend that sexist thinking emanating from either men or women should not be tolerated.

According to Scholz (2011), the history of feminism dates back to over two centuries ago. This was the struggle of women for equal economic, cultural, legal, and political rights which was the first wave of feminism. The second wave fought for equal cultural and social rights. The main goal of present-day feminism is the indisputable need to ensure recognition of women as human beings with all the rights and fundamental freedoms and responsibilities that are possessed by all the citizens (Sharma, 2012). This calls for the eradication of any male domination to establish an egalitarian society. Therefore, it is important to achieve equality as gender intersects with other hierarchies in society. According to Das and Patra (2009), this is possible through the eradication of discrimination, stereotyping, objectification, oppression, and patriarchy which push women to the periphery of society. Feminism is a broad movement that embraces numerous phases of the emancipation of women (Kaur, 2016). There are three main branches of feminism. These are liberal feminism, Marxist feminism, and radical feminism. In this study, radical feminism, African feminism, and liberal feminism were used. Hereunder follows a brief discussion of the above stated three feminist theories.

2.2.1 Radical feminism

Mackay (2016) posits that radical feminism can be identified through its main components which are a focus on patriarchy and recognizing male violence against women. Male violence perpetrated against women is part of the oppression of women by men. This means that the oppression of women is included in male violence against women. According to Cudd and Holstrom (2011), patriarchy is a phenomenon coined by society enforcing notions of sex and gender that connect male domination and female subordination. The main issue for radical feminists is the authority that men have over women. Eisenstein (1979) is of the view that the historically patriarchal culture of male domination creates the division of labour based on the biological sex of individuals. This patriarchal culture of male domination also determines social power and role. In other words, the patriarchal culture of male domination is used to dominate and suppress women. This difference in sex and roles between men and women culminates in women being assigned reproductive roles that link childbearing capacity with child-rearing. This capacity has translated to other spheres of social nature with the assumption that they have an inborn nurturing capacity and therefore women assume the role of caring for the whole

family (Tong, 1998; Goldberg, 2014). In the case of South Africa and Zimbabwe, this difference on reproduction has also been reinforced by the cultural practice of *mamalo*/*roora* payment system (payment of bride price). The payment of the bridewealth (price) is seen as an exchange of money or cattle both in South Africa and Zimbabwe for a women's reproductive and sexual capacities.

Radical feminists view sexuality as the site for women's oppression which is defined as meeting up with the male sexual fantasies and reproductive duties (Sempruch, 2008). This approach views sexuality as a gendered dominance and submission which is seen by radical feminists as the root cause of women's oppression. In the context of patriarchy, women are forced to submit to the domination of men which eventually leads to their subordination (International Committee on the Rights of Sex Workers in Europe, 2016). Therefore, radical feminists have managed to draw attention to ways in which men attempt to control women's bodies through restricting contraceptives, abortion, and violence against women (Tong, 2013).

Radical feminists call for the radical reordering of society. The main reason they are labelled as radical is that radical feminists call for immediate reordering of society through the immediate eradication of oppression of women rather than to wait for social change to happen on its own (Gunew, 2013; Bissong & Ekanem, 2014). Samkange (2015) is of the view that the underlying notion of radical feminism is to change the *status quo* of the institutions like the family and society. Gandari *et al*. (2012) concur and state that radical feminism works intending to create a society that allows women to make their own choices regarding sexual health issues and rejecting pressures exerted by patriarchal institutions. The domination of males has been accepted as normal in society and this needs to change. As noted by Gutsa *et al*. (2011:24), '*men create and maintain patriarchy not only because they have the resources to do so but also because they have real interests in making women serve their interests*.' In their quest to find an alternative system of patriarchy, radical feminists do not only aim to overthrow patriarchy but they deliberately venture to elevate feminism.

Heterosexual marriages and traditional roles of women as caregivers formalise the oppression of women. Radical feminists view the institution of marriage as binding women both in theory and in practice (Tandon, 2008). Radical feminists are against the roles in a marriage that depict women as powerless and whose role is at home bearing and rearing children. The institution of marriage is seen as binding women to depend on men economically, therefore,

perpetuating patriarchy which is self-destroying (Gunew, 2013). Greene (2011) argues that the family institution is organised to give more power to men. This can have adverse consequences on the health of women within marriages. Commission on Gender Equality (2005) found from their study that participants viewed men in customary marriages as always deserving of sexual intercourse and that wives should submit to the desires of their husbands. Radical feminism is against this notion as it aids in furthering violence against women through men demanding sexual intercourse even if it is against women's wishes. This research was intended to highlight the fact that customary marriages are one of the societal institutions that ensure that women from the time they are young until they are married grow up with a subordinate role. As the study unfolded it was proven that marriage constitutes a system of oppression and gender bias that is imprinted on the minds of women through the use of cultural practices.

The major standout of radical feminism against other feminist theories is that it specifically articulates issues of violence and patriarchy, the differences between the two sexes and goes further to suggest solutions such as the rejection of patriarchy (Van Gundy, 2014). Radical feminism does not adhere to the notion that the oppression of women can be altered through a particular set of policies but instead through addressing the gender system (Willarty, 2010). This same view is shared by Agering (2009) who states that radical feminism contrasts with liberal feminism as it claims that the law itself is gender inclined and these inequalities are rooted deeply in society. This, therefore, means that radical feminists think that liberal feminism is not effective enough to address the inequalities in society.

The major criticism levelled against radical feminism is its attack on masculinity rather than furthering the interests of women (Holmes, 2007). Also, Ukagba (2010) believes that radical feminism fails to consider human faculties that are in-born like empathy and intuition in women. These faculties tend to make women more highly susceptible to have inherent features more developed by factors such as culture and religion. This research investigated how such cultural practices can influence the rights of young women in South Africa and Zimbabwe.

2.2.2 Liberal feminism

The basic rationale of liberal feminism is that the dilemma of gender inequality is due to the imposition of the wills and wishes of men on women in society. As a result, men have control

in educational, judicial, economic, and political spheres. Liberal feminists (Friedman, 1974; Rossi, 1970 & Wollstonecraft, 1975) developed out of the liberal philosophical ideology that through the legal and political ways women can change laws and politics to achieve gender justice. According to Smith (2010), liberal feminism focuses primarily on transforming the order of society so that power in society is shared equally amongst all genders. This, therefore, means that individual rights and liberties for men and women can be enjoyed through the eradication of gender inequality. The proponents of the liberal feminist school of thought advance the argument that men and women are equal and as such they must have equal opportunities to pursue their interests (Awad & Eldon, 2013).

Liberal feminism focuses on inequalities that are inclusive of childcare within the family (Bhandary, 2016). This concept of care emanates from the views on femininity which is socialisation, women's traditional labour role, and social expectations. A result of this discrimination is that men are judged based on their ability and women on their sex (Zuhmboshi, 2016). The sources of gender inequality are legal, customary, economic, and social. These inequalities are visible in customary law, economic opportunities as well as in social interactions. Wollstonecraft (1975) was one of the first advocates of liberal feminism who argued that women's rights cannot be abdicated through the relegation of women to lesser beings because it hinders human development.

Patriarchal laws steer women into a way of life that is deemed socially acceptable and these are unfair restrictions that liberal feminism is against because women's choices should be guided by their self-interests (Baehr, 2013). Liberal feminists maintain that women just like men can take charge of their lives since they are responsible for their actions and choices (Brookes, 2008). Liberal feminism rejects the use of sex differences to discriminate between men and women. It advocates for neutrality and privacy wherein individuals may pursue forms of life that are most favourable for them. These assumptions of this theory helped to show how the rights of women should be protected and promoted through legislation to ensure that their sexual difference is not used to discriminate against them.

Liberal feminism is inclined to the idea of reform as opposed to the total eradication of the state of things (Saloom, 2006). Liberal feminism prefers a gradual change and a continued emphasis on the demand for equality before the law (Richardson & Sandland, 2013). This, therefore, means that liberal feminism focuses on eliminating barriers that exist between men

and women. According to Lee (2013), the representation of women is a question of justice but it acknowledges that women have a different set of values. Liberal feminism promotes the emancipation of women through legislation that awards equal rights for both sexes (Mpungose, 2010). This attainment of equal rights will free women from oppression. The struggle against gender inequality can be achieved through arranging the roles in a way that supports the fulfilment of sexual and reproductive health and gender equality. Generally, liberal feminists fight for the equality of women through changes in legal redress (Braverman, 2013).

Despite liberal feminism's strong emphasis on equality between both sexes, it was found to have some loop-holes which have led to its rebuttal by other theorists. The most common criticism levelled against liberal feminism is the notion that women and men should be treated equally. According to Chegwe (2014), this denies women's biological differences which among others neglects to take into consideration women's experiences as caregivers and child-bearers (Irefin *et al.*, 2012). This shows that liberal feminism does not adequately highlight other significant roles women play. Furthermore, it fails to amply provide enlightenment on the injustices universally inflicted on women (Leach, 2009). Despite progressive legislation, domestic violence has not decreased (Motta & Saez, 2013). This, therefore, undermines the argument of liberal feminism for equality before the law. Legislation plays a vital role in promoting equality among genders. Ortenblad *et al*. (2017) are of the view that equality among genders cannot be promoted in the absence of positive duties and obligations, there is a duty to bring about change, and the power vests in those with the capacity to do so. Men must act in a way that promotes, protects, and advances the rights of women in society. According to the proponents of liberal feminism, gender equality and women's rights are to be a priority in society because women are also entitled to basic human rights (Ryle, 2015).

Despite the criticisms levelled against the liberal feminist point of view, this study aimed to point out the full range of freedoms in society for young women by interrogating the role played by customary marriages in undermining the rights of women. Liberal feminists argue that women also deserve equal opportunities just as men.

2.2.3 African feminism

Mekgwe (2008) describes African feminism as taking care of the concerns that are unique to African experiences. Dove (1998) states that the concept of culture is a tool for analysing and understanding the nature of women's experiences in Africa. Atanga (2013) argues that African feminism is premised on the feminist discourse. Unlike other feminist theories, African feminist theory acknowledges the existence of the diversity of cultures and environments. The advocates of African feminist theory maintain that African women have different needs, views, challenges, and experiences which are different from those experienced by European women. Therefore, African feminism is seen as combining sexual, class, and cultural dimensions (Ponzanesi, 2012) to produce all-inclusive feminism through which women are viewed as human beings, not as sexual beings.

African feminism's point of departure is the struggle in the African continent against patriarchal power (Ahikire *et al.*, 2014). Goredema (2010) takes this argument further by stating that African feminism is a theory that provides arguments that validate the experiences of women in Africa. However, it also critiques the features of traditional African values without degrading them because they can be viewed differently amongst women. In the African culture, gender equality discourse is all about the balance between men and women. Ntseane (2011) is of the view that for women in Africa the struggle for equality is multifaceted. Therefore, it calls for a thorough negotiation process with both a male and female gendered context. This view calls for an understanding that whilst challenging oppression men should be challenged and tradition should be questioned without rejecting the culture in Africa. Smith and Ce (2015) concur and state that African feminism challenges African men to be aware of certain aspects of the oppression of women which is different from the oppression of European people.

Bearing in mind that African women fit into traditional roles such as childbearing and family maintenance seamlessly is crucial. It is a responsibility for African women to nurture the family. Mikell (2010) puts it that African women contribute not only at household levels but also in their communities through production and reproduction through their inclusion in social roles.

African feminism intends to liberate women from patriarchy. Nocalaides (2015) posits that what is needed is an African vision that eliminates the male domination that exists in society. Patriarchal societies in African culture constrain women and prevent them from realising their

potential beyond the traditional roles that are assigned to them as mothers and wives. Oyewuni (2005) concurs that African feminism does not only focus on male dominance with female subordination, but it goes a step further in challenging the order of situations that is the way African cultures constrain women and prevent them from realising their dreams beyond traditional roles assigned to them. Atanga (2013) in the same vein states that African feminism aims at creating a platform for women's participation by empowering them through access to resources such as health, education, and housing.

One major point of concern found in African feminism is that it is seen to fall short by failing to define feminism basing on its derivative terms rather than concerning Western feminism (Mwangi, 2010). Such kind of an idea means that African feminism is what Western feminism lacks. Western feminism does not recognise the uniqueness of the African culture (Jacobs, 2011). This critique of Western feminism forms the basis of African feminism. Ese (2016) describes African feminism in the same vein that this line of argument from the African feminist point of view leads to a continued entrapment in a colonial past which will most probably never reach total independence. This theory takes a flight to the past through constantly relating to colonialism.

In the context of this study, African feminist theory helped to inform the argument around African women's sexuality which also encompasses sexual and reproductive health rights. The proponents of African feminism hold the view that African women possess little or no power over their lives in the same way as men do.

2.3 The sex role theory

The sex role theory is one of the gender theories. It is critical to understand the way roles and responsibilities are assigned to individuals. It maintains that gender or sex of an individual is used to determine which role he or she can play. Gender theorists are concerned with understanding and articulating the differences between men and women. Some of the theorists are of the view that society teaches individuals to adhere to different gender-specific behaviours (Letherby, 2007). Women and men have different responsibilities in customary marriages and it is significant to understand the basis of the distribution of these responsibilities.

Sex is the genetic difference between men and women while gender is socially construed roles in society (Siann, 2013). Sex is a fixated natural makeup and it is self-evident. Sex is related to the procreative function. However, the social aspects of gender can tap into biology to create and maintain even furthering of physiological differences that are already in existence by classification into masculine and feminine (Oliffe, 2011; Krijnen & Van Bauwel, 2015). These even aid in how individuals view themselves. Sex differences are natural but gender is deeply rooted in culture (Oakely, 2015).

Sex role theory is based on the notion that individuals are socially construed as males and females and they tend to be judged against divergent expectations for how they must behave (Shimanoff, 2008). These differing roles are known as gender roles. Epstein (1988) as one of the first proponents of this theory argues that most of the differences between men and women are due to these celebrated social roles and what society expects. Epstein (1988) goes further to argue that if both sexes are awarded equal opportunities, the differences between them would vanish. This argument is similar to that of Tilly (1999) in his theory that the dynamics of supremacy and suppression are based on power. This brings Risman and Davis (2012) to the conclusion that gender is defined as deceptive rather than reality.

Gender roles address the issues of household labour, segregation of jobs, and gender differences about status and authority. These gender differences trigger the system of justification of inequalities between women and men (Morton *et al*., 2009; Kray *et al*., 2017). A belief that gender roles are indisputable tends to cement their association with masculinity and in turn, this becomes a defence of gender inequality. The learning of socially construed roles starts from birth and finds footing within the family and later extends to social institutions (Nkosi, 2011). Socialisation plays an important part in gender roles and marriage is one of the institutions that ensure the existence of social roles. As a practice that is associated with the institution of marriage which encourages the perpetuation of heterosexual partnership and division of roles based on sex, it would seem as if customary marriages play a role in the socialisation of individuals into appropriate gender roles.

Connell (1987) was the first person to put forward the idea of hegemonic masculinity. His theory was informed by gender frameworks and social construction. By contrast, Connell argues that the formation of identities through gender is motivated by the unpleasant acceptance of hegemonic masculinity. Hegemonic masculinity refers to the dominance in

society by a particular group (Howard-Payne, 2012; Leahy, 2017). Therefore, it is a crucial tool that assists with looking at how men position themselves to achieve dominance through this discussion of masculinity. Connell (2008) goes further to define this term as a gendered practice which legitimises patriarchy which in turn promotes domination of men over women.

In Africa, due to the prevalence of patriarchy, hegemonic masculinity has been important in theorising gender issues. Everitt-Penhale and Ratele (2015) are of the view that hegemonic masculinity leads to the complete cultural dominance of men in society as that which is socially appropriate. Morrell *et al*. (2013) are of the view that hegemonic masculinity is very important in analysing power relations of gender and health more especially sexual health. Domination based on masculinity undermines women (Mhkize, 2015; Mhkize & Njawala, 2016). In such circumstances, women find it difficult to discuss matters relating to sex with their partners. For example, in sexual matters, men decide on when and how it is done. This can lead to violence amongst married couples. This highlights the dominance of men in society. This is further corroborated by Groes-Green (2009) who states that male dominance is characterised by the use of force and coercion in situations where there is a disagreement. Connell's concept allowed the researcher to examine how socially-prescribed sexual relations between men and women may lead to unequal power in the domain of sexual reproductive health. The hegemonic masculinity can be analysed in terms of the five steps postulated by Connell (1987). These steps are:

1) Analysing and differentiating the person and the societal position attained. This means that men and women have different roles assigned to them by society and they are expected to abide by those roles.

2) The actions allocated to the position. The role of the wife as the primary caregiver involves cooking, cleaning, and rearing children. This might create dependency because some women are financially dependent on their husbands.

3) The proper and anticipated behaviour accepted by society. Society expects men and women to act according to the norms and standards set in a society that aligns with the role of their sex.

4) Involving people set in contrast. In this case, the people in contrast are the male and the female in the context of this study are husband and wife.

5) Resulting in advantages and disadvantages depending on one's action.

The criticism levelled against the sex role theory by other feminists is that this theory does not consider the power dynamics and inequality in gender relations (Boss *et al*., 2008). This view is also shared by McCormack (2013) who states that the sex role theory neglects the question of power dynamics. Power dynamics amongst genders is important in ways in which men and women define masculinity and femininity.

2.4 Theory of social justice

John Locke (1632-1704) is one of the philosophers who influenced the concept of social justice and equality. According to Locke (1689), people have natural and original rights given to them by God, in particular, the rights to life, health, and liberty that no one is allowed to interfere with. Hence Locke views social justice as a human right. Human rights are individual rights concerned with delivering the best society possible with positive entitlements which outline what a just society is all about (National Pro Bono Resource Centre, 2011).

The theory of social justice emphasises fairness between men and women irrespective of their gender, race, religion, or class (Rawls, 1971). The notion of justice is the establishment of a society based on social justice. Rawls' main position held that a person possesses dignity and worth that even the structures in society cannot override (Tjabane, 2010). The advocates of this theory propose two principles of justice, namely; the difference principle and the liberty principle. According to Yilmaz (2016), men and women should have equal opportunities and that society as a whole cannot countermand. These principles of justice are in place to govern the possession of rights and duties and to control the allocation of social and economic privileges. According to Rawls (1971) and Lawrence (2016), the principles of justice guiding a society are accepted norms defining the fundamental terms of a society based on equality. In Rawls' (1971) view, individuals in a society must be in a position to view one another as equals in all respects and justice is what equal persons would agree as basic terms of social cooperation in fair conditions (Arneson, 2008; Equity for Children, 2013).

Sen and Nussbaum tried to improve on Rawls' theory of social justice by adding capability and entitlement as important aspects of the theory of social justice. Nussbaum (2006) speaks of the entitlements that any just society should secure for all citizens which include life, health, bodily integrity to mention a few. Human rights principles are noticeable in this list of capabilities covering both first-generation and second-generation rights. First-generation

rights include the right to life, equality before the law, freedom of speech, while the second generation of rights includes the right to be employed in just and favourable conditions, rights to food, housing, and healthcare. Nussbaum emphasises that capability provides a framework for assessing the articulation of rights on gender equality (Morvaridi, 2008). Sen's (2001) capability approach also addresses the problem of gender inequality. Sen (2001) posits that equality should not only be based on how people command resources. But, it must also entail an inclusion on how people co-exist in society (Maboloc, 2008).

Social justice is seen to provide equitable outcomes to marginalised groups whose experiences are shaped by a political, social, and economic system that facilitates discrimination (Nieuwenhuis, 2010). Social justice provides a framework to assess policies and practices. According to Rawls (1971), there are two vital steps in achieving a fair society, firstly there must be deliberation on principles of justice. Secondly, there should be legislation in place to detect how justice would work among citizens. Rawls claims that health requires intense knowledge which should be handled by experts (Ekemekci & Arda, 2015). This, therefore, means that legislation must be drafted by those who have expertise within the ambit of social justice. Social justice recognises that in society the applications of norms are not the same across the entire spectrum, and this generates inequality. Therefore, the theory of social justice is utilised to analyse the injustices that vulnerable groups in society, especially women face (Flynn *et al.*, 2015), and right these wrongs. The assumptions of the theory of social justice helped this study to assess the policies and laws in South Africa and Zimbabwe to determine if they have indeed changed people's perception and attitudes towards the human rights of women, particularly sexual and reproductive health rights. However, there is a strong need to pay attention to cultural and economic discrimination as a starting point to remedy social marginalisation. Therefore, it is essential to avoid allowing gender differences to be used to discriminate or marginalise women as this will perpetuate inequality by circumventing social justice (Riddell, 2009).

Reproductive justice places reproductive health issues in a larger milieu with regards to the health and well-being of women, families as well as the community. This is the case because reproductive justice integrates individual and group rights especially those that belong to marginalised groups (Fédération du Québec pour le planning des naissances, 2014). This, therefore, means that reproductive justice embraces sexuality, health, and human rights framework with social justice. However, it should be noted that the ability of women to assert matters of reproduction is linked to the conditions prevailing in their society (Ross, 2011). This

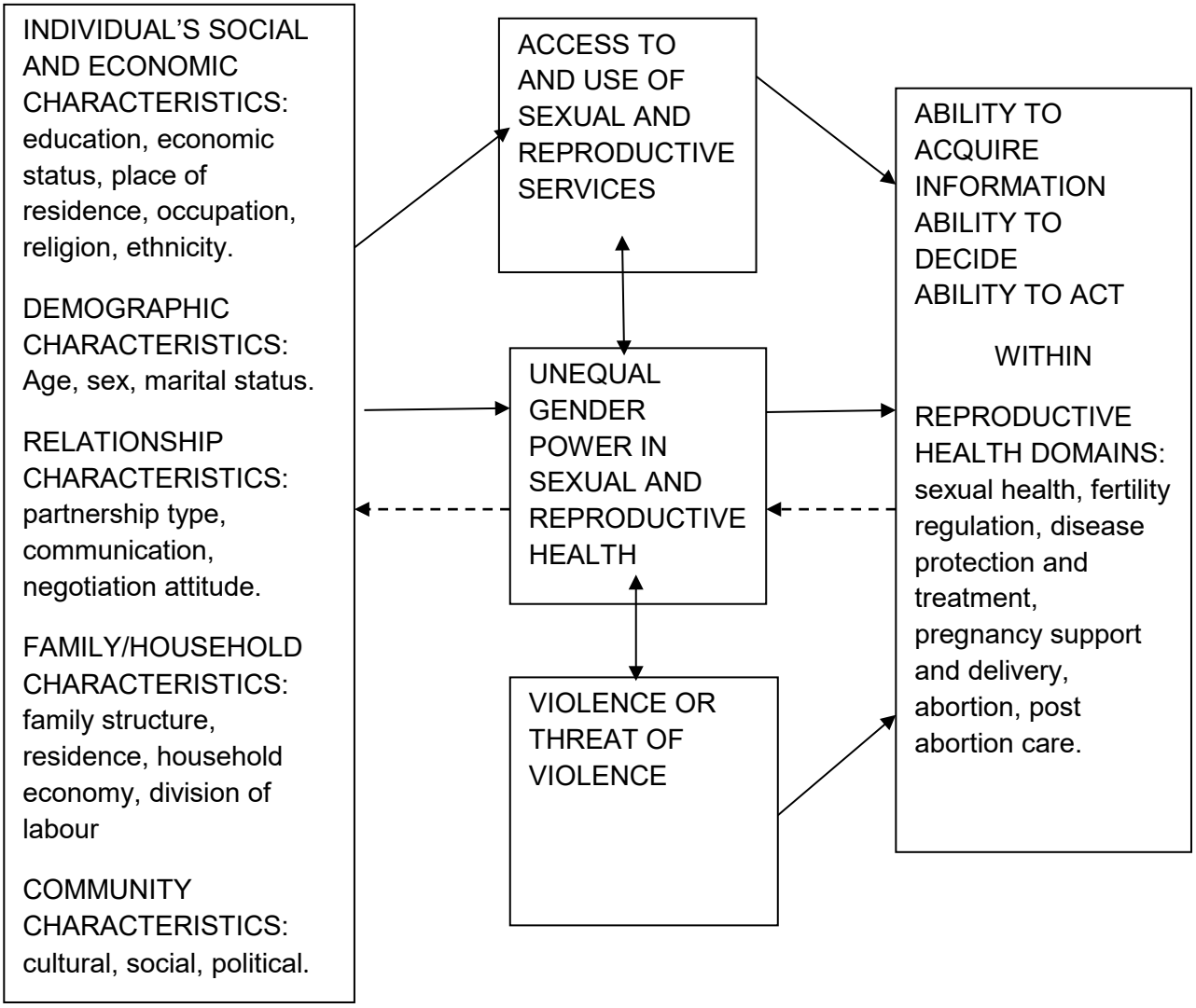
is one of the key areas that this study addresses to ensure that women can actively assert their sexual and reproductive health rights and the influences that emanate from practices and norms of the society in which they live.

The theory of social justice has had its fair share of criticism. From the feminist angle, the theory has been criticised because it ignores unjust labour divisions and power relations about gender (Morvaridi, 2008). These inequalities between men and women stem from gender roles within the family. However, Rawls in his theory does not take into consideration justice within the family as well (Doody, 2015). Okin (2013) concurs and states that Rawls, in his political philosophy, does not address inequalities within the family which are in direct contrast with feminism as feminists hold that equality is justice in itself. This study investigated the power dynamics amongst genders in customary marriages on sexual and reproductive health rights.

2.5 Framework of unequal gender power in sexual and reproductive health

A study by Bui *et al*. (2010) examined, through a focus group, how the participants viewed how gender inequity potentially influenced women's sexual and reproductive health about seeking information on health, responsible contraception use, and childbearing. Blanc (2001) conceptualised a framework which enunciates the relationship between gender power inequality and sexual and reproductive health. This framework depicts the nexus between family and community, and the relationship on how all this influences an individual's access to sexual and reproductive health. This view is also shared by Bottorff *et al*. (2011) who state that gender relations can have a huge impact on the acquisition of information, decision making, and taking positive action. These usually find footing in marriages, especially customary marriages, as they are characterised by adherence to cultural norms which in effect favour men. Marriage customs depict men as dominant heads of the family and women as passive and submissive (Anderson, 2015).

FIGURE 1: FRAMEWORK ON THE NEXUS BETWEEN GENDER ROLE IN SEXUAL AND REPRODUCTIVE HEALTH AND THE ROLE OF OTHER FACTORS IN PROMOTING HOW MEN ARE INVOLVED AND THE EMPOWERMENT OF WOMEN



Source: Blanc (2001:191)

Factors that increase the vulnerability to HIV and challenges for women in sexual relations include the traditional role of how women are supposed to socialize, social myths as well as women's lower socioeconomic position (Tadele & Kloos, 2013). This reduces women's sexual autonomy. As a result, it leads to gender-based violence and non-consensual sex which continues to expose women to vulnerability as well as other sexually transmitted infections and unplanned pregnancies (Higgins *et al.*, 2010). It is also very important to note that the low status of women brings about adverse health consequences throughout their life span. Kotch (2012) is of the view that disregarding women exposes them to risks of maternal mortality

which can be attributed to a lack of appropriate health care, lower contraceptive use, and early marriages.

Unequal power relations place women in difficult positions where they cannot make decisions regarding contraception use. Therefore, this impacts on their reproductive options (Woolf & Maisto, 2008). Women in such relationships seldom participate in decision making on sexual matters. These power balances can limit the ability of women to access sexual and reproductive information because of a lack of financial resources which also limits the mobility of women (Stephenson *et al.*, 2012). This is mainly because many women are financially dependent on their husbands or partners. Cultural and social values in customary marriages within South Africa and Zimbabwe seem to take precedence over laws that limit young women's sexual and reproductive decision-making. This is evidenced by the way culture has been strictly observed and traditional practices that violate women's rights are still being observed.

Rapheal (2016) defines social determinants of health (SDH) as social and economic conditions that shape individuals' health as well as the community. Cultural and societal norms have assisted in shaping a person's health in society. In the same vein, Auerbach *et al*. (2011) put it that these norms, values, and institutions influence and govern sexual behaviour. Parker (2009) and Collumbien *et al*. (2012) are of the view that it is generally accepted that society and culture shape the experiences of people and how they interpret it, especially, in terms of sexual matters which determine their desires, experiences as well as practices which are shaped by social determinants. Culture can promote and undermine sexual and reproductive health as it is a key determinant of sexual and reproductive health. Social determinants of sexual and reproductive health work differently to influence the exposure to the risks of unwanted pregnancies and access to and use of contraceptives (World Health Organization, 2016). Society, culture, and tradition bear a significant impact on the sexuality and sexual health of individuals. However, this impact differs in its degree mostly affecting those with lesser power such as women. While the acceptance of the community of sexual equity is important in the implementation of health interventions, traditional interventions will require legal and educational urging (Rao *et al*., 2012) for them to accept the humanity of all.

Gender roles do not operate in isolation but work in conjunction with social variables that shape health experiences. Incorporating SDH in a research framework assists by providing a

thorough analysis of factors that have an impact on gender and health while enabling the researcher to find other reasons for the health differences amongst communities (Olife & Greaves, 2011). For the above-mentioned reason, incorporating a framework with gender and SDH in this study was not only a thorough research paradigm but also a positive means for addressing social factors and injustices. Employing a quantitative research method in this study helped to determine the general view of SDH in the exploration of South African and Zimbabwean women's sexual and reproductive health and to understand the extent of these disparities. A better understanding of the determinants assisted in providing the needed guidance that the researcher requires to formulate strategies that address these challenges.

2.6 Social Representations Theory

The Social Representation Theory (SRT) is the notable model developed by Moscovici (1961, 1976, 2008) and Jovchelovitch (2007). According to Moscovici (2008), people attach meaning to things and this influences their behaviour. Moscovici (2008) proposed that certain conditions have to be in existence in a given context to qualify as a social representation of people's way of life, views, and behaviour. Such conditions produce certain values that play a critical role in determining or shaping people's way of life, views and behaviour. The people's way of life, views, and behaviour should be in line with the value systems under which they live. People's way of life, views and behaviour should conform to the societal expectations as determined by the prescribed values in their society. This means that people's way of life, behaviour, or views are determined or shaped by the prevailing value systems. Their way of life, behaviour, or views should resonate with the dictates of their value systems. Social representation only happens when there is a synergy between people's way of life, behaviour, or views and the value systems operating at that time. This creates collective thinking among people as they behave themselves in terms of the expectations as dictated to them by the values they subscribe to. In the end, this becomes a social representation of the way they are expected to behave in their community. However, people have to feel the need to subscribe to the value system that prescribes the way they should behave. In that manner, the social representation becomes relevant to different members (women, men or girls or boys) (Wachelke, 2012). A social representation is a system consisting of values which are in place to allow people to position themselves in the social world as well as enabling communication among people in a society wherein they establish aspects that they relate to (Hernandez, 2011). Hover (2011) concurs and states that social representations are a collective thinking of a society that creates culturally sanctioned repertoires for managing ideas and creating debates. This means that society often places certain expectations according to which people have to behave. For

example, women may be expected to behave in a certain way. In such a case, society tends to expect women to see the significance of not deviating from the expected way of behaviour. In other words, society expects people to behave according to certain values. They are expected to internalise those values so that their behaviour should not be seen as being in opposition to the established values of their society.

Based on the above definitions, it was important to study the effects of customary marriages on the sexual and reproductive health of young women for the reasons that will be mentioned below. The role of SRT is to make the unfamiliar familiar (Moscovici, 1973). In this case, sexual and reproductive health among young women possesses a degree of unfamiliarity characterised by it being a taboo or an unspoken area. Sexual and reproductive health is unfamiliar because generally women hardly feel free to engage in a conversation about their sexuality. The SRT helped the researcher to address unfamiliar sexual and reproductive health issues to sensitize people on the importance of women's sexual and reproductive health. This was important for this research because it will be apparent in the literature that addresses the differences between the modern and traditional practices as well as local and international legal instruments in the understanding of women's sexual and reproductive health.

Common sense knowledge of social issues amounts to daily conversations on topics like HIV/AIDS, gender, and health. Vico (1710/ 1988) introduced the concept of *verum factum* which states that a certain aspect is true because it originated from the human mind and it is what human beings make. To this Markova (2012) is of the opinion that this common understanding amongst members of the community is a norm accepted by the members. These are not individual outlines (Markova, 2008) but rather they belong to a group and are culture-specific (Hoijer, 2011). Therefore, this means that as social representations unfold in the community as well as institutions, in the end, results in a social representation culminating as laws, rules, and sanctions.

There exists a strong body of social representations research that has directed its attention to the dominant societal issues on education, gender, bodies, community narratives, stigma, and human rights (Breakwell, 2007; Castro & Bartel, 2008; Jovchelovitch, 2007, 2011; Lavie-Ajayi & Joffe, 2009; Phelps & Nadim, 2010; Andreouli & Howarth, 2012). Maurya (2009) states that social representations provide a broad framework from which to obtain information about

people's perceptions of issues relating to health. Therefore, defining what health is from a social representations perspective requires the individual to think with social knowledge by people who possess the same beliefs on the issue. As ideas within society transform into everyday practices they help us to understand social realities which include systems of inclusion, exclusion, and power (O'Sulivan, 2011). The relevance of this is to examine lay explanations of the risk society (O'Connor, 2012) like the rights of women in customary marriages. The broad framework of this theory provided a wider spectrum from which to explore dimensions of sexual health that remain unattended to in customary marriages and how these rights have been comprehended by the public.

At this point, it is vital to ask in what way does social representations relate to attitudes? The answer to this question is strongly put forward by Callaghan and Lazard (2011) who maintain that since attitudes are based on the social knowledge that is shared, therefore, it is not the object of the attitude that shapes our attitude but rather the social representation of it. Callaghan and Lazard (2011) question how can we know about an object if it is built upon a social representation. The answer to this is that we can never know the issue on its own but we can understand it through the social representation of it because it shapes our attitudes. Callaghan and Lazard (2011) continue to claim that the world is built on collections of social representations, for this reason, this theory questions the degree to which we can know the world objectively. To illustrate the place of social representations in the social world, the study by Correia and Broderick (2009) which looked at social representations of making a medically assisted reproductive treatment to single mothers and lesbian through donor insemination and IVF (in-vitro fertilization) in Australia will be used. From this study emanated representations of what a natural family is. The representations revolved around a heterosexual family unit comprising of father, mother, and children. This natural family was linked by the study participants to a unit with positive values, morality, and family ideals. Single and lesbian women were not seen as fitting this representation of the family because of the failure to provide a father. In the African context, women are taught to be passive and submissive to men from a young age. Sexually, women are expected to give in to the sexual desires of their husbands at the expense of their pleasure and well-being. This includes never refusing sex to the husband regardless of the number of partners he has or his non-willingness to use protection. The inferior position of women in South Africa and Zimbabwe is well documented and social representations of diseases like HIV/AIDS are likely to perpetuate power disparities.

Social representations consist of two structures that are central and peripheral. The central structure is influenced by social practice and social influence (Nikolay *et al*., 2014). In this context, it can be understood that social practices influence the interaction between people and the object of the representation, and the social influence impacts how social representations are construed within social interaction. This theory posits that communication amongst people occurs on three levels. Firstly, through societal representations that are through communications (Markova, 2008) which are then absorbed into institutions and become a notable part of their culture (Farr, 1998). Secondly, within the community people generate these representations amongst themselves through everyday conversations (Howarth, 2006). Finally, at the individual level, these representations develop through debates among people (Van Niekerk, 2014). It is based on the emphasis that this theory focuses on how the individual merges with the society that has also contributed to this approach being suitable for this study. In making sense of this connection, the researcher is guided by Howarth *et al.* (2004) on their conceptualisation of the community as the socially constructed places wherein people develop an understanding amongst each other. These representations infiltrate into relations in society, cultural practices, and power dynamics. Social representations are considered to be a source of knowledge for aspects of culture that people draw from everyday practice in their lives, for example, masculine attributes within a customary marriage. Therefore, social representations are important for the understanding of social issues (Szabo & Koch, 2017). They can help acquire an in-depth understanding of how men interpret and justify their dominance in customary marriages.

This theory was deemed suitable for this South African and Zimbabwean study on women's sexual and reproductive health rights. Due to the prevalence of the abuse of women's rights in both countries, likely, the social representation of sexual and reproductive health rights of women dominates as a subject of public discourse and social thinking (Gibbs & Jobson, 2011). What made this theory appropriate is that it allows for the complexity of sexual and reproductive health to be unpacked and that it necessitates the investigation of sexual and reproductive health as a social problem within a societal context amongst different social groups where people attach meanings to their everyday experiences.

Other scholars have found some faults in the Social Representations Theory. The most frequent criticism levelled against this theory is that it is too broad and vague. According to Voelklein and Howarth (2005), it is mainly since it contrasts sociological and psychological concepts. The broader concept makes it difficult to help focus on a particular area. Martins-

Silva *et al*. (2016) concur and state that the definition of social representation itself in this theory is vague. In other words, there is a lack of clarity on the differences between social representations and collective representations. This leads to a lack of adequate understanding of the relationship between social representations, culture, ideology, and group thinking.

2.7 Application of theories in the present study

In this study, the researcher has used the radical feminist theory, liberal feminism, sex role theory, African feminism, social representations theory, and the framework for unequal power in sexual and reproductive health. The researcher's choice of the radical feminism theory is motivated by the relevance of the theory's emphasis on gender inequality being reinforced by women's reproductive functions. African feminism was suitable in critiquing the position of women within an African context and how some of the unquestioned gender-related practices discriminate against women as well as affecting how they are perceived by men within the customary marriage. Additionally, sex role theory was applied in this study particularly the concept of hegemonic masculinity through the analysis of the five steps and how they apply to young women in customary marriages. While the framework of unequal power in sexual and reproductive health was employed to determine if unequal power in sexual relations can have an impact on decision-making. It was also employed to understand the disparities caused by SDH on the sexual and reproductive health of young women. A better understanding of the determinants assisted in providing the needed guidance that the researcher required to formulate strategies that address these challenges. The social representations theory was relied on by the researcher to provide a wider spectrum from which to explore dimensions of sexual health that remain unattended to in customary marriages and how these rights have been comprehended by the public. The researcher's choice of the liberal feminist theory was motivated by the relevance of the two main tenets of this theory to the study. The two tenets of this theory are legal reform and that women are responsible for their choices. With the first tenet, liberal feminists advocate for legal reforms that protect and promote the interests of women. On the other hand, the second tenet of the liberal feminist theory requires that women should be part of the initiatives and decisions which affect them. The researcher asked the questions as to how women's experiences in customary marriages can help raise awareness and provide an understanding of women's situation in customary marriages to establish the basis for legal reform which will help to promote women's sexual and reproductive health rights.

CHAPTER 3 LITERATURE REVIEW

3.1 Introduction

The previous chapter portrayed the framework of this study which centred around the theories that inform the issues of gender inequality, the effects of marriages and its role on sexual and reproductive health rights of young women. This chapter focuses on literature review on, among others, issues such as sexual and reproductive health rights, gender equality, customary marriages, human rights legislation on women's health rights. Sexual and reproductive health rights of women cannot be adequately evaluated without a thorough investigation of the status of women in the society. Some laws relate to women's legal status which are in place to expose the attitudes of people in the society on issues of sexual and reproductive rights. Such laws have direct impact on women's abilities to assert their sexual and reproductive rights.

3.2 Search strategy

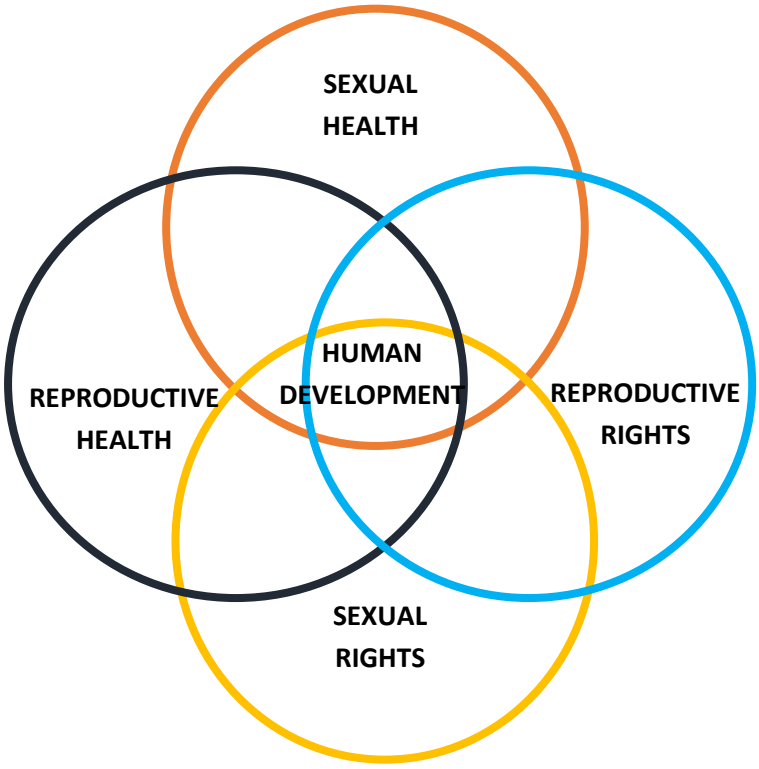
A literature search on the topic of sexual and reproductive health was conducted using EBSCOhost, PubMed, JSTOR, CINAHL, African Journal Online, Lexis-Nexis, Heinonline, ProQuest and Google Scholar using online databases of the University of Venda, University of Bergen and University of Ghana. The literature search also used key words like "sexual health", "sexual rights", "reproductive health", "reproductive rights", "customary marriages", "patriarchy", "position of women" and "African culture." Abstracts were first reviewed to assess the relevance to the main topic before reviewing the full article.

3.3 Sexual and reproductive health rights

Before paying attention to the literature on objective 1 of this study, to determine the relationship between customary marriages and gender equality, it is imperative to briefly go through the literature on the key concepts of this study. These concepts are sexual health, sexual rights, reproductive health, and reproductive rights. The diagram below aptly depicts how these concepts are inter-linked and inter-dependent as they all serve to achieve optimum human development in as far as sexual and reproductive health rights are concerned.

Sexual and reproductive health rights is a term used to describe various issues that affect both men and women in the domain of reproduction and sexuality.

FIGURE 2: AN ILLUSTRATION OF SEXUAL AND REPRODUCTIVE HEALTH RIGHTS



Source: **Developed for the study by the researcher**

3.3.1 Sexual health

Thorough research on sexual and reproductive rights in the continent of Africa is imperative as it will aid the achievement of the SDGs which, as stated earlier in this study, emphasise sustainability and equity. Achieving the health goal requires all-round efforts that will address emerging health problems and an analysis of the existing implementations. It is the hope of the researcher that this study will be used for effective decision-making.

According to the World Health Organisation (2015), sexual health is important for the physical, emotional health and well-being of all individuals for the sake of social and economic development of communities. However, it should be noted that being able to achieve this is attributed to the fact that people can acquire adequate information as well as the risks that are associated with negative sexual consequences. World Health Organisation (1975:3) first defined the term

'*sexual health'* as *the integration of the somatic, emotional, intellectual, and social aspects of sexual well-being in ways that are positively enriching that enhance personality, communication and love.*

Twenty years on the Programme Action of the International Conference on Population and Development (1994) included sexual health with the definition of reproductive health and went further to indicate its purpose as it aids the improvement of life and personal relations. Rita and Sultana (2017) reiterate the above and state that sexual health includes the enhancement of a person's life, personal relations, and it is also related to reproductive and sexually transmitted diseases. It can be understood that sexuality education assists young women to develop healthy behaviours that can produce positive sexual outcomes.

Sexual health moves beyond the reproductive years and can be adequately supported by a broadened understanding of sexuality (Kismodi *et al.*, 2015). To add on, there is an increased understanding in the international community that sexual health cannot be attained in the absence of the respect, protection, and fulfilment of all human rights. This is essential for social justice and not forgetting sustainable development and public health (International Planned Parenthood Federation, 2012; World Association of Sexual Health, 2014). The Framework of Action on Sexual Health which was developed by the World Health Organisation in 2014 highlighted the relationship between educational attainment and sexual health. A sexual health perspective leads to the examination of issues of discrimination about issues of sexuality. Dennis (2013) posits that the definitions of sexual health include the aspects of individual beliefs, values, and behaviours that reflect sexual rights, sexual knowledge, sexual choice, and sexual pleasure.

The negative effects of husband and wife communication on sexual matters place women in a problematic position because culturally women must be subordinate to the men. Therefore, women are expected to give in to the demands and expectations of the men although it can compromise their health. This means that women are, culturally, not expected to refuse the advances of their partners even if that can be detrimental to their sexual health. Their refusal of the advances may in the end cause spousal violence (Aina, Ariansola & Osezua, 2006; Wellings, Mitchell & Collumbien, 2012). Hence a woman is not able to question her husband over sexual matters even though she has to tolerate infidelity from him. Women are barely able to dictate terms in sexual matters more especially due to patriarchy within African

communities (Mlambo-Ngcuka, 2017). This threatens women's sexual health. It should be noted that an inclusive approach to sexual health requires a clear understanding of handling both sexual and non-sexual matters which in turn leads to personal development (Levine, 2017).

3.3.2 Sexual rights

In 1986, Ira Reiss described the links between sexuality across cultures and used the term *sexual rights* when describing the expected norm when it comes to sexual behaviour. Reiss was one of the first authors to link gender inequality and how it leads to the limitation of women's sexual freedom. Naomi McCormick in 1994 was also one of the few people who wrote about women's sexual rights before the Cairo Conference. McCormick (1994) puts forward one of the rights of sexual satisfaction which was one of the rights that were advocated by feminists in ICPD.

In 1999, the World Association for Sexual Health gave ascendency to sexual rights (Barrett & Hinchliff, 2017). Authors like Tahmindjis (2014) and Benhura (2016) postulate that sexual rights are important rights in sexuality and they culminate in upholding the basic principle of sexual autonomy and self-determination. The European Union (2015:4) defines sexual rights as the "*rights of women to have control and decide freely and responsibly on matters of their sexuality, including sexual and reproductive health free of coercion, discrimination, and violence."* Furthermore, Lottes (2013) is of the view that sexual rights are an important element of human rights.

As the idea of sexual health has broadened, sexual rights ensued, the achievement of sexual health and sexual rights are intertwined (Starrs & Anderson, 2016). To this, Russo (2017) states that sexual health and rights have a link to reproductive health and it provides an understanding of sexual rights as a group of rights that are self-regulating. Sexual rights are a broad term that is made use of to promote rights that relate to sexuality and there is no set definition agreed on internationally. Family Watch International (n.d) believes although there is no agreed definition of the term, United Nations Food Programme Action and WHO have reached an understanding as to the potential damage that might ensue in societies, families, and even individuals if these rights are not upheld. It can be understood that sexual rights include rights that are guaranteed in international instruments. However, some aspects of

these rights can be threatened by other institutions like culture. Therefore, it is important to demystify the contents of this group of rights and promote them through advocacy (Swedish International Development Cooperation Agency, 2010).

3.3.3 Reproductive health

An unambiguous definition of reproductive health was put forward by the United Nations (1994:45) that it is:

> "…*the basic rights of all couples to decide freely and responsibly about the number, spacing and timing of their children. It also includes the right to information and the right to attain the highest standard of sexual and reproductive health and the right to make decisions concerning reproduction, free from discrimination, coercion and violence*."

Reproductive health is therefore a collection of methods and techniques that aid in the attainment of reproductive health as well as solving reproductive health problems (Weigl, 2007; United Nations, 2014). Both sexual health and reproductive health work together to achieve the utmost standard of health for individuals. The focus of reproductive health in this study emanates from the fact that biologically and socially women are more affected than men by decisions that are shaped by gender inequality and gender roles which are expected of women in society. Reproductive health issues are matters that are sensitive and they ensue from the collision of gender equality, culture, and society (Black *et al.*, 2016). To this, the United Nations Population Fund (2010:1) states that "*reproductive health means that every child is wanted, every birth is safe, every young person is free of HIV and every girl is treated with dignity and respect*." The definitions of reproductive health bear a link between this term and social justice (Price, 2010) and therefore issues such as poverty, welfare, reform, and violence against women come to the forefront.

Lack of know-how within the reproductive domain about independence in this area can lead to ill-feelings. According to Miller and Roseman (2011), there is an increase in the movement in the reproductive health of women globally, which culminated in 1994 in the ICPD when reproductive health was discussed, and it recognised the importance of reproductive health (Adinew *et al.*, 2012). Zhang (2011) posits that ICPD stressed the importance of reproductive health along with the principle of quality of life for human beings rather than the number of

human beings. The reproductive health of women must be a priority internationally since it is a basic human right for girls and young women (Wang, 2016).

Even though reproductive rights are exclusive to both men and women, but many times this term is associated with women because of gender power dynamics between men and women. This results in women not being able to assert their reproductive rights, especially in marriages in an African context (Fahmida & Doneys, 2013, Princewill *et al.,* 2017). Adinma and Adinma (2011) reiterate the above point and state that reproductive health is critical for women because when they are healthy, they play a significant role in the social and economic developments in a country. Therefore, lack of reproductive autonomy has an adverse effect on the reproductive rights of women. Such consequences include the diseases which negatively affect the health and well-being of individuals as well as their families (Kilczycki, 2014). Research over the years has shown that reproductive health is extremely important for young women as this contributes significantly to their overall health and well-being. (Kurebwa, 2017).

3.3.4 Reproductive rights

Both gender equality and social development are imperative links to reproductive rights. Pillai and Gupta (2011) state that social development programmes adhere to the requirements of social justice. Therefore, an increase in gender equality will most likely result in an increase in women's rights in general and sexual and reproductive rights. These groups of rights include reproductive justice within them. The Asian Communities for Reproductive Justice (2005:2) defines reproductive justice as a

> *"… the complete physical, mental, spiritual, political, economic and social well-being of women and girls and will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about their bodies, sexuality and reproduction, our families and our communities in all areas of life.*"

Reproductive justice focuses on social, economic, and political disparities in communities (Anderson, 2017). Erdman and Cook (2008) as quoted in Hardee *et al.* (2014) state that reproductive right includes the right to self-determination, the right to sexual and reproductive

health services as well as the information that comes with the rights and the right to non-discrimination.

German, Sen, and Garcio-Moreno (2015) define reproductive rights as the rights that couples possess to determine when and if to have children, the number of children to have, and also being able to access reproductive services without being coerced and discriminated against. Furthermore, the Cairo Consensus (1994) viewed reproductive rights as the ability of both men and women to exercise control over their sexual and reproductive rights as an important part of health. These rights include the right to be able to make free and voluntary and informed choices regarding the number and spacing of offspring, when and if to marry as well as the access to information which will enable people to make informed decisions free of coercion or violence (Reinchenbach & Roseman, 2009; Hawkins, 2012). It is important to bear in mind that reproductive autonomy provides an enhancement of human beings and empowers women in the process (Anderson, 2017).

According to World Health Organisation (2017), the United Nations Committee on Economic, Social, and Cultural Rights views the right to sexual and reproductive health as an important part of the right to health which focuses on human rights and gender equality. Feminists around the world have emphasised the fact that reproductive rights are also part and parcel of human rights. They challenge the gender engineered dimensions in terms of international law while they purport that human rights are also women's rights (Bennett, 2015). However, it should be noted that there is no single legislative instrument dedicated to reproductive rights. These reproductive rights are found in bits and pieces in some of the international legislative instruments. Another important expose was put forward by the Danish Institute for Human Rights (2014) that the focus on reproductive rights have been mostly concerned with protecting the reproductive rights of women who more than men are affected by decisions that emanate from factors like gender equality, gender roles as well as the assigned status of women by society. Gable (2010) argues that reproductive rights intersect with the right to health and therefore they represent an understanding that is *sui generis (*of its kind*)* that focuses on considerations of reproductive health and the fulfilment of factors that are necessary to achieve the highest possible standard of reproductive health.

3.3.5 Summing up sexual and reproductive health rights

The development of any country depends on the health of its citizens. Therefore, the quality of sexual and reproductive health is of paramount importance. The rights-based approach (RBA) to sexual and reproductive health includes the principles of human rights to sexual and reproductive health. Adjei *et al.* (2015) and Tallis (2012) state that sexual rights are rights that facilitate access to conditions that enable the fulfilment and expression of sexuality. Meanwhile, reproductive rights are the recognition of the basic rights of all couples to freely choose the number and spacing of offspring as well as to have the information to do this. For individuals to be able to act accordingly, they must first possess the necessary information. Quality information on sexual, reproductive health, and services require promotion and fulfilment of the individuals' rights (Kumar, 2015). All this must be done to promote the dignity of individuals as well as to attain the highest possible standard of sexual and reproductive health. Sexual and reproductive health rights are defined by the International Conference on Population and Development as an absence of any medical condition in sexual and reproductive related issues (United Nations, 1994). It also includes social, physical, and mental well-being. According to the Beijing Platform for Action, women's rights also include the liberty to control and willingly make decisions on matters related to their sexual and reproductive health (Debussher, 2015). This right is also enshrined in some international instruments like the UDHR. The discourse on sexual and reproductive health is also part of the feminist discourse which struggles against violence perpetrated on women such as rape, domestic violence, and lack of access to safe contraceptives. Sen (2014) states that the recognition of sexual and reproductive health rights that was put forward in the ICPD made the notion of the right to health broad moving beyond just the right to health services through focusing on the autonomy of girls and women. For individuals to be able to act accordingly they must first possess the necessary information. Quality sexual and reproductive health information and services require promotion and fulfilment of the individuals' rights (Kumar, 2015).

Sexual and reproductive health is an important issue because individual sexual and reproductive health rights do not only save lives. They also empower women in the process. These rights are an important element of good health and human development. Information on sexual and reproductive health rights and other health-related services are essential in preventing HIV/AIDS. Improving the sexual and reproductive health of young women reaps personal, social, and economic benefits by aiding young women to make informed decisions. Kabra *et al.* (2016) argue that this right highlights the importance of empowering people to

make their own decisions about their sexual and reproductive health. This helps to strengthen poor people's ability to demand and use health information and services for the benefit of their well-being. In terms of human rights, governments are also expected to respect and protect women's sexual and reproductive health rights. Having knowledge, skills, and information about their sexual and reproductive health rights, young women are helped and empowered to make informed and positive sexual decisions including the choice of abstinence.

Sexual and reproductive health rights rely on the ability of the individual to make genuinely free decisions regarding his or her health. Governments are required to remove all barriers in the health system that hinder individuals from being protected (Goicolea, 2010). United Nations Population Fund (2010) cites the World Health Organisation's sexual and reproductive health five key areas which ensure contraceptive choice, an improvement in maternal and new-born life, reducing the spread of HIV and STIs, advocating for safe abortions and promoting healthy sexuality of adolescents and reducing harmful practices. Therefore, this means that sexual and reproductive health plays a crucial role in enabling people to choose responsibly in all aspects of their sexuality (Lukale, 2012; Galati, 2015).

Women's rights are constantly undermined by poverty and differences in the treatment of human beings based on gender, race, or ethnicity. The realisation of sexual and reproductive health rights of women, especially those living in poverty and HIV, poses serious challenges, such that, it denies them sexual and reproductive health rights (Muller & McGregor, 2014). Poverty and reproductive health rights are closely related. Women may in some cases, fail to get access to sexual and reproductive health due to poverty, insufficient health care, and several other barriers (World Health Organisation, 2014). According to the World Health Organization (2014), lack or disregard of sexual and reproductive health rights and gender-based violence render young women vulnerable to unplanned pregnancies, HIV/AIDS, and other sexually transmitted diseases. This ultimately hinders young women from attaining their educational aspirations.

In male-dominated relationships, women have little control over the sexual relations they have with men (Washington & Tallis, 2012). Thus, the unequal power in such relationships does not allow women to exercise their sexual and reproductive health rights. However, only male decisions prevail in such relationships. This means that women's lack of power cannot allow them to exercise their sexual and reproductive health rights by taking preventive measures to

safeguard their health and wellbeing. The fact that women are generally more economically dependent on men makes it extremely difficult for women to claim and assert their sexual and reproductive health rights. For example, women find it difficult to use condoms in their sexual activities with men. Men often refuse the use of condoms because they are risk-takers, even with their health and wellbeing (Griffin, 2006). Married women also have the right to assert their sexual and reproductive health rights. Marriage gives the impression that it offers social and emotional support which should make it easier for women to have increased access to sexual and reproductive health services. However, it is not always the case since married women cannot also assert their sexual and reproductive health rights because there is no guaranteed protection against violence in their marriages (Anderson *et al*., 2014). This is because married women are sometimes forced to have sexual intercourse. However, such treatment is against human rights as enshrined in the Universal Declaration of Human Rights.

However, in the post-2015 development agenda (SDGs) it was made clear that there must be recognition of sexual and reproductive rights for women (Temmerman *et al.*, 2014). Moreover, in institutions like marriage, women are expected to be passive while men initiate sexual encounters, this, therefore, reduces equality in decision-making (Shefer, Glowes & Vergnani, 2012; Stern, Cooper & Gibbs, 2015; Iqabal *et al*., 2017). Sexual and reproductive rights are affected and in turn, affect people's experiences. Furthermore, the attainment of the highest standard of sexual and reproductive health is closely linked to gender equality, non-discrimination, right to life, and security (Hartmann *et al*., 2016). Zimbabwe and South Africa just as other African countries have customary law which greatly influences people's way of life in both private and public life. Customary law condones beliefs and practices which are patriarchal. This is problematic because beliefs and practices which are deeply rooted in patriarchal culture are against human rights (Progressio, 2016). Yee *et al.* (2011) are of the view that it is important to come up with culturally sensitive ideas for addressing the sexual and reproductive health of women on the African continent. This is important because Africans are greatly influenced by their culture. Ngwenya (2016) is of the notion that young people in Zimbabwe still face reproductive challenges, amongst them is unsafe abortions and unplanned pregnancies. This is attributed to much stringent legislation that inhibits access to some reproductive services.

Oronje *et al*. (2011) and Iikkaracan (2016) are of the notion that the poor sexual and reproductive health on the continent of Africa shows the lack of policies and laws that are in place to implement effective programmes. Although some progress has been made in some

African countries, such progress is, however, not enough to fully inform the policies and programmes that address sexual and reproductive health rights on the continent. This can be attributed mainly to the prevailing political situation as it has been stated earlier that human rights have a political character. The language of rights is only starting to take shape in Africa. For this study, sexual and reproductive health rights are the rights that men and women possess but with a focus on women to make decisions about their sexuality, reproduction, and the right to access information and services needed to support these choices to achieve the highest standard of health. Sexual and reproductive rights increase access to services and enable people to enhance their health, well-being, and ultimately human development (Barosso & Sippel, 2011; Orza *et al*., 2017).

3.4 Human rights instruments and cultural practices

It is of paramount importance to note that many instruments recognise the applicability of African customary law. Article 22 of the UDHR states that everyone as a part of a society is entitled to cultural rights. Furthermore, article 27 (1) of the UDHR provides for individual's right to participate freely in their own cultural life. UDHR is a binding international instrument in both South Africa and Zimbabwe. It is therefore important to determine if cultural practices in South Africa and Zimbabwe are aligned to the provisions of the Universal Declaration of Human Rights.

Of particular reference to this study, however, is the question as to whether the protection of cultural rights at the international level offers a justifiable reason for the violation of human rights, especially women's rights? Mwabene (2010) posits that no instrument internationally states that culture is a basis on which protections may be infringed. Furthermore, Mwabene (2010) states that culture should not be protected at the expense of human rights but culture must comply with the universal standards. The above suggests that culture is protected by international instruments so that culture should not disregard and violate human rights.

Article 4 of CEDAW (1979) is against cultural relativism which endorses the notion that human rights are different from one culture to another. Billet (2016) is of the view that cultural relativism views every society to be different from others. This suggests that human rights apply to certain societies and that they cannot be applicable worldwide. Additionally, Howson (2009) states that it is associated with respect for the difference which is referring to the idea

that culture is important for the understanding of people's beliefs and values. In summation, international instruments for human rights protection call for government intervention on cultural practices that violate human rights.

3.4.1 Legal framework and policies for sexual and reproductive health rights

Many international organisations, like the United Nations and World Health Organisation, have set standards against gender inequality. Bangura and Thomas (2015) postulate that organisations like the World Health Organisation maintain that women are entitled to the highest standard of physical health. Hereunder follows a discussion of some legislative frameworks which regulate sexual and reproductive health rights in South Africa and Zimbabwe.

3.4.1.1 Sustainable Development (SDG) Goals

In September 2015, the SDGs were implemented until the year 2030. Goal 3 is an all-inclusive health goal that seeks to ensure a healthy lifestyle and to promote the well-being of all people. World Health Organisation (2016) states that The Global Strategy for Women, Children's and Adolescent's Health 2016-2030 is aligned with the SDG targets and it centers around the themes of Survive-Thrive-Transform. Therefore, this is a precedence on how health and health-related goals and targets should be addressed to improve the global health agenda. This 2030 Agenda requires states to take steps towards ending discrimination and violence against women including harmful practices (International Planned Parenthood Federation, 2015). It goes further to call for gender mainstreaming. Family planning is an indicator for goal 3 (good health and well-being) as well as goal 5 (gender equality). Investing in family planning aids gender equality by helping the prevention of unplanned pregnancies and to attain their highest level of education which in turn empowers women to make important choices in their lives (Health Policy Plus, 2016).

3.4.1.2 South Africa

3.4.1.2.1 Constitution of South Africa

Although the constitution of South Africa contains specific provisions against discrimination on grounds of sex, gender, race, language, and culture, some cultural and religious practices continue to discriminate against women (Durojaye *et al.,* 2014). The Gender Policy Framework

is one of the key South African national policies which were put in place to advance human rights. The Gender Policy Framework states that equality of treatment entails meeting specific standards and needs for both sexes (Simmons, 2014). The constitution of South Africa Act 108 of 1996 introduces standards and principles that are in place to promote and protect the human rights of all citizens in South Africa. Chapter 2 of the South African constitution contains the Bill of Rights that binds all state organs to abide by the democratic values stated in the constitution such as the right to equality, human dignity, and non-discrimination. The role of the state is to ensure that an individual can exercise her rights which allows women to reap the health and societal benefits (Rebouche, 2011).

The rights that are enshrined in the constitution which protect and promote sexual and reproductive health are the right to equality (section 9), right to dignity (section 10), right to life (section 11) freedom and security of the person (section 12), privacy (section 14), freedom of expression (section 16), right to health care including reproductive health care and access to information (section 12). Harries (2014) posits that it is important and that there is the need to put in place measures that would guarantee the treatment of young women with dignity and respect, more especially when they are accessing sexual and reproductive health information. The right to dignity cannot be limited as it accords people a fundamental worth. This importance was confirmed in the case of *S v Makwanyane* (1995) by the Constitutional Court as an important right which gives worth to many other rights.

The right to access health care as enshrined in section 27 of the constitution is an important aspect of the rights to equality and human dignity. Ijioha (2016) is of the view that this provision provides a solid platform to recognise and affirm young women's health. This recognises and assists young women to seek sexual and reproductive health services without any impediments.

A major impediment to the right of young women in Zimbabwe and South Africa to reproductive health care is a cultural bias that is tantamount to a refusal of health care for women. Thus, women are often not treated with dignity when seeking health services. In South Africa, health care providers, for example, use contentious objection to refuse assistance to young women who seek abortion procedures.

3.4.1.2.2 Choice of Termination of Pregnancy Act 92 of 1996

This Act was enacted to create an environment in which women can choose to make use of early safe termination of pregnancies. The Act gives effect to numerous rights that are enshrined in the constitution. According to Pickels (2012), to achieve equality, women must be able to freely decide whether to terminate the pregnancy or not. Thus, it is ideal since they are best placed to make that decision. Ngwena (2007) puts it forward that the Act promotes reproductive rights and gives women freedom and the right to decide whether to undergo an early safe termination of pregnancy. Furthermore, Morolong (2013) and Mahanyele (2016) are of the view that the liberal nature of abortion is regarded as a woman's right to be able to freely choose to do with her body as she pleases. This cements the idea that women have a right to self-determination. The Act extends freedom to every woman within the domain of reproductive health to what they believe and value (Harris *et al*., 2014).

3.4.1.2.3 National Health Act 61 of 2003

This Act provides for a progressive realisation of the constitutional rights guaranteed by the constitution which is the right to access health care services including reproductive health care in South Africa. The Act was enacted to regulate the national health system by highlighting the rights and duties of both the health care providers and health care seekers in South Africa. According to Savage-Oyekunle (2014), the Act reiterates the position stated by the Children's Act and the Constitution of South Africa which enforces the rights to healthcare, dignity, and privacy. It needs to be understood that the provisions will encourage young women to seek information and services in healthcare instead of relying on unreliable sources of healthcare and contraceptives which in turn affect their reproductive health negatively.

3.4.1.2.4 National Contraception Policy Guidelines 2001 (revised 2012)

These guidelines mandate that emergency contraception is in place and promoted in all public health facilities. Maharaj and Rogan (2007) posit that the Department of Health is affected by some countless socio-economic factors amongst these is gender inequality and education. These factors are important in the analysis of policies and legislative instruments that bear an effect on sexual health delivery services.

3.4.1.3 Zimbabwe

Zimbabwe seems to have laws and policies that are not progressive unlike South Africa, particularly the Bill of Rights. To this Ministry of Health and Child Welfare (2016) postulate that the dominance of customary law over the Bill of Rights affects the rights of women and girls. Despite that the constitution has a clause that promotes gender equality, it however cuts back on the fundamental rights through this legal pluralism.

3.4.1.3.1 Constitution of Zimbabwe

Section 3 (1), of the Zimbabwean constitution, guarantees equal protection to all citizens regardless of sex, class, and religion. According to Ndoma and Kokera (2016), section 17(1) of the Zimbabwean constitution requires the state to promote gender equality. This culminated in the Ministry of Affairs, Gender, and Community Development, putting in place the National Gender Policy for the protection and advancement of gender equality. The constitution of Zimbabwe embodies the right to health by mandating the state to take all possible measures to ensure that basic health services are adequate and accessible throughout the whole country.

3.4.1.3.2 Termination of Pregnancy Act 15:30

In Zimbabwe, the Termination of Pregnancy Act 29 of 1977 permits abortion in limited circumstances. It is only permissible where the life of a woman is in danger, where there is a risk of the child being born with physical or mental impairment, or where the pregnancy is due to rape or incest to mention a few. However, permission should be granted by a superintendent of the given institution and performed by a medical practitioner. The restrictions placed on abortion compel women to undergo unsafe abortions, which sometimes result in the death of young women since most abortions are performed by unskilled and unprofessional personnel (Mulenga, 2010; Chin'ombe, 2014). Section 60 (1) of the Criminal Law Act 2004, criminalizes abortion. This means that women's rights over bodily integrity and dignity are constrained by the Act.

CEDAW obligates state parties to take appropriate measures to ensure that there is equality in the field of health. It also raises very important issues regarding the way women must be

able to control their sexuality. From this point of departure, the Termination of Pregnancy Act is important as this law allows Zimbabwe to take a conservative approach by permitting abortion in limited circumstances. It then can be said that this approach to abortion does not include the perspective of the woman but it is approached from a morally laden perspective.

3.4.1.3.3. National Adolescent Sexual and Reproductive Health Strategy 2016-2020

The National Adolescent Sexual and Reproductive Health Strategy 2016-2020 have a principal aim to develop and disseminate guidelines on the misconception that, adolescents younger than eighteen need consent to receive contraception. The National Health Strategy (2016-2020) also provides guidelines that pave way for the achievement of the targets set in the Sustainable Development Goals which aim at achieving gender equality through the country's commitment to rights to all and empowerment of all women and girls (World Health Organisation, 2007).

The strategy incorporates three approaches which are community-based, facility-based, and school-based approaches. According to Murwira (n.d), the goal of this strategy is to reduce mortality and morbidity related to sexual and reproductive health in adolescents. This strategy calls for an environment that is strengthened to implement policies that protect adolescents and at the same time championing underlying causes for sexual and reproductive health problems that affect young people and protect their rights in this domain (Ministry of Health and Child Welfare, 2016).

According to the National Adolescent Sexual and Reproductive Health Strategy (2010-2015), young people do not know sexual health issues and services but have little knowledge of child abuse and HIV/AIDS (Biriwasha, 2012). Therefore, young women with little or no knowledge of provisions on sexual and reproductive health rights cannot assert their sexual and reproductive health rights.

3.5 Human rights, gender equality and culture

3.5.1 Human rights

Human rights are the rights that individuals hold simply because they are human beings (Dare, 2017). These rights cannot be removed by anyone even any institution cannot remove them. Grove (2014) puts it forward that human rights are a language for change in society particularly if institutions recognise that they emanated through struggles and bear a connection with the lived realities of people around the world. One would be inquisitive and ask the question whether human rights are still a language for social change, to this the author answers yes that this can be done through advocacy that will assist in making social justice a reality. It is important therefore to note that human rights are in place to further dignity and fulfil the basic rights of human needs. However, it is imperative to note that human rights have a political character in that they tend to conform to the prevailing political situation. Clapman (2015) posits that human rights represent claims that can be upheld as legal rights in an international court of law or even in a national court. According to London and Baldwin-Ragaven (2006), human rights are universally acceptable, social, and material entitlements that an individual can enforce on the mere fact of being a human being. The rights that individuals hold are bestowed upon them and also entitles the state to remove all inequalities in the social and economic sphere to limit all the disadvantages that can hamper human development (Kumar, 2015). It is important to note the position stated by Herbert (2015) that human rights ought to be respected irrespective of culture and that it should take an identical form across all societies. Human rights must be translated in ways that are informed by cultural practices.

Women's rights are human rights too. Therefore, the principles of inalienability, universality, and interdependence apply to women's rights as well (Bauer & Helie, 2006). Various human rights instruments also advocate gender equality. Advocacy of human rights is aimed at ending inequality and discrimination (Maparyan, 2015). The worth of any human being is defined by one's ability to enjoy all rights based on the fundamental dignity bestowed upon all human beings (Ntlama, 2010).

Rights are indivisible and interdependent; hence, it is impossible to claim rights without knowledge and information about laws, policies, and the right to organize and claim the right (United Nations Women, 2015). Therefore, the state must be able to provide individuals with all the necessary information, to ensure opportunities to obtain what they need which cannot

be secured by personal efforts (Braungardt, 2015). This means that depriving individuals of any of the rights negatively affects their enjoyment of the other rights.

The universality and inalienability of human rights are unquestionable in instances where cultural identity is recognized and taken into consideration (Equality Now, 2011). The United Nations has put in place several instruments that emphasise human rights which should be enjoyed by all people. According to Moriarty and Massa (2012), universality intends to make all nations work together to achieve the inalienability of human rights. This does not mean that the rights are absolute, because they can be overridden. For instance, some rights are in contradiction with public interests, however, due process should be maintained. To add on, Sayadmansour and Momenirad (2014) state that the universality of human rights finds footing on gender-neutral grounds.

A person's right to life is pre-determined by his or her health condition. Ciocan (2015) supports this by stating that a person's health is an important right. This, therefore, means that the right to health draws attention to the social determinants of health. All individuals have equal right when it comes to their sexual and reproductive health. Nevertheless, the realisation of the protection and promotion of sexual and reproductive health rights which includes an investment in women assists countries to move into the direction of universal access to treatment, care, support services for diseases such as HIV (Kismodi *et.al.*, 2015).

Health and human rights are closely interwoven since health is also a basic right to life and all people are entitled to it. Wesonga *et al*. (2015) and Mitchell (2015) posit that the promotion of health practices which are in line with the human rights agenda can be understood if there is a better level of observance of human rights. This view takes into account the influences that have an effect on human rights and health including the notion of promoting and protecting human rights so that people can flourish. Gruskin *et al.* (2012) are of the view that human rights have effectively improved the outcome of chronic diseases such as HIV/AIDS and as sexual and reproductive health through employing advocacy and the components of the rights-based approach to health to equip health policies and programmes with ammunition to further the health of all individuals. There is a strong link between gender norms and the influence men have over women's sexual and reproductive health rights. According to the International Planned Parenthood Federation (2015), gender inequality prevents women from reaping the benefits of the evolving world. Therefore, gender inequality must be stamped out to ensure

that women realise and assert their sexual and reproductive health rights. Sustainable and meaningful rights-driven development can be made possible through addressing the issues of gender inequality, which act as a barrier against women who wish to make their own decisions concerning their bodies (Universal Access Project, 2014). Therefore, it is important to note that the human rights of women involve much more than their reproductive rights, and these need to be protected as health is an important issue (Gostin & Sridhar, 2014).

3.5.2 Rights in indigenous African societies

As already stated above, rights are always individual as well as social. However, in African societies rights do not stand alone. They are part and parcel of the community in which the individual lives. To this, the African Charter also recognises that there is a closely knitted relationship between the community, the rights, and the individual. The African Charter does this by stating that these rights are meaningful when exercised with regards to security, values, and community interests. This concept of human rights is the concept of U*buntu/hunhu* or human dignity (An-Naim & Deng, 2010). This, therefore, means that in an African context the rights of individuals are coined in relations within the community (Musa & Domatob, 2012). It, therefore, implies that the individual in as much as he or she has rights also has a duty and responsibility to the community. In an African community, a human being is human because of the existence of others (Mushishi, 2010; Raselekoane, 2010). Hence, it is important to note that rights should be interpreted in an African context so that it is more appropriate to the context of the indigenous communities.

Undie and Izugbara (2011) are of the view that with regards to marriage the issue of rights in an African context is legalised by the payment of *lobola* (bride price) which reassigns the rights of the women to the husband's family.

3.5.3 Rights-based approach to health

A rights-based approach (RBA) emanates from treaties, pacts, and other international instruments that promote and recognise sexual rights. However, the inclusion of sexual and reproductive health issues through research has found a connection between sexual and reproductive health, individual health behaviour, and health outcomes (Berglas *et al.*, 2014). According to the RBA, the government has the mandate to fulfil the citizens' rights

(Beracochea *et al.*, 2010). This, therefore, means that RBA moves beyond just legal entitlements through the promotion of development. RBA centres around four principles which are universality, accountability, participation, and equality, and non-discrimination (Branco, 2016). Within the ambit of sexual and reproductive health, RBA offers another component as a social and cultural asset and more importantly as an ultimate right. It is also of paramount importance that the value that is created by this approach lies in the ability to create and enforce legal accountability for the respect of human rights by the state (Schuftan, 2016).

It is imperative to note that RBA is also a political process and also capacitates women to challenge their gender roles. Carella and Ackerly (2017) are of the view that RBA acknowledges the power imbalances that lie within relationships in society. Therefore, there is a need to challenge such an order from the perspective of the subordinated. However, scholars like Jacob (2010) are of the notion that to achieve this we need to realise that the rights of women are also rooted in social justice. Musto (2010) concurs with the above statement. But, this scholar goes further to state that the social justice struggle is deeply rooted in RBA. This means that RBA is based on collective action not just for individuals but for the state as well.

RBA to health seeks not only to mainstream human rights but also emphasises the centrality of the respect and promotion of human rights for all, including women (Van der Ploeg & Vanclay 2017). Therefore, RBA is based on the idea that human rights and development are mutually reinforcing. Androff (2015) is of the view that the developments particularly in the field of health must complement a rights-based approach that encompasses the social determinants of health to reduce health disparities. The right to health entails a mandate by the government to create and maintain conditions that assist people to lead a healthy life. This point leads to the discussion by the United Nations about the critical identities of RBA. These include the argument that all programmes should promote international human rights, all developments must be founded on human rights law, and that all development efforts confer a duty on institutions such as the state to meet their obligations and rights-holders to claim their rights (Cockerham, 2016). Although there is not yet a universally accepted definition of the right to health, for this study, an RBA to health aims at the realisation of the right to health by achieving other closely related fundamental human rights. RBA also pays attention to tackling problems of discriminatory practices that hinder development. To further add to the above definition, scholars like Preetha (2016) state that RBA takes the side of those who suffer injustice by acknowledging their equal worth and dignity. It also emphasises on rights and

responsibilities wherein the state as the duty bearer has the mandate to ensure the health and well-being of the right holder. This is extremely important because the progress of any nation is dependent on the health of its citizens.

RBA to health is seen at the forefront making explicit reference to human rights. Taket (2012) states that RBA has an emphasis on building capacity and does not employ the use of human rights after a violation has taken place. RBA prevents violations from taking place based on the principles of non-discrimination, participation, accountability, and transparency (Cockerham, 2016). Being able to uphold and enforce human rights is in itself a fundamental determinant of health. This RBA to health exists based on the condition that there exist frameworks and traditions of political, economic, and social rights (Durojaye, 2015; Yamin & Maleche 2017; O'Brien & Gwisai, 2017). To this Hunt (2016) adds that although the right to health is extensive, it is not as broad as the RBA. Therefore, looking at it through the wider lens of RBA can assist in developing a more comprehensive approach to health. The promotion and protection of human rights require clear efforts to pay attention to the social determinants of health. Therefore, the human rights movement should take into account the connection of social conditions such as poverty and discrimination and provide a lens from which to view health (Boyer, 2017). There exists a challenge to find, not only human rights that protect gender equality and health but also the rights that would aid in the provision of future remedies (Oluwu, 2014). It should be noted that the law that promotes and protects human rights and gender equality is found in nearly all the constitutions and also in international instruments to which Zimbabwe and South Africa are signatories.

An RBA to sexual and reproductive health provides for the right to the attainment of the highest standard of health and proceeds to acknowledge biological differences among people as well as the difference in availability of resources between developed and developing countries (Todress, 2011). This, therefore, means that expecting the same results is impractical. Gruskin *et al.* (2010) argue that RBA to health highlights the inequalities between both sexes within the domain of sexual and reproductive rights. Therefore, adopting an RBA to health means that the policies and programmes will contribute to the fulfilment of human rights for all. At the national level, there is a requirement for countries to develop policies like national health plans to promote women's right to sexual and reproductive rights.

RBA to health goes further by utilising the human rights standards that are laid out in international instruments that originate from the UHDR to guide policy analysis, legislation, programming, monitoring, and evaluation (Yamin & Maleche, 2017). As Sanghera *et al*. (2015) postulate, the New Global Strategy views the human rights-based approach as a derivative of accountability and it empowers women to assert their rights as well as to participate in decision-making.

3.5.4 Gender mainstreaming in health

Gender mainstreaming is a term used to refer to the promotion of equality among sexes in all aspects. Gender mainstreaming calls for an introduction of a gendered perspective in all spheres of life (European Institute of Gender Equality, 2015). It is also mentioned as a tool for gender and development (Karlson, 2016). However, the most widely accepted definition of gender mainstreaming is the one put forward by the United Nations Economic and Social Council (1997: 12) that:

> *"Mainstreaming is a process of assessing the implications for men and women of any planned action including legislation, policies or programmes in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political and economic and societal spheres so that women and men benefit equally, and inequality is not perpetuated. The ultimate aim is to achieve gender equality."*

The Women's Health Council (2007) is of the view that the aim of gender mainstreaming in health is to ensure that gender equality is recognised as an important determinant of health. Furthermore, it should be able to make sure that gender inequality is not perpetuated by new policies and actions. The ultimate goal is to ensure the highest attainable standard of health for men and women. To further emphasise the above, the World Health Organisation's Gender Policy states that the goal for gender mainstreaming in health-related matters is the contribution to healthier people utilising research, policies, and programmes which have a focus on gender and promote equality and equity as well (Ravindran & Kelkar-Khambete, 2008). These scholars go further to state that gender mainstreaming in health rests on four key principles (Ravinran & Kellar-Khambete, 2008:123) which are:

> "…*health as human rights, equity in health grounded on principles of social justice and human rights, gender is seen as social relations of inequality between men and women intersecting with other sources of inequality and democratic participation as necessary for meeting the objectives of equity, social justice and health rights defence effectively and sustainably*."

According to Rahman (2017), gender mainstreaming is an important approach for social justice and protecting the human rights for both sexes to obtain other social and economic goals while at the same time challenging the status quo. The main goal is to achieve gender equality. According to Sridharan *et al*. (2016), gender mainstreaming is not about adding woman's factor, but it takes a step further in promoting the participation of women and brings their experiences to assist in planning for development. Magar (2015) states that gender mainstreaming demands actions that will eliminate inequalities in both policy and practice while at the same time ensuring that universal health coverage and financial measure includes those that are subordinated. Tolhurt *et al.* (2012) posit that gender mainstreaming has been accepted as the method in which to protect and promote gender equality in health globally. What this simply means is that gender equality is a systematic approach that includes gender mainstreaming into policies and programmes. Men and women have different health problems (Diehl *et al.*, 2009). This is important because gender roles influence health-seeking behaviour. Gender mainstreaming, therefore, goes beyond the aspects such as discrimination within society, roles assigned to genders culturally, and status based on sex (Piang *et al.*, 2010). It is imperative that gender mainstreaming within the area of sexual and reproductive health programmes must include topics such as child-bearing as well as contraceptive assistance for men as well.

Advancing gender equality is a requirement of RBA so that gender mainstreaming can be realised (World Health Organisation, 2016). The combination of RBA and gender mainstreaming assists in upholding the commitments of the SDGs. Sen and Ostlin (2009) are of the view that the way society values men and women and also the expected ways of behaviour of both sexes influence the risk of developing risk programmes as well as health outcomes. This is the case because there exist patriarchal norms in society that do not give women the right to make decisions concerning their sexual and reproductive health which in turn exposes them to mortality (Beek *et al.*, 2017). This may be through STIs, forced sexual intercourse, or even death due to unsafe abortions because abortion is illegal in Zimbabwe. With this said, it is important to note how Vardanyan (2014) stresses that gender

mainstreaming gender should focus both on context and content. It should also highlight the different needs and problems of women so that different policies and practices are not based on discrimination. This, therefore, brings to light how gender mainstreaming has brought attention to major power dynamics among genders (Mabunza *et al.*, 2014; Thobejane *et al.*, 2017).

There are two main approaches to gender equality that are accepted globally. The first one is the Operational Gender Mainstreaming Approach. This approach seeks to address inequality and non-discrimination by way of applying tools of gender impact analysis. It is viewed as a systematic mainstreaming of the actions that aid in balancing power between sexes through policy development and programming (World Health Organisation, 2009). The second approach is known as the Institutional Gender Mainstreaming. This approach looks at administrative issues within organisations and institutions so that gender equality is promoted through policy implementations (National Women's Council of Ireland, 2014). Furthermore, Mannell (2017) states that institutional and operational mainstreaming are processes that are both important for achieving equity in health. The two approaches help to fulfil the ultimate goal of gender mainstreaming which is the attainment of equality among men and women.

It is of paramount importance to thoroughly breakdown the components of gender equality in this study. Gender mainstreaming does not only concern itself with the health of women only. It is also a process of identifying and dealing with the health of both sexes. Gender mainstreaming as a strategy promotes equality through legitimising differences between men and women so that providing opportunities that mean the same becomes the strategy that is worth pursuing (Sanchez-Lopez & Liminana-Grass, 2016). Within the ambit of gender mainstreaming in health, it means to engineer gender aspects in health needs and priorities as well as the obstacles that hinder the achievement of universal access to health. Therefore, it is a symbol of what a modern gender equality structure should be (Bendl & Schmidt, 2013; Lamprell *et al.*, 2015). This brings Bacchi and Eveline (2010) to the conclusion that gender mainstreaming is an equality policy that complements existing policies on equality.

3.5.5 Culture

This study analyses the effects of customary marriages on the sexual and reproductive health rights of young women with special reference to the cultural practices that are conducted within

customary marriages. It is therefore of paramount importance to have a detailed discussion of what culture is and how it positions women in society. According to Ngubane (2010), culture emanates as a result of behaviours people learn through social interactions which makes a group unique through the observance of those norms or practices. To this Idang (2015) states that culture marks people out from other societies and negative dimensions of culture need to be done away with as these hinder progress in society. Culture focuses on the way of life of a particular group. Nations around the world have their own cultures that connect communities and individuals. Culture helps individuals to connect with other people who share the same mind-set, values, history, and beliefs. Culture is important for both individuals and the communities because it contributes to the building of a person's identity, self-esteem and it also promotes social cohesion. Wadesango *et al.*, (2011) are of the view that every social grouping is characterised by the observance of certain cultural beliefs that guide members of a group on how to behave or live. Therefore, culture is like a fabric made up of different threads and some of these threads represent customs and practices. In a patriarchal society, these customs and practices are shaped in a way that creates and endorses the dominant position of men and the subservient position of women in society.

When it comes to women, culture as a way of life is interpreted very narrowly by those in the position of power (Tamale, 2011). For this reason, African feminists vehemently argue that culture is one of the areas that pose obstacles for women. Teays *et al*. (2014) are of the view that rationality and morality are an important component of culture and that no human culture is possible in the absence of these. Human rights also include morality which is a tool for behaviour change in the modern world.

The committee on ESCR has commented on cultural rights stating how culture is a broad concept that includes all indicators on how human beings must exist and also that cultural life explicitly refers to culture as a process that is evolving (Nyarango *et al*., 2017). Culture is not a static phenomenon, but the problem lies in how people perceive it and to what extent have people decided to preserve it. Gyekye (1997) thinks that the way people preserve a practice in whole or partially depends on the attitude of people towards it. This, therefore, means that the continuity of culture depends on the perceptions as generations come. Nzegwu (2006) concurs and further emphasises the notion by Gyekye that customs are evolving and no longer exist purely in their old form. This means that our focus should be on the attitudes and values that the individuals employ when interpreting these customs. Culture on its own is not a bad

thing. But the way human beings have decided to perceive culture and observe it could be the problem.

3.5.6 Cultural position of women in the African context

The position of women in Africa is, to a great extent, in line with what is stated in the Bible. In Genesis 3 verse 16 it is stated that:

> "*To the woman I will surely multiply your pain in childbearing, in pain you shall bring forth children. Your desire shall be for your husband, and he shall rule over you*"

(The Holy Bible English Standard Version, 2013:3).

Sociologists view the above verse as a justification for positioning women in a certain way in society. In many African cultures, women are considered second-class citizens who should always be subordinate to men. The differentiation in treatment between sexes starts at birth and continues throughout the life of a woman (Omaswa & Crisp, 2014). There are biological differences between men and women. But, in most societies, culture dictates terms rather than biology (Connell, 2008). In every society, people place a high value on culture. Thus, culture makes it possible for men to dictate and have control over nature. It is clear that this patriarchal thinking is informed and anchor on the pronouncement as stated in the above-cited bible verse. In other words, culture has been influenced by the Bible such that it accords women a lower status than that of men. This means that the bible and culture are contributors to the undermining of the status of women in society.

Patriarchy in most African countries socialises women into believing that they are subordinate to men. Patriarchy is rooted in the Biblical story of creation, where Eve is said to be a product made from Adam's rib. From this context, a woman is seen as nothing but just part of a man. Such doctrine tends to relegate women to subordinate positions both in the church and the family. This view promotes the notion that shows women as second-class citizens women because they are nothing but God's last piece of creation. Ngubane (2010) is of the view that a traditional South African family is patriarchal because men are considered as the heads of the family whereas women should obey the authority of men. Similarly, there is also an existence of unequal gender relations in the Shona culture. These unbalanced relations lead

to devastating results in young women's sexual and reproductive health rights. This is apparent in the relations between spouses in the sexual and reproductive health domain. Men put themselves in a position of privilege in culture (Mapuranga, 2012) while women are expected to be submissive even in the face of the possible danger of contracting HIV or a threat to their sexual health.

Some African cultures pose a threat to women's sexual and reproductive health since women find it extremely difficult to voice their concerns with their spouses since they are expected to obey and be submissive to the authority of their husbands as dictated by the Bible and culture. According to Vambe and Mupfariseni (2011), when a woman is limited to only domestic duties, it creates an opportunity for men to take advantage of the fate of women and suppress them by viewing them as less productive. For this reason, the gap of inequality between men and women continues to widen in African societies. These cultural practices make it difficult for women to report on the injustices they face at home and within the community. Gender ideologies act as a powerful tool for reinforcing the domination particularly of men over women which is shaped by the social experiences of men and women (Rwafa, 2016). African women are socialised to submit to men as they are the heads of the family. These cultural practices authenticate the inequality between sexes in most African societies.

Hartmann *et al.* (2016) state that harmful gender norms and practices which perpetuate male dominance, culminating in the neglect of human rights. Male dominance has often led to the disregard and undermining of women's rights. This often brings about negative health outcomes for women since they are denied opportunities to exercise their rights. This is because of the patriarchal systems in most societies across the world. Patriarchy is one of the biggest impediments to women's advancement and development. In patriarchal terms, women are seen as biologically inferior when compared with men. This view allows society to assign different and subservient roles to women. Hence, patriarchal systems in most societies justify male dominance and female inferiority based on their biological make-up (Mapuranga, 2012).

Feminists critique patriarchy in their quest to understand women's realities in society. They posit that the degree of patriarchy in each society reflects the extent of the control men has over women as reproductive beings. Thus, women are often overlooked in higher and powerful positions in patriarchal societies (Kruger *et a*l., 2014). Feminists view patriarchy as one of the strategies men use to oppress and deny women opportunities to develop. Thus, feminists are

a united front against patriarchy to liberate women from subjugation (Ahikire *et al*., 2015). Feminists oppose social systems which regard men as the source of authority and women as merely submissive objects.

Patriarchy is a social system that produced a culture which moulds people into accepting that, even though humans are social beings, men are dominant, and women are submissive (Serpa, 2016). This, therefore, means that culture has certain rules that are at some point against the law. This is the case because of the cultural norms which put women at a disadvantage since such cultural norms do not accord women the same status as men.

Women are relegated to positions of inferiority in many African societies and this leads to inequality among genders. Gender equality is one of the fundamental human rights. Gender equality is a situation wherein men and women have equal conditions for the realisation of their potential to equally contribute and benefit from human development (Kemi & Jenyo, 2016). According to the Australian Government (2016), gender equality is all about equal opportunities which can be hindered by the ongoing discrimination or weakness in laws, policies, and relations in societies which normalise inequality. Gender equality means expanding the freedoms in life for equality to be achieved without sacrificing male and female gains (United States Agency for International Development, 2012). Therefore, the causes of discrimination must be identified and eliminated to give both men and women equal chances. Durojaye *et al*. (2014) are of the view that mainstreaming gender is an important development strategy that can also be used to promote the position of women in society.

3.6 Marriage

3.6.1 What is a marriage

Marriage is the uppermost form of cooperation between human beings. It can be agreed that the definition of what marriage has two different views, that is the conjugal view and the revisionist view. According to Girgis *et al*. (2012), from a conjugal point of view marriage is a heterosexual union wherein two people commit to each other and naturally bear and rear children and the union is renewed by conjugal acts which unite them as a reproductive unit. Girgis *et al*. (2012) go further to state the revisionist view of marriage as encompassing a union between spouses who share the entitlements of love which are affection, romance, and

sharing the burdens of life. Therefore, a marriage bears some obligations on both spouses. In the same vein, Anderson (2013) states that a marriage intersects conjugal rights and love, a man and a woman and a result of this union is a child who now connects them as mom and dad. Van Zyl (n.d) concurs with the above definitions but goes on to add how a marriage shapes an individual's identity in society. Marriage is a gendered institution of fidelity, reproduction, and authority that impacts differently on genders. Jackson (2012) postulates that the rights, obligations, and expectations in marriage bring about specific gendered divisions of sexual and reproductive rights as well as labour. Despite the form it takes, marriage is an important tool in shaping how gender is construed (Ryle, 2015). Given this enormous strength of marriage amongst people in society as a cultural ideal, the functioning and how women relate and behave is mediated by marriage. For Africans marriage is the focus of survival and it seems to define success. This is in line with marriages in an African context that respond to the needs of the society. Marriage cuts across the dimensions of one man and one wife through uniting two families as well as the communities from which the spouses hail (Nkosi, 2007; Fikiri, 2016). In this study, the only marriage that will be referred to is heterosexual.

3.6.2 Customary marriage

The Recognition of Customary Marriages Act (RCMA)120 of 1998 defines a customary marriage as a marriage conducted under customary law. However, Fenrich *et al.* (2011) state that there is no well-defined definition of what customary law is. But there is some agreement as to what it entails which is morals, values, and traditions of ethnic groups. It should be noted that these values are passed down from one generation to the next. Section 35 of the Black Administration Act 38 of 1927 referred to a customary marriage as a union or an association of a man and a woman in a conjugal relationship under black custom. The Zimbabwean Constitution, Amendment 20 of 2013, defines marriage as an agreement between a man and a woman who has attained the majority age (18). In Zimbabwe, the Customary Marriages Act of 1951, does not make provisions for the minimum age of marriage. Religious and traditional groups take advantage of this Act. Hence, parents marry off their children because there is no specific age limit stipulated in the Act. However, this compromises human rights (Nyamadzawo, 2015).

3.6.2.1 Shona customary marriages

Culture has a way of influencing the behaviour of people and their perceptions as well. However, with the advent of Christianity, it has also shaped how people think and act. It was held by Machingura (2012) that the Bible has also been used as a tool to add to how the Shona culture perceives women. As a result, in Shona culture women are expected to be submissive. Yet men are traditionally and religiously the ones that dominate and control within a marriage. Furthermore, in 1 Corinthians 7 verse 4 *"see your body is mine to do with it what I want. So, you have to do what I say*." This text has been used to justify the cultural beliefs that subordinate women to men. Anderson (2008:41) poses a very interesting question that "*Should a wife submit to everything her husband wants her to do sexually? No, neither spouse has the right to violate the conscience of the other*….." To this Brennen (2011) argues that there is a need to understand what was going on in Paul's mind when he wrote this about the natural sexual role of spouses in healthy relationships. The Bible therefore is used to make women submit through the usage of what God expects from them. It is also important to note that the Bible constantly refers to the woman as the church and the husband as God. Therefore, one can conclude that Paul tended to make an example using this scenario. Christianity has greatly grown in Zimbabwe. But it has not completely altered some customary practices like the way marriages are conducted in the Shona culture. With this being said, the researcher argues that culture is responsible for some of the issues and obstacles faced by women particularly married women in the social arena.

Traditionally, for the Shona, marriage is not only between the spouses but between the families. The study investigates the effects of customary marriages on young women's sexual and reproductive health rights in Concession, Zimbabwe. The Shona people are an ethnic group in Zimbabwe which constitutes 85% of the population (Tatira, 2016). Marriage is the destination in society for every woman. Therefore, society places an obligation on the woman without placing an obligation on the man (Chikura, 2016). This is engraved into the minds of women through culture and it leads to mental enslavement of the woman who surrenders. The way that women in Shona marriages conduct themselves is regulated by a set of moral standards that are engraved in the mind of a Shona woman (Mouton *et al.,* 2015). This kind of Shona marriage awards the husband with exclusive sexual rights over his wife (Mukonyora, 2007; Jackson, 2012). Marriage is a place wherein Shona women have faced many challenges socially and economically. Women have cried out that the Shona cultural practices do not meet the human rights standards set internationally even though Zimbabwe is a

signatory to the SADC Declaration on Gender and Development (Maguraushe & Mukuhlani, 2014). Instead, women have been suffering from oppression within marriages.

In the traditional Shona custom, a man can have as many wives as he desires. Machingaura (2011) states that the practice of polygamy is acceptable, and spouses can operate within it and it is also a great social asset. Shona culture is also patriarchal. However, as will be revealed later in this chapter, polygamy is detrimental to the sexual and reproductive health rights of young women. Unfortunately, marriage seems not to have provided women with the protection that they need in sexual domains from HIV/STIs. Chitando (2011) sadly notes that the HIV epidemic has been important in bringing to light the challenges that women face especially those that are related to lack of power and gender.

Mhaka (2011) concurs with the above notion in a study wherein one of the participants stated how she knew about her husband's promiscuity. But she lacked the courage to negotiate for safer sex because she was married. This means that women are not empowered in sexual matters (Maree, 2010; Chimbandi, 2014). This response clearly shows that the Shona culture does little to fully empower women in marriages concerning sexual matters. Traditionally, it is culturally immoral for women to discuss sexual matters openly without them being labelled as immoral or uncultured. According to Shamu *et al*. (2012), in a conducted study the participants articulated how condoms are linked with lack of trust, love, and respect. Another finding of the study was the lack of power in women to negotiate for condom use. To add on a focus group discussion conducted from a male group discussion that when a wife refuses sexual advances, the man is seen as if he has lost control over the sexual relationship (Pearson & Makadzange 2008; Mugweni *et al*., 2012). Popular Shona sayings like "*musha mukadzi",* which simply means *a "home exists because of the woman"*, are invoked to convince women to stay in their marriages and endure even the violations of their sexual and reproductive health rights. There are some other popular cultural beliefs that celebrate masculinity, for example, the Shona saying that "*murume ibhuru rinoonekwa nemavanga-* a man is a bull when it is seen with the battle scars". This means that the scars manifest themselves when men engage in extra-marital affairs which expose their wives to diseases that threaten sexual and reproductive health right (Machingura, 2012). Therefore, marriage is an arena wherein men want to demonstrate control over the women under the guise of culture.

One cannot sufficiently discuss the cultural fabric of the Zimbabwean society without discussing the concept of *hunhu/Ubuntu*. According to Mawere and Mubaya (2016) and Mutangi (2016), *hunhu* has been highly praised for the way it places importance on human solidarity. Sibanda (2014) adds that a person with *hunhu* adheres to the African culture, the expectations that arise from it, and maintains the identity of an African. It is therefore perplexing how this concept allows trampling on a certain gender's rights.

3.6.2.2 Venda customary marriages

Traditional marriages in Venda involve the payment of bride price known as *mamalo* in Tshivenda which is in the form of cattle or money that is paid to the family of the bride. Just like in many African cultures, paying *mamalo* is seen as a transference of the reproductive rights of the woman to the husband's family (Mulaudzi, 2007). To this Raliphada-Mulaudzi (1982) states that the payment of *mamalo* further promotes the subordination of women which in turn limits their ability to negotiate for safer sex in a marriage. In the Tshivenda culture, the payment of *mamalo* assists in cementing a relationship between two families, and it is a gesture of gratitude for looking after the bride.

According to Raphalalani and Musehane (2013), Vhavenda have a lot of arranged marriages in which an obligation rests on the parents to look for a suitable suitor and also to train their children to be desirable marriage partners. Romantic love is considered irrelevant, but the needs of the family must be put first. Just like many African cultures, in a Venda marriage procreation is never left to an individual in the traditional African society but there is always an intervention from the family (Baloyi, 2010). This shows that the Tshivenda marriage too is patriarchal and this can have detrimental effects on the sexual and reproductive health of young women.

Traditionally in the Venda culture, the wife is a resilient person in the face of major offences. Ramuthaga (2002) posits that women must not disagree with their husbands. There is an accepted attitude towards a husband that is unfaithful which is accepted by phrases that depict a picture of how men are. However, this attitude cannot be tolerated by the more modern women who are more assertive about their rights because they are learned.

3.6.3 *Lobola/ roora/ mamalo*

As stated during the discussion of the theoretical framework, the radical feminist theory has been employed in this study to determine the difference in reproduction which is reinforced by the cultural practice of *lobola* or *roora* payment system and the bearing it has on gender power dynamics.

Lobola/roora/mamalo is bride price (wealth). It is an essential ingredient of a customary marriage. Therefore, the absence of this makes the marriage void *ab initio* (Wille, 2007). Mngena and Ndhlovu (2013) went further to state that an African marriage without the payment of bride wealth can be viewed as cohabitation or just casual sex. Dlamini in Posel *et al.* (2011) define *lobola* or *roora* or *mamalo* in Shona as bride price in the form of cattle paid to the family of the prospective wife in an African society which links the reproductive labour and the relationship created between the families. However, because of the dynamic change in culture, in Zimbabwean marriages have also employed the use of money as payment of *lobola/roora*. Mazibuko (2016) is of the view that *lobolo* enforces the subordination of women because it can be viewed that the husband has bought his wife, her labour and sexuality. In the case of *Meesadoosa v Links* (1915), the learned judge held that the payment of bridewealth should not be tolerated as it is a *quid pro quo* for the acquisition of rights over the woman who should also be respected with the same legal equality as men. *Lobola/roora/mamalo* makes a woman a subject matter of the negotiations and within these relations is how the subordination of women culminates (Musandirire, 2016).

In 1991, Zimbabwe ratified CEDAW, and *lobola/roora* is no longer a legal requirement for a customary marriage. In a scenario, wherein the bridewealth is so high, virginity is placed on high value and family members tend to want to control the young women to achieve this thus controlling the marriage patterns of the young woman (Mawere & Mawere, 2010). This, therefore, means that all family members have an interest in the marriage and can also influence the married couple. Chabata (2012) and Khomari *et al.* (2012) posit that the increase in violence against women is sometimes connected with the large amounts of money paid by men as *lobola/roora/mamalo*. Violence is used to gain control over women even in decisions regarding sex, health, and fertility (Odimegwu *et al.*, 2015). Reiterating the above point, Ndulo (2011:94) is of the opinion that "*lobola* has become what Westerners alleged as a bride-price and has ceased to be a source of African pride." This contributes to the control of women by men. Kambarami (2006) postulates that *lobola/roora/mamalo* gives a man all the rights and to

the woman, all the fundamental freedoms are taken away. The author goes further to state that in situations where the *lobola/roora/mamalo* is high, the woman is viewed as an acquired property. She concludes that *roora* is part and parcel of the Shona society which is patriarchal in its very nature and culminates in inequality which places the woman in an inferior position. Kambarami (2006) therefore views *lobola/roora* as a tool for perpetuating patriarchy which undermines and marginalises women. With this view, *lobola* dehumanises women by viewing them as commodities. The above depicts the negative aspects of *lobola/roora/mamalo*. However, there is a positive side of *lobola/roora/mamalo*.

Additionally, *lobala/roora* in its nature is patriarchal and results in oppression of women by men (Kambarami, 2006; United Nations Children's Fund, 2007; Townsend, 2008; Chireshe & Chireshe, 2010). This custom has been abused among families. In this regard *lobola/roora/mamalo* is seen as a place where oppression of women emanates and it has turned out to be a source of concern. It can be argued that *lobola* is suppressive and it violates the bodily integrity of the woman by treating her as a commodity (Chireshe, 2015). To this Chitakure (2016) states that a married woman is considered lost because she no longer owns her reproductive capacity as it now belongs to her husband. The fact that *lobola/roora/mamalo* links with reproduction gives men the idea that they can control the reproductive decisions after the payment of the bride-wealth. This results in some of the men even refusing to practice safe sex (Wojcicki, Van der Straten & Padian, 2010). It is, therefore, of paramount importance to examine whether *lobola/roora/mamalo* violates the equality and human dignity of women. This is how women are also stripped of control over their sexual and reproductive health rights. Customary marriages in Zimbabwe and South Africa, also allow men to practice polygamy. Wives in polygamous relationships have little or no control over their sexual behaviour or that of the other members in the circle (Mswela, 2009). Polygamy places women at a high risk of contracting sexually transmitted diseases. However, according to Chireshe and Chireshe (2010), *lobola/roora* is a stabilising factor and offers status to women and makes the children born in the union legitimate. It can be a guarantee of good faith.

3.7 Customary marriages on young women's sexual and reproductive health rights

For this study, only cultural practices such as wife inheritance and polygamy have been discussed to determine their effect on young women's sexual and reproductive health rights in customary marriages.

3.7.1 Wife inheritance

Losing a spouse is a moment that one faces devastation which leaves one feeling abandoned. The concept of wife inheritance was meant to safeguard a stranger into the family who might introduce alien offsprings into the family whose demeanour could be perceived as contrary to what is expected of in the family (Gunga, 2009). Therefore, the inheritor is in place to serve as the widow's only legitimate partner that is chosen by the family. According to Conroy (2011), traditional practices have become a cause for concern in the international community for the mere fact that it has a detrimental effect on the rights of women and girls. The unending patriarchal system in Zimbabwe and South Africa worsens the tension. The dominance of males is present in the practice of levirate marriages commonly known as wife inheritance. However, in Zimbabwe and South Africa, no legislation specifically prohibits wife inheritance. The only available recourse depends on the action that the family of the husband would have taken in a bid to compel the widow to abide by the custom. Several risks are associated with this type of practice which will be apparent as the discussions unfold.

In levirate marriages, the risk factors for contracting and transmitting HIV attributed to wife inheritance is that the inheritors usually have more than one sexual partner, therefore, this creates a sexual web. In most Sub-Saharan countries, wife inheritance arrangement often requires a widow to be sexually active with the inheritor in the face of the HIV crisis which places women at a greater risk of infection (Conroy, 2011; Doosuur & Arome, 2013). In a study conducted by Oluoch and Nyongesa (2013), the researchers noted that wife inheritance in Sub-Saharan Africa is one of the contributors to the spread of HIV/AIDS. To this, Ikpeze (2015) asserts that it is impossible for the widow or the wife of the inheritor to demand an HIV test because of the major fact that there are multiple sex partners involved as the woman lacks control over her own body.

In such a scenario, there is a low rate of condom usage as the widows are compelled to comply with the arrangement out of desperation. Therefore, this can be viewed as a willingness to engage in risky sexual behaviour (Hildebrand & Lewis, 2013). It is of paramount importance to note that abstinence or condom use is not practicable in levirate marriages as they bear the same expectations as in any cultural marriage. To this Perry *et al.* (2014) opines that abstinence is almost impossible because of the fear of the widow to be victimised for the failure to adhere to the cultural sexual ritual as well as the pressure to adhere to the rituals and possibly to conceive a child, therefore condom use is impossible. According to the World Bank

(2007), a woman is well within her rights to refuse this kind of marriage. But because there is great pressure in society to comply this, in turn, promotes the subordination of women to men.

Having mentioned the above, one can conclude that African women are not in control of their bodies because culturally women are viewed as properties. It should be noted that except in the case of an old woman, wife inheritance comes with sexual expectations. Therefore, the widow is under pressure to bear children for the inheritor. Ikpeze (2015) states that the obligation of a woman having to bear children even if she has passed her childbearing years places the reproductive health of a woman at great risk.

Levirate marriages violate the constitutional rights of women such as the right to dignity, non-discrimination, and reproductive health. Durojaye (2015) and Oluwakemi (2017) are of the view that this practice exhibits injustice done to women for the mere fact that women are inferior to men and therefore women suffer injustices and certain other pressures such as the bearing of children.

3.7.2 Polygamy

Polygamy can be defined as a social custom that people follow (McMahon, 2013). Mukhuba (2017) defines polygamy as a marriage wherein a man has more than one wife. According to Greek origins, it is a marriage wherein a man can simultaneously have more than one wife (Gwirayi, 2017). The prevalence and distribution of polygamy within the African cultures are widespread and different among social status, class, education, and geographical location (Ozer, Orhan & Ekerbicer, 2013; Gwirayi, 2016). The reasons for polygamy vary from country to country in all the communities in Africa. However, Baloyi (2013) states that one of the reasons why polygamy is still being practiced is that it is regarded as a solution to avoiding infertility even though the man can also be infertile (Al-Krenawi, 2010).

According to Strauss (2012), polygamist communities have strict gender impositions on women which in some cases restrict women's educational opportunities so that marriage becomes their only means of support. Smith (2007) contends that gender roles and relations bear an influence on the perceptions and the practice of polygamy. As a result, it shapes the vulnerability of women to HIV through sexual relations due to the risk-taking behaviour of men.

Religion and gender relations shape the experiences within and outside marital unions (Saddiq *et al.*, 2010). This, therefore, means that there is a strong connection between the way people are bound to behave in marriages and their vulnerability to HIV and STIs.

In Zimbabwe and South Africa, there are two types of customary marriages. These are registered and unregistered customary marriages. Thobejane (2016) states that the two types of customary marriages in Zimbabwe are the registered customary marriage which in terms of the law is governed by the Customary Marriages Act (Chapter 5:7). This Act allows a man to marry many wives. The second one is an unregistered customary marriage. Under the Customary Marriages Act (Chapter 5:07), the husband has no obligation to inform his other wife of the intention to take another wife (Thobejane & Takayindisa, 2014). In South Africa, customary marriages, both registered and unregistered, are prescribed under the Recognition of Customary Marriages Act 120 of 1998.

The disadvantage of polygamy is that once one of the sexual partners in this union is infected all the other members in the union are at great risk of getting infected (Mapuranga, 2010). Therefore, in this union, an injury to one is an injury to all. The vast body of literature in the area of human rights is strongly against polygamy as this robs women of their fundamental rights (Jonas, 2012; Mubangizi, 2012) which in most cases places women at a very huge risk of contracting HIV. There is an undeniable link between polygamy and HIV. For the mere fact that there are multiple partners involved, there are higher chances of being infected coupled with the fact that women have a more susceptible membrane which increases the chances of infection. In most cases, women in a polygamous marriage compete amongst themselves to have more children which in itself can pose a threat to their health. Women who are in polygamous marriages cannot even negotiate for condom use. Mwambene (2010) is of the view that a woman in a polygamous marriage cannot assert her rights due to the fear of being labelled an outcast. Siringi (2010) and Nyathikazi (2013) posit that women in polygamous marriages show no interest in condom use hence polygamy does more harm than good as it contributes to the spread of HIV/AIDS.

The human rights that are always infringed when people practice polygamy include the right to non-discrimination and the right to dignity which in some cases countries do not consider compelling enough to justify criminalising plural marriages (Gaffney-Rhys, 2012). Polygamy also relegates women to reproductive and service roles (Cook & Kelly, 2006) because the

man puts immense pressure on the first wife to perform even if it threatens her reproductive health. Polygamy violates the principle of consent amongst spouses (Tadesse, 2015) and it can also cause violence among spouses. Reiners and Watkins (2010) and Jonas (2012) are of the view that men can use polygamy as a weapon to threaten women into submitting and not asserting their rights in a marriage. Polygamy is another key feature that works against child spacing. Cherry and Dillon (2014) postulate that husbands are the ones that traditionally make all decisions regarding the number of children as well as when and if to have children. This places women in a precarious position.

Female genital mutilation (FGM) is one of the harms associated with polygamy. Gaffney-Rhys (2011) is of the notion that many African societies that practice polygamy, also engage in harmful traditional practices such as female genital mutilation. This is because polygamy is a cultural practice. Therefore, it is also a societal way of life. The reasons behind female genital mutilation vary from community to community. But, it tends to be a mixture of social and cultural factors. Female genital mutilation (FGM) amounts to sexually defined physical damage of the extreme kind, with irreversible consequences which are mostly done for male sexual gratification (Muteshi *et al.*, 2016). Among the reasons behind FGM, is ensuring virginity at marriage, through the suppression of a woman's sexual desires, while enhancing the social acceptance of women who undergo this ritual and adhere to cultural or religious practices (Committee on the Status of Women, 2007).

The practice of female genital mutilation is generally regarded as inhuman and unhygienic because it is undertaken without the use of anaesthetics. It is even worse because it is often performed by individuals who did not undergo any surgical training. According to the World Health Organization (2016), this practice, unfortunately, involves the use of mixtures of local herbs, earth, cow dung, ash, or butter to treat the wound. Unfortunately, unsterilized and blunt instruments are used on the girls. This exposes girls to the risk of contracting HIV and AIDS and other infectious diseases, consequently, violating their sexual and reproductive health rights (World Health Organization, 2016).

3.8 Sexual relationship power

The sexual relationship varies from context to context therefore, it is difficult to measure. A study conducted by Conroy (2011) in Malawi revealed that men proved higher levels of

relationship power than women in all spheres except for communication. A study conducted on Latina women indicates that higher levels of safe sex communication result in superior power in relationships that play a major role in sexual activities (Mastuda *et al*., 2014; Ramirez-Ortiz *et al.,* 2018; Luft *et al.,* 2020). A plethora of literature indicates that gender power has a bearing on negative or positive sexual and reproductive health behaviour outcome (Raiford, Seth & DiClemente, 2013; Haberland, 2015).

The social dominance theory is of the view that the groups in society that are at a disadvantage experience a lot of discrimination due to how our societies are ranked based on gender and class (Sidanius *et al*., 2004). In sexual relations, power has been described as the ability to act autonomously and being able to influence the decisions others make (Saasa & Mowbray, 2019). Scholars like Pratto and Walker (2004), Filson *et al*. (2010), and Klomegah (2011) state that how the use of force and violence, sexual harassment, and even emotional abuse are the first bases of gendered power as they aid in the maintenance of hierarchal power between men and women. Rosenthal and Levy (2010) postulate that social obligations such as caregiving duties that are expected from women is also another site of gendered power. An obligation is placed on women and not on men to provide care and to nurture. This concurs with the sex role theory that emphasises on the nurturing role of women. Acceptance by women of this role makes them vulnerable to HIV/AIDS as it reduces their power to protect themselves.

A study conducted in South Africa by Jewkes *et al*. (2010) revealed that low levels of relationship power in women are associated with HIV infection and there is a high prevalence of intimate partner violence in those relationships which results in negative health outcomes. Particularly in Africa, the main channel for HIV/AIDS is a high prevalence of unprotected sex and multiple sex partners with women are more likely to be infected than men because men refuse to use condoms and women lack negotiation power for safe sex (Mchombu & Mchombu, 2007). In response to the increased rate of the vulnerability of women to HIV/AIDS, the international community has called for interventions to empower women to improve functional aspects of power especially in the area of sexual decision-making (Higgins *et al*., 2010; Conroy, 2011).

A study that was conducted in Zambia highlights that limited power women possess in intimate relationships is endorsed by patriarchy, culture, and normalising males to have multiple sex

partners (Butts *et al*., 2017). These notions can provide a hindrance encourage safe sexual behaviours among men. To this, Hatcher *et al.* (2012), Siedner *et al*. (2012), and McMahon *et al*. (2015) put it forward that power imbalances caused by gender differences in sexual relationships can adversely affect the physical, mental, sexual, and reproductive health of women. According to Blanc (2001), power imbalances are linked to health in that they directly influence the access of women to health information, they are closely associated with violence and they influence the use of health services. Direct effects are visible in how women can negotiate for safe sex through condom use and preventing sexually transmitted diseases (Woolf & Maisto, 2008).

In patriarchal societies which is typically a characteristic of societies in Africa, hegemonic masculinity is emphasised (Connell, 2005) men are expected to take up the role of breadwinner and making decisions. Men who fail to take up those social roles may end up feeling that their roles being undermined (Lennon, Stewart & Ledermann, 2012; Cheung *et al*., 2019). Therefore, they might end up having compensatory behaviour to make up for the loss of control in other spheres of life. The theory of gender power when it is applied within the context of HIV/AIDS and STIs holds that gendered power inequities which are in society and in relationships between men and women where regulations on sexual relationships are exerted by men (Buelna, Ulloa & Ulibarri, 2009). Power in the relationship included deciding to use condoms, when and if to have sex, and the type of sexual intimacy (Lanier, 2013). Theories that elucidate control in sexual relationships are feminist theories, such as those used in this study. They put it forward that power differences that are usually cemented by societal expectations create an environment that accepts the dominance of males directly results in the control of women in several ways (Benotsch *et al*., 2017). An important element when examining control in relationships is the inequality in power and gender (Antai, 2011). This study offers analysis of sexual relationship power through investigating control in the relationship and dominance in decision-making. The dimensions of inequality used in this study include the ability to make decisions on sex, family size, employment status as well as type of marriage.

3.9 Conclusion

This chapter reviewed the literature on the effects of customary marriages on young women's sexual and reproductive health rights, defined what is meant by the term sexual health rights and what it entails, as well as the important aspect of human rights. This chapter also aided

in the choice of the methodology by the researcher as well as the formulation of the research instrument that will ultimately assist in answering the research questions. In this chapter from the literature reviewed it was found that culture is a social determinant of young women's sexual and reproductive health. It was also discussed in this chapter that patriarchal norms that exist in a society that also finds footing in Shona and Venda customary marriages hinder women from asserting their sexual and reproductive health rights in marriages. It was also apparent in this chapter that a rights-based approach to health and gender mainstreaming can assist with the commitments to the highest attainable standard of health for women.

CHAPTER 4 RESEARCH DESIGN AND METHODOLOGY

4.1 Introduction

To research the sexual and reproductive health rights of young women in customary marriages is a difficult area because it is prone to a lot of misunderstanding. This is mainly attributed to the cultural reasons that make it difficult for young women to disclose freely the details of their marital relations. For this reason, methodologies that were used to investigate and explore the experiences of young women's sexual lives are of paramount importance as some young women might find questions about their sexual lives embarrassing.

This study was conducted through a literature review and empirical research. An empirical investigation was conducted in this study using both qualitative and quantitative methods to acquire data that would strengthen the trustworthiness and validity of the research. The term empirical refers to knowledge that is based on observed and measured phenomena and derives knowledge from inquiries rather than from theory or belief (Cahoy, 2018). Empirical research has specific research questions and a description of the methods that are used to answer the research questions. Therefore, the process of collecting and analysing data must be well thought and planned. This is because the purpose of collecting data is to address the problem of the study.

The research problem under consideration in this study focused on the effects of customary marriages as one of the many cultural practices which disregard women's rights. Customary marriage is a marriage concluded according to black beliefs and customs. Customary marriage validates patriarchy, which disadvantages women by placing them in an inferior position thus promoting inequality between women and men. The study sought to answer the following four main research questions:

- What is the relationship between customary marriage and gender equality?
- How does customary marriage affect young women's sexual and reproductive health rights?
- What are the obstacles to the realisation of young women's sexual and reproductive health rights?
- How is the sexual relationship power in customary marriage?
- Which interventions can support and promote gender equality and young women's sexual and reproductive health rights?

An effort by the research participants to answer these research questions helped the researcher to understand the effects of customary marriages on women's rights in South Africa and Zimbabwe. This chapter also discussed the methodological framework of the study.

The study employed a comparative analysis to first establish experiences within customary marriages and its influences on the sexual and reproductive health rights of women within these countries. These were used to demonstrate commonalities and/or differences concerning sexual and reproductive health rights on customary marriages in South Africa and Zimbabwe. In the end, the commonalities and/ or divergences on sexual and reproductive health rights helped determine the role of customary marriages in promoting or undermining women's sexual and reproductive health rights.

4.2 Role of the researcher

The researcher's role in quantitative and qualitative studies is different. In the former, the role of the researcher is close to non-existent as participants act independently while in the latter it is rather difficult as the data is communicated to the researcher through interviews rather than through questionnaires (Simon, n.d). When a researcher acknowledges subjectivity he or she can account for what led the researcher to investigate the phenomena under study. The researcher as an interviewer plays an important role in how the interviewees construct their reality. The researcher as an unmarried independent Shona woman working towards establishing her professional career and also a holder of a Bachelor of Laws degree is a bit assertive about rights as she is knowledgeable on the aspect. The researcher has found that as a holder of a Bachelor of Laws degree she would be more comfortable if principles of egalitarianism were adopted within marriages. This is because women in marriages in the 21st century are also sharing the burdens and benefits of maintaining the household with their husbands. Given this background, it is easy for the researcher to identify and understand different views being presented by participants. As a result of her cultural background, it equipped the researcher with a better understanding of the social relationship that informs the situation under investigation. The researcher had to make sure that she does not impose her values or opinions on the participants during the interviews. This is to ensure that all the views on the effects of customary marriages on young women's sexual and reproductive health rights are based on the perspective of the participants.

4.3 Research paradigm

A researcher must possess an understanding of the philosophies that guide the principles of research. According to Fielzer (2010), a paradigm is a worldwide view that is a pattern accepted to organise a deeper philosophical position that relates to the nature of the social phenomena or structure. The philosophy of research explains the development and nature of all knowledge and comprises two categories which are ontology and epistemology.

According to Stabb and Studer (2010), the term ontology is used with different meanings in different communities. Ontology focuses on the nature and meaning of independent things. To this, Ahmed (2008) posits that ontology is the study of being and concerns itself with what kind of world we are investigating. Having provided the above definition for ontology, it is now worth identifying the ontology of this study. This study uses ontology which as defined above requires the researcher to assume that the world being investigated has human beings who have their thoughts, beliefs, and different ways of interpretations and meaning-making. Hence, the investigation by the researcher of the phenomenon under study was manifested by the employment of two research methods and techniques of interpretive design such as interviews to interpret the perceptions and views of young women in customary marriages. Furthermore, using the case study as a method in this study helped to focus on the young women's inner thoughts on the effects of customary marriages on their sexual and reproductive health rights.

On the other hand, epistemology is the study of knowledge and its sources. It is the information that is commonly understood by the laymen and it is necessary for knowledge and with the absence of it, people remain ignorant (Dretske, n.d). Therefore, questions of sources, structure, and limits and forms of knowledge are part of the epistemological view. In this study, the researcher sought a causal relationship between the effects of customary marriages and the sexual and reproductive health of young women.

4.3.1 Pragmatism

Pragmatists are of the view that the truth is what works to understand a research problem (Patton, 2014). The main argument by pragmatists is that qualitative and quantitative methods can be mixed because both approaches have similarities in fundamental approaches which allows combination in the same study (Maree, 2016). This is to say that it considers what works best to answer the research questions. Creswell (2014) articulates how pragmatism fits with the mixed methods approach as it states that the truth is what works at the time and it

contrasts between the mind and reality. Therefore, the adoption of mixed methods approaches assists in giving a more complete picture of reality (Berger & Kuckertz, 2016). With the use of mixed methods, the researcher can maintain subjectivity on their views on the research and objectivity while collecting and analysing the data (Shannon-Baker, 2016). It can be concluded that pragmatism offers a reason for combining both qualitative and quantitative approaches.

Dures *et al.* (2010) state that mixed methods researchers frame their work based on the intended purposes and what they hope will be achieved therefore the researchers must provide the rationale why both approaches will help in doing so. This means that pragmatic research is driven by a purpose with the belief that each approach has its contribution (McInerney *et al.*, 2011). Hence the research questions will determine the methods, techniques, and sources of data. This allowed the researcher in this study to "zero in" on the effects of customary marriages on young women's sexual and reproductive health rights and to "zoom-out" and look at the bigger picture by generalising the results to the population.

Brierley (2017:15) states that

> "*Furthermore, when paradigms are defined as shared beliefs among members of a speciality area this means that there is less emphasis on the ontological and epistemological perspective adopted for the research and more on developing a consensus as to which methods work and can be established as the speciality area*."

As a consequence of the two schools of thought, that is, ontology and epistemology, the differences between paradigms are not of significance but what is important to pragmatists is what the research seeks to achieve and the methods used to achieve it (Smith *et al.*, 2012).

4.4. Research approach

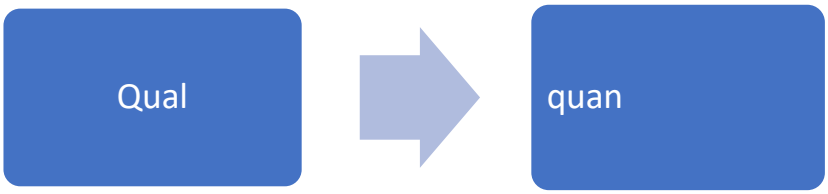
This research sought to analyse customary marriages and young women's sexual and reproductive health rights, most research conducted in this domain focuses on adolescents and sexual and reproductive programmes not the effects of customary marriages. Therefore, a research design was needed that could allow new themes to emerge. The purpose of a two-

phase exploratory design was to utilise the results of the first method (qualitative) to assist in informing the second phase (quantitative).

This study can be looked at from an application perspective, objective perspective, and mode of inquiry perspective. From the application perspective, the research is pure because it seeks to develop a research instrument that assesses the effects of customary marriages on the sexual and reproductive health rights of young women. On the other hand, from the perspective of objectives, this research is descriptive and exploratory in that it is designed to; (a) determine the relationship between customary marriages and gender equality, (b) explore the effects of customary marriages on young women's sexual and reproductive health rights, (c) identify obstacles to the realisation of young women's sexual and reproductive health rights (d) to investigate sexual relationship power in customary marriages (e) to formulate interventions that can support and promote gender equality and young women's sexual and reproductive health rights in customary marriages. Finally, from the perspective of the mode of inquiry, the study used a mixed methodological approach as opposed to a qualitative or quantitative approach only.

This study used the sequential exploratory mixed methods approach. According to Hesse-Biber (2010), sequential designs utilise the analysis of one form of data to inform the collection of the second form of data. The second phase has a task of providing evidence that supports the initial qualitative findings.

FIGURE 3: EXPLORATORY SEQUENTIAL DESIGN OVERVIEW



Source: Creswell (2003:213).

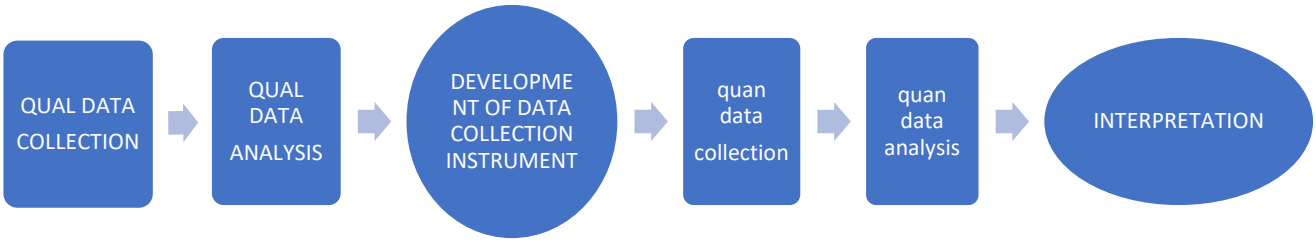
Using a design that begins qualitatively is desirable for exploring a phenomenon and is also suitable for generalising results to different groups. Sequential exploratory designs are used when the researcher wants to generalise the findings from the qualitative study with a larger

sample gathered using the quantitative study and to explore the phenomena in depth and measuring its prevalence (Petrosyan, n.d). Scholars like Creswell and Plano-Clark (2011) and Canales (2013) argue that the most valuable benefit that comes with using a mixed method design is its ability to focus on the research problem and outcome than being focused on explaining and endeavouring to avoid the short-comings of using a single method. The reasons for using a sequential mixed method approach is for triangulation, complementarity, expansion and development (Isakander, 2013). This brings to light the conclusions made by Venkatesh *et al*. (2013), which shows that the seven purposes of mixed method research are complementarity, completeness, development, expansion, confirmation, compensation and diversity.

Of the purposes of a sequential mixed methods design this study attempted to achieve the benefits of triangulation, complementarity, completeness and development. Triangulation was sought for through comparing the findings from the in-depth interview with that of the survey. According to Acet Incorporated (2013), triangulation helped to synergise the strengths of both qualitative and quantitative approaches. Beyene (2016) explains that triangulation deals with the use of different sources of data with the intention of corroborating findings while expansion occurs when it is necessary to expand the breadth of inquiry for a phenomenon that requires different methods of knowing. Triangulation can also be used for completeness purpose as Hussein (2009) puts it forward that researchers can use it to enhance their in-depth understanding of the problem being investigated using multiple methods and theories. O'Cathain *et al.* (2010) are of the view that the process of triangulation takes place at the interpretation stage of the data that will be analysed separately. In this case, using triangulation helped to provide a detailed understanding of the phenomenon being investigated, by collecting data qualitatively through interviewing women and men about their experiences in customary marriages. On the other hand, the quantitative data collection helped to generalize the overall experience of women in South Africa and Zimbabwe with regards to customary marriages and sexual and reproductive health rights by determining how is the sexual relationship power in customary marriages. Therefore, the sequential mixed method approach was employed to quantitatively provide a thorough assessment of the extent of the problem while qualitative approach was used to explore and provide an in-depth understanding of the phenomena (Kaur, 2016). The researcher listed the findings from each strand and considered where the findings converged or where there is a discrepancy.

Development occurred through the use of the qualitative findings from the in-depth interview to develop the quantitative survey. When it came to complementarity the interviews with the young women revealed several factors which affects their sexual and reproductive health and the survey was used to determine the sexual relationship power through decision dominance and relationship control of each factor using statistical analysis. Hence it should be noted that in this study, the goal of capturing the lived experiences of young women was tremendously enhanced as a consequence of adding depth to the qualitative data by using this design.

FIGURE 4: STAGES OF THIS SEQUENTIAL EXPLORATORY RESEARCH



Source: **Polat *et al.* (2015).**

TABLE 1: RESEARCH PROCESS OF THIS STUDY

Process	Process	Process	Process	Process	Process
Interpretation and explanation of qualitative and quantitative data	Data coding	Survey (N=802)	Writing questions based on qualitative data	Transcribing	Semi-structured interview (N=17)
	Analysis with SPSS version 25.0				
	Descriptive statistics				
Products	Products	Products	Products	Products	Products
Discussion of findings	Numeric data	Numeric data	5 point Likert scale questionnaire	Coded document	Non-numerical data (words)
Conclusion and recommendations	Frequencies, descriptive, cross-tabulation			Development of patterns	

Source: Developed for this study by the researcher

Table 1 above shows the mixed method sequential exploratory design of this study. It shows how the design was made use of in this study.

Weighting: This refers to the importance that is given to the two forms of data in a study. One form of data can be prioritised over the other or both data forms can have equal weight in the study (Creswell & Plano-Clark, 2007). In this study priority was given to the qualitative part of the study. This is the case because the qualitative phase of the study brought in an in-depth exploration and understanding of the effects of customary marriages on the sexual and reproductive health rights of young women in South Africa and Zimbabwe. In this study, the exploratory design first explored qualitatively women's experiences in customary marriages. Patterns and statements generated from this phase of the study were then used to develop a survey instrument from a larger sample of young women. The second phase was a quantitative description based on the results generated from the first phase (qualitative phase).

Integration: In mixed methods integration of data happens in a variety of ways, at the design level, interpretation level, at the methodology level or a combination of places (Fetters *et al.*, 2013; Berman, 2017). Creswell and Plano-Clark (2007:83) state that;

> "*a study that includes both qualitative and quantitative methods without explicitly mixing the data derived from each is simply a collection of multiple-methods. A rigorous and strong mixed methods design addresses the decision of how to mix the data in addition to timing and weighting*."

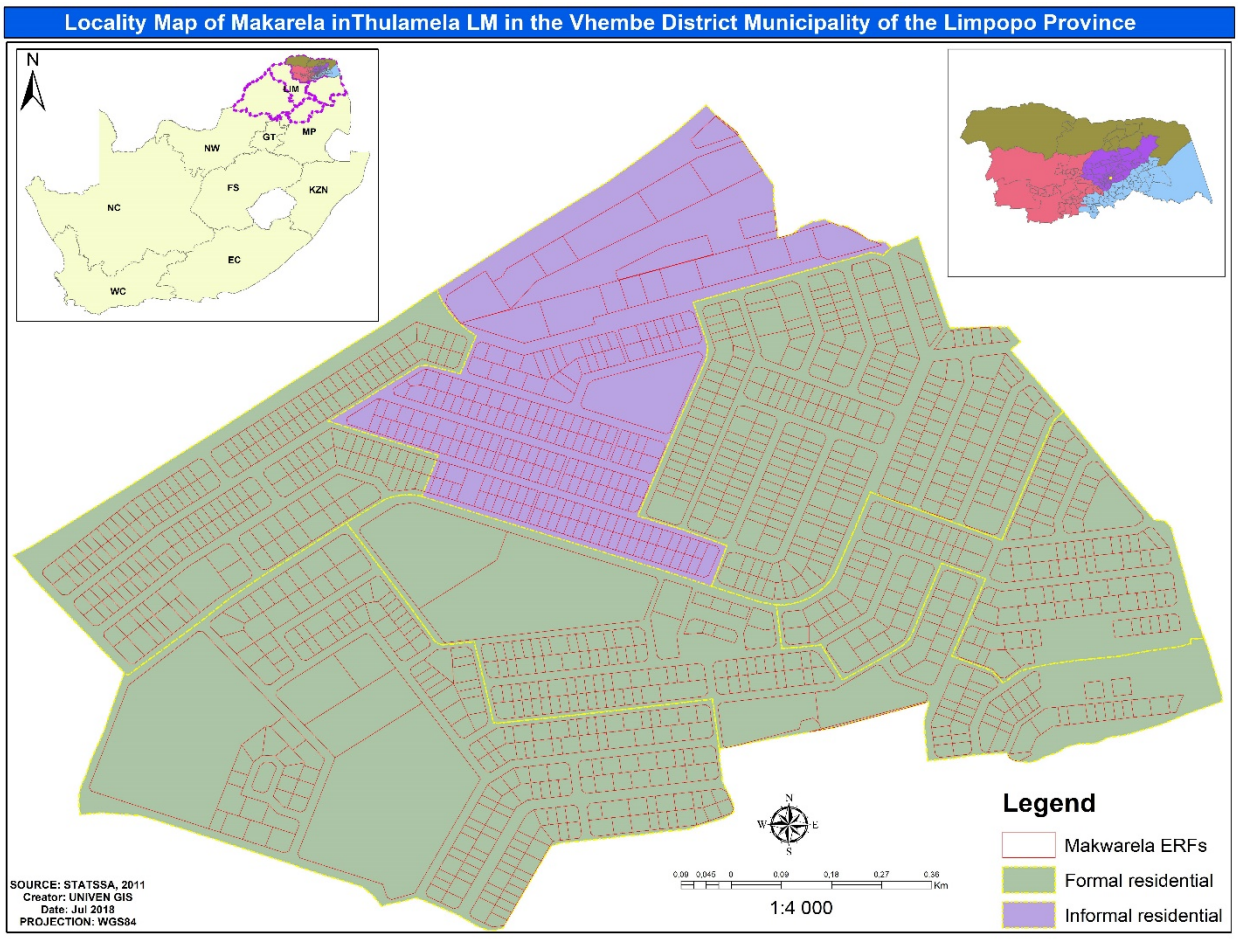
In this study integration occurred at different stages of the research. Firstly, the research question (what are the obstacles to the realisation of young women's sexual and reproductive health rights?) has both qualitative and quantitative components and this enabled data integration during the initial phase of the research. Secondly, the qualitative method was connected to the quantitative method by collecting and analysing the qualitative data first then using the findings to develop an instrument for the quantitative phase. These findings in other words was used to categorise what to study quantitatively. In using this approach (e.g. John-Akinola, 2014) the data from the first phase (qualitative) was used to design a quantitative instrument to determine the relationship between customary marriages and gender equality. Thirdly the data was merged during the data presentation phase but qualitative and quantitative findings will be reported in different sections. The discussion chapter merged the

findings with the purpose of the study: to analyse the effects of customary marriages on young women's sexual and reproductive health rights.

4.5 Study location

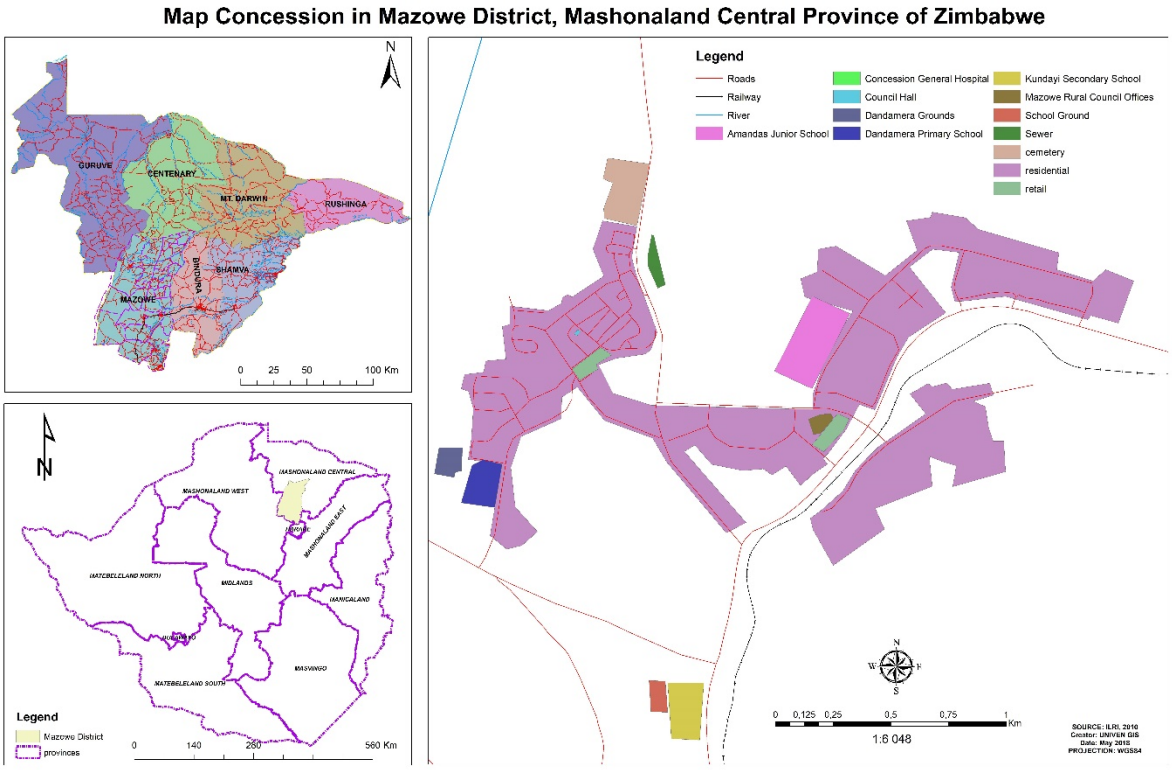
The study was conducted in Concession, which is a peri-urban town in Mazowe district, outside Harare, Zimbabwe. The study was also conducted in Makwarela which is also a peri-urban area in Limpopo, South Africa.

FIGURE 5: MAP OF MAKWARELA



Source: Farai Dondofema, Urban and Regional Planning, University of Venda 22 July 2018

FIGURE 6: MAP OF CONCESSION



Source: Farai Dondofema, Urban and Regional Planning, University of Venda 22 July 2018

The study locations were chosen due to them being a typical representation of young people. It was important to capture the different perspectives on the effects of customary marriages on young women's sexual and reproductive health rights. The rationale for conducting such a study in Zimbabwe and South Africa is that, South Africa seems to have an extensive protection and enforcement of human rights issues when compared to Zimbabwe. Historically, both countries were under colonial and apartheid rule, and after the attainment of independence; policies to advance human rights were put in place. However, the two countries seem not to have pursued the promotion of gender equality in the same way this can be evidenced from the mere fact that South Africa has more legal instruments that promote, protect and advance gender equality. Therefore, this study assessed the extent of progress made, particularly on the promotion of women's sexual and reproductive health rights and gender equality in Zimbabwe and South Africa.

4.6 Study population

The choice of population solely depends on the nature of the study and what the researcher seeks to achieve. The population of this study was young African Zimbabwean and South African women between 18 and 40 years of age and in customary marriages. The focus on this age group is that they are women within the reproductive age. The researcher also interviewed men in customary marriages aged between 20 and 45 years to solicit their perceptions on gender equality and women's sexual and reproductive health. The researcher recruited the participants separately not as couples. The researcher alternated the gender to conduct the interviews with for each household visited for the interview. However, men were only interviewed for the qualitative phase of the study.

4.7 Phase 1

4.7.1 Qualitative approach

Qualitative research places a strong emphasis on understanding and exploring issues inductively, that is, through the collected data which consists of an insider's viewpoint on the subject matter (Almalki, 2016). In this study, qualitative research centred on how young women make sense of the effects of customary marriages on sexual and reproductive health rights and young men on gender equality in marriages. Hesse-Biber and Leavy (2011) state that the central part of qualitative research is the social meanings that can be extracted from the data based on people's personal experiences and circumstances. In this study, the researcher collected qualitative data intending to understand the interplay between the issues of gender inequality as well as sexual and reproductive health rights of young women. The rationale of using qualitative research is that the researcher can acquire in-depth information on the effects of customary marriages on young women's sexual and reproductive health rights.

4.7.2 Qualitative research design

A comparative case study research design was used for the qualitative part of the study. Williams (2007) posits that a case study attempts to inquire more about a situation. This, therefore, means that the data collection for a case study must be rigorous through the interviews by the researcher. The main reason for a case study design is to answer the how

and why questions of the phenomenon of interest (Yazan, 2015). The advantage of using a case study is that, it could connect to people's everyday life and it provides a rich description of people's experiences. This is also confirmed by Starman (2013) who contends that a case study is an analysis, or description of a group of people, or individuals to identify the interaction among participants, connecting with their everyday life. In this study, a multiple case study approach was used, wherein the effects of customary marriages on gender equality, sexual and reproductive health rights of young women in selected Makwarela (South Africa) and Concession (Zimbabwe) was investigated. The strength of using a case study lies in the fact that the researcher could understand a phenomenon in society through relation with the people or community being studied.

Comparative cross-national research helped in identifying the similarities and differences amongst people in society, while generating in-depth contextual understanding of the phenomenon being investigated (Mare, 2015). Alasuutari *et al.,* (2008:252) explain the importance of comparative cross-sectional study as follows:

> "*A case-based comparative cross-sectional research is based on the view that the whole is greater than the sum of the parts and that parts cannot be understood without reference to the whole rather than proceeding by isolating and measuring discreet variables in each country, case-based designs seek to build a rounded understanding of each country regarding the phenomenon being investigated*."

A cross-national research plays an important role in contrasting observations among different people and societies which also acts as a powerful change-maker in the modern world (Uddin *et al.*, 2012). Hantrais and Mangen (2013) concur and state that cross-national research aids in developing a robust understanding between similarities or differences across nations either to draw conclusions or learn about best practices which in turn assist with a better understanding of the social process.

4.7.3 Sampling strategy and sample size in qualitative research

4.7.3.1 Sampling strategy

Data collection is important in research as the data is meant to contribute to a better understanding of the phenomena under investigation. Against this backdrop, it became important to acquire data based on sound judgement bearing in mind that no amount of data analysis can compensate for data that was wrongly collected. Researchers use their understanding on their experience or findings from previous studies to acquire units from the population from which they can sample. Non-probability sampling procedure was used for the selection of young women and men in South Africa and Zimbabwe in customary marriages. Merriam (2009) suggests that because case study analysis deals with answering the research questions of the study, probability sampling will not work for this. To this Rai and Thapa (n.d) opine that non-probability sampling technique requires that the researchers concern themselves with the people only to be included in the sample based on several criteria including specialist knowledge on the phenomena under investigation or the ability and consent to take part in the study. For this sole reason purposive sampling was used to select participants. This sampling technique is also known as judgmental sampling, wherein the probability of any element within the population to be included is not precise (Alvi, 2016). Merriam (2009) further states that this technique enables the researcher to pick case studies that are rich with information. Teddlie and Fu (2007) are of the view that this sampling technique is mainly used in qualitative studies and can be characterised by selecting individuals based on a specific purpose which is to answer the research questions. The researcher selects what needs to be known, and sets out who is in the best position to provide such information (Battaglia, 2008; Etikan *et al.*, 2016). The participants have a key demographic characteristic, in this case, the participants are young women and who reside in Concession (Zimbabwe) and Makwarela (South Africa) aged between 18 and 40. The researcher also interviewed men in customary marriages aged between 20 and 45 who reside in Concession (Zimbabwe) and Makwarela (South Africa). The selection of a sample, required the researcher to purposively sample the participants who have a certain characteristic.

Therefore, the researcher specifically used snowball sampling technique to identify and select the participants (i.e. men and women in customary marriages). This technique is a subtype of non-probability sampling method. It is used for populations that are not easily accessible (Shaghaghi *et al.*, 2011). This study used the linear sampling method in which a single participant will nominate the second and the second will nominate the third participant (Etikan

et al., 2016). The researcher therefore firstly assumed that there is a network of the study subjects that exists and hoped to be linked with the network through interaction with the first subject.

However, there are limitations of this sampling technique which is that it can tend to be biased as a friend can make referral to another friend. To overcome this aspect, the researcher did not interview the one referred but rather asked the one referred to refer to another.

4.7.3.2 Sample size

According to Creswell and Plano-Clark (2007:123), in exploratory designs there are different procedures. The individuals for this part of the study are not the same participants as this sample is smaller and it also reduces bias by sampling the same people for the quantitative part of the study. The number of participants that the researcher involved was determined by the point at which the researcher will reach data saturation. Failure to reach a point of data saturation negatively impacts the quality of the research conducted and this hinders content validity (Burmeister & Aitken, 2012; Fusch & Ness, 2015). The researcher reached a point of saturation with 17 participants (9 women and 8 men) from both countries with which there was an attainment of depth in data and no further data was required. According to Etikan *et al.* (2016), purposive sampling places an emphasis on saturation through on-going sampling until no new information is obtained.

4.7.4 Qualitative data collection

For the qualitative part of the study semi-structured interview guide will be used. According to Ryan *et al.* (2016), interviews are a valuable method of collecting data through the construction and conciliation of meanings in a natural setting. In this study, the researcher sought to unpack the everyday lived experiences of women in customary marriages. With this type of interview, the researcher had predetermined questions which were modified according to the situation at hand. Through the use of a semi-structured interview, the researcher can probe for more information, therefore, it allows depth to be achieved by allowing the participants to expand on their answers (Chilisa & Nteane, 2010). The researcher used face to face interviews. This offers the researcher an opportunity to expand the line of enquiry, follow up on issues in a way that a questionnaire cannot provide (Vuttanont, 2010).

McDowell (2010) and Walton (2016) put it forward that the purpose of an interview is to explore and gain a better understanding that explains human and environmental relationships at the same time providing the reasons why people act the way they do. An interview therefore paints a fuller picture of the situation. The researcher hoped that the interviews would explain how human relationships within customary marriages affect sexual and reproductive health rights of young women.

The researcher had key themes, issues and questions on women's rights and the barriers involved in accessing the rights. The researcher asked questions on gender equality, women's sexual and reproductive health to determine the relationship between these and customary marriages. The main advantage of this type of interview is that, it allows previously unknown information to emerge and the fact that, interviews are conducted face to face they yield rich data (O'Keefe *et al*., 2013). Semi-structured interviews also allowed the researcher to make follow ups for clarification. Participants in semi-structured interviews can be regarded as experts because of their experiences. This provided the researcher with new and original information on the phenomenon being investigated in this study. The researcher used a tape recorder to ensure that all the responses were recorded and then transcribed in verbatim during the data management and analysis phase.

4.7.5 Qualitative data analysis

The researcher used narrative analysis as a method of analysing qualitative data. It is used to find out how participants in interviews respond on the flow of their experiences to draw meaning from the events of their lives. Through this method, the researcher was able to identify, analyse and to report the stories that were constructed around women's rights during the interview process. According to Squire (2013), narrative analysis is designed to investigate, not just only how stories are structured but, also how meanings can be construed. However, it can be argued that narratives seek to explain events that have occurred. This method enables the researcher to decode, make sense and meaning from the participants' experiences (Bamberg, 2012).

Narratives do not only record what happened but they are selective arrangements of material (Brown *et al.*, 2010). Riesmann (2008) opines that the goal of narrative analysis is therefore

to keep a story intact through theorising from the available narratives. In this study, the researcher will engage in narrative analysis using a naturalistic approach. A naturalistic approach involves the rich description of the content of people's stories about significant issues (McAlpine, 2016). The researcher used the semi-structured interview as a means to derive the narrative. This method was very imperative to the researcher as the researcher seeks to stay close to the words of the participants. Narrative analysis is said to concern itself with how a person's narrative is moulded by cultural and historical context which the researcher believed would be significant in this study. Therefore, from this point of reasoning it seemed logical to study the storied-experiences of young women in customary marriages through the exploration of young female's stories and young men through their experiences on gender power dynamics in customary marriages, patterns can be revealed.

Gergen and Gergen (1984) were one of the first authors to put forward the elements and form in narrative construction and they suggest two components. Firstly, to succeed as a narrative the account must establish a goal which might be a discovery of something important and the description of the events must be related to the state of the goal. Bamberg (2010) concurs with the above and states that narratives provide an entrance into two realms which are that individuals provide subjective meanings to their experiences and the narrative means that are put in place to make sense. Therefore, the researcher as the analyst in this case placed an importance on analysing the narrative means to better understand the effects of customary marriages on young women's sexual and reproductive health rights.

To thoroughly analyse data from the field Riessman's (1993) widely used narrative analysis was employed. Riessman discussed three steps to narrative analysis which are telling, transcribing and analysing.

1. Telling

   The interview guide was used to produce a narrative of the effects of customary marriages on young women's sexual and reproductive health rights. The details from the narratives are the ones that hold the complexity of the effects of customary marriages on the sexual and reproductive health rights of young women. The widely-used method of analysing language by Burke (1945) brings forward how a narrative must contain several common elements: (i) act (describing what was done, what were the thoughts, what is going on). Example of a questions that addressed the act are "in your culture, what are your thoughts about men and women's position with regards to how they interact within customary marriages?" and "in your culture, what are your

thoughts about men and women's position with regards to how they interact within customary marriages?" (ii) scene (where and when was it done, background of the situation). A typical example is this question "in your own opinion, which roles are generally performed by men and women in Zimbabwe and South Africa. Do you think these roles played by men and women promote or undermine gender equality within customary marriages? Explain." (iii) agent (who did it, what are their roles). A question like "do you observe cultural practices in customary marriages? Explain," was formulated using this guide. (iv) purpose (why did they do it). Typical question is "please give us any other practice conducted under the guise of culture in customary marriages that affect your sexual and reproductive health rights." These are some of the examples of how the interview guide questions where structured in accordance to the above-mentioned method.

2. Transcribing

   The interview data was recorded by the researcher using an audio recording tape to enable transcriptions in verbatim.

3. Analysis

   The researcher manually made notes in the margins to help connect the data. Thereafter recurring language, opinions, and beliefs were identified using the participants' language. From this the researcher chose the best content to use to tell the story from the data.

4.8 Phase 2

4.8.1 Quantitative approach

Quantitative research approach is also deductive (Rovai *et al.*, 2014). Quantitative research is an objective process which uses numerical data collected from the target population to generalize the findings to the population (Maree, 2016). The three important elements of quantitative research process are objectivity, numbers and data. Quantitative research depends on the use of numerical data to test relationships between variables (Charles & Mertler, 2010). This, therefore, means that when using quantitative approach in this study, the researcher looked for the probable causes and effects of customary marriages on young women's sexual and reproductive health rights. To realise that, numerical data was used to determine the relationship between customary marriages, sexual and reproductive health rights as well as gender equality and to assess the sexual relationship power in customary marriages. Using numerical data was useful in ascertaining the severity of the situation as it produces a large amount of data that can be generalised to the population.

4.8.2 Quantitative research design

Ponelis (2015) defines research design as a logical plan that connects the research purpose and questions to the processes for practical data collection, and analysis to make conclusions from the data. The study used a survey research design which is a subtype of non-experimental research design for the quantitative part of the study. A survey is based on pre-coded responses with given options wherein the participants answer by picking one of the responses (De Jonge *et al.*, 2017).

The study used the cross-sectional survey with data collected at one point in time. A cross-sectional is a study in which all the measurements are collected at a single point in time although recruitment may take place over time (Sedgwick, 2014). Cross-sectional survey was ideal for this study because participants might be more willing to participate in a one-time survey than multiple surveys conducted over time (Lavrakas, 2008). According to Jones (2014), in a cross-sectional survey, relationships are identified from the data at hand which in turn assist to generate a causal hypothesis. In this study, a survey assisted the researcher in determining the distribution of certain behaviours and attitudes so that the researcher can ascertain how behaviours of young women and societal attitudes and expectations have an impact on the sexual and reproductive health rights of young women in customary marriages.

In this study, the purpose of a cross-sectional survey research design was to generalize the inferences made by the study population on the effects of customary marriages, gender equality, sexual and reproductive health rights with regards to young women. An advantage of using a survey research design is that, it is cost effective and there is a rapid turnaround in data collection (Creswell, 2014).

4.8.3 Sampling strategy and sample size in quantitative research

4.8.3.1 Sampling strategy

Probability sampling technique is a procedure that ensures that, each element in the target population has a probability of being selected in the sample (Terre Blanche *et al.*, 2016). Simple random sampling technique which is a subtype of probability sampling was used for the quantitative phase. The sample may be obtained through the selection in which all the

members of the population have an equal chance of being included (Alvi, 2016). The researcher by using this technique screened pre-selected addresses which involved drawing a very large population sample and asking two brief questions at the “doorstep” to establish if the individual falls within the relevant group for example if they are in a recognised union and which type. Alvi (2016) is of the view that in random sampling the population must contain some characteristics that meets the criteria described by the researcher. The survey was conducted only with young women. This type of sampling guaranteed every female in Concession (Zimbabwe) and Makwarela (South Africa) an equal chance to be selected if they meet the criteria for the study population. Latham (2007), sheds light on this type of procedure, by articulating that, each member of the population is selected individually. The advantages of using this kind of sampling technique are that it is easy to implement and the researcher also requires little knowledge of the population in advance.

4.8.3.2 Sample size

To determine the sample size for this study the researcher used Cochran’s formula to calculate sample size which was calculated as follows:

$$n = \frac{\left(Z_{1-\frac{\alpha}{2}}\right)^2 P(1-P)(1+r)n_{strata}}{e^2}$$

Where n is the sample size

$P = 39\%$ is the estimated gender inequality index in South Africa (UNDP, 2018)

$Z_{1-\frac{\alpha}{2}} = 1.96$ is the standard normal variate at the 5% significance level

$r = 10\%$ is the non-response rate

$e = 5\%$ is the margin of error

$n_{strata} = 2$ is the number of strata (countries)

Substituting the under listed parameters in the model, the sample size required is:

$$= \frac{(1.96)^2 \times 0.39 \times (1-0.39)(1+0.1) \times 2}{0.05^2}$$

$$= 802$$

Based on the above calculation, the sample size for the study is 802. Therefore, the researcher will sample 401 participants from each country.

4.8.4 Quantitative data collection method

For the quantitative part of the study, a structured questionnaire was used to interview participants. A closed ended questionnaire has possible answers defined in advance. Questionnaires are ideal because they seek facts and knowledge. They also find accurate information without the influence of the researcher. According to Vuttanont (2010), a questionnaire provides numerical data which requires statistical testing.

The study used self-administered questionnaire which is ideal for collecting data on young women's sexual and reproductive health rights as it diminishes vestiges of bias on the part of researcher because of its objectivity. According to Van Teijlingen (2014), the merits of using a questionnaire is that it is short, easy to follow, cheaper, quicker to administer and convenient for the participants. The questionnaire had a Likert scale as category partition method to record the responses of the participants in order of the frequency, strength and depth of the extent of customary marriages on the sexual and reproductive health of young women. Through the use of a Likert scale, the researcher was required to design a questionnaire which had indications of the extent of agreement with a particular question. In this study, a five-point Likert scale was used to enable scores of either strongly agree to disagree to represent the extent of the knowledge, opinion, judgment and experience of the participants about the effects of customary marriage on gender equality as well as their sexual and reproductive health.

The researcher designed a questionnaire which was completed anonymously. The researcher also assigned identity numbers to each questionnaire. To deal with incomplete questionnaires the researcher and the assistants rechecked the questionnaire for completion upon collection of the questionnaire from the participant. A brief introduction on what the study is about was provided in the questionnaire and also important information on the completion of the questionnaire. The questionnaire was formulated in line with the findings from the qualitative phase, literature review, the theoretical framework as well as the semi-structured interview guide to answer the research questions. The questionnaire sought responses on the relationship control and decision dominance with questions of who decides on sex and family size, whether the wife has the right to refuse sex and if husbands are to have sex whenever they desire despite the will and wishes of the wife.

4.8.5 Quantitative data analysis

Quantitative data was analysed using Statistical Package for the Social Science (SPSS) software. SPSS software is a package that contains programs meant to manipulate, analyse and present data. According to Field (2009), SPSS can be used to perform data entry, analysis and create tables and graphs.

The data was cleaned in three stages. The first stage was in the field, where the researcher and research assistants looked through completed questionnaires to ensure completeness and to correct all errors that they identify. Secondly, the questionnaires were cross-checked randomly to verify if the data have been correctly captured. The final stage was to code and capture data sets to be generated and cleaned before analysis and interpretation. The data analysis involved descriptive analysis and testing for significance of associations which will be carried out in the data that was collected. Descriptive statistics allowed data to be organised and presented using tables and graphs.

The quantitative data was subject to four levels of analysis. The first level involved the examination of the distribution of the respondents according to the characteristics selected by the researcher. This is borne out of the fact that behaviour of individuals in society is, to a great extent, influenced by their circumstances as well as the environment in which they live. Thus, it was expected that sexual and reproductive health is greatly determined by background characteristics such as employment status, state of marriage, age of spouse and if they chose their partner. Hence simple percentages were employed to describe these relationships.

A second step was implemented with a two-multiple regression analysis to determine if a woman's ability to make decisions about family size is based on age, employment and state of marriage and whether ability to decide on sex is based on age, employment status and state of marriage.

The third step was descriptive statistics on whether women have autonomous decision-making in customary marriages was carried out and population characteristics were summarised in percentages (for categorical outcomes) and means for continuous measures. Descriptive statistics were also ran on relationship control, that is, whether husbands must

have sex whenever they desire, right of the wife to refuse sex and that use of condoms can cause disagreements and sometimes violence. The results were also summarised in percentages and presented in tables and graphs.

Finally, a cross tabulation analysis was also done between the variable women should freely enjoy their sexual and reproductive health and five other variables namely culture plays a vital role on the sexual and reproductive health of young women, the practice of wife inheritance places young widows at the risk of contracting HIV/AIDS and other sexually transmitted diseases, the practice of wife inheritance is indeed a harmful practice for women, polygamous marriages are an agent that transmits HIV/AIDS and women in a polygamous marriage find it impossible to assert their sexual and reproductive rights. The analysis was used to test the relationship, using the Pearson's Chi Square between the independent variables and the dependent variable.

4.9 Inclusion criteria

The inclusion criteria were married young women aged between 18 and 40 years and young men married aged between 20 and 45 years customarily married residing in the study area during the study period; and voluntarily willing to take part in the study.

4.10 Exclusion criteria

Potential participants in the selected areas who were either unmarried, customarily married but over 40 years of age for females and over 45 years of age for the males or visitors who do not reside in the study area but stay there during the survey period were excluded from the study.

4.11 Reliability and validity

Reliability and validity are needed to be present in the research methodology of a study but a brief and concise manner. These two principles reduce the bias by the researcher in qualitative studies (Singh, 2014) through increasing transparency.

4.11.1 Validity

One of the first proponents of the doctrine of validity was Messick (1989:6) who states that validity "…*always refers to the degree to which empirical evidences and theoretical rationales support the adequacy and appropriateness of the interpretations and actions based on test score.*" In this study, this viewpoint was followed. Also, Pallant (2011) posits that validity requires that the questionnaire correctly measure the concepts that are under the study. Internal validity of the data from the research and the instruments can be enhanced through triangulation which is the collection of data through different sources in this case the researcher used a questionnaire and a semi-structured interview. Mohammad (2013) adds that triangulation assists researchers in gaining both types of data to corroborate the findings. In qualitative research validity refers to the credibility of the results that the evidence yielded and the subsequent conclusions that were informed by the lived experiences of the participants which the researcher needs to demonstrate an understanding on (Lukka & Modell, 2010; Christensen *et al.*, 2014). To this Ihantola and Kahn (2011) postulate that the crucial question to ask is whether the study indeed captured the phenomena it intended on capturing.

The researcher also used face validity to validate the survey. The researcher distributed the questionnaire to fellow PhD candidates in the Institute for Gender and Youth Studies and the Department of Public Health to seek their opinions on the questionnaire to assess whether the questions effectively capture the topic under investigation or not. A statistician was also asked to check if the research instrument effectively measured the phenomenon being investigated in this study. The participants were also asked to comment on the location of the items, grammatical structure and the necessity of adding or removing some of the questions.

4.11.2 Reliability

Babbie (2014:152) defines reliability "*as a matter of whether a particular technique applied repeatedly to the same objects yields the same result each time*…" This is in the case of quantitative studies while in qualitative studies it is referred to as when a researcher's approach is consistent across different projects (Mohajan, 2017). This means that reliability concerns itself with the measure of precision, repeatability, consistency and trustworthiness (Chakrabartty, 2013).

The researcher used Cronbach's Alpha (α) to measure the internal consistency. The scores of all 802 participants were entered in an Excel spreadsheet then a reliability test was conducted using SPSS. Guidelines for the interpretation of Cronbach's alpha coefficient have been suggested by many researcher and they seem to agree that:

- 0.90-high reliability
- 0.80-moderate reliability
- 0.70-low reliability

Based on the above, when items are strongly correlated with each other, their internal consistency is high and the alpha coefficient will be close to one. In this study the researcher used SPSS to measure the internal consistency. The researcher measured the internal consistency and acquired a value Cronbach's α .801 which was above .7 as this indicates a good internal consistency.

4.12 Ethical considerations

Research ethics involves the conduct requirements of day–to-day contact in the field, which includes the protection of dignity and publications of information in the research. For this study the researcher used informed consent, no harm, respect for privacy and respect for anonymity and confidentiality. The researcher also sought permission from the University of Venda Ethics and Publications Committee to collect data for this study.

4.12.1 Informed consent

The research participants should make informed decisions to participate in the research voluntarily. To do this they need to have adequate information on the possible dangers that might ensue from the study, if any (Fouka & Mantzokou, 2011). This principle ensures that participants are not coerced into participating. Informed consent entails three main principles, which are; information, voluntariness and comprehension. Therefore, the researcher introduced the study, its purpose and rationale for the selection of the participants and the procedures which follow. This gave participant enough information to enable them to decide whether they want to participate in this study or not.

4.12.2 Respect for privacy

The invasion of privacy happens when private information is shared/distributed without the consent of the individual concerned (Fouka & Mantzokou, 2011). Researchers must protect the privacy of their participants even during data collection. According to the University of New Hampshire (2015), privacy relates to people whereas confidentiality relates to data, therefore privacy cannot be violated. This, therefore, means that this right to privacy promotes individual or participant's welfare. The European Commission (2010) posits that violation of privacy can relate to both physical inference and the exposure of personal information. In collecting the data for this study, the researcher asked the participants to write their names on the consent form but the same was not required for the survey. To ensure privacy, the interviews were conducted in a private room with the participants using only a tape recorder to record the interviews. The participants were interviewed separately.

4.12.3 No harm

According to Harris and Nolan (2016), one must not inflict harm on or expose people to unnecessary risk because of a research project. Ethical standards impose an obligation on the researcher to remove the participants from a potentially harmful situation. Harm may refer to harm caused by the actual conduct of the research or harm arising from the participation of research outcomes (Mollet, 2011). Harm can either be psychological or physical harm. To ensure this the researcher informed the participants to withdraw or decline to answer any question that they feel uncomfortable answering and further assure them that there are no consequences.

4.12.4 Respect for anonymity and confidentiality

The identity of the participants must not be revealed. If the researcher is in a position where she cannot guarantee anonymity, then confidentiality, which is the management of private information by the researcher to protect the subject's identity should be adhered to (Fouka & Mantzokou, 2011). The researcher must not disclose any identifiable information and try to protect the identity of the participants, to uphold anonymity (Wiles, *et al.* 2006). The researcher used pseudonyms to ensure anonymity when reporting the findings. The researcher had to adhere to confidentiality when the information is given under the agreement that it will not be disclosed without prior permission. The consent forms with the names of the participants for

the interview were only kept as record by the researcher. The researcher used pseudonyms when reporting the findings.

4.13 Conclusion

This chapter discussed the methods that were employed by the research to answer the research questions of this study. The researcher outlined how using the mixed methods approach assisted with well-validated conclusions, the sampling techniques, sample size, data collection instruments as well as the data analysis procedures that were employed to come up with well-corroborated conclusions.

CHAPTER 5 QUALITATIVE RESEARCH FINDINGS

5.1 Introduction

Throughout this study, the word participant was used to describe the people who responded to this study. This chapter will present patterns that arose from the repeated analysis of interview transcripts. It gives a brief description of the participant's thoughts on the effects of customary marriages on sexual and reproductive health rights based on life events. In this chapter, the researcher has presented, analysed, compared and interpreted the results from the interviews of the participants from both countries in which they were required to answer the following research questions of this study:

- What is the relationship between customary marriage and gender equality?
- How does customary marriage affect young women's sexual and reproductive health rights?
- What are the obstacles to the realisation of young women's sexual and reproductive health rights?
- How is the power of sexual relationship exercised in a customary marriage?
- Which interventions can support and promote gender equality and young women's sexual and reproductive health rights?

5.2 Description of participants

To maintain anonymity as one of the ethical considerations assured by the researcher in this study, all participants were given pseudonyms to maintain anonymity. Demographic characteristics collected from each participant were on information about age, state of marriage, age of partner, number of children and employment status. The participant's age ranged from 18-45 years of age. All participants are in customary marriages. From the sample 53% percent of the sample were women and 47% men. From this sample 80% of the female participants were employed while only 20% of the female participants were unemployed. On the other hand, 75% of the male participants were employed whilst only 25% of the participants were unemployed.

5.3 *Roora/mamalo* as an important component of customary marriage

Participants gave vivid accounts of how *roora/mamalo* is an important component and plays a crucial role in customary marriages. Women in most cases find themselves in precarious positions for the mere fact that their families received bride price hence they are expected to work and behave in a befitting manner. The statements that were uttered by the participants depict how this is an important part of the African culture. The young women seem to acknowledge that *roora/mamalo* place them in a vicarious position as it comes with some expectations which the participants stated during the interviews. These narratives also reveal the difficulties experienced by young women in customary marriages as a result of *roora/mamalo* as stated by women in both South Africa and Zimbabwe.

> *When mamalo is paid for you, you are expected to be humble, obedient and respectful to your husband and his family and do whatever you are told to even if it might affect your health as a young woman* (Mukondi, 34 years old - South Africa).

The role and purpose of bride price since time in memorial is to bring families together through peace and stability. However, on the part of the man it is deemed that he now has legitimate rights over the sexuality of the woman. The man takes control of the economic and domestic services that the woman can offer and generally takes over in matters relating to that family. Payment of bride price has been abused and became an avenue from which women are oppressed and it reduces their human worth as they are priced goods and exposes them to all sorts of abuse, widow inheritance and the risk of HIV infection. Women from both South Africa and Zimbabwe stated how they will be frequently reminded that the bride price has been received therefore they are expected to behave according to the traditions and expectations of a married woman.

> *Customary marriage through the process of paying bride-price is a way of appreciating bride's parents but men often take it as a price they bought women. This results in gender disparities with men dominating women who are regarded as a person who came to bear children. This puts the woman in a vulnerable position where she can be subjected to abuse, making it difficult for her to leave, especially where her family cannot afford to return the bride price or is unwilling to do so. We endure even spousal rape but because of this you just stay* (Sekai, 33 years old- Zimbabwe).

It is a marriage where mamalo is paid and I as the women I must leave my parent's house and go stay with my husband's house where I will start a family there. I cannot even leave the marriage because my family will say we have already spent your bride price as a result do whatever you are told there, give them children. They do not care even if it affects my health, I must just bear children so that the family name continues (Rendani, 38 years old - South Africa).

The participants were quick to point out how the payment of *roora/mamalo* has a bearing on how young women are assertive in marriages. Of relevance was the issue raised by women from both countries on how the payment of bride price is seen as a purchase of sexual and reproductive functions of a woman. This suggests that they are uncomfortable with their current positions.

Customary marriages involve the payment of the bride-price to the family of the woman hence the wife is seen to be bought through the payment of this money. Therefore, a woman does not have a say on her sexual and reproductive health since roora has been paid for her (Rudo, 31 years old-Zimbabwe).

In a customary marriage, a man pays roora and it also allows him to marry another wife as this marriage is not monogamous. Indeed, bride price relegates women to 'an item of trade to be bought or sold' because in many instances it implies that the man has purchased the wife to provide labour, he can demand sex at any time and has control over the reproductive capacity of his wife among others (Chipo, 27 years old – Zimbabwe).

It is a disadvantage because sometimes you are told that we paid money for you therefore you have to do this and do that to the point that your opinion does not matter in the marriage when it comes to things that affect your sexual health directly (Fhulu, 35 years old - South Africa).

Mamalo comes with the expectation that I now must change my name and give my husband children. When we look at it is like they have purchased my reproductive capabilities to do as they please (Maduvha, 27 years old-South Africa).

Of interest with regards to the above participants is the fact that they are both women who are employed who seemed to be more vocal about the fact that *roora/mamalo* translates to a purchase of their sexual and reproductive capabilities.

5.4 Challenges that impede the enjoyment of sexual and reproductive health rights in marriages

Some women find themselves in precarious positions where they do not have reproductive decision-making abilities. The participants were asked to provide the researcher with the challenges that in their opinion impede the enjoyment of their sexual and reproductive health rights within their marriages. The participants from both countries interestingly stated how not being able to refuse sexual advances from their husbands placed them in a position where they had to engage in a sexual encounter against their wishes. This can be perceived as a challenge within the sexual and reproductive health domain as it was a pattern that emerged from both countries. It was of interest to the researcher that most women who provided these responses in both countries were in their thirties. This being a challenge raised by women in the same age group. It can be understood that this was as a result of them being married for longer than their counterparts in the twenties age range. Below are the excerpts from the participants:

> *Yes, there are challenges especially not being able to practice safe sex is one of my major challenges* (Rudo, 31 years old- Zimbabwe).

> *The issue of not being able to have sexual intercourse when I as the woman want but when he wants to end up hurting your organs due to dry sex because you do not desire any sexual encounter, but you are compelled. Traditionally I am not allowed to turn down the advances from my husband* (Sekai, 33 years old- Zimbabwe).

> *Being expected to have sex regardless of your wills and wishes. Forced sex injures the woman's organs* (Tariro, 36 years old- Zimbabwe).

> *Men believe that sex is for pleasure. There is little information or knowledge on women's bodies which might lead to sex which can cause injury to the woman's private organs like forced sex has terrible effects (*Tatenda 33 years old- Zimbabwe).

Being expected to have sexual relations with your husband even though at times you don't wish to engage in these relations (Fhulu, 35 years old- South Africa).

Sometimes you do not even want to have sex, but you have no choice. Having dry sex poses a great risk to a woman's delicate organs as she will not be willing to have sex and is forced just because she is married to him (Rendani, 38 years old- South Africa).

Having to ask for the use of contraceptives like condoms and the husband refuses. At times, I would not be wanting to have any sexual intercourse with him. There was a time I was sick, I assumed it was an infection. I asked my husband that we use protection until I can go to the clinic to determine the cause of the sickness he blatantly refused. You need to be safe we never know it might be sexually transmitted diseases (Maduhva, 27 years old- South Africa).

Contrary to what the other participants stated, Mukondi had a different view postulating how women are expected to give up their sexual desires upon the death of their husbands.

Sometimes when your husband dies you are expected not to move on with your life and be married again. You are expected to stay loyal and live as a widow. This affects the sexual rights of young women as I might have a desire to be sexually active but because of this kind of marriage and the traditional norms I am expected to remain celibate (Mukondi, 34 years old- South Africa).

5.5 Inability to make decisions on family size and sex

The nature of customary marriages and the influences from both culture and societal expectations influences the sexual and reproductive health of young women. These expectations provide a representation of how spouses should relate, and this has an influence on the health and well-being of women in most instances. Women seem powerless in marriages particularly when it comes to making certain decisions concerning their bodies. The researcher asked the young women if they can determine the number and spacing of children Rudo explained that she does not have the power to make those kinds of decisions on her

own and Fhulu and similarly Maduvha put it forward that it is merely up to her husband to make those kinds of decisions.

> *My husband has a say in everything the number of children we have and when and if to have children* (Rudo, 31 years old- Zimbabwe).
>
> *No. My husband dictates all those things* (Maduvha, 27 years old- Zimbabwe).
>
> *No. My husband as the head of the house and the one who earns more money in our marriage is the one who decides on the number of children we ought to have based on his finances* (Fhulu, 35 years old- South Africa).

Whilst two women in Zimbabwe stated how they were unable to unilaterally decide on the number of children without having to discuss this with their husbands.

> *I can only do this after my husband, and I agree on the number of children we will have. But it is not like it's a discussion anyway whatever he says will go. At this moment I do not want any more children, but I am forced to do so (*Sekai, 33 years old- Zimbabwe).
>
> *I cannot unilaterally decide on the number of children but after a discussion with my husband we agree on the number and the spacing of the children* (Chipo, 27 years old- Zimbabwe).

Having been asked about their ability to decide on the family size a pattern arose with two women from South Africa who raised an issue that was not raised by the women in Zimbabwe on how men exercise control in marriages. They explicitly explained how they lack any power to make decisions and the existence of the dominance of men in the marriage.

> *Men want to control women. They are very bossy and want to be listened to. A woman is said to have no say in anything even love sometimes it is not even there. Some men are abusive to the point that you are forced to have children even if you do not want* (Mukondi, 34 years old- South Africa).
>
> *No. Because you are a married woman, even if you know that it is not safe you cannot voice out your opinion. The head of the house which is the man seeks to control every aspect of the marriage* (Rendani, 38 years old- South Africa).

Contrary to the men in Zimbabwe who were vocal about women having the ability to decide on the family size this pattern never rose with the young men in South Africa that took part in this study. Two young men from Zimbabwe stated clearly that women do not hold the power to dictate and decide on certain aspects within the marriage.

> *That lies with the man if he feels he wants four children and the wife two children that now lies with the woman to justify why she wants two children because if I feel that I need four children I can afford to take care of them who is the woman to say that she wants this number of children* (Danai, 29 years old- Zimbabwe).

> *A woman cannot choose to do as she pleases for example, she cannot choose to use the pill, condoms or injection. But the moment she starts using condoms now we have a big problem. Some of these children we have in marriages are as a result of not agreeing on the use of contraceptives hence there is no agreement on the spacing of children. They say that they have a right to do so and giving birth later in life can cause complications, but I paid bride-price for those things* (Anesu, 31 years old- Zimbabwe).

5.6 Polygamy

The researcher also wanted to find out from the young women some of the cultural practices that are harmful to the sexual and reproductive health of young women in marriages. Polygamy was one practice that the researcher asked the participants to state in their opinion whether it disadvantages women and proceeded to ask the participants to elucidate their thoughts and views on this aspect. Young women stated particularly how this practice is detrimental to their health and well-being as some of them were in these kind of marriage set-ups. There was a consensus among the participants in both countries that polygamy has a direct effect on a young woman's sexual and reproductive health rights. The participants had this to say:

> *The competition among wives lowers the woman's negotiating power and multiple partners also increase the risk of diseases* (Tatenda, 33 years old- Zimbabwe).

> *A polygamous marriage makes it impossible to choose freely when you want to have sex because for example you are compelled to have sex if the husband is sleeping in your bedroom that night. There is also a competition*

to give the husband children even after you might have passed your reproductive age (Tariro, 36 years old- Zimbabwe).

*Polygamy affects the health of women. It affects women negatively because it might expose you to STIs and other infections like HIV (*Fhulu, 35 years old- South Africa).

In a polygamous marriage one can never be sure if the partners in the union are being faithful and not being sexually active with other people. We seldom use condoms therefore it is a very risky arrangement. This also is an agent that spreads diseases like HIV (Rendani, 38 years old- South Africa).

….it poses a threat because if a man brings a disease into the house a woman cannot ask for the use of a condom because they are married (Mukondi, 34 years old- South Africa).

Some of these practices do no benefit women at all. Like polygamy disadvantages women as it creates a sexual web (Maduvha, 27 years old- South Africa).

Polygamy is one of the practices adhered to by our fathers and their fathers back in the day but nowadays it's a problem. Because it attracts a lot of sexually related diseases and divides the family and gives the wife unnecessary pressure and might even force her into infidelity forcing her into this setup is discriminatory (Mulalo, 36 years old- South Africa).

Participants in Zimbabwe mainly spoke about how polygamous marriages culminate in a competition among wives. They said this puts enormous pressure on them to perform. Unlike their counterparts in South Africa who alluded to how HIV/AIDS and sexually transmitted diseases are easily contracted due to the creation of a sexual web. It was also interesting to note that one of the male participants thought that polygamy is a practice that poses a threat to the health and well-being of a woman as it transmits sexual diseases.

5.7 Wife inheritance

Cultural practices can be harmful if they have adverse consequences on the well-being of young women. These practices are discriminatory as they only target women and seldom men. Several participants' responses illuminated how the cultural practices that are conducted

in customary marriages place women in a precarious position. The participants went further to elaborate by providing the researcher with some examples of how wife inheritance pose a threat to the sexual and reproductive health of young women. Some of the participants linked the practice of wife inheritance with the lack of desire for sexual relations while the other opined on the expectations on having children in the marriage. Only the participants in South Africa gave their opinion on how wife inheritance as a harmful practice conducted within customary marriages poses a threat to the health and well-being of a young woman in a marriage.

> *I am not free to have sexual relations with someone other than my husband. This type of marriage is not ideal and something that one would not opt for but because of our traditions you find yourself in that position and it is hard to have sexual relations with that man there is usually no desire on the part of the woman. I will be forced so it's a risk to my health as a woman* (Rendani, 38 years old- South Africa).

> *It affects the health of a woman and well-being as now you are forced to have sexual relations with a man you do not even love* (Maduvha, 27 years old- South Africa).

> *This is a problem because in a reproductive way it is a threat. After all, you are not connected to this new partner in any way and now you are expected to have them as your husband* (Fhulu, 35 years old- South Africa).

> *You are expected to give this new husband children and you might be old, and it is difficult to conceive when you are old. It's a big risk* (Mukondi, 34 years old- South Africa).

Contrary to what their counterparts in South Africa stated, the young women in Zimbabwe who were participants in this study when asked how wife inheritance about this cultural practice of wife and how it poses a threat. They were unable to definitively provide the researcher the answer as to how but gave a general view on how cultural practices are harmful.

> *These practices disadvantage women because some of them are harmful to me as a woman. This is because women are seen as the lower-class citizens hence their rights are never taken into consideration* (Sekai, 33 years old- Zimbabwe).

Some practices are a threat because a young woman married customarily you do not possess the power to negotiate for safe sex in your marriage (Tariro, 36 years old- Zimbabwe).

The participants from Zimbabwe also stated how the practice of wife inheritance makes it difficult for women to assert their sexual and reproductive health rights.

Having to marry someone I did not choose for myself makes it difficult to have sexual relations with that person and it might lead to forced sexual intercourse. To add on you will be expected to bear children which you might not be able to do due to age (Tariro, 36 years old- Zimbabwe.)

Some of the practices disadvantage women as they do not promote the rights of women. For example, practices like wife-inheritance which is still being practiced in many rural communities in the country contributes to the spread of sexually transmitted infections (Chipo, 27 years old- Zimbabwe).

Wife inheritance poses a threat to a young woman's sexual and reproductive health because it also creates a sexual web. Furthermore, one cannot be sure of the HIV status of the inheritor (Sekai, 33 years old- Zimbabwe).

5.8 Patriarchy

Patriarchy is a system that also dictates the role of women in society. This system culminates in the discrimination against women both in society and within the families. Gender inequality is usually an indicator of the existence of patriarchy in the society. This gender-based gap makes it difficult for women to assert their rights within the family life. For some of the participants, patriarchal ideals proved to present a hurdle as some of the challenges they faced were primarily caused by the dominance and presence of male ideologies in their marriages. This was brought to light by the participants when they were asked about their opinion on the roles that are generally performed by men and women and how these roles promote or undermine gender equality.

In customary marriage, the man is the head of the house hence he should provide and take care of his family. The woman is supposed to be bearing and rearing children while the husband is expected to work for the family. These roles undermine gender equality as women are seen to be inferior to

men and we are not able to voice out our opinions even on things that pose a threat to your health like preventing sexually transmitted diseases (Chipo, 27 years old- Zimbabwe).

Customary marriages tend to be patriarchal and men are dominant while women are expected to be passive and submissive (Tatenda, 33 years old- Zimbabwe).

To this Rudo (Zimbabwe) added that

Men are superior than women because men can do as they wish in a marriage even taking many wives without consulting with the first wife. Men and women are not equal, and this shows in the way men interact with women. They always try to pull rank and act superior through oppressing women. I once asked my husband if we could use condoms as I suspected that he was cheating he refused and even beat me up. But I was merely trying to protect my health (Rudo, 31 years old- Zimbabwe).

There seems to exist patriarchal notions in society as was shown from some of the excerpts when young women were asked about the relations between men and women. Some of the participants could not hide their emotions and expressed their feelings regarding this vehemently.

It is a patriarchal society where men consider themselves superior to women. Men regard women as their items of possession the same way they view their properties hence women in customary marriages are made to feel like properties by men to do as they please with our bodies for their sexual satisfaction (Sekai, 33 years old- Zimbabwe).

The relations are not equal as men are always seen as they are above women in all spheres of life. We are expected to communicate and seek permission first from a man especially in marriages (Tariro, 36 years old- Zimbabwe).

*Men always dictate terms mainly due to fear of being perceived as controlled by the woman. At the end I have a problem because he does not listen to me when I speak and cannot voice out my opinion on anything in the family (*Maduvha, 27 years old- South Africa).

> *This type of marriage is very patriarchal. Men have the last say and whatever they say goes* (Mukondi, 34 years old- South Africa).

Because women's voices are not heard within the marriage it can create the sense of being undermined. This seems to shape the terms in the marriage as the young women expressed their feelings about the state of the marriages when it comes to decision-making in and out of the family life. This was evidenced from the response by Fhulu and Rendani who also echoed the same sentiments about patriarchy by stating that

> *Respect your man and you don't have to speak that's what we were taught in Tshivenda. Women end up not expressing themselves due to culture* (Fhulu, 35 years old- South Africa).

> *Men do not respect the opinions of women. They expect to lead always, and we follow* (Rendani, 38 years old- South Africa).

Young women in Zimbabwe similarly raised the same issues as the young women in South Africa. From the views of the young women it emerged how the patriarchal notions of masculinity have deep roots in society and then it finds footing in marriages as it is seen as a societal norm generally accepted. However, this has a ripple effect on other aspects of life of young women as it affects their ability and power to be able to assert their rights in the sexual and reproductive domain where men are expected to be dominant through patriarchal ideology.

To understand the underlying factors at play in marriages the researcher needed to solicit the views of young men who were also participants in this study about their views on gender equality. The researcher sought out personal feelings about gender equality, thoughts and views to be able to understand how the dynamics would unfold within a marriage. There seemed to be a consensus among participants from both countries about the superiority of men. Young men providing their thought and perceptions would assist in understanding how relevant this concept is to young married men.

> *It is an animal that is not supposed to be there. Biblically we are saying that women are under men so should never have gender equality the woman should be placed in her position and the man is the head of the house. We*

should not have gender equality, but woman should be respected. There is no equality in our customary marriages (Danai, 29 years old- Zimbabwe).

Gender equality as much as it exists it should be there but considering that we are talking about customary marriages I do think it exists there are cultural dynamics which do not allow gender equality in the marriage but personally I would like to believe that there should have space for gender equality (Anesu, 31 years old- Zimbabwe).

I am very African I respect gender equality but there are things I feel I should not discuss with my wife, there must be certain measures that should be taken care of first. It is good, but women should be treated the same as men and we need to respect them (Nyasha, 40 years old- Zimbabwe).

It is good thing but in our African society there are levels where it ends when it comes to gender equality. Women must know where they end and men where they end (Tendai, 38 years old- Zimbabwe).

I think is a good stance for equality among men and women in other ways. But in other ways it is not a right thing. Because it gives women a lot of powers to the point that she will be taking the male duties and making them her own (Mulalo, 36 years old- South Africa).

Traditionally I would not say there is equality but if we are to live according to our customs a man imposes those things. Luckily some men are understanding even if they are married traditionally would ask if you are comfortable with these number of children. But from my observation there is no gender equality in this in society (Rofhiwa, 32 years old- South Africa).

I think it is alright that people be equal but with this equality there must be a leader like the head of the house. There is a difference in the words mother and father, there is a bigger word that carries more weight (Ronewa, 28 years old- South Africa).

The researcher went further to ask Ronewa to explain what he meant as he had raised a concept that was of interest. The researcher asked what the bigger word was and how it had an influence within the household.

The bigger word in this case is father. The father is the head of the house he is the one who paid the bride price and is the provider and protector of

the family not the mother therefore his word goes (Ronewa, 28 years old- South Africa).

5.9 Understanding gender equality

The participants having provided the researcher with the above it was imperative for the researcher to solicit information on whether they understood what the term gender equality meant. It is important because it helps to understand the reasons for their attitude towards this concept and how they express it in their marriages as this is a problem both globally and nationally. Not only does it affect the lives of individual men and women, but the inequality between genders also hinders human development as it shapes the relations among genders. Because gender biases are embedded in culture, it is very difficult to eliminate them without having a holistic view and involving men as a part of the solution this was the point of departure the researcher used. According to participants from both countries, gender equality meant awarding equal opportunity to both men and women mainly in terms of opportunities. This is evidenced from the excerpts below:

Two participants eloquently outlined their understanding of gender equality as follows:

To me it means affording and giving equal opportunity to both male and female in terms of work and it goes to both decision-making as well and people having the ability of when they can do what they want. Having this opportunity is what I call gender equality (Rofhiwa, 32 years old- South Africa).

I think gender equality means men and women have the same rights and responsibilities. However, there is no gender equality in a marriage to be honest there is nothing like that in a marriage set up (Nyasha, 40 years old- Zimbabwe).

To me it means equal standing for both men and women. I do support this concept because it helps us to recognise that women can do what men can do. It gives something that enables us to respect and recognise women as powerful women. I can give an example from a Biblical verse that says, "Women should submit to your husbands" (Danai, 29 years old- Zimbabwe).

> *Gender equality means that men and women are the same. We are now living in a modern world different from our fathers where the rights of women matter. Now at least they are seen as human beings* (Anesu, 31 years old- Zimbabwe).

> *What I perceive about gender equality is the mutual understanding or co-existence of male and females in terms of decision making* (Mulalo, 36 years old- South Africa).

The researcher went further to ask the participant to explain what they understood about co-existence in decision making between men and women.

> *The co-existence of men and women to a greater extent changes the position of women as there was always a gender imbalance woman have been subjected to oppression and excluded from a lot of decision-making. This concept of gender equality is changing the norm and making men very uncomfortable. Some traditional people who still ascribe to old traditions feel like this disturbs the norm* (Mulalo, 36 years old- South Africa).

One male participant from South Africa seemed not to possess the adequate level of understanding. In his response Ronewa stated how there is no gender equality but provided his explanation from a Biblical point of view.

> *There is no such thing as sexes being equal. What are we talking about here is the same as what the Bible says that a woman shall bear children and a man shall eat the fruits of his labour. Meaning that a man must provide but a woman must stay home* (Ronewa, 28 years old- South Africa).

5.10 Men's attitude towards equality in customary marriages

Statements about gender equality were analysed by the researcher across the several responses provided by the young men who were part of this study. It is important to understand their attitude towards gender equality in customary marriages as these differences shape how women are viewed in marriages and whether their ambition to attain the highest standard of sexual and reproductive health is supported. Some of the male participants from South Africa in their responses made it clear that they had reservations towards this concept because

equality would result in them losing their status as the man of the house and exercise the power that comes with that.

Mulalo and Ronewa put it forward that:

> *I just do not want to be overridden by my wife because of this gender equality concept. But I do allow her to some extent to do things that were seen back in the day as something that cannot be done by women* (Mulalo, 36 years old- South Africa).

> *A man is always the one who is supposed to be the provider of the family while the woman is taking care of the household. But in most cases if a woman earns more money than the husband, they tend to be forgetful that the man is the head of the house. At the end if we are equated it will seem as if the man is under the wife that's why some men refuse that their wives go to work* (Ronewa, 28 years old- South Africa).

While on the other hand their counterparts in Zimbabwe Danai and Anesu in their responses vehemently stated that there is no gender equality in their marriage due to fear of the repercussions like the wife regarding herself as being equal to the man.

> *If I would like to bring this concept of gender equality my wife would like to put it into effect in our marriage because she will think that we are equal whereas I fend for the family and she stays at home how can we be equal, we can never be equal one has to be superior and one inferior* (Danai, 29 years old- Zimbabwe).

> *I am against the whole idea of equality in our marriages that can never happen. God created man to be the head of the house, how can the head of the house be equal to someone else, there is no such thing* (Anesu 31 years old- Zimbabwe).

On the other hand, Khakhathi pointed out that this notion of being inferior to women can also be exacerbated by family members who in most cases meddle into the marriage affairs and end up causing a rift among the spouses.

Now because of this equality a woman can go out there and get a better job some men feel threatened and the need to provide especially if the man is not working it does not make one lesser of a man. The other issue is like relatives cause problems about who does this and especially if the man is not working……. (Khakhathi, 43 years old- South Africa).

5.11 Discrimination against women

While the researcher was asking the young men to provide their understanding about equality in marriages a pattern arose which suggested a discrimination against women. This discrimination influences the employment and empowerment of women and their ability to make well informed decisions about their sexual and reproductive health in customary marriages. Some of the participants stated how women were not allowed to work. This could also be emanating from the young men's attitudes towards equality in marriages.

Like I said, a woman must not work. No right is being challenged this is how it should be (Ronewa, 28 years old- South Africa).

A woman is expected to do household chores. So, people subscribe to this norm because it has always been like that and it is generally accepted. As a man, you cannot be under your wife, so you must make sure that she knows her place and as a result she must stay at home and take care of the children (Rofhiwa, 32 years old- South Africa).

A woman is not in a position where she gets to refuse to have children, in fact she has no right to do that. I am a man who subscribes to this which might be viewed as affecting the spacing of children and a woman is expected to have children and not use contraceptives and you cannot resist sex in a customary marriage because bride price was paid for you. You can have a child yearly if I as the husband so wishes (Khakhathi, 43 years old- South Africa).

Unlike in South Africa, the participants in Zimbabwe stated how the traditional values also provide an avenue from which women face discrimination. This is mainly due to the cultural expectations which places women in a precarious position to the point that women cannot assert their sexual and reproductive rights in marriages due to lack of empowerment.

…. *women being expected to live by certain customs without having so much say in the matter because of traditional expectations* (Anesu,31 years old-Zimbabwe).

Women are expected to do cooking and all the household chores. This discriminates because they cannot work and make their own money and without money it is difficult to be independent. Traditional expectations tend to discriminate against women, and this is how things have always been like we as men we have no problem at all with that (Danai, 29 years old-Zimbabwe).

…. *up to now some people subscribe to the traditional norms that claim that that a woman is not supposed to go to work. She is expected to be just at home working* (Tendai, 38 years old- Zimbabwe).

5.12 Expectations of marriage

5.12.1 Family expectations

Marriage occurs in a society that is influenced by both culture and adheres to certain societal values. As a result, societal-cultural views influence the expectations in marriages. It is observed that in many instances these roles affect equality among genders as it has already been noted by some of the participants in this study. The researcher asked the participants about their opinion on how roles that are performed in marriages can promote or undermine gender equality. Participants from both countries similarly felt that families in Africa view marriage as a means of securing reproduction. Family dynamics play a huge role in customary marriages as the expectations vary from expectations of loyalty, respect to each other, reproduction and nurturing of children which means can be difficult for wives to protect themselves from HIV and establishment and maintenance of the home.

Rendani indicated that the roles that are assigned to women because of gender undermines women:

According to our culture, a women's place is in the kitchen. This role is not supposed to undermine us, because I am married, we must help each other but in our culture, that is not the case. This makes things difficult because

women are expected to play minor roles (Rendani, 38 years old-South Africa).

On the other hand, Fhulu, Tatenda and Mukondi expressed how they felt since women are expected to be only concerned with bearing and nurturing children. As with many 21st century marriages naturally one would expect that men and women naturally bear the burdens and benefits of life together. Not only are women expected to be passive but also to tolerate practices that pose harm to their health and well-being.

Men perform the role of being the provider in the house. This role undermines gender equality because women are often abused because they are told that you are not the head of the house and we are expected to know our place which is in the kitchen (Fhulu, 35 years old- South Africa).

A woman's role is said to be that of a caregiver and bearing children, the husband's role is to provide for the family. Women bear an unequal brunt. This expectation that women are supposed to bear all the household burden is uncomfortable and unfair on women. Because we are undervalued our decisions do not even matter even in cases where our sexual health is at stake (Tatenda, 33 years old- Zimbabwe).

Not being able to voice out your opinion as a woman and expected to be obedient and tolerate things that are harmful to your health makes it hard for us as women to enjoy our rights (Mukondi, 34 years old- South Africa).

While Chipo and Sekai shared their opinion that

The expectations that come with roora are that the woman is expected to bear children that will grow the family name as well as to take care of the in-laws (Chipo, 27 years old- Zimbabwe).

A woman is expected to have children, work for the whole family, be submissive and tolerate her husband's shortcomings even infidelity in an era where HIV/AIDS is a real threat to the sexual and reproductive health of a young woman (Sekai, 33 years old- Zimbabwe).

5.12.2 Societal expectations

From the responses provided by the participants one pattern emerged which was the societal expectations that are attached to the institution of marriage. Both the young men and women from both countries who took part in this study expressed how society similarly with families have some expectations which tend to make people conform to certain ideologies and ways of living. This can be evidenced by what the participants in this study stated.

> *Society values customary marriages a lot. If you check, these days those people that are married customarily are still together. But the treatment that comes within these marriages sometimes is not good for the woman* (Fhulu, 35 years old- South Africa).

> *Family value marriages a lot. You are trained as a young woman for marriage from an early age. This just shows how important it is to be married to family and society* (Maduvha, 27 years old- South Africa).

> *Once a woman is married people in society expect you to be homely and to bear their husbands children and, in some cases, it poses a serious threat especially to women who start giving birth later in life to continue giving birth even after her reproductive years* (Chipo, 27 years old- Zimbabwe).

> *Society and family always make customary marriages important. It is unacceptable to stay with a man without a customary marriage. You are seen as an outcast if you stay with a man without mamalo paid and respected if mamalo is paid for you* (Mukondi, 34 years old- South Africa).

To add two young men also gave their view on the societal expectations in a marriage. The researcher sought to understand how this concept of gender equality affect the way society function especially when it comes to changing the *status quo*. Two men from South Africa and Zimbabwe concurred on how society places an important role on the institution of marriage and the importance of the expectations from the society.

> *This concept is seen in society as something that destroys marriages according to my understanding. Because as a nation we are deeply rooted in culture and we are raised and taught that a woman takes care of the household and a man will work and provide* (Mulalo, 36 years old- South Africa).

> *…. society has a role to play because when they see certain thing in a marriage, they might say akadyiswa (wife used dark/black magic on him to make him do as she pleases) and so many things. There is also influence of religion on gender equality that the society attaches to it and it is still struggle in society. As men, we end up expecting some things from our wives because of people in society to a point that some of it is a threat to the health and well-being of your wife but we are afraid of what people will say if we do not do those things* (Anesu, 31 years old- Zimbabwe).

To add on Anesu stated how there is no gender equality in society to the point that a woman cannot use contraceptives because of the expectations in society.

> *There is no equality. She cannot even use contraceptives. There are no control measures over these things. Society will expect the man to have a lot of children therefore the wife cannot choose or else he will go and sire other children out of wedlock* (Anesu, 31 years old- Zimbabwe).

5.13 Intervention strategies

The researcher asked the young women to provide any strategies that can help to support and that in their own opinions informed with their lived experiences can help to promote and protect the sexual and reproductive health rights of young women in customary marriages. However, there were differing views shared by the participants from both countries on this aspect. One aspect stood out from the participants from both South Africa and Zimbabwe that is the importance of education.

> *We need to educate young boys and girls about gender equality so that they grow up with adequate knowledge* (Fhulu, 35 years old- South Africa).

> *One of the major challenges in this country is that women are getting married at a very young age. They should be in school getting educated. We need to stop child marriages* (Maduvha, 27 years old- South Africa).

> *Parents need to teach their children at home about issues about gender equality. I think exposing them to this at a young age will help them grow as mature and responsible and it avoids gender stereotyping* (Chipo, 27 years old- Zimbabwe).

> *There is need for people who know this aspect to raise awareness concerning the sexual and reproductive health rights of women in our community. We do not know about this* (Tariro, 36 years old- Zimbabwe).

> *There is need to educate everyone about these cultural practices that we face in marriages and people must know how they are a disadvantage in most times* (Rudo, 31 years old- Zimbabwe).

With education comes empowerment as rightly put by Rendani.

> *Empowering young women and girls because some of this dependence on men is because you are financially dependent on him as well* (Rendani, 38 years old- South Africa).

On the other hand, three other young women who took part in this study one from South Africa and two from Zimbabwe opined a different strategy from the other participants and each other. But it is hoped that all these combined provide a holistic approach.

> *There is a need to enforce strict laws for example the law needs to take seriously the issue of spousal rape and domestic violence cases that women bring forward and punish the perpetrators to set a good example* (Mukondi, 34 years old- South Africa).

> *Having a lot of women's organisations that raise money to promote the cause for sexual and reproductive health rights of young women and girls* (Sekai, 33 years old- Zimbabwe).

> *Using media as a game changer to promote positive gender roles and to disseminate information on gender equality* (Tatenda, 33 years old- Zimbabwe).

5.14 Conclusion

This chapter presented the findings from the 17 participants that took part in this study. The researcher was able to code the responses from the participants into the common patterns. The patterns centred around gender equality, family and societal expectations in a customary marriage, harmful cultural practices, lack of decision-making abilities of young women, *roora/mamalo* as an important practice used to subjugate women in patriarchal societies. The

responses from participants from both South Africa and Zimbabwe were similar in many aspects. This was the case because women from both countries alluded to the same experiences they went through in their customary marriages. However, the researcher noted some differences among the young women due to employment status as well as age. Similarly, with the male participants they concurred with each other but in some aspects, there were differences in opinions from men in Zimbabwe and their counterparts in South Africa. For example, the male participants in Zimbabwe, unlike their counterparts in South Africa, stated how the traditional values also provide an avenue from which women face discrimination. There were more similarities compared to the differences cited by participants in Zimbabwe and South Africa.

CHAPTER 6 QUANTITATIVE RESULTS

6.1 Introduction

This chapter provides an analysis of the data using descriptive statistics and frequencies, tests the relationships between variables and highlights the results. The thrust of the study is to analyse the effects of customary marriages on young women's sexual and reproductive rights in Makwarela (South Africa) and Concession (Zimbabwe.) This chapter presents the results on decision-making dominance, relationship control factors and the relationship between cultural practices conducted in customary marriage and sexual and reproductive health.

6.2 Socio-demographic characteristics

The sample size of this study was 802. 401 participants were from South Africa and the other 401 participants were from Zimbabwe. The population of the quantitative study was young women in customary marriages aged between 18 and 40 residing in Makwarela (South Africa) and Concession (Zimbabwe). Table 2 and 3 illustrates demographic characteristics that were assessed in the current study.

According to the results in Table 2, the majority of young women were aged between 28-35 (37.75%) and 34-40 (37.7%) with the least number of respondents aged between 18-20 (3.5%.) Overall 66.3% of the participants had between 0-3 children, 68.8% were in monogamous marriages with 81.3% of the participants having chosen their partners, 46.1% were married for between 0-5 years and 56.9% of the participants in South Africa were employed.

TABLE 2: PERCENTAGE DISTRIBUTION OF RESPONDENTS' SOCIO-DEMOGRAPHIC CHARACTERISTICS (SOUTH AFRICA)

Variables	Frequency	Percentage (%)
AGE		
18-20	14	3.5
21-27	35	21.2
28-35	151	37.7
34-40	151	37.7
NUMBER OF CHILDREN		
0-3	266	66.3
4-6	135	33.7
STATE OF MARRIAGE		
Polygamous	125	31.2
Monogamous	276	68.8
CHOSE PARTNER		
Yes	326	81.3
No	75	18.7
EMPLOYMENT STATUS		
Employed	228	56.9
Unemployed	173	43.1
DURATION OF MARRIAGE (yrs.)		
0-5	185	46.1
6-10	172	42.9
10-15	44	11.0

The results in Table 3 below show that the majority of the participants in Zimbabwe were aged between 34-40 (42.9%) as compared to South Africa's who had 37.7% in the same age range but Zimbabwe also had the least number of participants (11.5%) aged between 18-20 which was also the age group with the least number of participants like South Africa. Like their counterparts in South Africa, the participants in Zimbabwe had the highest number of children ranged between 0-5 (60.8%), while 30.7% had been married for between 0-5 years with 93.0%

of the participants in monogamous marriages and 97.0% of the participants having chosen their partners. However, South Africa had the higher percentage for the number of children between 0-5 among those that were employed while Zimbabwe had the higher percentage for participants who had chosen their partners. From the data, one can notice that participants that were employed in Zimbabwe were 46.4% which was lower compared to the participants that were employed in South Africa.

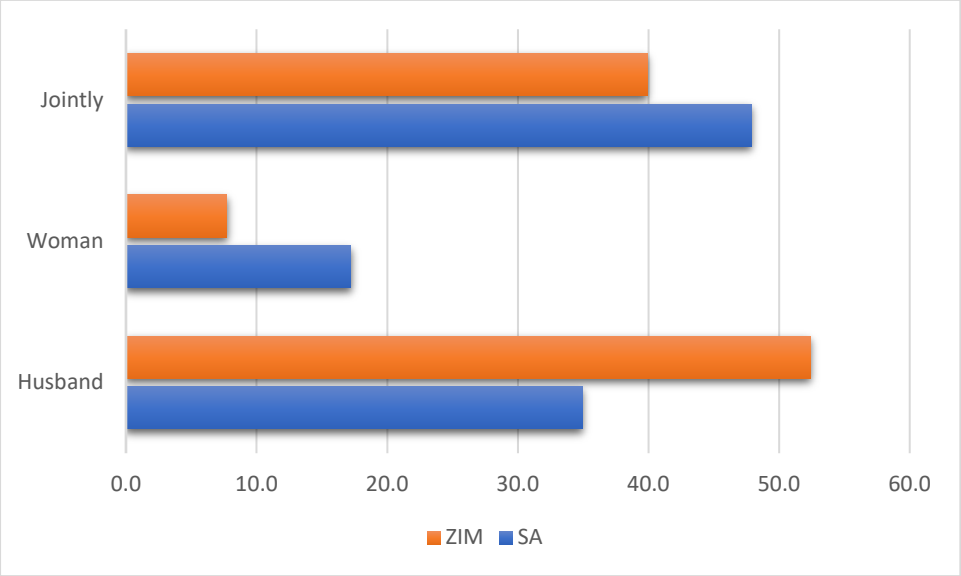
TABLE 3: PERCENTAGE DISTRIBUTION OF RESPONDENTS' SOCIO-DEMOGRAPHIC CHARACTERISTICS (ZIMBABWE)

Variables	Frequency	Percentage (%)
AGE		
18-20	46	11.5
21-27	84	20.9
28-35	99	24.7
34-40	172	42.9
NUMBER OF CHILDREN		
0-3	244	60.8
4-6	157	39.2
STATE OF MARRIAGE		
Polygamous	28	7.0
Monogamous	373	93.0
CHOSE PARTNER		
Yes	389	97.0
No	12	3.0
EMPLOYMENT STATUS		
Employed	186	46.4
Unemployed	215	53.6
DURATION OF MARRIAGE (yrs.)		
0-5	123	30.7
6-10	159	39.7
10-15	119	29.7

6.3 Decision-making dominance

A second step was implemented with a multiple regression analysis to determine if a woman's ability to make decisions about family size was based on age, employment and state of marriage.

Figure 7 Decision on family size



From the results in Figure 7 above, 47,9% of the participants in South Africa stated that decisions on family size are made jointly while 39.3% of the participants in Zimbabwe concurred to this. The majority (52,4%) of the participants in Zimbabwe stated that decisions on family size are made by the husband contrary to 34.9% in South Africa. The smaller percentages were recorded for a woman making decisions on family size in South Africa 17.7% whilst in Zimbabwe it was 7.7%. This data shows that women alone cannot make decisions on family size suggesting that its either the husband or a joint decision-making. This might be a reflection of women's position within an African context where patriarchy plays a major role in everyday way of life.

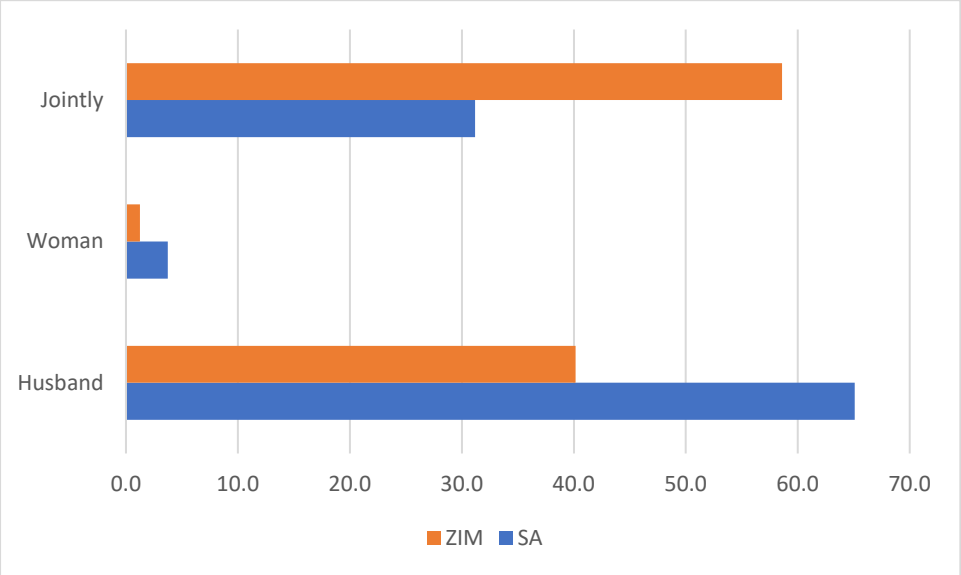
Table 4 below of the multi-nominal regression analysis that included three control variables. The overall model had a chi-square value of 9.081 for South Africa and 11.228 for Zimbabwe with 6 degrees of freedom. From the analysis, it shows that in South Africa age and employment status do not influence women's ability to make decisions about family size. However, the analysis showed that there is a statistical significance (*p=0.039<0.05)* in the ability to make decisions jointly about family size due to the state of marriage. Hence, polygamy does influence a joint decision on family size in South Africa. Contrary to Zimbabwe, there was a statistical difference *(p=0.022<0.05)* in women's ability to make decision on family size based on employment. Therefore, employment was significantly associated with women's ability to make a decision on family size among participants in Zimbabwe. The findings were thought-provoking particularly in polygamous marriages given the dynamics and expectations of this state of marriage where there are many actors in the marriage.

TABLE 4: LOGISTIC REGRESSION OF SELECTED VARIABLES AND DECISION ON FAMILY SIZE

NATIONALITY			B	DF	SIG.	EXP(B)	95% CONFIDENCE INTERVAL FOR EXP(B)	
							Lower Bound	Upper Bound
SA	Woman	Intercept	0.278	1	0.630			
		Age	-0.190	1	0.277	0.827	0.588	1.164
		Employment	-0.382	1	0.202	0.682	0.380	1.227
		State of marriage	-0.567	1	0.083	0.567	0.299	1.076
	Jointly	Intercept	1.015	1	0.025			
		Age	-0.123	1	0.360	0.884	0.680	1.151
		Employment	-0.263	1	0.249	0.769	0.492	1.202
		State of marriage	-0.492	1	*0.039	0.611	0.383	0.975
ZIM	Woman	Intercept	-1.321	1	0.024			
		Age	-0.096	1	0.601	0.908	0.633	1.302
		Employment	-1.001	1	*0.022	0.367	0.156	0.863
		State of marriage	0.757	1	0.218	2.132	0.639	7.112
	Jointly	Intercept	0.324	1	0.320			
		Age	-0.188	1	0.063	0.828	0.679	1.010
		Employment	-0.087	1	0.683	0.917	0.605	1.390
		State of marriage	0.118	1	0.781	1.125	0.489	2.591

REFERENCE CATEGORY;
***P<0.05**

FIGURE 8: DECISION ON HAVING SEX



Less than 70% of the participants in South Africa stated that their husbands decide on when and if to have sex whilst it was 40.1% percent of the participants in Zimbabwe. Only 3.7% of the participants in South Africa stated that this decision is up to the women on the other hand 1.2% of the participants in Zimbabwe concurred to this. Most of the participants (58.6%) in Zimbabwe stated that decision on having sex is made jointly whilst 31.2% if the participants in South Africa concurred. Likewise, the data shows that, on their own, women alone do not have the power to make decisions on when to have sex. Such a decision is often made by the husbands or jointly by the couple.

Table 5 below is the results of a logistic regression analysis showing whether ability to decide on sex is based on age, employment status and state of marriage. The overall model of the chi-square value was 34.326 for South Africa and 4.810 for Zimbabwe with 6 degrees of freedom. According to the results, there is a statistical significance *(p=0.000<0.05)* between joint decision making and age in South Africa. This could be because the majority of women in South Africa who took part in this study were older (Table 2). Therefore, they were able to engage into these discussions since they were older and more mature. There was no statistical difference between all the categories in Zimbabwe.

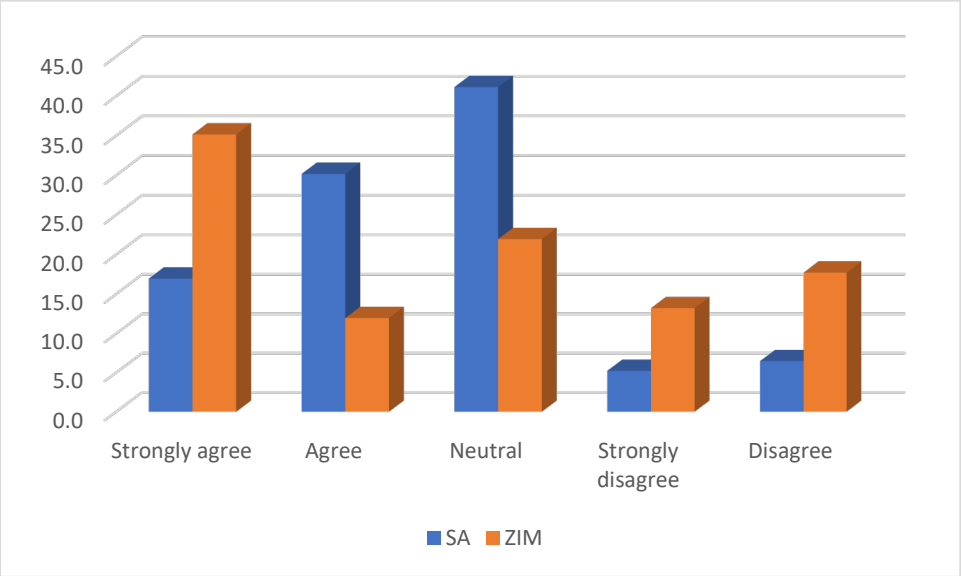
TABLE 5: LOGISTIC REGRESSION OF SELECTED VARIABLES AND DECISION ON SEX

NATIONALITY			B	Df	Sig.	Exp(B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
SA	Woman	Intercept	-1.891	1	0.077			
		Age	-0.285	1	0.379	0.752	0.399	1.419
		Employment	0.190	1	0.726	1.210	0.417	3.510
		State of marriage	-0.657	1	0.320	0.518	0.142	1.891
	Jointly	Intercept	1.412	1	0.001			
		Age	-0.740	1	*0.000	0.477	0.365	0.623
		Employment	0.231	1	0.319	1.260	0.800	1.983
		State of marriage	-0.172	1	0.490	0.842	0.516	1.372
ZIM	Woman	Intercept	-2.006	1	0.083			
		Age	-0.341	1	0.400	0.711	0.322	1.572
		Employment	-1.241	1	0.275	0.289	0.031	2.679
		State of marriage	-18.136	1		1.329E-08	1.329E-08	1.329E-08
	Jointly	Intercept	0.785	1	0.016			
		Age	-0.121	1	0.225	0.886	0.729	1.077
		Employment	-0.054	1	0.793	0.947	0.632	1.421
		State of marriage	-0.254	1	0.520	0.776	0.358	1.682

REFERENCE CATEGORY;
***P<0.05**

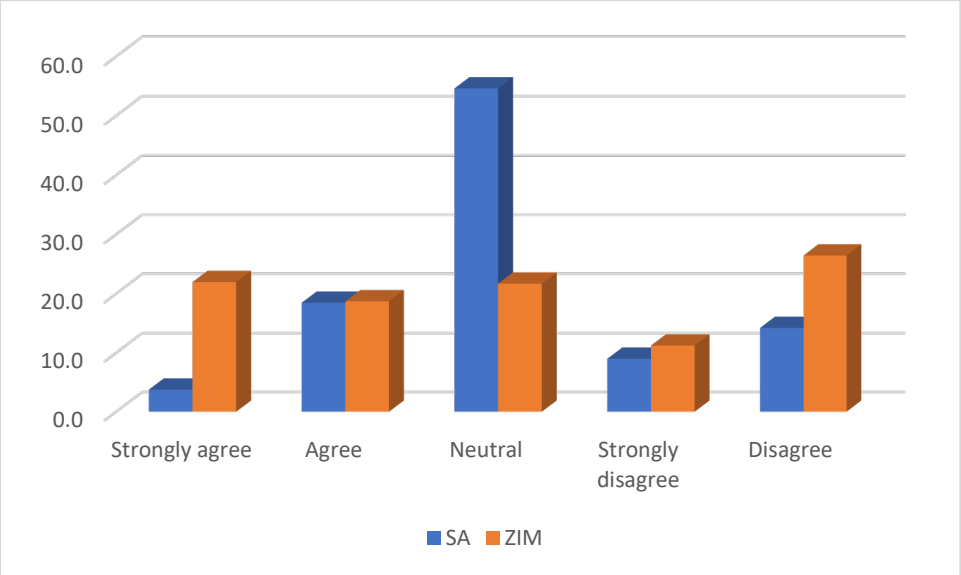
The researcher also determined women's ability to exert power in every sphere of their lives. The researcher aimed to find out whether the participants agreed or disagreed with the fact that women were more powerful at work and amongst their friends or colleagues. The results of this study proved that generally women were powerless in their marriages. The results (Figure 8) show that majority of the participants in South Africa were neutral (41.1%) while 30.2% agreed and less than 10% strongly disagreed (5.2%) that women were powerless in marriages. Contrary to South Africa, the survey indicated that 35.2% of women in Zimbabwe strongly agreed that women were powerful at work but powerless in their marriages. However, 21.9% were neutral and 13.2% strongly disagreed. This may relate to the nature of customary marriages.

FIGURE 9: POWERLESS IN MARRIAGE



The survey was also intended to gather data on whether women had autonomous decision-making in customary marriages. Figure 10 below shows that 14.2% of the women surveyed in South Africa disagreed that women had autonomous decision-making whilst 54.6% were neutral and 18.5% agreed. Likewise, in Zimbabwe, 18.7% of the participants agreed, 21.7% were neutral and more than a quarter (26.4%) disagreed. The similarity in the responses may be because women in this study also gave responses which suggested that women in customary marriages could not make decisions on when to have sex and deciding on family size.

FIGURE 10: WOMEN HAVE AUTONOMOUS DECISION-MAKING



6.4 Relationship control

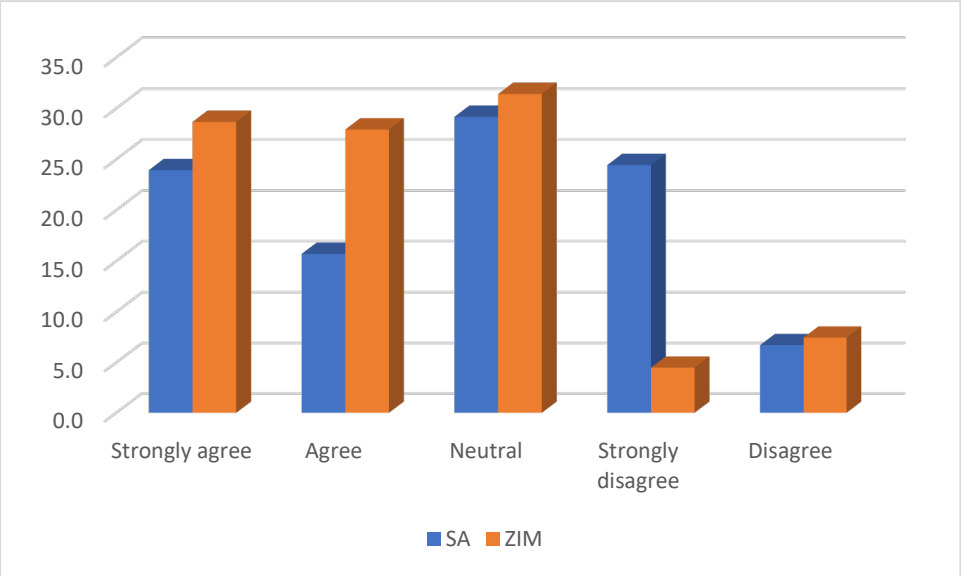
Descriptive analysis was conducted on relationship control. In terms of whether husbands wanted to have sex whenever they desired, 14.7% of participants in South Africa agreed whilst 36.2% in Zimbabwe agreed. Furthermore, 25% in South Africa strongly disagreed and 20% in Zimbabwe. Most of the participants (54.6%) in South Africa were neutral. Many of the participants in Zimbabwe agreed and this may relate to the fact that employment has a relationship on the ability to make decisions on family size because 53.6% (Table 3) of women in Zimbabwe are unemployed.

TABLE 6: HUSBANDS SHOULD HAVE SEX WHENEVER THEY DESIRE

Nationality		Percent
SA	Strongly agree	14.7
	Agree	25.7
	Neutral	26.7
	Strongly disagree	23.4
	Disagree	9.5
ZIM	Strongly agree	36.2
	Agree	10.0
	Neutral	19.0
	Strongly disagree	20.0
	Disagree	15.0

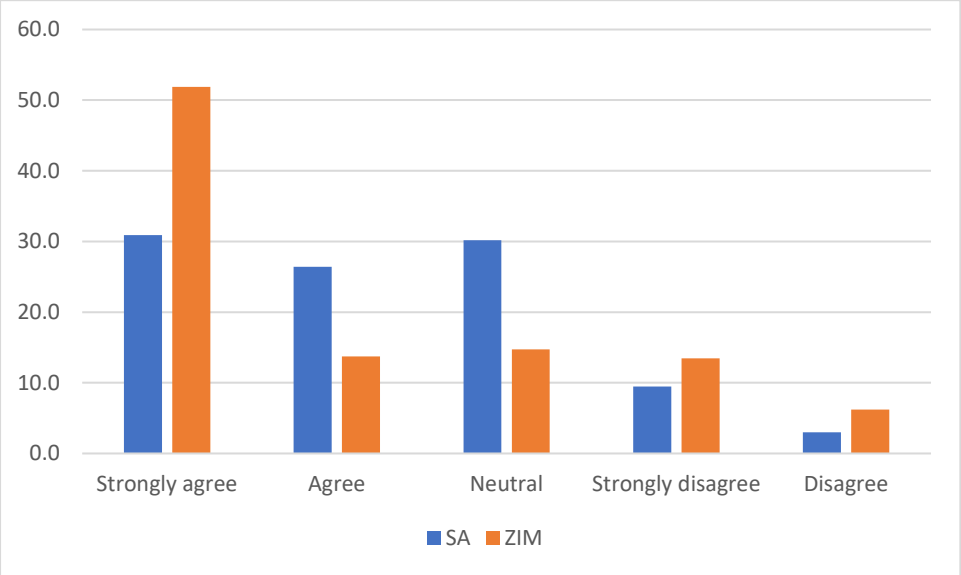
The inability of wives to refuse sexual advances from their husbands had detrimental effects on the health and well-being of young women within the sexual and reproductive health domain. From the results in Figure 11, 23.9% of the participants in South Africa strongly agreed that wives have the right to refuse sex while in Zimbabwe 28.7% concurred. On the other hand, 29.2% of the women surveyed in South Africa were neutral and 31.4% in Zimbabwe. From the survey, 24.4% in South Africa strongly disagreed that wives had the right to refuse sex compared to 4.5% in Zimbabwe who strongly disagreed to this. The data shows less than 5% level of agreement difference between the women who agreed that wives should have a right to refuse sex in South Africa and Zimbabwe. This suggests that women were aware that their sexual and reproductive health can be at risk due to the failure to assert this right.

FIGURE 11: RIGHT TO REFUSE SEX



The use of condoms can cause disagreements within the household. The survey asked the participants whether they agreed or disagreed that the use of condoms can lead to quarrels and in some instances spousal violence. The data shows varying results between both countries. It is revealed that 51.9% in Zimbabwe strongly agreed, 14.7% were neutral and 13.5% strongly disagreed that the use of condoms can lead to quarrels and at times spousal violence. Compared to Zimbabwe, the results in South Africa show that 30.9% strongly agreed while 30.2% were neutral and 9.5% strongly disagreed. There is a difference among the two countries with high percentage differences between agree and strongly agree responses.

FIGURE 12: USE OF CONDOMS CAN LEAD TO QUARRELS AND VIOLENCE



6.5 Cultural practices in customary marriages and young women's sexual and reproductive health

Women find it difficult to achieve the highest standard of health within the sexual and reproductive health domain. If some of the leading causes of the failure for women to attain the highest standard of health are identified and the playing field is level women could achieve the highest standard of health in sexual and reproductive health.

TABLE 7: CROSS TABULATION AND PEARSON CHI²- WOMEN SHOULD FREELY ENJOY SEX AND INDEPENDENT VARIABLES

Countries	Independent variable	X^2	p-value
SA	Culture	19.963[a]	0.222
	Wife inheritance	40.067[a]	*0.001
	Inheritance harmful	48.591[a]	*0.000
	Polygamous marriage as an agent of HIV/AIDS	41.941[a]	*0.000
	Impossible to assert	55.850[a]	*0.000
ZIM	Culture	30.086[b]	*0.018
	Wife inheritance	95.192[b]	*0.000
	Inheritance harmful	67.072[b]	*0.000
	Polygamous marriage agent of HIV/AIDS	18.729[b]	0.283
	Impossible to assert	21.882[b]	0.147

Reference category; *p<0.05

A cross tabulation analysis was also done between the variable women should freely enjoy their sexual and reproductive health. It was done with five other variables namely culture plays a vital role on the sexual and reproductive health of young women, the practice of wife inheritance places young widows at the risk of contracting HIV/AIDS and other sexually transmitted diseases. It was also done on the variable: the practice of wife inheritance is indeed a harmful practice for women, polygamous marriages are agents that transmits HIV/AIDS and women in a polygamous marriage find it impossible to assert their sexual and reproductive rights. The analysis was used to test the relationship, using the Pearson's Chi Square between the independent variables and the dependent variable. The objective is to determine if the independent variables affect the enjoyment of young women's sexual and reproductive health rights in customary marriages.

The analysis of data solicited from South African women yielded a chi-square value of 19.963; 40.067; 48.591; 41.941 and 55.850 respectively. While in Zimbabwe it yielded 30.086; 95.192; 67.072; 18.729 and 21. 882 respectively. From the results in Table 6, there is a significant relationship in both countries between the dependent variable (women should freely enjoy sex) and the practice of wife inheritance placing young widows at the risk of contracting HIV/AIDS and other sexually transmitted diseases ($p= 0.001<0.05$ in South Africa and $p=0.000<0.05$ in Zimbabwe) and the practice of wife inheritance is indeed a harmful practice ($p=0.000<0.05$ in South Africa and $p=0.000<0.05$ in Zimbabwe). Therefore, based on the statistical significance it can be concluded that the above-mentioned variables affect women's ability to freely enjoy their sexual and reproductive health in both countries.

Furthermore, the results in Table 6 show that in South Africa the two variables, namely, polygamous marriages are an agent that transmits HIV/AIDS and polygamous marriages make it impossible for women in South Africa to assert their sexual and reproductive rights have a significant relationship with women freely enjoying their sexual and reproductive health rights ($p= 0.000<0.05$). However, in Zimbabwe this is not significant. The results demonstrate clearly that there is a relationship between these variables in South Africa and not in Zimbabwe.

Table 7 shows that there is a significant relationship between culture and women should freely enjoy their sexual and reproductive health in Zimbabwe ($p=0.018<0.05$). However, in South Africa this is not significant. Therefore, this indicates that women in Zimbabwe enjoy their sexual and reproductive health rights than their counterparts in South Africa based on the statistical significance.

6.6 Summary of the results

As a conclusion, results based on the data collected from 802 women who were interviewed for this study show that majority of the participants in both countries belonged to two age groups, 28-35 and 34-40. South Africa had a higher number of employed young women than Zimbabwe. Furthermore, majority of the participants were in monogamous marriages as compared to polygamous marriages in both countries and also a majority stated that they had chosen their partners.

The results of the multiple regression analysis to determine if women's ability to make decisions about family size was based on age, employment and state of marriage found that there was a statistical significance between joint decision-making in South Africa and polygamy. Whereas in Zimbabwe there was a statistical significance between a woman's ability to make decisions on family size and employment. The analysis also found a statistical significance between joint decision making on sex and age in South Africa.

The descriptive analysis was conducted on relationship control factors on whether husbands must have sex whenever they desire. The data revealed that 14.7% of participants in South Africa agreed whilst 36.2% in Zimbabwe also agreeing. From the same analysis, the data revealed that 23.9% of the participants in South Africa strongly agreed that wives had the right to refuse sex with 28.7% of Zimbabwean women concurring. The data also revealed a large difference on the percentages in both countries on the responses on whether the use of condoms can lead to quarrels or spousal violence within the household.

The last analysis was a cross tabulation and chi-square tests on the relationship between the variable whether women should freely enjoy their sexual and reproductive health rights and five other dependent variables. In South Africa, there was a statistical significance between the dependent variable and four independent variables while in Zimbabwe there was only a statistical significance with only three variables.

CHAPTER 7 DISCUSSION OF THE FINDINGS

7.1 Introduction

The study employed a mixed methods research methodology to analyse the data collected from the participants on customary marriages and young women's sexual and reproductive health rights in Makwarela (South Africa) and Concession (Zimbabwe). By sampling and interviewing men and women separately, the researcher was able to highlight differences between men and women on their understanding and interpretations of sexual and reproductive health rights of young women in customary marriages. The integrated data is considered in its totality to provide a holistic interpretation of the data to answer the research questions of the study. The following discussion outlines the key findings, draws on the literature relevant to this study and highlights the importance of the theoretical framework in outlining implications of the research results and interpretations.

7.2 *Roora/mamalo* as an important component of customary marriage

To solicit information on the role of *roora/ mamalo* in customary marriages, the female participants who were interviewed for the qualitative phase of the study were requested to express their views on the question: *Roora/mamalo* is an important component of a customary marriage, what are the expectations that come with the practice of *roora/mamalo*? This was done to answer the research question this study posed: How do customary marriages affect young women's sexual and reproductive health rights? In this study, the participants revealed how much the payment of *roora/mamalo* (bride price) affects the power dynamics in the family. The participants highlighted how they were expected to bear children, not to question anything in the marriage, being submissive and bearing the unequal brunt in the marriage.

> *It is a marriage where mamalo is paid and I as the women I must leave my parent's house and go stay in my husband's house where I will start a family there. I cannot even leave the marriage because my family will say we have already spent your bride price as a result do whatever you are told there, give them children. They do not care even if it affects my health, I must just bear children so that the family name continues* (Rendani, 38 years old-South Africa).

> *Customary marriages involve the payment of the bride-price to the family of the woman hence the wife is seen to be bought through the payment of this money. Therefore, a woman does not have a say on her sexual and*

reproductive health since roora has been paid for her (Rudo, 31 years old- Zimbabwe).

In a customary marriage a man pays roora and it also allows him to marry another wife as this marriage is not monogamous. Indeed, bride price relegates women to 'an item of trade to be bought or sold' because in many instances it implies that the man has purchased the wife to provide labour, he can demand sex at any time and has control over the reproductive capacity of his wife among others (Chipo, 27 years old- Zimbabwe).

Due to *roora/mamalo,* a woman's position is still regarded to be in the kitchen and at home to bear and rear children. Though this is one of the areas where the discrimination against women emanates, the payment of the bride price is highly regarded and a customary marriage needs to be valid. Interestingly, women in the study who were employed were the ones who stated that their reproductive rights are purchased through bride price payment. One could assume that employment equips women and provides them with choices of action, but the findings clearly show that employed women are also not immune to negative consequences of *roora/mamalo*.

A possible explanation for this is that in both South Africa and Zimbabwe men are valued more than women. Women are seen as inferior to men and are always expected to be passive and submissive. This confirms what the literature review in this study puts forward. The literature reviewed in this study support the above argument as some scholars state that the payment of bride price has been abused by families and used as an avenue from which women are oppressed (Kambarami, 2006; United Nations Children's Fund, 2007; Townsend, 2008; Chireshe & Chireshe, 2010). Asiimwe (2013) also opines that bride price payment creates a situation where men strive to exert control over women to reinforce their masculinity while at the same time women will be trying to fulfil the gendered roles. For example, the payment of bride price tends to give men an entitlement to sex (Mugweni, Omar & Pearson, 2015) which increases the vulnerability of women because they cannot assert their sexual and reproductive health as a consequence of payment of *roora/mamalo* in Makwarela (South Africa) and Concession (Zimbabwe) to sexual violence and a high risk of HIV infection.

The study examined whether *roora/mamalo* violated the equality and human dignity of women. As revealed by the participants, they were not equal to their spouses because bride price has

been paid for them and their sexual and reproductive health rights have been forfeited since they are now seen as a property which belong to their husband. Relegating women to the position of a commodity priced and then bought violates the right to dignity and worth of women. Men in customary marriages felt entitled to sex because they have paid the bride price (*roora/mamalo)*. This is evidenced from the statement from one of the male participant who took part in this study.

> *A woman cannot choose to do as she pleases for example, she cannot choose to use the pill, condoms or injection. But the moment she starts using condoms now we have a big problem. Some of these children we have in marriages are as a result of not agreeing on the use of contraceptives hence there is no agreement on the spacing of children. They say that they have a right to do so and giving birth later in life can cause complications, but I paid bride-price for those things* (Anesu, 31 years old- Zimbabwe).

As a result, they are neither valued nor respected by their husbands and other family members. The right to human dignity is non-derogable. This means that this right cannot be suspended even in a state of emergency. Therefore, the right to dignity of women should be enjoyed by all women as guaranteed by the constitution. Akolokwu (2017) argues that since women are not able to refund this bride price that means that they are technically imprisoned. This then amounts to a form of slavery that contravenes all the international instruments against slavery and infringes upon the right to human dignity. In *Mifumi (U) Ltd. and Others v Attorney General Kenneth Kakuru*, (2015) the court in Uganda held that not only does the practice of bride price dehumanise women but it likens women to a personal possession that is sold and bought in the market. Women find it even hard to get out of abusive marriages since they are expected to return the bride price if they were to ask for divorce. Sambe, Avanger and Agba (2013) found in their study in Uganda that women have had their rights violated because of bride price payment and it affects their freedom.

In the context of the present study and light of radical feminist theory used in this study, one can argue that the system of *roora/mamalo* enforces the differences in reproduction and it culminates in gender inequality. It was held in this study that the feminist theory of radical feminism will be employed to determine the difference in reproduction which is reinforced by the cultural practice of *mamalo* or *roora* payment system and the bearing it has on gender power dynamics.

Conclusions drawn from these findings indicate that *roora/mamalo* is a key contextual factor for gender inequality and violation of the sexual and reproductive health rights of young women in marriages. Women are also relegated to the position of a commodity priced and then bought which also infringes the right to dignity and worth of women.

7.3 Expectations in marriage

The findings from the qualitative phase of the study established that society and family have expectations that have been attached to the role and standing of a woman in a customary marriage. This was done in an effort to answer the research question: *How do customary marriages affect young women's sexual and reproductive health rights?* These expectations vary from the role of a homemaker to a child bearer which in the participants' view is also a site where women experience discrimination. Social norms affect how families also perceive women in the family. The study established that norms for the marital relations suggest that married women are expected to comply with the social and family expectations linked with customary marriage.

> *A woman's role is said to be that of a caregiver and bearing children, the husband's role is to provide for the family. Women bear an unequal brunt. This expectation that women are supposed to bear all the household burden is uncomfortable and unfair on women. Because we are undervalued our decisions do not even matter even in cases where our sexual health is at stake* (Tatenda, 33 years old- Zimbabwe).

These could even go against safe sex practices and also safe sex discussions with the partner for young married women in Makwarela (South Africa) and Concession (Zimbabwe).

The findings of the study confirm the literature reviewed in this study on the societal and family expectations from women (Gunga, 2009; Sultrana, 2010; Beek, Dawson & Whelan, 2017). The social representations theory used in this study explains that society often places certain expectations according to which people have to behave. For example, women may be expected to behave in a certain way. In such a case, the society tends to expect women to see the significance of not deviating from the expected way of behaviour. According to Mtenga, Masanja and Mamdani (2016), social norms as rules are cemented in accordance with the social and cultural expectations. While Bicchieri (2006) puts it forward that norms are important

for they construct realities in society and imply consequences for disobedience. For this reason, they have the capability of shaping health practices and health seeking behaviour. A study by Mugweni, Omar and Pearson (2015) revealed that in Zimbabwe, extended family members and also the elders of the churches strongly discouraged women to negotiate for safe sex with their husbands. While a study conducted in Malawi found that cultural beliefs prevented partners from using condoms (Chirwa, Malata & Norr, 2011). Beyond the influence on sex norms, a study by Mtenga *et al*. (2015) in Tanzania found that social norms are also influenced by gender outlooks that significantly influence HIV status of married men and women in the country. Mtenga, Masanja and Mamdani (2016) argues that in most societies the norms that are in society have an influence on the sexual communication which is dictated by behavioural guidelines that create the norms about how sex and sexuality are regulated. This indicates that women face injustice within their marriages.

The finding also answer the question asked by the social representations' theory, in what way does social representations relate to attitudes? The study found that socialization determines the ability or inability of a woman to negotiate condom use.

> *…. society has a role to play because when they see certain thing in a marriage, they might say akadyiswa (wife used dark/black magic on him to make him do as she pleases) and so many things. There is also influence of religion on gender equality that the society attaches to it and it is still struggle in society. As men, we end up expecting some things from our wives because of people in society to a point that some of it is a threat to the health and well-being of your wife but we are afraid of what people will say if we do not do those things* (Anesu, 31 years old- Zimbabwe).

To this Dube, Nkomo and Khosa (2017) hold that socialisation is important in order for one to understand the ability or inability of women to negotiate for condom use because according to the African traditions, men are socialised to be in charge of decision-making in all aspects. Through the continuation of these expectations from generation to generation the behaviour in society is owed deeply to sexual stereotypes (Galy-Badenas, 2015). Social gender is a concept that is related to how women are regarded, viewed, considered and what they are expected to do as women by society and families based on the socially ascribed meanings and not on biology (Adana *et al*., 2011). In light of the family life, women are expected to be at home rearing and bearing children.

Conclusions drawn from the findings indicate that some marital expectations go against health practices of young women and customary marriage expectations imply that women must comply with the social expectations.

7.4 Challenges impeding the enjoyment of sexual and reproductive health rights in marriages

Enjoyment of sexual and reproductive health rights leads to the attainment of the highest standard of health. The lack of this results in negative sexual and reproductive health outcomes which disproportionately affects women and even the children they give birth to. The fourth research question: What are the obstacles to the realisation of young women's sexual and reproductive health rights? To get the views of the participants' which were explored qualitatively, the researcher posed the following question to the young women: What are the challenges which impede the enjoyment of your sexual and reproductive health rights in your customary marriage? The study revealed that there were various challenges that women faced in their customary marriages which impeded the enjoyment of their sexual and reproductive health rights.

> *Being expected to have sex regardless of your wills and wishes. Forced sex injures the woman's organs* (Tariro, 36 years old- Zimbabwe).
>
> *The issue of not being able to have sexual intercourse when I as the woman want but when he wants to end up hurting your organs due to dry sex because you do not desire any sexual encounter, but you are compelled. Traditionally I am not allowed to turn down the advances from my husband* (Sekai, 33 years old- Zimbabwe).
>
> *Sometimes when your husband dies you are expected not to move on with your life and be married again. You are expected to stay loyal and live as a widow. This affects the sexual rights of young women as I might have a desire to be sexually active but because of this kind of marriage and the traditional norms I am expected to remain celibate* (Mukondi, 34 years old- South Africa).

Being forced to have sex against your desires amounts to spousal rape. Most women are not even aware that this is an offence that is punishable by law both in South Africa and Zimbabwe. This is the case because none of the participants in this study even raised that although they

categorically stated they were often forced by their husbands. The women did not see that being forced to have sex by their husbands was tantamount to rape. The husbands thought that paying bride price entitled them to sex and their wives were expected to relinquish their sexual and reproductive rights.

Spousal rape can be described as any unwanted sexual act committed by a spouse without the consent of the other spouse. The sexual act could be forced, induced by threat or intimidation and it includes any form of sexual activity that could be degrading, unwanted and painful (Kolaide-Faseyi, 2018.) This is flagrant violation of a woman's right to dignity and other human rights of women. It can be understood that marriage creates unlimited rights and sexual responsibilities on the part of the wife that can never be coined as rape by the husband. Spousal rape is a form of gender-based violence. Women who experience sexual violence experience have a high risk of gynaecological problems like vaginal infection, pain during intercourse, chronic pelvic pain and urinary tract infections unlike those who do not encounter sexual violence (World Health Organization, 2012.) According to the International Conference on Population Development (1994), dry sex, which is a result of forced sex, may leave women being more vulnerable to sexual and reproductive diseases. This compromises the health and well-being of women. A study conducted by Martina, Taft and Resick (2007) found that women with a history of intimate partner physical and sexual violence were at a greater risk of developing cervical cancer and cervical dysplasia than women who had experienced only physical violence, only psychological violence, and no intimate partner violence.

The study also found that widowhood rites which did not allow women to have sex was a flagrant violation of their sexual rights. Women whose husbands have passed on should, regardless of the circumstances, be free to engage in sexual relations without any restrictions. This violates their fundamental human rights such as the right to dignity, the right to equality and non-discrimination. This practice is discriminatory, especially that men do not also undergo same restrictions when their female spouses pass on. This finding was thought-provoking because many studies on widowhood rites focus on levirate marriages and not usually on the mandated celibacy of widows. Therefore, this study adds literature to the existing body of knowledge on widowhood rites.

The literature that was extensively reviewed in this study indicated that in a marriage there is unequal power which does not allow women to exercise their sexual and reproductive health

rights (Washington & Tallis, 2012; Shefer, Glowes & Vergnani, 2012; Stern, Cooper & Gibbs, 2015; Iqabal *et al*., 2017). However, only male decisions prevail in such relationships. This means that women's lack of power does not allow them to exercise their sexual and reproductive health rights through taking preventive measures to safeguard their health and wellbeing. Married women cannot also assert their sexual and reproductive health rights because there is no guaranteed protection against violence in their customary marriages (Anderson *et al*., 2014). This is because married women were sometimes forced to have sexual intercourse by their husbands. The finding of the study confirms the above-mentioned notions from the literature review and adds onto the existing body of literature on the challenges in customary marriages that impede the enjoyment of sexual and reproductive health rights of young women in Makwarela (South Africa) and Concession(Zimbabwe) (Mukonyora, 2007; Jackson, 2012; Machingura, 2012). The powerlessness of women in Makwarela (South Africa) and Concession (Zimbabwe) is rooted in gender inequality as was apparent in this study because women occupy an inferior position due to factors like the payment of the bride price. Women are subjected to conditions that threaten their health and well-being because of men's entitlement to sex (Madiba & Ngwenya, 2017). The analysis above shows that challenges that exist in customary marriages hinder women to assert their sexual and reproductive health rights which results in negative health outcomes.

A study by Ezeanolue *et al*. (2015) is in line with the findings of this study that women who cannot assert their sexual rights are less likely to use contraceptives because their spouses disapprove. This is also corroborated by Kibira *et al*. (2014) who contend that women who are not empowered have no power over their sexual and reproductive health and rights. As a result, such women are not allowed the use of contraceptives to safe-guard and enhance their health. This also means that they are not allowed to use contraceptives to control their fertility. This makes them to miss an opportunity to decide on the number of children they can have. This situation forces them to have more children they can afford. This leaves them with more children and stuck in poverty forever. If the family is too big, the family will not be able to afford the school necessities of their children. Some of these children may drop out of school very early in their lives. Girls are likely to be forced into early marriages which may result in maternal and infant mortality. Canning and Schultz (2012) concur with the foregoing argument when they state that improvements in reproductive health can benefit the economy through the reduction and control of the population. Scholars like Bashir (2017) postulate that an increase in education leads to greater exposure of life outside the family and beyond the boundaries of marriage. Consequently, most of the children born to parents in customary marriages are likely to drop out of school since their parents cannot afford to keep all of their children in school. All

this is due to the failure of most parents in customary marriages to practice safe sex and control fertility which as highlighted has countless benefits.

As evidenced in this study, the quantitative phase of the study indicated that some women's attempts to insist on condom use may result in spousal violence. The survey asked the participants whether they agreed or disagreed that the use of condoms can lead to quarrels and in some instances spousal violence. The data showed that 51.9% of women in Zimbabwe strongly agreed whilst in South Africa show that 30.9% strongly agreed to this notion. In some cases, it results in forced sex which in turn is harmful to the women as one of the women stated in the interview.

> *Having to ask for the use of contraceptives like condoms and the husband refuses. At times I would not be wanting to have any sexual intercourse with him. There was a time I was sick, I assumed it was an infection. I asked my husband that we use protection until I can go to the clinic to determine the cause of the sickness he blatantly refused. You need to be safe we never know it might be sexually transmitted diseases* (Madhuva, 27 years old-South Africa).

This also exposes women to a high possibility of HIV infection (Nyamhanga & Frumence, 2014). From the above-mentioned conclusions drawn from the findings indicate that sexual coercion is crucial to fertility outcome, furthermore there is a correlation between sexual coercion and negative sexual reproductive health outcomes. The study links forced sex to gender based violence.

7.5 Polygamy

The spread of HIV is minimal in a monogamous marriage as it traps the virus between two people. The qualitative phase of the study found that women in polygamous marriages find it impossible to assert their sexual and reproductive health rights for example being able to negotiate for safe sex.

….it poses a threat because if a man brings a disease into the house a woman cannot ask for the use of a condom because they are married (Mukondi, 34 years old- South Africa).

This study also found that polygamy is responsible for the transmission of STDs like HIV/AIDS. The quantitative study revealed an association between polygamous marriages as an agent of HIV transmission and the ability of women to freely enjoy their sexual and reproductive health rights. This finding concurs with the literature that the researcher reviewed in this study on how it is practiced both among Vhavenda and the Shona people and the consequences borne from it like transmission of HIV/AIDS and unplanned pregnancies (Mapuranga, 2010; Machingaura, 2011; Jonas, 2012; Mubangizi, 2012). McDermott and Cowden (2015) are of the view that polygamy is one of the sites where cultural traits tend to exist in particular social environments where the empowerment of women is low. As already highlighted in this study, the lack of women empowerment limits women's choices of action. Data that has been collected in many countries worldwide clearly show that polygamy is a practice that constitutes fundamental abuse of human rights and dignity (Lawson & Mhairi, 2018). This makes the practice to be in direct contravention of all international and national legal instruments. Smith-Greenaway and Trinitapoli (2014) posit that polygamous marriages violates the right to equality of women and as such it affects their financial and emotional standing for women and their dependents.

In answering the research question: What are the obstacles to the realisation of young women's sexual and reproductive health rights? The study findings that women find it impossible to assert their sexual and reproductive health rights in polygamous marriages were similar to the findings of the study carried out by Baschieri *et al*. (2013). That study indicated that women in polygamous marriages are at an increased risk of HIV transmission and they also experience intimate partner violence. This is due to the gender power dynamics in customary marriages. Not only do women in polygamous marriages suffer from physical abuse, they also experience emotional, sexual and psychological abuse (Mabaso, Malope & Simbayi, 2018). A study by Yerges *et al*. (2017) found that women in Malawi who were in polygamous marriages view it as an injustice and they also judged the dominating behaviours of their husbands negatively. A study in South Africa revealed that the lack of education and empowerment among women play a crucial role in polygamous relationships (Mabaso, Malope & Simbayi, 2018). This can be because women who are more educated are less likely to be in a polygamous marriage, more likely to marry later in life and are highly independent.

To further cement this notion, a study in Malawi found that women who are in monogamous marriages are more able to use contraceptives than women in polygamous marriages (Baschieri *et al*., 2013).

Participants in this study highlighted how difficult it is to ascertain whether each person in the union is faithful.

> *In a polygamous marriage one can never be sure if the partners in the union are being faithful and not being sexually active with other people. We seldom use condoms therefore it is a very risky arrangement. This also is an agent that spreads diseases like HIV* (Rendani, 38 years old- South Africa).

Similarly, a study by Mtenga *et al*. (2016) revealed that it was difficult for women to practice safe sex since one cannot be certain about the sexual risk behaviours of co-wives. Conclusions that can be drawn from this are that women in polygamous marriages do not have autonomy and there is a barrier in polygamous marriages to have conversations on reproductive health outcomes.

7.6 Wife inheritance

To answer the research question: What are the obstacles to the realisation of young women's sexual and reproductive health rights? The researcher asked a question: How does the practice of wife inheritance pose a threat to a young woman's sexual and reproductive health right? The qualitative phase of the study revealed that wife inheritance is a practice that poses a threat to the health and well-being of young women. This is through expecting women to bear children and to have sex with the inheritor whose, in most cases, the HIV/AIDS status is unknown. A study by Agot *et al*. (2010) revealed 63% HIV/AIDS infection rate among widows in Nyanza Province who were inherited to perform sexual rituals. Furthermore, in this same study it was found that there is limited to use of condoms with only 2.7% of the widows reported to have used condoms after the death of their husbands. This reveals that the lack of condom use among widows aids in the transmission of HIV/AIDS. Perry *et al*. (2014) reveal that each partnership within this marriage increases the potential of being exposed to HIV/AIDS which not only puts the widow and inheritor at risk but also the inheritors partner at risk. Brown (2011) is of the view that in the face of HIV/AIDS, such practices like wife inheritance are an agent of transmission. In African communities, the cause of death is never divulged in the end there is now a marital union between a widow who might be infected and a suitor who is not. The virus

can now be spread to the brother and possibly future children born out of the union. This practice encourages the creation of a sexual web just as polygamy does.

The researcher contends that mandating or giving away the widow to an inheritor is disposing her like a property of the deceased. This is a violation of the human rights of women such as the rights to equality and dignity. However, Kudo (2017) states that the empowerment of women can highly contribute to the disappearance of wife inheritance.

Much is not done to protect women and girls from the cultural practices. The society and families turn a blind eye to some of the harms that women and girls face. One could say that being quiet on these practices is perpetuating their rate and prevalence. To this Shonayin (2012:98) says that:

> *Africa does not protect its women. Generation after generation the same old mistakes are repeated because atrocities and injustice against women are justified by traditional beliefs*.

These beliefs create dire health consequences for women as this study revealed and women are viewed as available to men for their benefits and it hampers women's equality. In many cultures, a discussion about sexual matters is a taboo hence there is a silence on HIV/AIDS therefore it becomes difficult for some groups in society to negotiate and practice safe sex (Mkhize & Njawala, 2016).

Conclusions drawn from the findings indicate that condom use is not acceptable in widowhood inheritance as it is viewed as placing a barrier between the practice. Women are vulnerable to sexual morbidities due to cultural practices.

7.7 Inability to make decisions on family size and sex

The study sought to answer the research question: How is the sexual relationship power in customary marriages exercised? The results from the qualitative phase of the study prompted the researcher to explore this phenomenon quantitatively. This study revealed that women are not able to make decisions on family size as well as decisions on sex due to culture and

societal expectations. As already stated in the previous section, women do not have control over their bodies in customary marriages (c.f Section 2.2.1). Some women in this study stated how they do not have the power to control the number and spacing of children, but it is entirely the decision of their husband.

> *No. My husband as the head of the house and the one who earns more money in our marriage is the one who decides on the number of children we ought to have based on his finances* (Fhulu, 35 years old- South Africa).

The findings were further explored quantitatively to determine the extent to which women do not have autonomous decision-making abilities. The study revealed that woman alone cannot make the decision its either made by the husband or jointly confirming the findings from the qualitative study. As stated in the literature review (Khosla *et al.*, 2015; Androff, 2015), social determinants of health play a significant role on the health of women. The findings of the study depict how the ability to make decisions on family size is determined by employment status in Concession (Zimbabwe). The study also found a relationship between joint decision-making and polygamy in Makwarela (South Africa).

The results from the Demographic and Health Survey (Zimbabwe National Statistics Agency and ICF International, 2016) in Zimbabwe shows that majority of the women can participate in decisions concerning their health. One would have expected a higher percentage of women to be able to voice out their opinions on their health. The results of the Demographic and Health Survey also show that women's participation in decision making, either alone or jointly with their husbands, increases with education and wealth. Women in the wealthiest households are more likely to participate in all three decisions than women in the poorest households finds the survey. The results of the Demographic and Health Survey in South Africa show that 94% of the women can participate in decisions concerning their health (NDoH, Stats SA, SAMRC & ICF, 2019.) This could also explain why in this study the percentage of women who could make decisions on family size and sex was higher than in Zimbabwe.

The point of departure of every health system is the household, and the household characteristics are fundamental to issues of health like maternal health. Maternal health and household characteristics are strongly related (Amzat & Grandi, 2011). A study found that household and financial decision-making were closely related to the health of women, attitude to gender roles and the authority to make decisions (Chirowa, Atwood & Van der Putten,

2013). Another study conducted in Zimbabwe shows that when men control household decisions it means that women are less likely to use any contraceptives and discuss the number and spacing of children they desire with their spouses (Abekah-Nkrumah, 2013). This means that the lack of input in household decision-making is associated with negative reproductive health outcomes. Based on the results of this study, women in Concession (Zimbabwe) and Makwarela (South Africa) who are unable to make decisions in the household such as deciding on family size are not in a position to propose for safe sex to control the number of children they will have.

The findings of the study are consistent with the framework of unequal power in sexual and reproductive health that gender relations can have a huge impact on decision-making. These usually find footing in marriages especially customary marriages as they are characterised by adherence to cultural norms which in effect favour men. The findings also concur with the literature reviewed in this study by authors such as Tadele and Kloos (2013) and Stephenson *et al.* (2012) that challenges of women in sexual relations include the traditional role of how women are supposed to socialize, social myths as well as women's lower socio-economic position. The traditional role of women places them in an inferior position and it is against some societal norms that women voice their opinions on sexually related matters. These power balances can limit the ability of women to access sexual and reproductive information because of lack of financial resources which also limit the mobility of women. The findings of this study therefore extends knowledge in this area and also reinforces current thinking.

Kofi (2015) breaks down the autonomy of women as the power to create and execute independent decisions about matters that are of personal importance to their lives and their relatives although men may be an obstacle to their wishes. This is means that people become autonomous when they can act according to their wills and wishes. Oakley (2015) argues that the type of power men possess is given to them because in society they are seen as the head of the house and this makes them to feel entitled to everything about their wives. Studies have shown that family planning decisions are not made by women alone (Adamczyk & Greif, 2010). This signifies how the sexual relationship power is in customary marriages that women wiled no power regarding making decisions on sex and family size.

The ability of women to make independent decisions on their own is dependent of their economic stability that is to say how much they depend on their husband for financial support.

Scholars like Djamba and Kimuna (2015) advocate for the education of women signifying how it empowers women and is a health variable. Evidence show that women's reproductive powers are undermined due to their subordinate role (Smith, 2013). In countries like South Africa and Zimbabwe as evidenced by this study, men dominate sexual decision-making which leads to damaging results for women's health rights.

The findings of the quantitative study revealed a link between employment of women and ability to decide on family size. This could also be related to the fact that over the past two decades the economy in Zimbabwe had deteriorated and women are also seeking employment to share the burdens of taking care of the family. Based on this it is hard for women to have full time employment and to bear more children. As the framework for unequal power in sexual and reproductive health that was used in this study states, individual and social characteristics like education and occupation is associated with unequal power in sexual and reproductive health which influences the ability of women to acquire information, ability to decide and ability to act within the reproductive health domains. The findings of the study confirm the study by Beguy (2009) who stated that women who are employed generally have lower fertility rates than women who are not working in Sub-Saharan Africa, but the context differs from country to country. Greater access to resources means that women are more able to control their reproductive behaviour. As was also evidenced in this study from the responses of some of the male participants, the involvement of women in economic activities is met with resentment as they claim that it is against the norm that women must not work and should be confined at home doing household activities.

> *Like I said, a woman must not work. No right is being challenged this is how it should be* (Ronewa, 28 years old- South Africa).

> *Now because of this equality a woman can go out there and get a better job some men feel threatened and the need to provide especially if the man is not working it does not make one lesser of a man. The other issue is like relatives cause problems about who does this and especially if the man is not working*……. (Khakhathi, 43 years old- South Africa).

To this Oakley (2015:19) states that "a woman's economic dependence has shown to be a predictor of high perceived relationship power. When a man has more money, he has "power over" the woman, but when the woman is financially independent she has the "power to" make her own choices and use her resources." The researcher contends that a woman's financial

independence improves negotiating and bargaining power and decision-making in the household.

The findings of the study bring the questions of women's decision making on family size and decisions on sex to the fore through the decision-making dominance results from the quantitative study. As revealed in the literature review conducted in this study, an RBA approach focuses on human dignity, integrity and protection of the vulnerable. When this approach is applied to the health and well-being of women it is inescapable not to speak about the autonomy and control of the body of a woman. The position of women as people with no autonomy shows that they are illegitimately oppressed. Azmat and Grandi (2011) put it forward that, due to the lack of self-determination it is often difficult for health professionals to advise married women on unplanned pregnancies because they are powerless to make such decisions. Studies have shown a relationship between the empowerment of women and contraceptive use (Do & Kurimoto, 2015). Similarly, a study in Nigeria revealed that women who have a say in decision-making are more likely to be able to control their fertility compared to those that do not have a say in their homes (OlaOlorun & Hindin, 2014). While a study by Farmer *et al.* (2015) revealed that the attitude that men possess over the use of modern contraceptives and the dominance of their power is associated with the low usage of contraceptives.

The study found an association between making a joint decision on family size and the state of the marriage (*p=0.039<0.05)*. Being in a polygamous or monogamous marriage affects the ability of women to decide willingly the number of children they desire. This concurs with the findings of Kang'ethe and Munzara (2014) that polygamy affects a woman's right to reproductive autonomy simply because the decision to have sex is determined by the sexual activities of the husband with the other women in the marriage.

> *A polygamous marriage makes it impossible to choose freely when you want to have sex because for example you are compelled to have sex if the husband is sleeping in your bedroom that night. There is also a competition to give the husband children even after you might have passed your reproductive age* (Tariro, 36 years old- Zimbabwe).

This study revealed that there is a relationship between age and joint decision-making on sex in Makwarela (South Africa) *(p=0.001<0.05)* unlike in Concession (Zimbabwe). These findings

are in line with the finding from a study conducted in Asia. The study in Asia found that the age of a woman and family structure are the strongest determinants of women's decision-making (Anum, 2017.) Igboin (2011) puts it forward that women are powerless in marriages because they are mostly younger than their husbands in Africa and due to this, there is an unequal power which culminates in seniority in decision-making. Bearing this in mind, women improve their negotiating skills as they age and the desire to fulfil family expectations becomes lesser as the woman ages. However joint decision-making improves women's health too as the discussion about this in the household also educates the man on the eminent dangers of negative sexual and reproductive health outcomes. Tumlison *et al*. (2013) concurs and states that when a couple communicates and makes decisions together in matters such as contraceptive use it creates a platform that encourages sincere conversations about sexual and reproductive health, decisions about family size as well as desired contraceptive. Couples in turn make better choices on fertility and the health and well-being of a woman and also it avoids unplanned pregnancies as well as consequences of maternal morbidity. Joint decision-making has been held in previous studies to be the best choice for couples especially in terms of contraceptive adoption (Opoku, 2017) and thus it is an ideal choice for couples.

Conclusions drawn from the findings indicate that women do not have autonomous decision-making abilities, gender inequality is a form of discrimination that reflects powerlessness of women in aspects of sexual and reproductive health decision-making. Joint decision-making improves women's health and engages the husband in the sexual and reproductive health awareness of women's health. The study extends knowledge on unequal power in sexual relations and reinforces current thinking.

7.8 Relationship control

The study sought to determine some factors that control the relationship such as the use of condoms, the right of the wife to refuse sex and whether husbands have the right to have sex whenever they desire. The researcher endeavoured to answer the research question: How is the sexual relationship power in customary marriages exercised? The results from the qualitative study revealed how some women are powerless in their marriages and how men seek to control every aspect of the relationship hence the study quantitatively explored this aspect.

In this study, majority of the participants who were surveyed reported that a wife has the right to refuse sex in customary marriage in Makwarela (South Africa) 23.9% of the participants strongly agreed while in Concession (Zimbabwe) 28.7% concurred. The right to refuse sex is considered hostile because of the belief that sex is part of the marriage covenant made by spouses (Upadhyay & Karasek, 2012.) Studies have observed that in many societies the existence of cultural beliefs deny women the right to refuse sexual advances from their husbands (Adinkrah, 2011; Adinkrah, 2017). The ability of a woman to refuse sex in a marriage can be used to determine the autonomy of a woman as well as her empowerment. The ability of a woman to be able to refuse to have sex is very important to her health because it avoids forced and unwanted sexual intercourse, diminishes chances of unwanted pregnancies and abortions. In a study conducted by Adebowale and Palamuleni (2014) in Nigeria, it was found that the ability of women to refuse sex has positive health consequences especially if the husband agrees to use condoms. However, it should also be noted that women who earn an income can refuse sex. In this study, the majority of the participants were employed hence they have more choices of actions available to them since they are empowered, they can turn down sexual advances.

In this study, majority of the participants put it forward that husband should have sex whenever they desire (14.7% of participants in South Africa agreed whilst it was 36.2% in Zimbabwe). Sex is a right in marriage that is endorsed by the customs. Anyemedu, Tenkorang and Dold (2017) explain that it is a cultural belief that sex is a man's right in a marriage. Sex is a right that a husband can claim from his wife at any time he desires (Adodo-Samani, 2015.) In this study, it can be said that due to the payment of the bride-price and the expectations that come with it, young women feel that their husbands are entitled to sex whenever they desire. Due to this, young women cannot say no to the sexual advances of their men because they still want to live up to the expectations of the family and the society.

The literature that was reviewed in this study highlighted how women lacked the power to negotiate for condom use in their marriages (Shamu *et al*., 2012; Perry *et al.,* 2014). The quantitative study revealed that the use of condoms can cause spousal violence and also disagreements with the husband. The study findings concur with the literature review that women lack autonomy and the power to negotiate for safe sex and that the power lies with the husband in the marriage who has the power in the relationship. The findings from this study alongside other studies reveal that women can experience violence after they bring up the use of a condom within the household. According to Coma (2014) on condom use within marriage,

HIV prevention programs have managed to send a wrong message across that makes condoms conflict with the rules of marriage as they have been promoted as a method for preventive risky sexual behaviours and commercial sex exchanges outside marriage. Sharma and Nam (2018) are of the view that using condoms is associated with casual sex which is outside the borders of a marital union. This has made the practice of condom use seem as if it goes against the values of marriage which are trust and fidelity. Use of condoms are welcome in short term relationships not long-term relationships such as marriage (Anglewicz & Clark, 2013). According to Otjeg (2009), some men are of the view that if they accept condom use they are indirectly admitting to infidelity. Researchers like Chimbiri (2007) are bold enough to label condoms as 'intruders' in the marriage and further state that the use of condoms in the house is unwelcome. Chimbiri (2007) further states that the use of condoms is like an obstruction of something that is supposed to happen naturally. A suggestion for condom use in the household implies that there is no trust and there is a risk of infection of diseases like HIV, then it will raise questions about where the risk came from (Ojteg, 2009). As the quantitative study revealed about the threat of violence or quarrels once a condom is used, a study by Bauni and Obonyo (n.d) concurred that condom use it threatens the trust that comes with marriage and the reaction might be violence.

Given the foregoing discussion, married women find negotiation for safer sex and condom use for the family planning more difficult than single women (Wellings *et al*., 2006). A study in South Africa found widespread dissatisfaction towards the use of condoms in a marriage (Maharaj *et al*., 2012). While in India a study found that most of the women that are married have a pressure from society to prove their fertility through bearing children hence no use for contraceptives (Maharaj *et al*., 2012). The findings of the study indicate that women married customarily in Zimbabwe and South Africa found it challenging to negotiate for condom use with their husbands. In the continent of Africa married women are discouraged from using condoms because they are generally expected to bear children (Ojteg, 2009). Condoms have a beneficial effect as a family planning method and its double protection effects are not even mentioned but it is very feasible. The improved condom use will bring direct benefits when it comes to the reduction of HIV among the couple. Patriarchal ideologies coupled with other factors influence the resistance to the use of condoms. Furthermore, cultural norms such as the need to have children to stamp your masculinity as a man promotes promiscuity thereby and facilitates the lack of condom use (Dube, Nkoma & Khosa, 2017). To add on, the fear of losing financial support is also a contributing factor for women in Africa to negotiate safer sex because most of the women are not empowered (Amoyaw *et al*., 2015).

Conclusions drawn from the findings indicate that women can refuse sex when they are empowered and the ability of a woman to refuse sexual advances from the husband have positive sexual and reproductive health outcomes. Cultural expectations make husbands entitled to sex whenever they desire, and women adhere to this expectation. Therefore, suggestion of condom use may be viewed as bringing out weakness of the relationship base and may lead to physical violence. Condoms are seen as preventive measures against unwanted pregnancies not as a preventive measure for STIs and HIV/AIDS and customarily married women cannot negotiate for condom use due to various reasons.

7.3 Expectations in marriage

The findings from the qualitative phase of the study established that society and family have expectations that have been attached to the role and standing of a woman in a customary marriage. This was done to answer the research question: How do customary marriages affect young women's sexual and reproductive health rights? These expectations vary from the role of a homemaker to a child bearer which in the participants view is also a site where women experience discrimination. Social norms affect how families also perceive women in the family. The study established that norms for the marital relations suggest that married women are expected to comply with the social and family expectations linked with customary marriage.

> *A woman's role is said to be that of a caregiver and bearing children, the husband's role is to provide for the family. Women bear an unequal brunt. This expectation that women are supposed to bear all the household burden is uncomfortable and unfair on women. Because we are undervalued our decisions do not even matter even in cases where our sexual health is at stake* (Tatenda, 33 years old- Zimbabwe).

These could even go against safe sex practices and also safe sex discussions with the partner for young married women in Makwarela (South Africa) and Concession (Zimbabwe).

The findings of the study confirm the literature reviewed in this study on the societal and family expectations from women (Gunga, 2009; Sultrana, 2010; Beek, Dawson & Whelan, 2017). The social representations theory used in this study explains that society often places certain expectations according to which people have to behave. For example, women may be expected to behave in a certain way. In such a case, the society tends to expect women to

see the significance of not deviating from the expected way of behaviour. According to Mtenga *et al*. (2016), social norms as rules are cemented by the social and cultural expectations. While Bicchieri (2006) puts it forward that norms are important for they construct realities in society and imply consequences for disobedience. For this reason, they have the capability of shaping health practices and health seeking behaviour. A study by Mugweni, Omar and Pearson (2015) revealed that in Zimbabwe extended family members and also the elders of the churches strongly discouraged women to negotiate for safe sex with their husbands. While a study conducted in Malawi found that cultural beliefs prevented partners from using condoms (Chirwa, Malata & Norr, 2011). Beyond the influence on sex norms, a study by Mtenga *et al*. (2015) in Tanzania found that social norms are also influenced by gender expectations that significantly influence HIV status of married men and women in the country. Mtenga *et al*. (2016) argues that in most societies the norms that are in society influence the sexual communication which is dictated by behavioural guidelines that create the norms about how sex and sexuality are regulated. This indicates that women face injustice within their marriages.

The finding also answer the question asked by the social representations' theory, in what way does social representations relate to attitudes? The study found that socialization determines the ability or inability of a woman to negotiate condom use.

> *…. society has a role to play because when they see certain things in a marriage, they might say akadyiswa (wife used dark black magic on him to make him do as she pleases) and so many things. There is also influence of religion on gender equality that the society attaches to it and it is still struggle in society. As men we end up expecting some things from our wives because of people in society to a point that some of it is a threat to the health and well-being of your wife but we are afraid of what people will say if we do not do those things* (Anesu, 31 years old- Zimbabwe).

To this Dube, Nkomo and Khosa (2017) hold that socialisation is important for one to understand the ability or inability of women to negotiate for condom use because according to the African traditions men are socialised to be in charge of decision-making in all aspects. Through the continuation of these expectations from generation to generation the behaviour in society is owed deeply to sexual stereotypes (Galy-Badenas, 2015). Social gender is a concept that is related to how women are regarded, viewed, considered and what they are expected to do as women by society and families based on the socially ascribed meanings

and not on biology (Adana *et al*., 2011). In light of the family life, women are expected to be at home rearing and bearing children.

Conclusions drawn from the findings indicate that some marital expectations go against health practices of young women and customary marriage expectations imply that women must comply with the social expectations.

7.9 Patriarchy

To answer the research question: What is the relationship between customary marriages and gender equality? The study revealed that patriarchy has detrimental effects on the health and well-being of young women in customary marriages. This was evidenced by one of the participants who stated that:

> *Customary marriages tend to be patriarchal and men are dominant while women are expected to be passive and submissive* (Tatenda, 33 years old-Zimbabwe).

The study has revealed through the literature review as well as the findings of this study how the patriarchal norms have a role to play on the power dynamics in customary marriages (Ngubane, 2010; Mlambo-Ngcuka, 2017). According to the participants, men were the ones that hold enormous power. The literature reviewed in this study states that patriarchy in most African countries socialises women into believing that they are subordinate to men (Ngubane, 2010; Mapuranga, 2012; Kruger *et a*l., 2014). Thobejane (2017) concurs with what was stated by the participants in this study that the role of a woman in patriarchal societies is reduced to being sexual objects. Women in Makwarela (South Africa) and Concession (Zimbabwe) indicated how they are subjugated by men within their marriages. The study also found that expectations ranked because of patriarchy provide a structure in society that gives man unquestionable authority. According to Johnson (2014:28), “the roots of a tree represent patriarchy they demonstrate a deep-rooted male control that is tangled and difficult to disentangle.” Patriarchy is a social norm that is deeply rooted in culture therefore its woven into the attitudes and behaviours of young men.

This study revealed that women are controlled by men in every sphere of life including in the area of reproduction by dictating the number of children they must bear.

> *My husband has a say in everything the number of children we have and when and if to have children* (Rudo, 31 years old- Zimbabwe).

According to Stromquist (2014), women in South Africa suffer due to patriarchy which seeks to control female sexuality and fertility. When women depend entirely on men it implies their involvement in family decision-making and reproductive health decision-making (Nwokocha, n.d). A study conducted in Nigeria revealed that how a man defines his position in the family determines his perception towards the use of family planning (Eborka, Oyefara & Oyekanmi, 2017).

A study by Shoola (2014) found that the gender divide in Sub-Saharan Africa which is influenced by patriarchy directly affects the ability of women to protect themselves from STIs and HIV/AIDS. Patriarchy leaves women vulnerable to HIV/AIDS as it creates a way for women to be powerless. Patriarchy also diminishes women's decision-making ability and it affects their sexual life (Kang'ethe & Munzara, 2014). When women do not have the power to negotiate sexual relations it makes it easier for them to be prey to STIs and HIV/AIDS. The study further held that lack of adequate healthcare offered to women contributes significantly to high maternal mortality rate. In some Sub-Saharan African countries, maternal mortality rates are higher than elsewhere in the world with women dying either in childbirth or from complications in pregnancy (Banque, 2012). Based on this study, complications can be experienced by women due to the inability to assert their sexual and reproductive health rights within their marriages. Shoola (2014) argues that women suffer from the lack of good health and reproductive rights and this disadvantages women and it is harmful to their mortality and influences the number of years they live.

The theory of radical feminism which was used in this study contends that the culturally symbolic and accepted roles of reproduction that the society assigns to women contributes to their subordination by restricting women to certain roles. This study concurred with the literature reviewed and found that the differences in the roles of men and women have developed a meaning that reflect a hierarchy based on gender which results in male domination and female insubordination. This finding is similar to Ademiluka (2018) who

revealed that patriarchy in the household is also defined by the roles that women play usually which are domestic.

In this study, the researcher used the concept of hegemonic masculinity which is embedded in the sex role theory. Connell's concept allowed the researcher to examine how socially prescribed sexual relations between men and women may aid to unequal power in the domain of sexual reproductive health. The sex role theory refers to different aims namely:

1) Analysing and differentiating the person and the societal position attained. Men and women have different roles assigned to them by society. The study links this to the social position assigned to women as that of being a wife and a mother.

2) The actions allocated to the position. As highlighted in this study, the wife has a primary role of taking care of the house which involves cooking, cleaning and rearing children. Therefore, women tend to be very dependent on their husbands which might have implications on their health seeking behaviours as they will be financially incapacitated. As a result, the sexual and reproductive health of young women is comprised.

3) The proper and anticipated behaviour accepted by society. Based on this study and the literature reviewed, the proper behaviour accepted by the society is that of fulfilling the tasks mentioned above. Moreover, the wife is highly expected to bear children.

4) Involving people set in contrast. In this case, the people in contrast are the male and the female in the context of this study are husband and wife. The wife is usually younger than the husband and this creates an imbalance when deciding on sexual health matters as seniority will always apply.

5) Resulting in advantages and disadvantages depending on one's action. It was revealed in this study that becoming a wife traditionally usually has no perks. The power dynamics disadvantage women as they cannot live a life that is desirable to them and assert their sexual and reproductive rights without being controlled by their husbands.

From the male participants, this study found that men do not believe in gender equality as most of them maintain that the men are always the heads of their families.

> *I think is a good stance for equality among men and women in other ways. But in other ways it is not a right thing. Because it gives women a lot of*

powers to the point that she will be taking the male duties and making them her own (Mulalo, 36 years old- South Africa).

The researcher maintains that patriarchy should be replaced by something that has equality at the core with no one in the marriage holding power, but everyone is equal.

Conclusions drawn from the findings indicate that attitudes and expectations ranked through superiority of one sex over the other provides an unquestionable authority of men. Additionally, gender ideology negatively impacts women's ability to access healthcare and their understanding and knowledge of good health practices. Differences in the roles of men and women have developed a meaning that reflect a hierarchy based on gender which results in male domination and female subordination. Furthermore, socially prescribed sexual relations between men and women may aid to unequal power in the domain of sexual reproductive health.

7.10 Understanding gender equality

The qualitative phase of the study found that there is adequate knowledge by the men in this study on the meaning of gender equality. This was to answer the research question: What is the relationship between customary marriages and gender equality? The men stated how to them it means men and women are equal, they deserve the same opportunities but however they stated that there should be no equality in marriage but in other spheres of life. The study revealed that it is important to examine the relationship between young men's understanding of gender equality as it helps one to ascertain the value that they assign to sexual and reproductive health of young women and how this in turn affects the health seeking behaviour of young women.

The findings from the study are in line with Levtov *et al*. (2014) who states that men's understanding of gender equality is an important component in understanding the studies for men and women. To this Connell (2005b:1802) is of the view that "widespread social support, including significant support from men and boys" is required in reducing gender hierarchies. In addressing this, it is very important to educate men about the importance of gender equality and women's rights (Waxman *et al.,* 2016). The researcher contends that when there is an

understanding of what equality means men are able comprehend this concept women are asserting their rights. Concerning the study, the way men construe gender equality hinders women the ability to stand on an equal footing with men especially in the reproductive arena.

Conclusions drawn from the findings indicate that the relationship between the way men perceive gender equality helps to ascertain the value men place on sexual and reproductive health of women.

7.11 Men's attitude towards equality in customary marriages

The study found that the men are against gender equality in marriages and it negatively affects women in answering the research question: What is the relationship between customary marriages and gender equality? The majority of the men stated how a woman is supposed to be under the authority of a man. This is evidenced by one of the excerpts below:

> *If I would like to bring this concept of gender equality my wife would like to put it into effect in our marriage because she will think that we are equal whereas I fend for the family and she stays at home how can we be equal, we can never be equal one has to be superior and one inferior* (Danai, 29 years old- Zimbabwe).

When women work and they can empower themselves and men fear that their positions will be challenged. This study has already revealed the importance and the consequences of women empowerment especially within the domain of sexual and reproductive health. When women are empowered they disregard some of the gender norms and this can facilitate women in acquiring positive health outcomes. Gender norms affect the health seeking behaviour of women within the sexual and reproductive health ambit. This concurs with the literature reviewed in this study that gender is a strong determinant of health (The Women's Health Council 2007; Ravindran & Kelkar-Khambete, 2008; Piang *et al.*, 2010; Magar, 2015).

Restrictive gender norms and inequalities in the health system affect the interaction of the women with the health system (Gender Equality Steering Committee, 2019). Gender norms also create a situation where men are unquestioned and the sexual subordination by women exposes them to higher risks of reproductive health challenges and like maternal mortality,

STIs and HIV/AIDS (Pruss-Ustun, 2013; Ramjee & Daniels, 2013). Gender inequality and power imbalances also affects interpersonal relationships. A survey conducted in 2018 from fifty-four countries indicate that four in five women do not have power in important aspects of the family relationships (Heyman *et al*., 2019). Previous studies have found that men outlive women and girls and women have the higher burden of disabilities and morbidities (Cullen *et al*., 2016; Hesse, Greene & Opper, 2019). The differences of this cannot be shown by sex alone but by other factors related to gender as shown by the Global Burden of Disease data (Institute of Health Metrics and Evaluation, 2018). These gender norms violate the principles of RBA. Every individual has the right to determine their own choices. Gender inequality depicts powerlessness, vulnerability and makes women susceptible to pain in many aspects of their lives.

The study also found that perceptions of greater access to financial independence of women may lead to the reduction of interpersonal independence if their male partner feels threatened.

> *Now because of this equality a woman can go out there and get a better job some men feel threatened and the need to provide especially if the man is not working it does not make one lesser of a man. The other issue is like relatives cause problems about who does this and especially if the man is not working*……. (Khakhathi, 43 years old- South Africa).

Men are very sensitive to threats of masculinity more reluctant to diverge from masculine norms and motivated to restore threatened status to their manhood or masculinity. Gendered behaviours and traits are an important part of the identity of people while threatening them motivates people to act in ways that they try to restore their status within the group by strongly adhering to strong group norms (Kosakowska *et al*., 2016). Previous studies have shown that when men feel like their manhood has been threatened they incorporate compensatory behaviour which includes increased aggression (Bosson *et al*., 2009; Macmillan & Gartner, 2009). This is done for the sole purpose of maintaining the *status quo* that is embedded in society (Kosakowska *et al*., 2016). In support of this notion, Laurin, Kay and Shepherd (2011) put it forward that the stereotype of men as born to lead and rule and women as the followers is seen as a set of complementary labels which acts as tools for the maintenance of *status quo*.

A previous study in Bangladesh revealed that about 80% of the men subscribe to traditional gender ideologies that expect men to fulfil family obligations through being a breadwinner and providing financially for the family while women are at home taking care of the household (Karim & Law, 2013; Karim *et al*., 2018). On the other hand, a study in Honduras found similar traits of masculine enforcement wherein the men hindered women from participating in development related initiatives (Vonderlack & Navarro, 2010). Therefore, young women in Makwarela (South Africa) and Concession (Zimbabwe) experience restrictive gender norms which negatively affect the interaction of women with the health system.

Conclusions drawn from the findings indicate that the autonomy of women is viewed as a threat to the *status quo* hence the need by men to reduce it.

7.12 Discrimination against women

The study endeavoured to answer the question: What is the relationship between customary marriages and gender equality? The study found that women face a lot of discrimination in the family life such as being confined to household activities which means their mobility is restricted due to gender-related socialisation processes and power relations. Women are also expected not to be part of decision-making process in terms of childbirth while they are also expected to adhere to traditional practices however discriminatory. The extensive literature reviewed in this study highlighted how women face discrimination because there is no equality in both the private and public life.

This finding is in line with other studies carried out that revealed that the discrimination of women creates barriers in the participation of women in the family life (Shastri, 2014). According to Adana *et al*. (2011), discrimination of women has negative effects on women's social life. Dickson and Louis (2018) found in their study that women in Zimbabwe experience discrimination especially on the issues of masculinity considerations which rank men superior than women in the rural areas. A study conducted by Dharagi (2007) revealed that discrimination has different angles, some men are not open to the idea of women educating themselves because according to them, educated women think that they must not do household chores. This study revealed the thoughts of some men in Makwarela (South Africa) and Concession (Zimbabwe) on how they view their wives within their marriages and how

gender inequality is a form of discrimination against women and it is revealed in the way that women are powerless in decision-making within the marriage.

> *A woman is expected to do household chores. So people subscribe to this norm because it has always been like that and it is generally accepted. As a man you cannot be under the wife, so you must make sure that she knows her place and as result she must stay at home and take care of the children* (Rophiwa, 32 years old- South Africa).

The African feminist theory was used in this study to shape the argument around African women's sexuality which also encompasses sexual and reproductive health rights. According to the advocates of the theory, African women possess little or no power over their lives in the same way as men do. This theory was suitable in critiquing the position of women within an African context and how some of the unquestioned gender related practices discriminate against women as well as affecting how they are perceived by men within the customary marriage. Therefore, it is clear that both countries despite the advanced legal protections in South Africa and Zimbabwe women still suffer discrimination at the hands of men in marriages. Conclusions drawn from the finding indicate that patriarchy exacerbates discrimination.

7.13 Intervention strategies

The study sought to answer the final research question: Which intervention can support and promote gender equality and young women's sexual and reproductive health rights in customary marriages? The participants were asked to provide an opinion on what could be done to facilitate the promotion, protection and support for the sexual and reproductive health rights of young women in customary marriages. This was deemed befitting as the young women through their own experiences in their everyday lives possibly acquired the knowledge of what can be possibly lacking. The researcher felt that an insider view will possibly assist with what works best and what does not work and why. The participants stated the importance of education and went on to explain the results that ensue from educating young people both at school and at home. They also stated the importance and strict laws, women organisations promoting sexual and reproductive health rights as well as using the media as a positive influencer as some of the strategies.

The United Nations Educational, Scientific and Cultural Organization (2009) defines sex education as an approach that involves teaching about sex and relationships at an appropriate age providing information that is scientific and realistic. The researcher posits that it is important to teach young people about sex at an age at which their minds can fully comprehend and grasp the information. To this the World Health Organisation (2019) sexual health requires an approach that is constructive and portrays the respect for a pleasurable sexual life free from coercion and discrimination. This is what some of the young women had in mind, education about sexual health and gender that will diminish oppression. Not only does sex education empower young people, but it also nurtures their minds so that they can synthesize appropriate sexual health content as well as the model of adult relationships that they desire which ultimately increases the quality of life. It was apparent in this study that when young people suffer from negative sexual and reproductive health outcomes, it not only undermines their well-being, but their future as well to become productive citizens. As already stated in the literature review, positive sexual and reproductive health outcomes leads to optimum health and ultimately human development.

According to Moghadam and Ganji (2019), sexual beliefs originate from early years in adolescence and adulthood with direct and significant effects on sexual behaviours in life. Sex education must centre around cultural infrastructure, social attitudes, age, sex and every person's needs (Yousefzadeh, 2017). For sex education to be effective, it must also be informed by empirical evidence (Adofoli, 2018) therefore it must be informed by what works best and why. A study by Strasburger and Brown (2014) found that sex education in the early years have a positive impact on sexual attitudes. Teachings at home especially from the parents is one of the most important environments that affect the way children assimilate information (Khu & Lee, 2015). Previous studies have revealed that nurturing and sexuality education can charter sexual behaviours in the right place (Ganji *et al*., 2017).

Education on gender equips young people, both girls and boys, with critical thinking skills, decision making and empower them with the ability to claim their rights and at the same time making decisions that are informed on sexuality matters and reproduction that are respectful to others (International Planned Parenthood Federation, 2016). Studies also reveal that the educational attainment of men as well is associated with an increase in the use of contraceptives like condoms (Adamczyk & Greif, 2010). This is a foundation of healthy relationships and positive sexual and reproductive health outcomes concurring with what has

been held by the literature review that results in negative sexual and reproductive outcomes through gender inequality and patriarchy.

Furthermore, young girls should stay in school and acquire adequate education that will equip them with the knowledge, skills and confidence to be able to assert their sexual and reproductive rights. Sonfield *et al*. (2013) posits that education makes women independent socially and economically which enables them to command respect in the family. There is a relationship between the number of years that a woman is in school and maternal mortality as well as the number of children they have. Girls who go to school have a lower chance of getting pregnant and marrying early compared to those who are not attending school (World Health Organisation Regional Office for Europe and BZgA, 2010.) When young women attain a decent education, they are more informed about the different family planning options available and they can gain employment and be able to stand up and challenge when their rights are being trampled upon. One cannot say the same about young people who have not attained a decent education, they in turn do not value what education brings hence they create an intergenerational cycle of women who do not have a high regard of their sexual and reproductive health rights.

The study also indicated that there is need to enforce strict laws for the protection and promotion of sexual and reproductive health rights. Currently in both countries there is no one stop piece of legislation that addresses sexual and reproductive health of young women specifically, but it is scattered in different pieces of legislation and policies that are to be read together. This at times poses a challenge because there is nothing comprehensive. Failure to enforce strict laws enables some gross injustices committed against women to go unpunished. Lack of punishment means that there is no deterrence. Harmful cultural practices are being practiced as evidenced by this study the perpetuation of this is a stark revelation that there is lack of enforcement of the international, regional and domestic laws that specifically prohibit certain traditional practices because they are discriminatory against women (Pearson & Makadzange 2008; Mugweni & Pearson, 2012; Machingura, 2012.) In light of the liberal feminist theory used in this study that proposes change through demanding equality before the law one can understand how this strategy is in alignment with this theoretical underpinning. Awarding equality through the enforcement of the law will provide men and women with equality in both society and the family.

The study also found that media is a positive tool to raise awareness on the issues of sexual and reproductive health rights. There is so much social media presence among young people globally hence it will be the right platform through different forms like dramas, movies or advertisements. The main goal of health promotion is to allow people to improve and further control over their health. Veale *et al.* (2015) posits that media, especially social networking platforms such as Facebook and Twitter, have grown rapidly in popularity, there are a lot of opportunities for interaction with people from all walks of life enhancing their health promotion potential. Such platforms are being used for sexual health promotion but with varying success in reaching and engaging users.

7.14 Development of a strategy

Based on knowledge and also the results of the study, the researcher needed to come up with a strategic approach for the strengthening, promotion and protection of sexual and reproductive health rights of young women. Many strategic approaches hinge on HIV/AIDS and fail to interlink strategies that depend on each other and some strategies lack well informed baseline data such as this study before strategies are formulated and implemented for specific communities. The researcher developed an intervention strategy named A Multi-Level Approach to Strengthen, Protect and Promote Sexual and Reproductive Rights of Women.

A Multi-Level Approach to Strengthen, Protect and Promote Sexual and Reproductive Rights of Women

The approach identifies six key domains in which action must take place if the sexual and reproductive health of women is to be promoted: sex education, engendering sexual and reproductive health rights, healthy relationships, interpersonal communication, sexual decision-making and contraceptives and unintended pregnancies. Various obstacles impede women to enjoy their sexual and reproductive health rights. To add on, the family and society are also stakeholders in the promotion and protection of the sexual and reproductive health of women. There is lack of knowledge on sexuality, contraceptives and lack of adequate knowledge on sexual and reproductive health rights from the community and family members. Women are one of the most important stakeholders for their sexual and reproductive health. There are various obstacles apart from those that this study highlighted. Amongst these

obstacles are gender roles, gender inequality, marriages, unmet need for contraception, lack of reproductive health care, lack of access to information and the use of reproductive services. Promotion of sexual and reproductive health requires co-ordinated action on different areas. Education alone will not produce the benefits needed but coordinated action and intervention. This strategy aims to strengthen, promote and protect the sexual and reproductive health rights of young women through pushing the health of women past societal and cultural norms.

Stakeholders

Young married women

Young married women are important stakeholders in their sexual and reproductive health. They must be able to take charge of their own lives and be equipped with knowledge to assert their rights with wits and freedom. Young married women must possess adequate information on matters such as consent in a sexual relationship as well as the consequences and dangers of unwanted pregnancies hence the knowledge and use of contraceptives is important. Women must be able to pass down and instil positive values in their girl children. It cannot be emphasised enough how women's attainment of optimum health reaps beneficial effects for a country as a whole due to it being a key element in human development.

Young married men

Men possess distorted meanings of sexuality and gender roles and they also lack ideal models on healthy relationships because societal and cultural norms create intergenerational effects such that men inherit patriarchal attitudes and exhibit gendered behaviours. Therefore, men are important stakeholders if a strategy is to be implemented that protects and promotes the sexual health of women.

Family and community members

Children relate more teachings from home especially from the parents and it affects the way children process information. Parents serve as role models for their children's specific

development hence studies have revealed that it is very effective when parents and children discuss sex related matters with their children. However, a study by Jin (2011) found that parents find it very difficult to discuss sexual related matters with their children due to lack of knowledge as well as just being uncomfortable about the matter. Sex is a word rarely spoken in African homes. It is considered as something embarrassing, a taboo to talk about and a conversation never to be had because it might instigate unwarranted sexual activities. Based on this, parents are not comfortable to have 'the talk" with their children. This it is therefore important to develop resources that equip parents with the knowledge to improve parent's education. Given that behaviour is also influenced by what they observe in sexual behaviours in their surroundings which is the family whose behaviours is also influenced by cultural, religious and social beliefs (Hagan, Shaw & Duncan, 2008). The family is the primary socialising agent; children exhibit to the world what they would have learnt from the family. The social learning theory by Bandura specifically highlights the link between socialising and the behaviour that people reveal in society.

It therefore starts with the family to instil positive ideas about sex in a young person before the community. The community members are also part of the family unit and it is imperative that they also instil positive values within their families. Communities give people a sense of belonging and one therefore finds it difficult to survive on their own without a community. Equipping young people with the right knowledge on sexuality helps to avoid the distorted and wrong meanings about sexuality from their peers which results in negative sexual health outcomes. Having positive societal norms about sexual health, gender and equality will facilitate young women in attaining positive sexual and reproductive health outcomes. It helps to strip male and female societal expectations. In childhood, socialisation begins by treating children by genders and awarding them specific treatments according to genders, if the society could treat a boy and a girl equally the values will go a long way in achieving positive sexual outcomes.

Obstacles

The way the African society views gender roles signify inequality due the patriarchy and the cultural position within an African society. Gender roles place women in an inferior position wherein they are expected to be at home bearing and rearing children while men are working. Theses expected roles result in inequality among men and women. These gender roles and

inequality place women's sexual and reproductive health rights at risk because when women are confined at home to household functions they might not be economically empowered therefore their choices of action are limited.

Marriages can be viewed as a site wherein women are oppressed. In a marriage there are expected roles and responsibilities that women play that place them at a disadvantage. In marriage women can find it hard to negotiate for safe sex, that is the use of condoms and also to determine the number and spacing of their children. In some marriages these terms are decided on by the husband and in some marriages these decisions are made jointly which has beneficial effects for women. Being unable to assert sexual and reproductive health rights especially for women who has bride price paid for them is detrimental to their health and well-being.

Furthermore, unmet need for contraceptives results in women not being able to take charge of their fertility. Women who do not use any contraceptives end up bearing more children than they can afford which results in increased poverty. If this cycle of poverty continues it creates an intergenerational cycle of women who bear their children in poverty stricken conditions and are unable to afford basics such as education, food and health care. Therefore, women contraceptives should be accessible so that women can assert their reproductive rights.

Lack of access to information results in lack of awareness on sexuality, lack of knowledge on contraceptives and lack of adequate knowledge on sexual and reproductive health rights. For a person to be able to act positively they must first of all have the necessary information to inform their behaviour. When women are confined at home and unable to access information they cannot act within reproductive health domains.

Intervention strategies

Sex education

Sex education is very important during the childhood years. It is important because it establishes the proper values and attitudes towards sex, this is because formative years are a potential turning point in terms of reasonable decision-making and through the fast-going

changes in physical development (Kar, Choudhury & Singh, 2015). Sex education must centre around the themes that every child will require when they become adults such as social attitude, sex and culture. For sex education to be effective it must be informed by practical evidence from previous studies.

The goals of the International Conference on Population Development (ICPD) are to be achieved by states so that all citizens achieve the highest standard of health attainable. One of the goals set by the conference (principle 8) was that governments create policies that provide adequate access to reproductive and sexual health especially for young adults (United Nations Population Fund, 1994). The ICPD further emphasises that education must take place in schools and the community delivering age appropriate education. In 2009 and 2012, the Commission on Population Development reaffirmed this through provisions that called upon governments to provide people who are young with comprehensive sexual health and sexuality education, human rights and gender equality which will enable them to deal positively with sexual related matters (United Nations, 2009; United Nations, 2012). Approaches that also work are those that cover human rights, to advocate for the sexual and reproductive health rights of women.

An approach to strengthen and protect sexual and reproductive health of vulnerable groups in society (i.e. women and children) should include a comprehensive sexuality education in young people. Investing in young people will create intergenerational benefits as they will grow up with a model of positive attitude and behaviour and respect for the rights of others. There must be comprehensive education imparted to the family, community members, young men and women as well as health care providers. The researcher relied on the findings of this study as a baseline for what could be an ideal strategic approach to sexual and reproductive health of women. It is also the view of the researcher that the interventions that work are those that seek to change the knowledge, perception, skills and attitudes of people in tackling the broader societal issues that can hinder the attainment of positive sexual and reproductive health for vulnerable groups in society.

Engender sexual and reproductive health rights

What it means to incorporate gender in sexual and reproductive health rights is to engender all sexual and reproductive health aspects. It requires interventions to be gender engineered to achieve optimum potential for women and girls. Previous studies have revealed that programmes and interventions that incorporate the effects of gender and power have more positive effects than the programmes that do not (Haberland, 2010). The gender power dynamics in Africa often undermine the human rights principles. Every individual has a moral right to choices in their lives that they determine. The area of sexual and reproductive health rights includes numerous things such as health, education and family planning.

Engendering sexual and reproductive health rights is also premised on challenging traditional norms about gender roles and attitudes about “what makes a man.” Societal gender norms have it that being a man is all about exerting power and influence over the other sex. This results in men trying exceedingly and abundantly to stamp their masculinity in both the public and the family life. Challenging traditional norms will go a long way in ripping benefits for women and girls in the area of sexual and reproductive health rights. Traditions can be changed and passed down from generation to generation thereby being a culture. It is not a hurdle that cannot be passed for change is constant, but it requires appropriate education of both men and women as mothers, fathers, wives, husbands, daughters and sons on the importance of equality in all aspects of life. For sexual and reproductive health strategies to work, they must be culturally sensitive addressing the needs and fundamental values of the community. As even traditionally culturally conservative societies are experiencing rapid changes in attitudes and practices towards sexual lifestyles, the challenge is to ensure that sexual health strategies combine evidence informed by empirical studies, measures and good practices with culturally appropriate communication and implementation approaches.

Enhancing men’s awareness of and support for their partner’s reproductive health is also part of engendering sexual and reproductive health rights. It is of paramount importance that men support their partners in decisions related to seeking medical care, family planning methods as well as other requirements for women to achieve optimum reproductive and sexual health. It is believed that when men are aware and actively involved in their partner’s reproductive health decisions, for example, family planning decisions taken together, it allows an open and honest discussion of which family planning method is ideal for both partners and why.

Participation by men includes positive and supportive attitude that men express to their spouses with regards to the use of contraceptives.

Finally, to engender sexual and reproductive health requires the mobilisation of men to participate actively in the promotion of gender equality and breaking the culture of gender-based violence. Violence against women also results in negative sexual and reproductive health outcomes. Women who suffer from gender-based violence in most cases experience spousal rape and forced sexual intercourse which results in unwanted pregnancies and also complications in childbirth which leads to maternal mortality and morbidity. When men fully grasp the importance of gender equality, it leads to the promotion and protection of women's rights and also it has beneficial effects on men educating each other and fathers being role models to their children in the family.

Contraceptives and unintended pregnancies

Based on the findings of the study, the researcher is of the view that education about the different types of contraceptives is important. There is a dire need to educate both men and women on the available types of contraceptives. As the study has already noted there is a misconception on the use of condoms within marriages therefore education on how condoms can prevent unwanted pregnancies too will go a long way rather than the notion that it is for the prevention of STIs and HIV. Education will equip women with the negotiating power to negotiate for the use of contraceptives to control child spacing and frequent births. Adequately spacing children gives a woman more time to recover physically before they give birth again. This also helps with the reduction of possible maternal mortality and morbidity due to complications in childbirth. Negative health consequences will most likely also affect the infant. There is a plethora of literature on how the improved health of mothers and children is the rationale of family planning. The logic is that improved family planning leads to improved health status which ultimately results in human development which aids in improved economic growth. Unwanted pregnancies can result in unsafe abortions which has an association with heightened risk of maternal mortality (Stover *et al*., 2016).

Given the risks that are existing in the world from STDs, it is important to advance the knowledge of young people on other aspects such as unwanted pregnancies and sexual

violence which can affect healthy relationships. Young people need to understand the risks and consequences of unplanned pregnancies and unsafe abortions. The rate and prevalence of abortions and unplanned pregnancies can be significantly reduced through appropriate knowledge. Young people need to grow up with the appropriate knowledge about the consequences of their sexual activities and what it means to have sex.

Interpersonal communication

Interpersonal communication is the ability of being able to communicate with other people on a personal level. Once a person speaks a word you cannot take it back hence it is important to utter words that do not harm others. Knowledge of interpersonal communication equips one with the ability of being mindful towards others, showing empathy and being thoughtful when speaking with other people (Galvin, Byland & Brommel, 2018). Therefore, educating people on the importance and benefits of interpersonal communication is important.

Sarwatay and Divatia (2016) defines interpersonal communication as an important part of family planning discussions because it allows partners to discuss openly their preferred method of family planning as well as the number and spacing of children. Interpersonal communication is very important because it increases men's participation in the use of contraceptives which results in every pregnancy being wanted. This is mainly because being able to communicate effectively about childbirth and family planning is related to the ability to use contraceptives. Effective communication among spouses enables them to raise their concerns on sexual and reproductive health issues like unplanned pregnancies and STDs. Interpersonal communication leads to joint decision-making in the household.

Healthy relationships

Healthy relationships are as a result of being able to communicate effectively and being equipped with the adequate knowledge on sexual and reproductive health. Healthy relationships and positive communication have resulted in improved sexual and reproductive health. When couples communicate they make healthy decisions about the use of

contraceptives, the prevention of STDs and HIV/AIDS and avoidance of unwanted pregnancies.

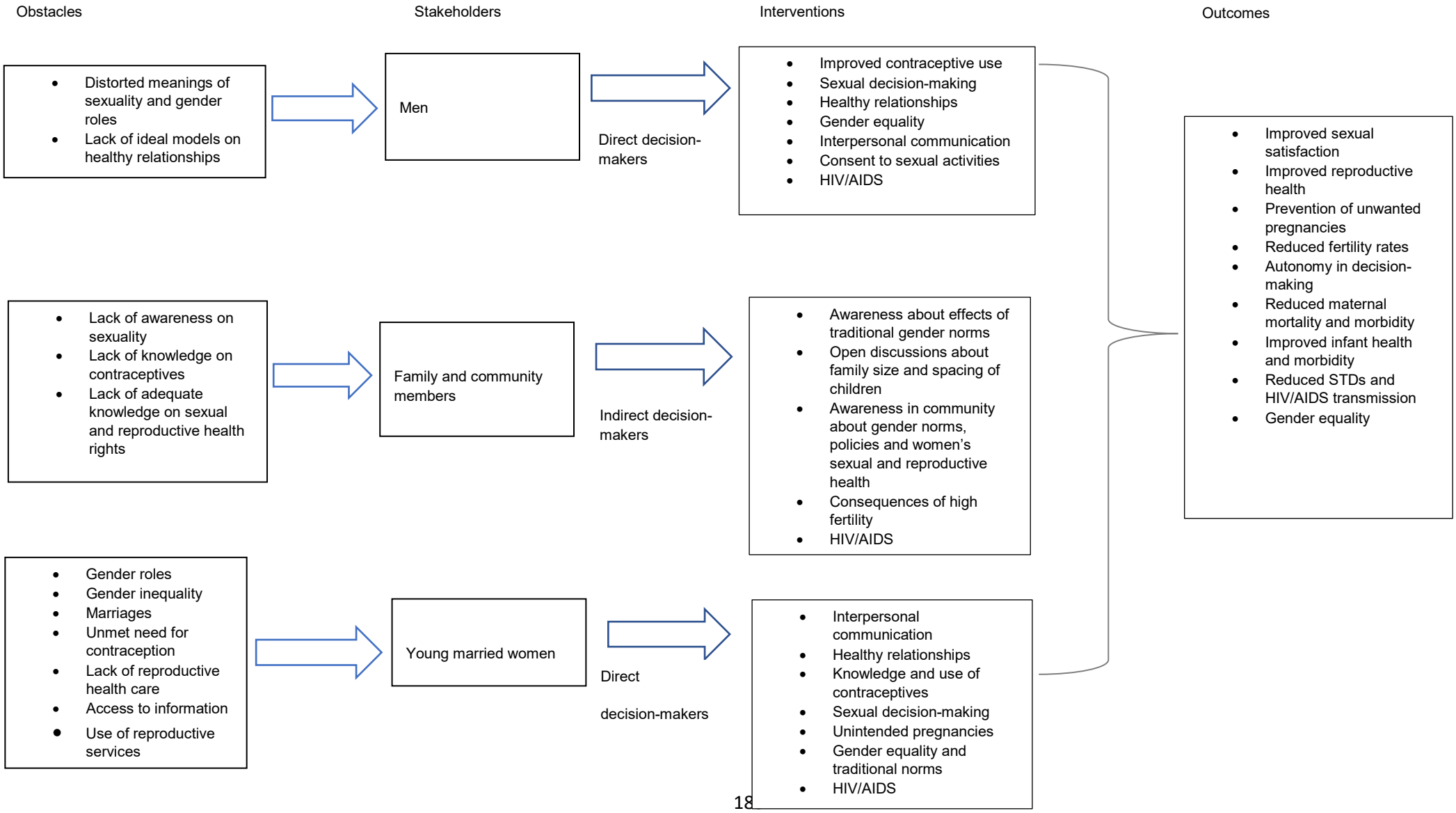
Healthy relationships also result in women being able to give their consent or not to sexual intercourse. When a wife does not give consent, it results in marital rape which is seen as non-existent in marriages by many African communities because according to them the marriage itself implies consent. There are so many health consequences of forced sexual intercourse. Therefore, the knowledge and importance of consent cannot be overemphasised in relationships.

Sexual decision-making

The influence of knowledge on sexual decision-making on HIV/AIDS may help to reduce the risk of contraction and transmission of the disease. Women being able to assert their rights within the sexual and reproductive domain results in reduction of unwanted pregnancies, unsafe abortions and STIs. The rationale of a woman's ability to make decisions on reproductive and sexual matters is to be able to control fertility. In most cases power dynamics hinder women from being able to make bold decisions about their health. Positive sexual health outcomes are as a result of women being at the helm of decision-making in the household.

Empowerment of women and communities as well as strengthening health services to make positive progress to improve sexual health and well-being will require knowledge of appropriate legislation, policies and channels to take once their rights are infringed upon. There must be human rights education at grassroots level. For people to be able to realize their human rights they must first appreciate and acknowledge the existence of those rights to them.

FIGURE 13: A MULTI-LEVEL APPROACH TO STRENGTHEN, PROTECT AND PROMOTE SEXUAL AND REPRODUCTIVE HEALTH RIGHTS OF YOUNG WOMEN



7.15 Conclusion

This section of the study discussed the findings of this study. The study found that payment of *roora/mamalo* affects the power dynamics in the family which subordinates women to men and makes it difficult for women to assert their sexual and reproductive health rights. The study revealed that there are various challenges that women face in their customary marriages which impede the enjoyment of their sexual and reproductive health rights. The study revealed challenges like the effects of dry sex, being unable to practise safe sex and widowhood rites of being celibate. This study revealed that women are not able to make decisions on family size as well as decisions on sex due to culture and societal expectations. The study also found that relationship control factors make it difficult for wives to refuse sexual advances from their husbands as well as to negotiate for condom use. Furthermore, the study revealed how cultural practices such as widowhood inheritance and polygamy affect women's sexual and reproductive health rights through transmitting HIV/AIDS as well as other STIs. Due to all this, women find themselves facing discrimination in the family life. The study also revealed the intervention strategies that were used by the researcher to develop strategies for the promotion and protection of sexual and reproductive health rights of women.

CHAPTER 8 OVERVIEW, CONTRIBUTIONS AND RECOMMENDATIONS OF THE STUDY

8.1 Introduction

This study aimed to use the key human rights principles of non-discrimination and gender equality to promote women's rights and emancipation, through the abolition of primordial cultural practices in customary marriages which infringe on the rights and dignity of young women. This chapter provides an overview of the study by giving a summary of the findings of the study, contributions of the study, recommendations of the study, areas for future research and limitations of the study as well as the general conclusion on the entire study.

8.2 Overview

The triangulation of theories in this study enabled the researcher to use different theoretical keys to unlock different problems. In the end, the researcher was able to use the theories for the choice of a research design, formulation of the research instruments and to arrive at well-reasoned conclusions through being able to broaden the understanding of the problem under investigation.

The literature that this study reviewed revealed a gap on the role of customary marriages on the sexual and reproductive health rights of women. The literature went further to highlight the importance of human rights approaches to health, mainstreaming gender in health and it also disintegrated the concept of sexual and reproductive health rights. The literature also revealed the position of women within an African context and how patriarchal notions of masculinity find footing in both Shona and Venda customary marriages.

Compared to some previous studies on sexual and reproductive health rights of women, this mixed method study represents one of the few studies to empirically investigate the effects of customary marriages on young women's sexual and reproductive health rights. A study that was not comparative study of two countries would not have allowed this insightful exploration that the researcher undertook. This is the case because a single case study would not have allowed the researcher to draw a general conclusion such as the one provided by this study.

The study sought to answer the following research questions:

- What is the relationship between customary marriages and gender equality?
- How do customary marriages affect young women's sexual and reproductive health rights?
- What are the obstacles to the realisation of young women's sexual and reproductive health rights?
- How is the sexual relationship power in customary marriage exercised?
- Which interventions can support and promote gender equality and young women's sexual and reproductive health rights in customary marriages?

To generate empirical answers for the above-mentioned questions, this study employed a mixed method research design wherein both qualitative and quantitative data was used. The researcher placed more weight on the qualitative data and used the results to develop the survey instrument. A semi-structured interview guide was deployed to capture the views of young men and women in customary marriages with questions on gender equality, women's sexual and reproductive health to determine the relationship between these and customary marriages. The results of the qualitative phase were further explored with a survey that sought to determine sexual relationship power in customary marriages. The quantitative phase explored decision dominance and relationship control in customary marriages. The overarching discussion was on the experiences of young men and women in customary marriages followed by their thoughts and views. The researcher conducted an initial coding of the data which helped to define patterns and what was happening in the data. In other words, what does the data show? By using this method, the researcher avoided imposing ideas that were preconceived on the categories of data. Instead, patterns were created based on what the data was saying. Patterns facilitated the reduction of the data to come up with relationships within the data from which short phrases were used to symbolize a portion of the data. The researcher opted for the use of narrative analysis method because of its ability to stay close to the words of the participants in light of the objectives of this study. The findings of this study are presented in a narrative form wherein the participants described their experiences in customary marriages.

8.3 Contribution of the study

8.3.1 Empirical contribution

8.3.1.1 What is the relationship between customary marriages and gender equality?

The study established that there are restrictive gender norms which negatively affect the interaction of women with the health system thereby impacting gender equality. Gender inequality is a form of discrimination against women and it is revealed in the way that women are powerless in decision-making especially within the customary marriage as this study has revealed. This shows that the relationship between the way men perceive gender equality helps to ascertain the value men place on sexual and reproductive health of women. The study discovered that patriarchy has detrimental effects on the health and well-being of young women in customary marriages. In this study, it was found that expectations that are predicated on patriarchy provide a structure in society that gives men unquestionable authority. This was revealed through how male participants in this study stamped their authority over women even in the reproductive arena. From the interviews, young women who took part in this study from both countries had a consensus on the dominating power exercised by men and the unequal nature of their roles within the customary marriage. The study revealed that there is no gender equality in customary marriages. This has implications on the sexual and reproductive health of women. This is the case because it results in lack of autonomy and lower levels of decision-making regarding sexual and reproductive health rights of young women in Makwarela (South Africa) and Concession (Zimbabwe).

8.3.1.2 How do customary marriages affect young women's sexual and reproductive health rights?

While striving to answer the above research question, the study also sought to examine whether *mamalo/roora* violates the equality and human dignity of women. The participants highlighted how they were expected to bear children, not to question anything in the marriage, being submissive and bearing the unequal brunt in the marriage. The study found that customary marriages enforces the differences in reproduction which culminates in gender inequality. The findings of the study revealed that customary marriages affect the sexual and reproductive health rights of young women. This is as a result of the fact that women are expected to adhere to norms that affect their health. Such norms also relegate women to positions of inferiority and women are also treated as property purchased through the payment of the bride-price. The young women in South Africa and Zimbabwe revealed how the societal

and family norms go against safe sex practices and also safe sex discussions with their partners.

8.3.1.3 What are the obstacles to the realisation of young women's sexual and reproductive health rights?

To answer this research question, the study explored qualitatively and quantitatively obstacles women in Makwarela (South Africa) and Concession (Zimbabwe) face in realising their sexual and reproductive health rights. The study revealed that there were various challenges that women are faced with in their customary marriages which impedes the enjoyment of their sexual and reproductive health rights. The study revealed challenges like the effects of dry sex, being unable to practise safe sex and widowhood rites of being celibate. This study also found that polygamy and wife inheritance are responsible for the transmission of STDs like HIV/AIDS. The quantitative data revealed an association between polygamous marriages as an agent of HIV transmission and the ability of women to freely enjoy their sexual and reproductive health rights. The study revealed the above-mentioned cultural practices as a hindrance to the realisation of the sexual and reproductive health rights of women in both South Africa and Zimbabwe.

8.3.1.4 How is the sexual relationship power in customary marriage exercised?

The study found that women lack autonomy and the power to negotiate for safe sex. The study showed that in customary marriages, the power lies with the husband. The relationship is structured in favour of the husbands since interests of wives are not entertained at all. This study exposed how women are not able to make decisions on family size as well as decisions on sex due to culture and societal expectations that place men in positions of authority. The study revealed that there was also a significant relationship between sexual relationship power and forced sex and condom use in both Makwarela (South Africa) and Concession (Zimbabwe). The study did so by revealing how the lack of sexual relationship power (relationship control and decision dominance) hinders the ability to avoid unplanned pregnancies, intimate partner violence and consistent condom use which all point to relationship power which is an important component of sexual decision-making. Despite legal instruments in both countries to protect women against discrimination, women still experience lack of autonomy at the hands of men.

8.3.1.5 Which interventions can support and promote gender equality and young women's sexual and reproductive health rights in customary marriages?

To answer the above research question, the researcher asked the young women what in their opinion would be ideal strategies to promote gender equality and support sexual and reproductive health rights of women. The participants stated the importance of education and went on to explain the results that ensue from educating young people both at school and at home. They also stated the importance of strict laws, women organisations promoting sexual and reproductive health rights as well as using the media as a tool to raise awareness about women's sexual and reproductive health rights. From the findings of this study, the researcher developed a strategy named A Multi-Level Approach to Strengthen, Protect and Promote Sexual and Reproductive Health Rights of Women. This strategy identifies six key domains in which action can be taken if the sexual and reproductive health of women is to be promoted. These are sex education, engendering sexual and reproductive health rights, healthy relationships, interpersonal communication, sexual decision-making, contraceptives and unintended pregnancies.

8.3.2 Knowledge and policy contribution

The study adds to the existing body of literature particularly about customary marriages concerning women's sexual and reproductive health rights. The study also adds to knowledge on the health seeking behaviours of women within customary marriages and the impact that this has on the health and well-being of women and the children they give birth to. Therefore, it then becomes apparent that a research on sexual and reproductive health rights and customary marriages is imperative as it aids the achievements of some of the SDGs which emphasise on equity and health care. To add on, the literature that was reviewed demonstrated that there were still many unexplored cultural issues which affect women's sexual and reproductive health, especially concerning traditional practices such as customary marriages. Therefore, this research has addressed the unknowns to provide information which can be used to form a knowledge base on and for women's sexual and reproductive health rights. Furthermore, the study reinforces current thinking on the demand for principles of egalitarianism in marriages and advances the existing literature because it adds to the body of knowledge relating to effects of certain cultural practices on the sexual and reproductive health rights of young women in customary marriages.

As the study has revealed, the sexual and reproductive health rights of women is an area that requires attention therefore policies must be put in place to address this challenge. This study has contributed to policy formulation since the researcher has developed a strategy called Multi-Level Approach to Strengthen, Protect and Promote Sexual and Reproductive Rights of Women. The strategy will be beneficial when formulating policies as an option or alternative course of action for addressing the impediments to the realisation of young women's sexual and reproductive health rights.

8.4 Recommendations

Findings of this study have implications for both research and policy making. The study shows the significant associations between customary marriages and the inability of women to assert their sexual and reproductive health rights in Makwarela (South Africa) and Concession (Zimbabwe). Therefore, recommendations were made against this backdrop.

The study recommends that the Multi-Level Approach to Strengthen, Protect and Promote Sexual and Reproductive Rights of Women be adopted to facilitate women's enjoyment of their sexual and reproductive health rights.

It was evident from the study that young women do not have autonomous decision-making abilities. Women must be empowered educationally, politically and financially so that they can be able to make their own decisions regarding their health and well-being. There is a need for community initiatives that empower and equip women who do not have higher educational attainments, they can be empowered through life skills trainings. Empowering women in this regard can bring about huge benefits for the entire family.

Impediments to women emancipation which are brought about by patriarchal culture need to be decisively dealt with at family and community levels to promote gender equality in sexual and reproductive health rights.

As a part of promotion of gender equality, men must be included as part of the programmes highlighting the range of benefits that improvement of gender equality has for men too.

Commitment and involvement of men in such programmes is likely to also bring about healthy relationships and improved communication among spouses.

Governments of both countries, in conjunction with relevant stakeholders, should formulate a comprehensive sexuality education strategy which is targeted at young boys and girls and ensure that it is infused into the school curriculum. The school curriculum should include issues such as human rights, safe sex, gender equality, unwanted pregnancies and HIV/AIDS. This will ensure that boys and girls are equipped with the relevant knowledge about sexuality and gender and equality at a younger age. These children will grow up with the correct notions of this not learning it from their peers which may result in distorted meanings on sex, sexuality and gender equality. Teachers will also need a special training for this as many are not able to handle sex, sexuality and gender equality issues.

It was found that women in customary marriages were relegated often to the position of a commodity priced and then bought, which contravenes the right to dignity and worth of women. Thus, it is also necessary to educate elderly members of the community on the essence of gender equality and the negative consequences of bride-price payment. The rationale is not to do away with the payment of a bride price but to realign that practice with human rights principles. Contributions must be made on both sides by members of communities through consultative meetings with relevant stakeholders. Therefore, it would be ideal for the relevant government departments in both countries to take a lead on these legislative and educational initiatives.

The quality of sexual and reproductive health services should be improved. The health care professionals should be trained and able to offer psycho-social support to young women seeking services.

The study recommends strict enforcement of laws such as those that deal with sex without consent as the study showed that many women in customary marriages experience coerced sex at the hands of their spouses. Such offences are never dealt with accordingly by the law enforcement agencies and the statistics cannot be determined since many cases go unreported. This will serve as a deterrence to sexual abuse and women will also not shy away from reporting crimes of abuse within their families. Abuse of women and femicide is one of

the crimes on the rise in South Africa therefore enforcement would help thwart intimate partner violence which in many cases leads to murder.

Condoms serve as a preventive measure against unwanted pregnancies not only as a preventive measure for STIs and HIV/AIDS. Thus, the study recommends that religious organizations should educate their congregants especially the married couples on the benefits of condom as fertility control measures. Faith plays a huge role on people's everyday lives and many religious sects command huge following. It would have a huge impact on how people perceive condoms if it also comes from their religious leaders.

Young women should be involved in policy formulation on family matters to address their health needs and rights. A participatory approach will instil a sense of ownership in women hence they can demand change and assert their rights.

There is also a need for strong systems to be put in place for monitoring and evaluation of projects that promote and protect sexual and reproductive health rights. Within the evaluation component it would be beneficial to conduct control trials a period after which a programme has been implemented to evaluate whether or not the intervention is working, if not, why.

Seeing that the culture in Africa creates a close knitted relationship between the community, and individual's rights, rights need to be exercised in a manner that is meaningful when this is exercised with the community interests and values at the core. It might be challenging to engage cultural gatekeepers in initiatives that might seem alter the status quo. It is therefore important to have stakeholder meetings to engage, integrate attitudes, values, standards and the opinions of cultural gatekeepers to enhance and protect the health and well-being of women without refuting culture.

Based on the findings of this study, it is recommended that further research should be carried out on:

1. Association between contraceptive use and culture.
2. Investigation on coercive sex among married couples and its effects on maternal mortality and morbidity.

3. A critique on marital expectations and health seeking behaviour of women.
4. Spousal communication on contraceptive use needs more exploration.
5. Longitudinal study on sexual and reproductive health rights of women in customary marriages with a control group for women in civil marriages on a specified time frame.

8.5 Limitations of the study

This study encountered several limitations. One of the limitations was that the study was carried out only in Makwarela (South Africa) and Concession (Zimbabwe) which ideally are smaller towns. The sample was restricted to young women married customarily and did not cater for civil marriages. Therefore, the findings are limited in terms of generalisation. The results thus can only be applied to women married customarily. However, transferability may be done by one doing the generalizing when the context is similar.

8.6 General conclusion

This study aimed to use the key human rights principles of non-discrimination and gender equality to promote women's rights and emancipation, through the abolition of primordial cultural practices in customary marriages which infringe on the rights and dignity of young women. The literature that this study reviewed unequivocally highlights a gap on customary marriages and the effects it has on sexual and reproductive health rights of young women. Therefore, this study became a knowledge base on and for women's sexual and reproductive health rights in customary marriages.

The study relied on the strengths of mixed method research approach. Doing so facilitated in triangulation of theories in this study on which the assumptions of the theories informed the researcher. The study revealed that sexual relationship power is wielded by men leaving women in customary marriages without autonomous decision-making abilities. This means that young women in customary marriages in Makwarela (South Africa) and Concession (Zimbabwe) cannot control their fertility outcomes due to factors such as patriarchy and also the cultural position of women. The study also found that women face discrimination both in social and family life with expectations attached to marriages placed on women due to the differences in reproduction between men and women. It was also found that men fully comprehend the aspect of gender equality but they do not welcome the concept to be applied within marriages.

The interventions that can be deployed to promote and protect sexual and reproductive health rights of young women must involve young men, family and community members and young women. The study developed a Multi-Level Approach to Strengthen, Protect and Promote Sexual and Reproductive Rights of Women. This strategy seeks to address obstacles such as distorted meanings of sexuality and gender, lack of knowledge on sexual and reproductive health rights, gender roles and gender inequality. It provides interventions that can be used to achieve positive sexual and reproductive health outcomes for women which facilitates the attainment of the highest standard of health leading to ultimate human development.

REFERENCES

Abekah-Nkrumah, G. 2013. *Women's empowerment and household health in Sub Sahara Africa: Examining the importance of social norms*. A dissertation submitted for the requirements of University of Manchester for Doctor of Philosophy. Manchester: University of Manchester.

Acet, Incorporated. 2013. Selecting an evaluation: Qualitative, quantitative and mixed method approaches. Minneapolis: ACET Incorporated.

Adamczyk, A. and Greif, M. 2010. Education and risky sex in Africa: Unravelling the link between women's education and reproductive health in Kenya. *Social Sciences Research 40 (2) 654-666*.

Adana, F., Arslantas, H., Ergin, F., Bicer, N., Kiransal., N. and Sahin, S. 2011. Views of male students about social gender roles: An example from East Turkey. *Journal of Family Violence 26 579-526*.

Adebowale, A.S. and Palamuleni, M.E. 2014. Modern contraceptive use, sex refusal and spousal difference in level of education among married women in Nigeria: Are they interrelated? *International Journal of Human and Social Science 4 (6) 217-231*.

Ademiluka, S.O. 2018. Patriarchy and women's abuse: Perspectives from ancient Israel and Africa. *OTE 31 (2) 339-362*.

Adinew, Y.M., Worku, A.G. and Mengesha, Z.B. 2012. Knowledge of reproductive and sexual rights among university students in Ethiopia: Institution-based cross-sectional. *BMC International Health and Human Rights 13 (12).* Available at https://doi.org/10.1186/1472-698X-13-12 retrieved 10 January 2020.

Adinkrah, M. 2011. Criminalizing rape within marriages: Perspectives of Ghanaian University students. *International Journal of Offender Therapy and Comparative Criminology 55 982-1010*.

Adinkrah, M. 2017. When a wife says "no": Wife's sexual refusal as a factor in husband-wife homicides in Ghana. *Journal of Interpersonal Violence 00 (0) 1-27*.

Adinma, J.I.B. and Adinma, E.D. 2011. Impact of reproductive health on socio-economic development: case study of Nigeria. *African Journal of Reproductive Health 15 (1) 7-12.*

Adjei, B., Wolterbeek, R. and Peters, A.A.W. 2015. An evaluation of the rights of women in Ghana. *Journal of Psychosomatic Obstetrics and Gynaecology 38 (4) 155-160*.

Adodo-Samani, P.M. 2015. *Criminalisation of marital rape in Ghana: The perceptions of married men and women in Accra*. A dissertation submitted for the requirements of University of Ghana for Master of Arts in Sociology. Accra: University of Ghana.

Adofoli, G.M. 2018. *Parents-adolescent communication on sexual health and behaviour in Anfoega-North Dayi*. A dissertation submitted for the requirements of University of Ghana for Master of Science in Applied Health. Accra: University of Ghana.

Agering. I. 2009. *The making(s) of law. Post-modern feminist perspectives on local court justices under Zambian customary law*. A dissertation submitted for the requirements of University of Lund for Master's in development studies. Lund: University of Lund.

Agot, K.E., Van der Stoep, A., Tracy, M., Obare, B.A., Bukusi, E.A. and Ndinya-Achola, J.O. 2010. Widow inheritance and HIV prevalence in Bondo District, Kenya: Baseline results from a prospective cohort study. *PLoS One 11:e14028*.

Ahikire, J., Musiimenta, P. and Mkwiine, A.A. 2015. *Making a difference: Embracing the challenge of women's substantive engagement in political leadership in Uganda*. In Alshengqeeti, H. 2014. Interview as a data collection method: A critical review. *English Linguistics Research 3(1) 39-45.*

Ahmed, A. 2008. Ontological, epistemological and methodological assumption qualitative versus quantitative. Available at https://files.evic.ed.gov/fulltext/ED504903.pdf retrieved 10 May 2018 retrieved 20 December 2019.

Aina, O, I., Ariansola, J.A. and Osezua, C. 2006. Sexual health and sexual rights within. Africa Regional Sexuality Resource Centre. *Understanding Human Sexuality Seminar Series 2-20*.

Akahire, J. 2014. African feminism in context: Reflections on the legitimation battles, victories and reversals. *Feature article 19 7-23.*

Akolokwu, G. 2017. The mirage of the girl-child's rights to dignity of the human person in the Niger Delta: Examining the relevance of bride price. *Port Harcourt Journal of Business Law 3 (1) 62-73*.

Alasuutari, P., Bickman, L. and Brannen, J. 2008. *The Sage handbook of social research methods.* London: Sage.

Albertyn, C. 2016. Claiming and defending abortion rights in South Africa. *Working paper 2 1-42. Oxford Human Rights Hub. Oxford University.*

Albertyn. C. 2015. Claiming and defending abortion rights in South Africa. *Revista Dereito Gv 11 (2) 429-454.*

Al-Krenawi, A. 2010. A study of psychological symptoms, family functioning, life and marital satisfaction, and mental health of women in polygamous and monogamous marriages: The Palestinian case. *International Journal of Social Psychiatry 58 (1) 79-86*.

Almalki, S. 2016. Integrating quantitative and qualitative data in mixed methods research-challenges and benefits. *Journal of Education and Learning 5 (3) 288-296*.

Alshengqeeti, H. 2014. Interview as a data collection method: A critical review. *English Linguistics Research 3(1) 39-45.*

Alvi, M.H. 2016. A manual for selecting sampling techniques in research. Munich Personal RePEc Archive Paper Number 70218. Available at https://mpra.ub.uni-muechen.de/70218/.pdf retrieved 8 March 2017.

Amin, A. 2015. Addressing gender inequalities to improve the sexual and reproductive health and wellbeing of women living with HIV. *Journal of International AIDS Society 18 6 Supp 5.*

Amnesty International, USA. 2005. Sexual and reproductive health rights. Available at www.amnestyusa.org/women.pdf retrieved 10 June 2016.

Amoyaw, J.A.,Kuuire, V.Z., Boateng, G.O., Asare-Bediako, Y. and Ung, M. 2015. Conundrum of sexual decision-making in marital relationships: Safer-sex, knowledge, behaviour and attitudes of married women in Zambia. *Journal of Sex Research 52 (8) 868-877*.

Amzat, J. and Grandi, G. 2011. Gender context of personalism in bioethics. *Developing World Bioethics 11 (3) 136-145*.

Andereouli, E., Howarth, C. and Sonn, C. 2012. National identity, citizenship and immigration: Putting the identity in context. *Journal for the Theory of Social Behavior 43 (3) 361-382*.

Anderson, A., Panchaud, C., Singh, S. and Watson, K. 2015. *Demystifying data: A guide to using evidence to improve young people's sexual health and rights*. New York: Guttmacher Institute.

Anderson, R.E. (eds). 2017. *Alleviating world suffering: The challenge of negative quality of life*. Cham: Springer.

Anderson, R.E. 2015. *Gender, HIV and risk: Navigating structural violence*. New York: Springer.

Anderson, T. 2008. *Winning the battle within: Realistic steps to overcoming sexual strongholds.* Oregon: Harvest House Publishers.

Anderson, T. 2013. Marriage: What it is, why it matters and the consequences of redefining it. *Backgrounder number 2775 1-12*.

Androff, D. 2015. *Practicing rights: Human rights-based approaches to social work practice.* London: Routledge.

Anglewicz, P. and Clark, S. 2013. The effects of marriage on HIV risks on condom use acceptability in rural Malawi. *Social Science and Medicine 97 29-40*.

An-Naim, A.A. and Deng, F.M. 2010. *Human rights in Africa: Cross cultural perspectives.* Brookings Institution Press.

Antai, D. 2011. Controlling behaviour, power relations within intimate partner relationships and intimate partner physical and sexual violence against women in Nigeria. *BMC Public Health 511 (11) 1-11*.

Anum, R.N. 2017. Determinants of women's autonomy in health care decision making in Ghana. . A dissertation submitted for the requirements of University of Ghana for Master of Arts in Population Studies. Accra: University of Ghana.

Anyemedu, A., Tenkorang, E.Y. and Dold, P. 2017. Ghanaian women's knowledge and perceptions of services available to victims of intimate partner violence. *Journal of Interpersonal Violence doi: 10.1177/0886260517689886*.

Arneson, D. 2008. *John Rawls' theory of justice*. Notes for philosophy 167. Spring.

Asian Communities for Reproductive Justice. 2005. *A New Vision for advancing our movement for reproductive health, reproductive rights and reproductive*. Canada: Asian Communities for Reproductive Justice. Available at http://strongfamilies.org/assets/docs/ACRJ-A-New-Vision.pdf retrieved 5 December 2017 retrieved 10 June 2018.

Asiimwe, H. 2013. *The changing dynamics, trends and perceptions in the bride price custom in Uganda and implications- A feminist perspective. A case of Banyakitra ethnic group in Western Uganda*. A dissertation submitted for the requirements of Institute of Social Studies for Master of Arts in Development Studies. Hague: Institute of Social Studies.

Atanga, L.L., Ellege, S.E., Litosseliti, L. and Sunderland, J. 2013. *Gender and language in sub-Saharan Africa: Tradition, struggle and change*. Amsterdam: John Benjamins Publishing.

Atanga, W.L. 2013. *African feminism? Gender and language in sub-Saharan Africa. Tradition, struggle and change*. Amsterdam: John Benjamins Publishing Company.

Auerbach, J.D, Parkhurst, J.O. and Caceres. F. 2011. Addressing social drivers of HIV/AIDS. for the long-term response: Conceptual and methodological considerations. *Global public health 6* (3) 293-S309.

Australian Government. 2016. *Gender equality and women's empowerment strategy. Australian Government Department of Foreign Affairs and Trade*. Sydney: Australian Government.

Awad, F. and Eldon, N.R. 2013. Questioning liberal feminist theory: A case study of the American ERA. *International studies module project 1-34.*

Babbie, E. 2014. *The basics of social science research*. Belmont: Wadsworth.

Bacchi, C. and Eveline, J. 2010. *Gender mainstreaming or diversity mainstreaming? The politics of doing.* Adelaide: University of Adelaide Press.

Baehr, A.R. 2013. *The Stanford encyclopaedia of philosophy. Liberal feminism*. Stanford: Metaphysics research lab, Stanford University.

Baloyi, E.M. 2010. *An African view of women as sexual objects as a concern for gender equality: A critical study.* Available at http://verbumetecclesia.org.sa/index.php/VE/article/view/380html retrieved on 18 February 2018.

Baloyi, E.M. 2013. Critical reflections on polygamy in African Christian context. *Missionalia 41 (2) 164-181.*

Bamberg, M. 2010. *Narrative analysis. In H, Cooper, APA handbook of research methods in psychology*. Washington D.C: APA Press.

Bamberg, M. 2012. *Narrative analysis*. In: Copper, H., Camic, P.M., Long, D., Panter, A.T., Rindskopf, D. and Kenneth, J. 2012. APA handbook of research methods in psychology: Volume 2 quantitative, qualitative, neuro psychological and biological.

Bangura, A.K. and Thomas, A.K. 2015. The nexus between good governance and gender equality as a human right in Africa: A correlation statistical analysis. *Journal of Third World Studies 1 (XXXII) 45-58.*

Bank, B.M., Delamont, S. and Marshall, C. 2007. *Gender and education: An encyclopaedia*. Westport: Greenwood Publishing Group.

Banque, M. 2012. *Le rapport sur le developpement dans le monde* 2012 : Egalites des genres ET Development. Washington.

Barosso, C. and Sippell, S. 2011. Sexual and reproductive health rights: Integration as holistic and rights based responses to HIV. *Women's Health Issues 21 (6) S250-S254*.

Barrett, C. and Hinchliff, 2017. *Addressing the sexual rights of older people. Theory, policy and practice.* London: Routledge.

Baschieri, A., Cleland, J., Floyd, S., Dube, A., Msona, A., Molesworth, A., Glynn, J.R. and French, N. 2013. Reproductive preferences and contraceptive use: A comparison of monogamous and polygamous couples in Northern Malawi. *Journal of Biosocial Science 45 (2) 145-165*.

Bashir, S. 2017. *Reproductive behaviour in Pakistan: Incorporating men and couples to understand change over time*. A dissertation submitted for the requirements of Bowling Green State University for Doctor of Philosophy. Ohio: Bowling Green State University.

Batisa, K. 2015. *The politics of control and ownership over women's bodies. Discourses that shape reproduction and sexual rights in Zimbabwe*. In: Bodies, morals and politics reflections on sexual and reproductive rights in Africa. Perspectives in Africa. Heinrich-Boll-Stiftung.

Battaglia, M.P. 2008. *"Non-probability sampling". Encyclopaedia of survey research methods*. London: Sage Publications.

Bauer, J. and Helie, A. 2006. *Documenting women's rights violations by non-state actors. Activist strategies from Muslim communities. Rights and democracy*. Montreal - Quebec: International Centre for Human Rights and Democratic Development.

Bauni, E.K. and Obonyo, J. n.d. The low acceptability and use of condoms within marriage: Evidence from Nakuru District. Kenya. *African Population Studies 18 (1) 51-65*.

Beek, K., Dawson, A. and Whelan, A. 2017. A review of factors affecting the transfer of sexual reproductive health training into practice in lower-middle income country humanitarian settings. *Conflict and Health 11 (16) 10-12.*

Beguy, D. 2009. The impact of female employment on fertility in Dakar (Senegal)and Lome (Togo). *Demographic Research 20 97-128*.

Bendl, R. and Schimdt, A. 2013. Gender mainstreaming: An assessment of its conceptual value for gender equality. *Gender, Work and Organisation 20 (4) 364-383.*

Benhura, A. 2016. Displaced and dispossessed: Sexual reproductive health and rights for women in Hopley, Zimbabwe. *The Oriental Anthropologist 16 (2) 215-227.*

Bennett, B. 2015. Women's health and a framework convention on global health. *Global Health Governance 9 (1) 149-164.*

Beracochea, E., Weinstein, C. and Evans, D. 2010. *Rights-based approaches to public health*. New York: Springer Publishing Company.

Berger, E.S.C. and Kuckertz, A. 2016. *Complexity in entrepreneurship innovation and technology research: Applications of emergent and neglected methods.* Switzerland: Springer.

Berglas, N.F., Constantine, N.A. and Ozer, E.J. 2014. A rights-based approach to sexuality education: Conceptualization, clarification and challenge. *Perspective on Sexual and Reproductive Health 46 (2) DOI:10.1363/4601114.*

Berman, E.A. 2017. An exploratory sequential mixed methods approach to understanding researchers data management practices at UVM: Integrating findings to develop research data services. *Journal of eScience Librarianship 6 (1) 1104 1-26*.

Beyene, K.A. 2016. *Sharing prescription medicines: An exploration of patients' and health professionals' perspectives*. A dissertation submitted for the fulfilment of the requirements of the degree Doctor of Philosophy in Pharmacy at the University of Auckland.

Bhandary, A. 2016. A Millian concept of care: What Mill's defence of the common arrangement can teach us about care. *Social theory and practice 42 (1) 155-182.*

Bicchieri, C. 2006. *The grammar of society: The nature and dynamics of social norms*. Cambridge: Cambridge University Press.

Bickman, L. and Rog, M.S.D.J. 2009. *The Sage handbook of applied social research methods.* London: Sage.

Billet, B. 2016. *Cultural relativism in the face of the West: The plight of women and female children.* London: Springer.

Biriwisha, M.K. 2012. Young Zimbabweans face sexual and reproductive health rights challenges. *Global editor at large. Posted September 16 2012*.

Bissong, P.B. and Ekanem, S.A. 2014. A Critique of feminism. *American Journal of Social and Management Sciences 5 (2) 33-38.*

Black, P., Laxminrayan, R., Temmerman, M. and Walker, N. (eds). 2016. *Disease control priorities. Third edition (volume 2): Reproductive, maternal, new born and child health.* Washington D.C: The World Bank Publications.

Blanc, A.K. 2001. The effect of power on sexual and reproductive health: An examination of Evidence. *Studies in Family Planning 32 (3) 189-213.*

Boss, P., Doherty, W.J., LaRossa, R., Schumm, W.R. and Steinmetz, S.K. 2008. *Sourcebook of family theories and methods: A contextual approach*. Berlin: Springer Science and Business Media.

Bosson, J.K., Vandello, J.A., Burnaford, R.M., Weaver, J.R. and Wasti, S.A. 2009. Precarious manhood and displays of physical aggression. *Personality and Social Psychology Bulletin 35 623-634*.

Bottoff, J., Oliffe, J., Robinson. C. and Carey, J. 2011. Gender relations and health research: A review of current practices. *International Journal of Equity in Health 10 (1) 60*.

Bove, R.M.,Vala-Haynes, E. and Valeggia, C. 2013. Polygyny and women's health in rural Mali. *Journal of Biosocial Science 46 66-89*.

Boyer, Y. 2017. First Nations, Metis and Inuit women's health: ARBA. *Alberta Law Review 54 (3) 611-637.*

Branco, M.C. 2016. Rights based approach to land reform. *International Journal Latest Trends Financial Economic Science 6 (4) 122-131.*

Braungardt, J. 2015. Characteristics of human rights. Philosophical exploration. Available at http://braungardt.trialectics.com/projects/political-theory/characteristics-of-human-rights/pdf retrieved 7 February 2017.

Braverman, L. 2013. *Key perspectives in criminology*. Pennsylvania: McGraw-Hill Education.

Breakwell, G.M. 2007. *The psychology of risk*. Cambridge. Cambridge University Press.

Brennen, B.A. 2011. *Marital rape, myth or reality*. Available at http://www.soecouragement.org/maritalrape.pdf retrieved on 12 July 2017.

Brierley, J.A. 2017. The role of pragmatist paradigm when adopting mixed methods in behavioural accounting research. *International Journal of Behavioral Accounting and Finance 6 (2) 140-154.*

Briggs, C.A. and Pepperell, J.L. 2009. *Women, girls and addiction celebrating feminine in counselling treatment and recovery*. Abigdon: Taylor and Francis.

Brookes, L. 2008. What is liberal feminism? Available at http://ezineaticles.com/?expert=lucy_Brookes retrieved on 15 December 2016.

Brown, J., Dodd, K. and Vetere, A. 2010. "I am a normal man" : A narrative analysis of the accounts of older people with down's syndrome who lived in institutionalised settings. *British Journal of Learning Disabilities 38 217-224.*

Browning, M.D. 2011. *Patriarchy, Christianity and the African HIV/AIDS epidemic. Rethinking Christian marriage in light of the experiences of HIV positive women in Tanzania*. A dissertation submitted for the requirements of University of Chicago for Doctor of Philosophy in Theology. Chicago: University of Chicago.

Buelna, C., Ulloa, E.C.and Ulibarri, M.D. 2009. Sexual relationship power as a mediator between dating, violence and sexually transmitted infections among college women. *Journal of Interpersonal Violence 24 (8) 1338-1357*.

Bui, T.C., Diamond, P.M. Markham, C., Ross, M.W., Nguyen-Le, T.A. and Tran, L.H. 2010. Sexual communication among female students in the Mekong river delta of Vietnam. *Culture, Health and Sexuality 12 (6) 591-601.*

Burke, K. 1945. *Introduction. The key elements of dramatization*. In K. Burke (eds). A grammar of motives(pp xv-xxiii). New York: Prentice Hall.

Burmeister, E. and Aitken, L.M. 2012. Sample size: How many is enough? *Australian Critical Care 25 271-274.*

Butts, S. A., Parmley, L. E., Alcaide, M. L., Rodriguez, V. J., Kayukwa, A., Chitalu, N. and Jones, D. L. 2017. Let us fight and support one another: Adolescent girls and young women on contributors and solutions to HIV risk in Zambia. *International Journal of Women's Health 9 727–737.*

Cahoy, E. 2018. Empirical research in education and the behavioural/ social sciences. Available at http://guides.libraries.psu.edu/emp retrieved 19 May 2017.

Callaghan, J. and Lazard, L. 2011. *Social psychology*. London : Sage

Canales, G. 2013. Transformative mixed methods. Checklist for psychological research with Mexican Americans. *Journal of Mixed Methods 7 (1) 6-21*.

Canning, D. and Schultz, T.P. 2012. The economic consequences of reproductive health and family planning. *The Lancet 389 165-171*.

Carella, A. and Ackerly, B. 2017. Ignoring rights is wrong: Re- Politicizing gender equality and development with the rights-based approach. *International Feminist Journal of Politics 19 (2) 137-152.*

Castro, P. and Patel, S. 2008. Social representations, change and resistance: On the difficulties of generalizing new norms. *Culture and Psychology 14 (4) 475-497*.

Chabata, T. 2012. The commercialisation of lobola in contemporary Zimbabwe: A double-edged sword for females. Available at

http://kubatana.net/docs/health/osisa_buwa_3_sex_health-120022.pdf retrieved on 14 June 2017.

Charkkabartty, S,N. 2013. Best split-half and maximum reliability. *IOSR Journal of Research and Methods in Education 3 (1) 1-8.*

Charles, C.M. and Mertler, C.A. 2010. *Introduction to an educational research*. 7th edition. Boston MA: Pearson/Allyn and Bacon.

Chauke, M.T. 2015. The role of women in traditional leadership with special reference to the Valoyi tribe. *Stud Tribes Tribals 13 (11) 34-39.*

Chegwe, E. 2014. A gender critique of liberal feminism and its impact on Nigerian law. *International Journal and the Law 14 (1) 66-78*.

Cherry, A.L. and Dillon, M.E. 2014. *International handbook of adolescent pregnancy: Medical, psychosocial and public health responses*. Springer Science and Business Media.

Cheung, A.K. 2019. Husband-to-wife sexual coercion in cross border marriage: A relationship perspective. *Current Sociology 00 (0) 1-22*.

Chikura, J. 2016. *A study of Karanga bride welcoming ceremony songs.* A dissertation submitted for the requirements of Midlands State University of Bachelor of Arts Honours Music and Musicology. Gweru: Midlands State University.

Chilisa, B. and Nteane, G. 2010. Resisting dominant discourses: Implications of indigenous, African feminist theory and methods for gender and education research. *Gender and Education 22 (6) 617-632.*

Chimbandi, P.R. 2014. *The experienced reality of married Shona women: The impact of their husband's sexual practices on them and the relationship.* A dissertation submitted for the requirements of Stellenbosch University of Master of Philosophy. Cape Town: Stellenbosch State University.

Chimbiri, A.M. 2007. The condom is an 'intruder' in marriage: Evidence from rural Malawi. *Social Science & Medicine 64(5) 1102-15*.

Chin'ombe, P. 2014. *An analytical analysis of abortion laws in Zimbabwe from human rights perspective.* A dissertation submitted in partial fulfilment for the requirements of Midlands State University for Bachelor of Law Honours. Gweru: Midlands State University.

Chireshe, E. 2015. Christian women's experiences of domestic violence in Zimbabwe. *Affilia: Journal of Women and Social Work 3 (13) 380-394.*

Chireshe, E. and Chireshe, R. 2010. Lobola: Perceptions of Great Zimbabwe University students. *The Journal of Pan African Studies 3 (9) 211-221.*

Chirowa, F., Atwood, S. and Van der Putten, M. 2013. Gender inequality health expenditure and maternal mortality in Sub Sahara Africa. A secondary data analysis. *African Journal of Primary Health Care and Family Medicine 5 (1) doi: https://doi.org/10.4102/phcfm.v5i1.471*.

Chirwa, E., Malata., A. and Norr, 2011. HIV prevention awareness and practices among married couples in Malawi. *Malawi Medical Journal 23 32-37*.

Chitakure, J. 2016. *Shona women in Zimbabwe- a purchased people?: Marriage, bride wealth, domestic violence and Christian traditions on women.* Eugene: WIPF and Stock Publisher.

Chitando, E. 2011. *Aids-free generation: A possibility of Utopian deal?* Available at http://chishresourcecentre.org/index.php?view=article=73%AHIV-a-aids&id=250%3Aprof-ezia-chitando&format=pdf&option=com.content&Hemid+238 retrieved on 12 July 2017.

Christensen, L.B., Johnson, R.B. and Turner, L. 2014. *Research methods, design and analysis*. 12th edition. Upper Saddle River: Pearson.

Clapman, A. 2015. *Human rights: A very short introduction*. Oxford: Oxford University Press.

Classens, A. and Mnisi, S. 2011*. Rural women redefining land rights in the context of living customary law*. In: Goldblatt, B. and McLean, K. (Eds). Women's social and economic rights: Developments in South Africa. Cape Town: Juta Law.

Cockerham, W.C. 2016. *International encyclopaedia of public health*. Cambridge: Academic Press.

Coican, M. 2015. Health- a human rights issue. *Juridical Current 19-26.*

Collins, K.MT., Onwuegbuzie, A. and Jiao, Q.G. 2006. Prevalence of mixed methods sampling. *Designs in Social Science Research Evaluation and Research in Education 19 (2) 83-101.*

Collumbien, M.J., Busza, J., Cleland, J. and Campello, O. 2012. *Social science methods for research of sexual and reproductive health.* Geneva: World Health Organization.

Coma, J.C. 2014. HIV prevention and marriage: Peer group effects on condom use acceptability in rural Kenya. *Social Science and Medicine 116 169-177*.

Commission on Gender Equality. 2005. *National Gender Opinion Survey*. Johannesburg: Commission on Gender Equality.

Committee on the Status of Women, 2007. Research Report on Glossary of Violence against Women. Geneva: Switzerland.

Connell, R.W. 1987. *Gender power*. Cambridge and Oxford: Polity Press.

Connell, R.W. 1995. *Masculinities*. Berkeley: University of California.

Connell, R.W. 2005. Change among gatekeepers: Men, masculinities and gender equality in the global arena. *Signs: Journal of Women in Culture and Society 30 1801-1825*.

Connell, R.W. 2008. *Masculinities*. 2nd Edition. Crows Nest: Allen and Unwin.

Conroy, A.A. 2014. Gender, power, and intimate partner violence: a study on couples from rural Malawi. *Journal of Interpersonal Violence 29 (5) 866e888*.

Conroy, S. 2011. Women's inheritance and conditionality in the fight against AIDS. *Wisconsin International Law Journal 706-741.*

Cook, R. and Kelly, L.M. 2006. *Polygyny and Canada's obligations under the International Human Rights Law.* Vancouver: Department of Justice, Canada.

Correia, H. and Broderick, P. 2009. Access to reproductive technologies by single women and lesbians: Social representations and public debate. *Journal of Community & Applied Social Psychology 19*(4) *241-256*.

Creswell, J. W. 2003. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches.* 2nd edition. Thousand Oaks, CA: Sage Publications

Creswell, J. W. 2009. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches.* 3rd edition. Thousand Oaks, CA: Sage Publications.

Creswell, J. W. 2014. Research design. 4th edition. Lincoln: Sage.

Creswell, J. W. and Plano Clark, V.L. 2007. *Designing and Conducting Mixed Methods Research.* Thousand Oaks, CA: Sage.

Creswell, J.W. and Plano Clark, V.L. 2011. *Designing and Conducting Mixed Methods Research*. 2nd edition. Sage Publications, Los Angeles.

Creswell. J.W. 2014. *Research design: Qualitative, quantitative and mixed methods approaches.* London: Sage.

Cudd, A. and Holstrom, N. 2011. *Capitalism for and against: A feminist debate*. Cambridge: Cambridge University Press.

Cullen, M.R., Baiocchi, M., Eggleston, K., Loftus, P. and Fuchs, V. 2016. The weaker sex? Vulnerable men and women's resilience to socio-economic disadvantages. *SSM Population Health 512-524*.

Dare, F. 2017. What are human rights? Tim dares considers how far human rights claims can stretch. *Philosophy Now 118 February/March 2017 18-19.*

Das, K. and Patra, D. 2009. *Studies in women writers in English*. New Delhi: Commonwealth Publishers Private Limited.

De Jonge. T., Veenhoven. R. and Kalmjin. W. 2017. *Diversity in survey questions on the same topic: Techniques for improving comparability.* Volume 68 of the Social Indicators Research Series. London: Springer.

Debussher, P. 2015. Evaluation of Beijing Platform for Action +20 and the opportunities for achieving gender equality and the empowerment of women in the post- 2015 development agenda. Study for the FEMM Committee. Available at http://www.europar/.europe.eu/studies.pdf retrieved on 12 January 2017.

Dennis, F. J. 2013. The evolving sexual health paradigm: *Transforming definition into sexual health practices 27 S127-S133.*

Dersnah, M.A. 2012. *Women in political and public life*. Global report for the working group on the issue of discrimination against women in law and practice.

Dharagi, Y.B. 2007. *Educational system in Africa: An assessment on Uganda*. Kampala. Uganda Papers.

Dickson, M. and Louis, N. 2018. Discrimination and oppression of women a social work exploration in Zimbabwe. *Social Criminology 6 (2) 1-5.*

Diehl, E., Becker, C. and Prytherch, H. 2009*. Gender mainstreaming in health- "an analysis of the Tanzanian-German Programme to support health.*" Dar es Salaam: Tanzania German Programme to Supplement Health.

Djamba, Y.K. and Kamuna, S.R. 2015. *Gender-based violence: Perspectives from Africa, the Middle East and India*. London: Springer.

Do, M. and Kurimoto, N. 2012. Women's empowerment and choice of contraceptive methods in selected African countries. *International Perspectives Sexual Reproductive Health 38 (01) 23-33*.

Doody, R. 2015. *Criticism for Rawls' principles of justice*. Available at www.mit.edu.rdoody/Gov%2010%Political%20Theory/RawlsCriticismsGov10.pdf retrieved 10 May 2017.

Doosuur, A. and Arome, A.S. 2013. Curbing the cultural practices of wife inheritance and polygamy through information dissemination in Benue State. *IOSR Journal of Humanities and Social Science 13 (1) 50-54.*

Dove, N. 1998. African feminism: An afro-centric theory. *Journal of Black Studies 5 (2) 515-539.*

Dretske, F. n.d. Epistemology and information. Available at https://www.resources://c.uva.nl.HPI/Draft_Epistemelogy-and-information.pdf retrieved 10 May 2018.

Dube, N., Nkomo, T.S. and Khosa, P. 2017. Condom usage negotiation among customary married women in Katlehong, Johannesburg. *Sage Open 1-7*.

Duggard, J. 2007. *International Law: A South African perspective*. 3rd edition. Cape Town: Juta.

Dulay, B. 2009. *Adolescent social support seeking: A narrative analysis*. A dissertation submitted for the fulfilment of the requirements of the degree Master of Arts in Counselling at BA Simon Fraser University.

Dures, E., Rumsey, N. and Morris, M. 2016. Mixed methods in health psychology. Theoretical and practical considerations of the third paradigm. *Journal of Health Psychology 16 (2) 332-341.*

Durojaye, E. 2015. *Litigating rights to health in Africa: Challenge and prospects.* Farnham: Asheat.

Durojaye, E., Okeke, B. and Adebanjo. A. 2014. Harmful cultural practices and gender equality in Nigeria. *Gender and Behavior 12 (1) 6169-6181*.

Dyani-Mhango, E. 2016. The consent of first wife in a polygamous marriage as a requirement of the validity of her husband's subsequent marriage under South Africa's Recognition of Customary Marriages Act: Maleyane v Ngwenyama. *Journal of African Law 60 (1) 156-169.*

Eborka, K., Oyefara, J.L. and Oyekanmi, F.A.D. 2017. Conceptions of maleness within conjugal and sexual contexts and involvement in family planning/household tasks among males in Delta State. *Ife PsychologIA 25 (2) 280-295.*

Eipstein, C.F. 1988. *Deceptive distinctions: Sex, gender and the social order*. Berkerley: University of California Press.

Eisenhart, M. 1991. Conceptual frameworks for research CIRCA: Ideas from a cultural education researchers. *Paper presented at the proceedings of the Thirteenth Annual North American Paper of the International Group for the Psychology of Mathematics Education*. Virginia, United States of America: Blacksburg.

Eisenstein, Z.R. 1979. *Capitalist patriarchy and the case for socialist feminism*. New York: Monthly Review Press.

Ekmekci, P.E. and Arda, B. 2015. Enhancing John Rawls' theory of justice to cover health and social determinants of health. *Acta Bioethica 2 (2) 227-236*.

Equality Now. 2011. A guide to using the protocol on the rights of women in Africa for legal action. Equality Now on behalf of Solidarity for Africa Women's Rights Coalition. Available at http://www.equalitynow.org/sites/default/files/Manual%20on%20Protocol20%Women20%Rights20%in20%Africa_EN/pdf retrieved on 12 September 2016.

Equality Now. 2014. Protecting the girl child. Using the law to end child, early and forced marriage and related human rights violations. New York: Equality Now. Available at http://www.girlsnotbrides.org/reports-and-publications/protecting-girl-child-using-law-end-child-early-forced-marriage-related-human-rights-violatons/ retrieved on 16 December 2016.

Equity for children. 2013. Equity and social justice: A short introduction. Available at www.equityforchildren.org/wp-content/uploads/2013/07/Final-paperandSocialJustice-AnIntroduction-1/pdf retrieved on 4 November 2016.

Erdman, J.N. and Cook, R.J. 2008. *Reproductive rights*. In Heggenhougen (eds) *International Encyclopaedia of Public Health.* Oxford: Academic Press.

Etikan, I., Alkassim, R. and Abubakar, S. 2016. Comparison of snowball sampling and sequential technique. *Biometrics and Biostatistics International Journal 3 (1) 1-2*.

Etikan, I., Musa, S.A. and Alkassim, R.S. 2016. Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics 5 (1) 1-4.*

European Commission. 2010. *European textbook on ethics in research*. Luxembourg: Publications office for the European Union.

European Institute of Gender Equality. 2015. *What is gender mainstreaming?* Available at http://www.eige.europa.eu/gender-mainstreaming/what-is-gender-mainstreaming retrieved 20 May 2018.

European Union. 2015. What are sexual and reproductive health and rights? *European Humanist Federation 1-6.*

Everritt-Penhale, B. and Ratele, K. 2015. Rethinking traditional masculinity as constructed multiple and hegemonic masculinity. *South Africa Review of Sociology 46 (2) 4-22*.

Eze, C. 2016. *Ethics and human rights in Anglophone African women's literature: Feminist empathy.* Manhattan: Springer.

Ezeanolue, E., Iwelunmer, J., Asaolu, I., Obiefune, M., Ezeanolue, C., Osuji, A. and Ehiri, J. 2015. Impact of male partners awareness and support for contraceptives on female intent to use contraceptives in South East Nigeria. *BMC Public Health 15 (1) 879 1-6*.

Fahmida, R. and Doneys, P. 2013. Sexual coercion within marriage in Bangladesh. *Women Studies International Forum 38 117-124.*

Family Watch International. nd. Sexual rights defined. Policy Brief. Available at http://familywatch.org/fwi/documents/sexual_Rights_Defined.pdf retrieved 14 August 2017.

Farmer, D.B., Berman, L., Ryan, G., Habumugusha, L. and Nutt, C. 2015. Motivational and constraints to family planning: A quantitative study in Rwanda's Southern Kayonza District. *Global Health Science Practice 3 (2) 242-254*.

Farr, R.M. 1998. The collective to social representation. *Aller et Retour: Culture and Psychology 4 (3) 275-296.*

Fédération du Québec pour le planning des naissances, 2014. Reproductive justice or applying a social justice lens to sexual, reproductive and maternal health and rights. Available at http://www.fqpn.qc.ca/main/wp-content/uploads/2014/03/PDF-EN-COULEUR.pdf retrieved 21 May 2017.

Feilzer, M.Y. 2010. Doing mixed methods research as a research pragmatically: Implications for the rediscovery of pragmatism as a research paradigm. *Journal of Mixed Methods Research 4 (1) 6-16.*

Feinrich, J., Galizzi, P. and Higgins, T.E. 2011. *The future of African customary law.* Cambridge: Cambridge University Press.

Fetters, M.D; Curry, L.A. and Creswell, J.W. 2013. Achieving integration in mixed methods decisions-principles and practices. *Health Services Research 48 (6pt 2) 2134-2156*.

Field, A. 2009. *Discovering statistics using SPSS*. London: Sage.

Fikiri, D. 2016. Symbols and rituals of marriage: A plea of inculturation. *Hekima University College Number 55 163- 173.*

Filson, J., Ulloa, E., Runfola, C. and Howoda, A. 2010. Does powerlessness explain the relationship between IPV and depression. *Journal of Interpersonal Violence 25 (3) 400-415*.

Flynn, P.M., Hayness, K. and Kilgour, M.A. 2015. *Integrating gender equality into business and management education. Lessons learned*. Yorkshire: Greenleaf Publishing.

Forere, M. and Stone, L. 2009. The SADC Protocol on Gender and Development: Duplication or complementarity of the African Union Protocol on Women's Rights. *African Human Rights Law Journal 9 434-458.*

Fouka, G. and Mantzorou, M. 2011. What are the major ethical issues in conducting research? Is there a conflict between the research ethics and the nature of nursing? *Health Science Journal 5 (1) 3-14.*

Friedman, B. 1974. *The feminist mystique*. New York: Dell.

Fusch, P.I. and Ness, L.R. 2015. Are we there yet? Data saturation in qualitative research. *The Qualitative Report 20 (9) 1408-1416*.

Gable, E. 2010. Reproductive health as a human right. *Case Western Reserve Law Review 60 (4) 957-996.*

Gaffney-Rhys, R. 2011. Polygamy and the rights of women. *Women in Society 1 1-15.*

Gaffney-Rhys, R. 2012. A comparison of child marriage and polygamy from a human rights perspective: Are the arguments equally coherent? *Journal of Social Welfare and Family Law 34 (1) 49-61.*

Galati, A. 2015. Onward to 2030: Sexual and reproductive health and rights in the context of the Sustainable Development Goals. *Guttamcher Policy Review 18 (4) 77-84.*

Galvin, K.M., Bylund, C.L. and Brommel, M.J. 2012. *Family communication: Cohesion and change* 8th edition. Boston: Pearson Education.

Galy-Badenas, F. 2015. A qualitative study of male and female perceptions in differences in the working and domestic sphere: A comparison of the French and Finnish cultures. A dissertation submitted for the requirements of University of Jyvaskyla for Masters. Jyväskylä: University of Jyvaskyla.

Gandari, E., Chiminuka, L. and Mafumbate, R. 2012. Introduction to gender. *Issue: Module BSCC406*. Harare. Zimbabwe Open University.

Ganji, J., Emamian, M.H., Maasoumi, R., Keramat, A. and Merghati Khoei, E. 2017. The existing approaches to sexuality education targeting children: A review article. *Iran Journal of Public Health 46 890-898*.

Gaspard, F. 2007. "*Unfinished battle: Political and public life*". In: Hanna Beate Schoop-Schilling and Cees Flinterman (Eds). The Circle of Empowerment twenty-five years of the United Nations Committee on the Elimination of Discrimination Against Women. New York: Feminist Press.

Gender Equality Steering Committee. 2019. Disrupting gender norms in health systems: Making the case for the change. *The Lancet 4 doi: 10.1016/S0140-6736(19)30648-8*.

Gergen, M.M. and Gergen, K.J. 1984. *Social construction of the narrative accounts*. In K.J Gergen and M.M Gergen (eds) (in press) Historical social psychology. Hillsdale, New Jersey: Erlbaum.

Germain, A., Sen, G., Garcio-Moreno, C. and Shankar, M. 2015. Advancing sexual and reproductive and rights in low and middle-income countries: Implications for the post 2015 Global Development Agenda. *Global Public Health 10 (2) 137-148*.

Gibbs, D.R. and Jobson, G. 2011. Narratives and masculinity in the Daily Sun: Implications of HIV risk and prevention. *South African Journal of Psychology 41 (2) 173-186*.

Girgis, S., George, R.P. and Anderson, R.T. 2012. What is a marriage man and women: A defense. *Harvard Journal of Law and Public Policy 34 (1) 245-287.*

Goicelea, S. 2010. Adolescent pregnancies in the Amazon Basin of Ecuador: A rights and gender approach to adolescents sexual and reproductive. *Global Health Action 3: 5280 1-12*.

Goldberg, M. 2014. What is a woman? *New Yorker 90 (22)*.

Goredema, R. 2010. *African feminism: The African woman's struggle for identity* In Kangaira, J. and Salazar, Ph-J. Gender rhetoric: North-South 33-41. Windhoek: Poly Press.

Gostin, L.O. and Sridhard, D. 2014. Global health and the law. *New England Journal of Medicine 370 (18) 1732-1740.*

Grant, E. 2006. Human right, cultural diversity and customary law in South Africa. *Journal of African Law 50 (1) 2-23.*

Grant. C. and Osanloo, A. 2014.Understanding, selecting and integrating a theoretical framework in dissertation research: Creating the blueprint for your "house." *Administrative Issue Journal: Connecting Education Practice and Research 13-25.*

Green, H. 2014. Use of theoretical and conceptual frameworks in qualitative research. *Nurse Researcher 21 (6) 34-38.*

Greene, R.R. 2011. *Human behaviour theory and social work practice*. New Jersey: Transaction Publishers.

Griffin, S. 2006. Literature review on sexual and reproductive health rights: Universal access services, focussing on East and Southern Africa and South Asia. Department of International Development. Available at www.realising-rights.org/docs/SRHLiterature review.pdf retrieved on 13 August 2016.

Groes-Green. C. 2009. Hegemonic and subordinate masculinities: Class violence and sexual performance among young Mozambican men. *Nordic Journal of African Studies 18 (4) 286-304.*

Grove, C. 2014. To build global movement to make human rights and social justice a reality for all. *SUR: International Journal on Human Rights 353-362.*

Gruskin, S., Ahmed, S., Bogecho, D., Ferguson, L., Hanefield, J., MacCarthy, S., Raad, Z. and Steiner, R. 2012. Human rights in health care systems framework: What is there, what is missing and why does it matter. *Global Public Health 7 (4) 337-351.*

Gruskin, S., Bogecho, D. and Ferguson, L. 2010. "Rights based approaches" to health policies and programmes, articulations, ambiguities and assessment. *Journal of Public Health Policy 31 (2) 129-145.*

Gunew, S. 2013. *Feminist knowledge (RLE feminist theory): Critique and construct.* London: Routledge.

Gunga, O. 2009. The politics of widowhood and re-marriage among the Luo of Kenya. *Thought and Practice: A Journal of the Philosophical Aspect of Kenya 1 (1) 161-174.*

Gutsa, I., Tom, T., Chihambakwe, W. and Chideya, T.N. Gender and development. *MODULE ds 103.*

Gwirayi, C. 2016. Bachelor of adult education students' perceptions on polygamy at a state university in Zimbabwe. *Dzimbahwe Journal of Multidisciplinary research 1 (1) 25-35.*

Gwirayi, C. 2017. Experiences of Shona men in polygamous marriages in Ward Four Chivi District, Masvingo Province, Zimbabwe. *Africology: The Journal of Pan African Studies 10 (1) 25-39.*

Gyekye, K. 1997. *Tradition and modernity philosophical reflections on the African experience*. Philadelphia: Tempe University Press.

Haberland, L. 2010. What happens when programs emphasise gender? A review of the evaluation research. *Presented at United Nations Population Fund Global Technical Consultation on Comprehensive Sexuality Education*. Bogota, Colombia November 30, 2010.

Haberland, N.A.2015. The case for addressing gender and power in sexuality and HIV education: A comparative review of evaluation studies. *International Perspectives on Sexual and Reproductive Health 41 (1) 31-42.*

Hagan, J., Shaw, J. and Duncan, P. 2008. *Theme 8: Promoting healthy sexual development and sexuality. Bright futures and guidelines for health supervision of infants, children and adolescents* . 3rd edition. Elk Grove Village, IL: American Academy for Paediatrics.

Hall, W.J., Jones, B.H.L., Witkemper, K.D., Collins, T.L. and Rodgers, G.K. 2019. State policy on school-based sex education: A content analysis focused on sexual behaviours, relationships and identities. *American Journal of Health Behaviour 43 (3) 506-519*.

Hankivsky, O. 2014. Intersectionality 101. The Institute for intersectionality research and policy, Simon Fraser University. Available at http://www.docplayer.net/4773103-Intersectionality-101-olena-hankivsky-phd.html retrieved 10 June 2016.

Hantrais, L. and Mangen, S. 2013. *Cross-national research methodology and practice*. London: Sage.

Hardee, K., Kumar, J., Bakamjian, J., Harris, S., Rodriguez, M. and Brown, W. 2014. Human rights-based family planning: A conceptual framework. *Studies in Family Planning 45 (1) 1-18.*

Harries C.K. 2014. Conscientious objection and its impact of abortion services provision in South Africa: A qualitative study. *Reproductive Health 11 3-4.*

Harris, E. and Nolan, E. 2016. *Guidelines for good research practice. Research, Business and Innovation.* De Montfort University.

Harris, J., Cooper, D., Strebel, A. and Calvin, C.J. 2014. Conscientious objection and its impact on abortion service provision in South Africa; A qualitative study. *Reproductive Health 2014 11 (16)*.

Hartmann, M., Khosla, R., Krishnah, S., George, A., Gruskin, S. and Amin, A. 2016. How are gender equality and human rights interventions included in sexual reproductive health programmes and policies: A systematic review of existing research foci and gaps. *PLoS One 11 (12) 1-14.*

Hatcher, A.M., Tsai, A.C. and Kumbakumba, E. 2012. Sexual relationship power and depression among HIV- infected women in rural Uganda. *PLOS One 7 (12),1e7*

Hawkins, C. 2012. Women's human rights: The global intersection of gender equality, sexual and reproductive justice and healthcare. *Journal of Research on Women's Gender 4 159-184*.

Health Policy Plus. 2016. *Boosting family planning within Sustainable Development Goals framework: A way forward for Sindh, Pakistan*. Washington D.C: Health Policy Plus.

Herbert, L.A. 2015. "Women run the school?" Gender violence reform and the "stretching "of human rights in Rwanda. *Journal of Human Rights 14 23-40.*

Herek, G. 1995. In Pequegnat. W. and Stover, E. (eds) 1995. *How to write successful research grant application: A guide for social and behavioural scientists*. Berlin: Plenum Press.

Hernandez, J.P. 2011. *Sexual and reproductive health among indigenous Mexican Adolescents: A socio-representational perspective*. A dissertation submitted for the requirements of London School of Economics for Doctor of Philosophy. London: London School of Economics.

Hesse, L., Greene, M.E. and Opper, N. 2019. Gender inequality and restrictive gender norms: Framing challenges to health. The Lancet. Available at http://www.dx.doi.orf/10.1016/50140-6736(19)30652-X retrieved 21 November 2018.

Hesse-Biber, S.N. 2010. *Mixed method research: Merging theory with practice*. New York: Guilford Press.

Hesse-Biber, S.N. and Leavy, P. 2011. *The practice of qualitative research.* 2nd edition. Thousand Oakes: Sage.

Heymann, J., Levy, J.K., Bose, B., Ríos-Salas, V., Mekonen, Y., Swaminathan, H., Omidakhsh, N., Gadoth, A., Huh, K., Greene, M.E., Darmstadt, G.L. and Gender Equality, Norms and Health Steering Committee. 2019. Improving health with programmatic, legal, and policy approaches to reduce gender inequality and change restrictive gender norms. *The Lancet doi: 10.1016/S0140-6736(19)30656-7*.

Higgins, J.A., Hoffman, S. and Dworkin, S.L. 2010. Gender, heterosexual men and women's vulnerability to HIV/AIDS. *American Journal of Public Health 100 (3) 435-445*.

Higgins, J.A., Hoffman, S. and Dworkin, S.L. 2010. Rethinking gender, heterosexual men, and women's vulnerability to HIV/AIDS. *American Journal of Public Health 100 (3) 435e442*.

Hildebrand, C. and Lewis, J. 2013. Kenya: Wife inheritance. African grandmothers tribunal-seeking justice at the frontlines of the AIDS crisis. *September 7, 2013 1-10.*

Hindin, M. 2005. *Women's autonomy, status and nutrition in Zimbabwe, Zambia and Malawi in a focus on gender using Demographic and Health Survey Data*. Calverton: Marco.

Hodson, L. 2014. Women's rights and the periphery: CEDAW's Optional Protocol. *The European Journal of International Law 25 (2) 561-578.*

Hoijer, B. 2011. Social representations theory: A new theory for media research. *Nordicom Review 3-16.*

Holmes, M. 2007. *What is gender? Sociological approaches*. London: Sage.

Hooks, B. 2014. *Feminism is for everybody: Passionate politics*. London: Routledge.

Hover, J. 2011. Social representation theory. A new theory for media research. *Nordicom Review 32 (2) 3-16.*

Howard-Payne, C. 2012. *Young men's responses to media portrayals of masculinity: A South African qualitative investigation*. A dissertation submitted for the requirements of University of Witwatersrand for Master of Psychology. Johannesburg: University of Witwatersrand.

Howarth, C. 2006. A social representation is not a quiet thing: Exploring the critical potential of social representations theory. *British Journal of Social Psychology 45 (1) 65-86.*

Howarth, C; Foster, J and Dorrer, N. 2004. Exploring the potential of the theory of social representations in community-based health research- and vice versa. *Journal of Health Psychology 9 (2) 229-243.*

Howson, A. 2009. Cultural relativism. *Ebsco Research Starters 1-5.*

Hunt, P. 2016. Interpreting the international right to health in a human rights -based approach to health. *Health and Human Rights 18 (2) 109-130.*

Hunter, J.E., Jensen, J.L and Rodgers, R. 2014. The control group and meta analyses. *Journal of Methods and Measurements in the Social Sciences 5 (1) 3-21.*

Hussein, A. 2009. The use of triangulation in social science research: Can qualitative and quantitative methods be combined. *Journal of Comparative Social Work 4 (1) 1-12.*

Idang, G.E. 2015. African culture and values. *Phronimin 16 (2) 97-111.*

Igboin, O.B. 2011. Colonialism and African cultural values*. African Journal of History and Culture 3 (6) 96-103*.

Ihantola, E. and Kahn, L. 2011. Threats to validity and reliability in mixed methods accounting research. *Qualitative Research in Accounting and Management 8 (1) 39-58*.

Iikkaracan, P. 2016. Theme: Sexual health, human rights and the law. Commentary: Sexual health and human rights in the Middle East and North Africa: Progress or backlash? *Global Public Health 10 (2) 268-270.*

Ijioha, I.A. and Nwabueze, R.N. 2016. *Comparative health law and policy: Critical perspective on Nigerian global health law.* London: Routledge.

Ikepeze, O.V.C. 2015. Appraisal of the effects of customary practices on reproductive health rights of Nigerian women. *Research on Humanities and Social Sciences 5 (18) 191-204.*

International Committee on the Rights of Sex Workers in Europe (ICRSE), 2016. Feminism needs sex workers; sex workers need feminism: A sex-worker inclusive women's rights movement. *Intersection briefing paper 2. March 2016.*

International Planned Parenthood Federation. 2012. *Sexual rights and the universal periodic review: A toolkit for advocates.* London: Sexual Rights Initiative and IPPF.

International Planned Parenthood Federation. 2015. *Sustainable Development Goals: A sexual reproductive health and rights CSO guide for national implementation.* London: International Planned Parenthood Federation.

International Planned Parenthood Federation. 2016. *Everyone's right to know: Delivering comprehensive sexuality education for all young people*. London: International Planned Parenthood Federation.

Iqbal, S., Zakar, R., Zakar, M.Z. and Fischer, F. 2017. Perceptions of adolescents sexual and reproductive health and rights: A cross-sectional study in Lahore district Pakistan. *BMC International Health and Human Rights 17 (5) 1-13.*

Irefin, P., Iffah, S.S. and Bwala, M.H.2012. Organisation theories and analysis: A feminist perspective. *International Journal of Advancements in Research Technology 1 (1) 1-27*.

Isakander, G. 2013. *A sequential exploratory decision for the e-learning maturity model in the Middle-Eastern countries*. A dissertation submitted for the fulfilment of the requirements of the degree Doctor of Philosophy at the Middlesex University. London: Middlesex University.

Iyanuolu, A. E. 2008. *The Challenge of Culture for the Rights of Women in Africa: A Critical Analysis of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.* A dissertation submitted in partial fulfilment for the requirements of University of Cape Town for masters. Cape Town: University of Cape Town.

Jackson, C. 2012. Conjugality as social change: A Zimbabwean case. *The Journal of Development Studies 48 (1) 41-54.*

Jacob, M. 2010. Claiming health and culture as human rights. *International Feminist Journal of Politics 12 (3-4) 361-380.*

Jacobs, B. 2011. Unbound by the theory of naming: Survival feminism and the women of South Africa Victoria Mxenge Housing and Development Association. *Journal of Gender Law and Justice 19-77.*

Jewkes, R.K., Dunkle, K., Nduna, M. and Shai, N. 2010. Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. *The Lancet 376, 41e48.* Available at http://dx.doi.org/10.1016/S0140-6736(10)60548-X retrieved 14 December 2019.

Jin, H.S. 2011. *Sexual knowledge and perception and current status of sex education among parents of first and second grade elementary schoolers*. A dissertation submitted for the requirements of Catholic University of Korea for Masters. Korea: Catholic University of Korea.

John-Akinola, Y.O. 2014. *Children and parents' participation: Socio-ecological perspectives and health promotion in schools*. A dissertation submitted for the fulfilment of the requirements of the degree Doctor of Philosophy in Health Promotion at the University of Ireland. Dublin: University of Ireland.

Johnson, A.G. 2014. *The gender knot: Unravelling our patriarchal legacy*. Philadelphia: Temple University.

Jonas, D. 2012. The practice of polygamy under the scheme of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa: A critical appraisal. *Journal of African Studies and Development 4 (5) 142-149.*

Jones, I. 2014. *Research methods for sport studies*. 3rd edition. London: Routledge.

Jovchelovitch, S. 2006. *Knowledge in context: Representations, community and culture*. London: Routledge.

Jovchelovitch, S. 2007. *Knowledge, community and culture*. New York: Routledge.

Jovchelovitch, S. 2011. *Communicative action and dialogical imagination* In D. Hook., B. Franks and M.W. Bauer (eds) Social psychology of communication. Hampshire: Palgrave Macmillan.

Kabra, R., Ali, M., Gulmezoglu, A.M. and Say, L. 2016. Research capacity of sexual reproductive health and rights. *Bulletin of the World Health Organisation Article BLT 15.163261 1-7.*

Kalinda, T. and Tembo, R. 2010. Sexual practices and levirate marriages in Mnasa District of Zambia. *Electronic Journal of Human Sexuality 13*.

Kambarami, M. 2006. *Femininity, sexuality and culture: Patriarchy and female subordination in Zimbabwe.* Culture, feminist and sexuality, African Regional Sexuality Resource Centre. University of Fort Hare.

Kammah, L.C. 2014. *Legal and policy framework for gender equality and women's empowerment: A critical analysis of the third MDG in Liberia.* A dissertation submitted in partial fulfilment for the requirements of Mamlo University for Bachelor of Arts in Human Rights. Malmo: Malmo University.

Kang'ethe, S.M. and Munzara, M. 2014. Exploring and inextricable relationship between feminisation of poverty and feminisation of HIV/AIDS in Zimbabwe. *Journal of Human Ecology 47 (1) 17-26*.

Kar, S.K., Choudhury, A. and Singh, A.P. 2015. Understanding normal development of adolescents sexuality: A bumpy ride. *Journal of Human Reproductive Sciences 8 (2) 70-74*.

Karim, K.M.R. and Law, C.K. 2013. Gender ideology, microcredit participation and women's status in Rural Bangladesh. *International Journal of Sociology and Policy 33 (1/2) 45-62*.

Karlsson, S. 2016. *Is gender mainstreamed? A study of the European Commission's use of gender mainstreaming in development policies.* A dissertation submitted for the requirements of Uppsala Universitet for Master of Political Sciences. Sweden: Uppsala Universitet.

Katswe Sisterhood and Sexual Rights Initiative. 2016. *Universal Periodic Review of Zimbabwe. 26th Session November 2016.*

Kaur, M. 2016. Application of mixed methods approach in public health research. *Indian Journal of Community Medicine 41 (2) 93-97.*

Kaur, R. 2016. Feminism: Introduction and aims. *Imperial Journal of Interdisciplinary Research 2 (6) 1107-1109.*

Kemi, A.D. and Jenyo, O.G. 2016. Gender equality and the empowerment of women and girls in Nigeria: The way forward to national security. *Open Journal of Social Sciences 4 230-240.*

Khomari, D., Febele, C. and Nel, K. 2012. The social value of lobola: Perceptions of South African college students. *Journal of Psychology in Africa 22 (1) 143-145.*

Khu, B.Y. and Lee, J.A. 2015. The structural relationships among perceived parenting roles, teacher leadership learning, leaning motivation for leaning flow in elementary school students. *Korean Journal of Youth Studies 22 (6) 355-387*.

Kibira, S., Ndugga, P., Nansubuga, E., Sewannonda, A. and Kwagala, B. 2014. Contraceptives uptake among married women in Uganda: Does empowerment matter? *African Population Studies 28 (2) 968-978*.

Kimmel, M.S. 2008. *The gendered society*. 3rd edition. New York: Oxford University Press.

Kismodi, E., Cottingham, J., Gruskin, S. and Miller, M.A.2015. Advancing sexual health through human rights: The rule of law. *Global Public Health 10 (2) 252-267.*

Klausen, S.M. 2010. Reclaiming the white daughters' purity: Afrikaner nationalism, racialised sexuality and the 1975 Abortion and Sterilisation Act in the apartheid South Africa. *Journal of Women's History 22 39-63.*

Klomegah, R.Y. 2011. Sexual behaviour and HIV/AIDS in Sub-Saharan Africa: A comparative analysis of Swaziland and Niger. *International Review of Modern Sociology 37 (2) 217-237*.

Kofi, A.R. 2015. *The effect of women's empowerment of utilisation of reproductive health services in Ghana*. A dissertation submitted for the requirements of University of Ghana for Master of Philosophy in Health Science. Accra: University of Ghana.

Kohlasch, J. 2017. *African women volunteer's retention in community organisations: A qualitative narrative analysis.* A dissertation submitted for the fulfilment of the requirements of the degree of Doctor of Management in Organizational Leadership at the University of Phoenix. Phoenix: University of Phoenix.

Kolaide-Faseyi, L. 2018. Spousal rape in globalised world. Nmadi Azikwe University Journal of International Law 9 (1) 107-116.

Kosakowska-Berezecka, N., Besta, T., Adamska, K., Jaswewicz, M., Jurez, P. and Vandello, J.A. 2016. If my masculinity is threatened I won't support gender equality? The role of agentic self-stereotyping in restoration of manhood and perceptions of gender relations. *Psychology of Men and Masculinity 17 (3) 274-284*.

Kotch, J. 2012. *Maternal and child health*. Burlington: Jones and Bartlett Publishers.

Kray, L, J., Howland, L., Russell, A.G. and Jackman, L.M. 2017. The effects of implicit gender role theories on gender system justification: Fixed beliefs strengthen masculinity to preserve status quo. *Journal of Personality and Social Psychology 112 (1) 98-115*.

Krijnen, T. and Van Bauwell. 2015. *Gender and media: Representing, producing, consuming*. London: Routledge.

Kruger, D.J., Fisher, M.L. and Wright, P. 2014. Patriarchy, male competition and excess male mortality. *Evolution Behavioral Sciences 8 (1) 3-11*.

Kudo, Y. 2017. Why is the practice of levirate marriage disappearance in Africa? HIV/AIDS as an agent of institutional change. Interim report for female empowerment and social institutions *IDE-JETRO, FY 1-10*.

Kulczycki, A. (ed). 2014. *Critical issues in reproductive issues in health*. London: Springer.

Kulshreshta, A.C. 2013. Basic concepts of sampling brief review: Sampling designs. Second pap regional workshop on building training resources for improving agriculture and rural statistics. Sampling methods for agricultural statistics review of current practices. *SCI Islamic Republic of Iran September 10- 17 2013.*

Kumar, R. 2015. Classification of rights. *International Journal of Engineering and Management Research 5 (6) 756-758.*

Kurebwa, J. 2017. Knowledge and perceptions of adolescent sexual and reproductive health issues among rural adolescents in Gutu rural district of Zimbabwe*. International Journal of Advanced Research and Publication 1 (1) 21-28.*

Lalthapersad-Pillay, P. 2015. The state of maternal mortality in South Africa. *Gender and Behavior 13 (1) 647-6481.*

Lamprell, G., Greenfield, D. and Braithwaite, C. 2015. The paradoxes of gender mainstreaming in developing countries: The case of healthcare in Papua New Guinea. *Global Public Health 10 (1) 41-54.*

Lanier, L.R. 2013. African American women: Gender, beliefs, peer perception, relationship power and sexual behaviour. A dissertation submitted for the requirements of Georgia State University for Doctor of Philosophy in Nursing. Atlanta; Georgia State University.

Latham, B. 2007. Sampling: What is it? Qualitative research methods. Available at http://www.webpages.acs.ttu.edu/rlatham/Coursework/5377(Quant)/Sampling_Methodology_Paper.pdf retrieved on 4 June 2016.

Laurin, K., Kay, A.C. and Shepherd, S. 2011. Self-stereotyping as a route to system justification. *Social Cognition 29 360-375*.

Lavie-Alaji, M. and Joffe, H 2009. Social representations of female orgasm. *Journal of Health Psychology 14 (1) 98-107.*

Lavrakas, P.L. 2008. *Encyclopaedia of survey research methods. A-M Volume 1*. London: Sage.

Lawrence, M.A. 2016. *Justice-as-fairness as judicial guiding principle: Remembering John Rawls and the Warren court*. Michigan: Michigan State University College of Law.

Lawson, D.W. and Mhari, A.G. 2018. Polygamous marriages and child health in Sub Sahara Africa: What is the evidence from harm? *Demographic Research 38 (6) 177-208*.

Leach, R. 2009. *Political ideology in Britain*. Basingstoke: Palgrave Macmillan.

Leahy, T. 2017. *Humanist realism for sociologist*. London. Routledge.

Lee, S. 2013. Legal feminism and the United Nations Gender mainstreaming policy: Still searching for the blind spot? *Journal of East Asia International Law VI 2 9 367-384.*

Lennon, C.A., Stewart, A.L. and Ledermann, T. 2012. The role of power in intimate relationships. *Journal of Social and Personal Relationships 30 (1) 95-114*.

Letherby, G. 2007. Constructing Risk and Safety in Technological Practice. Available at http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2007.01059_3.x/abstract retrieved 5 June 2017.

Levine, S.B. 2017. Why sex is important: Background for helping with sexual lives. *BJ Psych Advanced 23 (5) 300-306 DOI:ID.1192/apt.bp.116.016424.*

Levtov, R,G., Barker, G., Contreras-Urbina, M., Heilman, B. and Verma, R. 2014. Pathways to gender-equitable men findings from the international men and gender equality survey in eight countries. *Men and Masculinities 17 467-501*.

Locke J.1689. *An essay concerning human understanding*.

London, L. and Baldwin-Ragaven, L. 2006. Human rights obligations in the health care. *Continuing Medical Education 24 (1) 20-24.*

Lottes, I.L. 2013. Sexual rights: Meanings, controversies and sexual health promotion. *Journal of Sex and Research 50 (3-4) 367-391.*

Luft, H., Ke, W., Trifol, L., Halpern, M., and Larson, E. 2020. Sexual Relationship Power and Safe Sex Communication Among Partnered Women in the Dominican Republic. *Journal of Transcultural Nursing, 31(1), 28–37*.

Lukale, N. 2012. Sexual and reproductive health and rights for young people in Africa. *Arrow for Change 18 (2) 7-8.*

Lukka, K. and Modell, S. 2010. Validation in interpretive management accounting research. Accounting Organisations and Society 35 (4) 462-477.

Lysaght, Z. 2011. Epistemological and paradigmatic ecumenism In Pasteur's Quadrant: Tales of doctoral research. *Official conference proceedings of the third Asian Conference on Education in Osaka, Japan.*

Mabaso, M.L.H., Malope, N.F. and Simbayi, L.C. 2018. Socio-demographic and behavioural profile of women in polygamous relationships in South Africa: A retrospective analysis of the 2002 Population based Household Survey Data. *BMC Women's Health 18 (133) 1-8*.

Maboloc, C.R.B. 2008. *The concept of human development. Nussbaum*. A dissertation submitted for the requirements of Universitet of Linkopings for Master's in applied Ethics. Sweden: Universitet Linkopings.

Mabundza, R., Dlamini, C.S and Nkambule, B. 2014. *Gender mainstreaming in smallholder agriculture development: A global and African overview with emerging issues Swaziland.* A dissertation submitted for the requirements of the University of Free State. Free State: University of the Free State.

Machangura, F. 2011. A diet of wives as a lifestyle of the Vapositori sects: The polygamy debate in the face of HIV and AIDS in Zimbabwe. *Africana 5 (2) 185-210.*

Machingura, F. 2012. A lock at the struggle of Zimbabwean married women regarding safe sex. *Africana 6 (1) 40-68.*

Mackay, F. 2016. Political not generational: Getting real about contemporary United Kingdom radical feminism. *Social Movement Studies 428-442.*

Macmillan, R. and Gartner, R. 2009. When she brings home the bacon: Labor force participation and the risk of spousal violence against women. *Journal of Marriage and the Family 61 947-958*.

Madiba, S. and Ngwenya, N. 2017. Condom use increase vulnerability to HIV infection: Narratives from married and cohabiting women in rural communities in Mpumalanga Province South Africa. *Global Health Action 10 (sup2) 1341597*.

Magar, V. 2015. Gender, health and Sustainable Development Goals. *Bulletin of the World Health Organisation 2015 93 743.*

Magaraushe, W. and Mukuhlani, T. 2014. Kupururudzira muroora songs in the muzvezve bride welcoming ceremony or relegation of women to the subaltern. *Nokoko 41-65*.

Mahanyele, B.B. 2016. *Community perception regarding legal choice of termination of pregnancy.* A dissertation submitted for the requirements of University of South Africa for Master of Arts in Health Studies. Pretoria: University of South Africa.

Maharaj, P. and Rogan, M. 2007. Reproductive health and emergency contraception in South Africa: Policy context and emerging challenges. *Working Paper 48.*

Maharaj, P., Neema, S., Cleland, J., Busza, J. and Shah, I. 2013. Condom use within marriage: An assessment of changes in South Africa and Uganda. *AIDS Care 24 (4) 444-450*.
Maharaj, P., Neema, S., Cleland., J., Busza, J. and Shah, I. 2013. Condom use within marriage: An assessment of changes in South Africa and Uganda. *AIDS Care 24 (4) 444-450*.

Mangena, T. and Ndhlovu, S. 2013. Implications and complications of bride price payment among the Shona and Ndebele of Zimbabwe. *International Journal of Asia Social Science 3 (2) 472-481.*

Mannell, J. 2017. Community mobilisation supplementary issue. Gender mainstreaming practice: Considerations for HIV/AIDS community organisations. *AIDS Care 22 (2) 1613-1619.*

Manuh, T. 2009. Understanding the Ghanaian context of gender based violence in K. Cusak and T. Manuh (eds). The architecture of violence against women in Ghana, Accra. *Gender Studies and Human Rights Documentation Centre 35-67*.

Maparyan, L. 2015. Research and action report. Wellesley Centres for Women. Spring/summer 2015. *Research and Action Report, Book 28.*

Mapuranga, T.P. 2010*. A phenomenological investigation into the effects of traditional beliefs and practices on women and HIV/AIDS, with special reference to Chipinge District Zimbabwe.* A dissertation submitted for the requirements of University of Zimbabwe for Doctor of Philosophy. Harare: University of Zimbabwe.

Mapuranga, T.P. 2012. Tozeza baba: Gender based violence in Oliver Mutukudzi's music. *Muziki 9 (1) 58-70.*

Mare, A. 2015*. Facebook, youth and political action: A comparative study of Zimbabwe and South Africa.* A dissertation submitted in partial requirements of Rhodes University for the degree of Doctor of Philosophy. Grahamstown: Rhodes University.

Maree, J.E. 2010. *"*No condom no sex". Easy to say but not possible for all South African women. *Health SA Gesondheid 15(1), Article 506.*

Maree, K. 2016. *First steps in research.* 2nd edition. Pretoria: Van Schaik Publishers.

Markova, I. 2003. *Dialogicality and social; representations*. Cambridge: Cambridge University Press.

Markova, I. 2008. The epistemological significance of the theory of social representations. *Journal for the Theory of Social Behaviour 38 (4) 461-487*.

Markova, I. 2012. Method and explanation in history and social representations. *Integrative Psychological and Behavioural Science 46 457-474.*

Martin, E.K., Taft, C.T. and Resick, P.A. 2007. A review of marital rape. *Aggression and Violent Behaviour 12 (2007) 329-349*.

Martins-Silva, P.D., Da Silva, A.J., Peroni, G.GH., Porto de Medeiros, C. and Vitoria, N.O. 2016. The social representation in Brazilian organisational studies: A bibliometric analysis from 2001-2014. *FGV Ebape 891-919.*

Matsuda, Y., McGrath, J. M., Knafl, G. J., Worthington, E. L., Jallo, N. and Corona, R. 2014. Examining relationship/family planning factors and sexual relationship power among immigrant Latino couples in the United States. *Hispanic Health Care International*, *12(4), 161-173.*

Maurya, A.S. 2009. Integrating social representations theory and bio-psychological model for intervention in mental health. *Journal of the Indian Academy of Applied Psychology 35 (2) 195-202.*

Mawere, M. and Mawere, A.M. 2010. The changing philosophy of African marriage: The relevance of the Shona customary marriage practice of kukumbira. *Journal of African Studies and Development 2 (9) 224-233.*

Mawere, M. and Mubaya, T. 2016. *African philosophy and the thought systems: A search for culture and philosophy of belonging*. Bemenda: Research and Publishing CIG.

Mazibuko, N.C. 2016. *Ilobolo*, the bride price that comes at a price and the narratives of gender violence in Mamelodi, a South African township. *IFE Centre for Psychological Studies/Services 7373-7378.*

McAlpine, L. 2016. Why might you use narrative methodology? A story about narrative. *Eesti Haridusteaduste Atakiri nr 4 (1) 32-51*.

McCormack, M. 2013. *The declining significance of homophobia*. Oxford: Oxford University Press.

McCormick, N. 1994. *Sexual salvation: Affirming Women's sexual rights and pleasures: Affirming women's sexual rights and sexual pleasures*. Westport, CT: Praeger.

McDermott, R. and Cowden, J. 2015. Polygyny and violence against women. *Emory Law Journal 64 (6) 97-141.*

McDowell, L. 2010. *Interviewing: Fear and liking in the field* In D. DeLyser, S. Herbert, S. Aitken, M. Crang and L. McDowell. *The Sage handbook of qualitative geography*. London: Sage.

Mchombu, K. and Mchombu C. 2007. Overview and Information Concerning the HIV/ AIDS Situation in Africa. Available at http:// www. ifla.org/TV /ifla73/papers/l 07-Mchombu-en.pdf retrieved 30 December 2019.

McInerney, D.M., Liem, G.A.D. and Walker, R.A. 2011. *Sociocultural theories of learning and motivations: Looking back and looking forward*. Charlotte: Information Age Publishing Inc.

McMahon, J.M., Volpe, E.M., Klostermann, K., Trabold, N. and Xue, Y. 2015. A systematic review of the psychometric properties of the sexual relationship power scale in HIV/AIDS research. *Archives Sexual Behaviour 44 (2) 267e294.*

McMahon, K. 2013. The institution of polygamy in the Chinese Imperial Palace. *The Journal of Asian Studies 72 (4) 917-936.*

Meesadoosa v Links 1915 TPD 357 @ 359

Mekgwe, P. 2008. Theorising African feminism(s): The colonial question. *Journal of African Culture and Society 165-174.*

Mensah, C.A., Antwi, K, B. and Dauda. 2014. Female traditional leaders (Queen mothers) and community planning and development in Ghana. *Environmental Management and Sustainable Development 3(1) 205-220.*

Merriam, S. 2009. *Qualitative research: A guide to design and implementation*. San Francisco: John Wiley and Sons.

Mertens, D.M. 2014. *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative and mixed methods*. London: Sage.

Messick, S. (1989). Meaning and values in test validation: The science and ethics of assessment. *Educational Researcher 18(2) 5-11.*

Metcalfe, J. 2011. *Desirable difficulties in the region of proximal learning* In Benjamin, A.S (ed) Successful remembering and successful forgetting: A Festschrft in honour of Robert, A. Bjork. New York: Psychology Press.

Mhaka, R. 2011. Zimbabwean women fail to negotiate safe sex. Available at http://www.-zimbabwemetro.com/health/zimbabwean-women-fail-to -negotiate-safe-sex/ retrieved 22 November 2017 retrieved 12 February 2017.

Mhkize, G. 2015. Problematizing rhetorical representations of individuals with disability-disabled or living with disability. *Agenda 29 (2)133-140*.

Mikell, G. 2010. *African feminism: The politics of survival in sub-Saharan Africa*. Pennsylvania: University of Pennsylvania Press.

Miller, M.A. and Roseman, M.J. 2011. Sexual and reproductive rights at the United Nations: Frustration of fulfilment? *Reproductive Health Matters 19 (38) 102-118.*

Mills, J. and Birks, M. 2014. *Qualitative Methodology: A Practical Guide*. London: Sage.

Ministry of Health and Child Wealth. 2016. *Standard national adolescent and youth sexual and reproductive health training manual. Strengthening, designing, provision, monitoring, evaluation and sustainability of adolescent friendly sexual and reproductive health services in Zimbabwe.* Harare: Government of Zimbabwe.

Mireku, O. 2010. Customary law and the promotion of gender equality: An appraisal of the Shilubana decision. *African Human Rights Law Journal 10 (2) 515-523*.

Mitchell, V.A.2015. The human rights: An innovative tool for teaching health and human sciences. *African Journal of Professional Education 7 (1) 39-42.*

Mkhize, G. and Njawala, L. 2016. Rethinking hegemonic masculinity and patriarchal privilege within heterosexual interpersonal relationship. *The Oriental Anthropologist 16 (2) 379-397*.

Mlambo-Ngcuka, P. 2017. Sexual health and women's rights. *Harvard International Review. Summer 2017.*

Mohajan, H. 2017. Two criteria for good measurements in research. Validity and reliability. *Munch Personal RePEc Archive No. 83458.*

Mohammad, Z. 2013. Mixed methods research instruments, validity, reliability and reporting findings. *Theory and Practice in Language Studies 3 (2) 254-262.*

Mollet, J.A. 2011. *Ethical issues in social science research in developing countries: Useful or symbolic?* In Cribb, R. (Ed) Transmission of academic values in Asian Studies: Workshop proceedings. Canberra: Australian-Netherlands Research Collaboration.

Moriarty, B. and Massa, E. 2012. *Human rights law. Law Society of Ireland Manuals*. Oxford: Oxford University Press.

Morolong, J.J. 2013*. Young men's construction of their lived experiences.* A dissertation submitted for the requirements of University of Pretoria for Masters. Pretoria: University of Pretoria.

Morrell, R., Jewkes, R. and Lindegger, G. 2012. Hegemonic masculinity/ masculinities in South Africa: Culture, power and gender politics. *Men and Masculinities 15 11-30*.

Morton, T.A., Postmes, T., Haslam, S.A. and Hornessy, M.J. 2009.Theorising gender in the face of social change: Is there anything essential about essentialism. *Journal of Personality and Social Psychology 96 653-664.*

Morvaridi, B. 2008. *Social justice and development*. Berlin: Springer.

Moscovici, S. 1973. *Foreword* in C. Herzilch. *Health and illness*. London: Academic Press.

Motta, C. and Saez, M. 2013. *Gender and sexuality in Latin-America- cases and decisions*. London: Springer Science and Business Media.

Mouton, E., Kapuma, G., Hansen, L. and Togo, M. 2015. *Living with dignity African perspectives on gender equality.* Pulpy: African Sun Media.

Mpungose, Z.M. 2010. *Perceived gender inequality reflected in Zulu proverbs: A feminist approach.* A dissertation submitted for the requirements of University of Kwa-Zulu Natal for Master of Arts Degree. Durban: University of Kwa-Zulu Natal.

Mswela, M. 2009. Cultural practices and HIV in South Africa: A legal perspective. *PER 4 (12) 172-213.*

Mubangizi, J.C. 2012. A South African perspective on the clash between culture and human rights with particular reference to gender-related cultural practices and traditions. *Journal of International Studies 13 (3) 33-48.*

Mufumi (U) Ltd. and Others v Attorney General. 2015. *UGSC 13 (6 August 2015)*.

Mugweni, E., Omar, M. and Pearson, S. 2015. Understanding barriers of safe sex practice in Zimbabwean marriages: Implications for future HIV prevention interventions. *Health Education Research 30 388-399*.

Mugweni, E., Pearson, S. and Omar, M. 2012. Traditional gender roles forced sex and HIV in Zimbabwe Marriage. *Culture, Health and Sexuality 12 577-59.*

Mujuzi, J.D. 2008. The protocol to the African Charter on human and people's rights on the rights of women in Africa: South Africa's reservations and interpretative declarations. *African Journals Online 2 (12) 41- 61.*

Mukhuba, T.T. 2017. The representation of patriarchy perception in selected literary works. *Gender and Behavior 8567-8576.*

Mukonyora, I. 2007. *Wandering a gendered wilderness: Suffering and healing in an African Church.* New York: Peter Lang.

Mulaudzi, F.M. 2007. Indigenous health beliefs, attitudes and practices among VhaVenda: A challenge to promotion of HIV/AIDS prevention strategies. *Curationis 30 (3) 31-38.*

Mulenga, E. 2010. *"Bentham's utility principle of the greatest happiness to the greatest number" with reference to the current abortion law*. A dissertation submitted in partial requirements of University of Zambia for the degree of Bachelor of Laws. Lusaka: University of Zambia.

Muller, A. and MacGregor, H. 2014. *Sexual and reproductive health rights of women living with HIV in South Africa. Sexuality, poverty and law*. London: Institute of Development Studies.

Munalula, M.M. 2011. SADC Protocol on Gender and Development: Road map to equality? *SADC Law Journal 1 189-196*.

Murwira, D. n.d. Adolescent and youth sexual and reproductive health- experience from Zimbabwe. Available at www.partners-popdev.org/docs/presentation/M-Murwira.pdf retrieved 18 October.

Musa, B.J. and Domatob, J.K. 2012. *Communication, culture and human rights in Africa*. Lanham: University Press of America.

Musandirire, B. 2016. *Is marriage a haven or a risk for women in Zimbabwe in the era of HIV/AIDS: Interrogating women's reproductive rights in marriage*. A dissertation submitted for the requirements of University of Zimbabwe for Bachelor of Laws. Harare: University of Zimbabwe.

Mushishi, C. 2010. *Aspects of Budya traditional religion which promote human rights.* A dissertation submitted for the requirements of University of Cape Town for Doctor of Philosophy in Religious Studies. Cape Town: University of Cape Town.

Musto, J.L. 2010. Carceral protectionism and multi-professionalism anti-trafficking human work in the Netherlands. International Feminist Rights is Wrong: Re-Politicizing Gender Eral protectionism and multi-professionalism anti-trafficking human work in the Netherlands. *International Feminist Journal of Politics 12 (3-4) 381-400.*

Mutangi, P. 2016. *Human rights versus culture: The plight of young women concerning sororate marriage in Zimbabwe.* A dissertation submitted for the requirements of Midlands State University of Bachelor of Laws. Gweru: Midlands State University.

Muteshi, J.K., Miller, S. and Belizan, J.M. 2016. The ongoing violence against women: Female genital mutilation/ Cutting. *Reproductive Health 13 (44) 1-4.*

Mwambene, L. 2010. Marriage under African customary law in the face of the Bill of Rights and international human rights standards in Malawi. *African Human Rights Journal (10) 78-108.*

Mwangi, E. 2010. *Africa writes back to self: Metafiction, gender and sexuality*. New York: Sunny Press.

National Department of Health (NDoH), Statistics South Africa, South Africa Medical Research Council (SAMRC) and ICF International. 2019. *South Africa Demographic and Health Survey, 2016*. Pretoria and Rockville, Maryland United States of America: National Department of Health , Statistics South Africa, South Africa Medical Research Council and ICF International.

National Pro Bono Resource Centre. 2011. What is social justice. *Occasional Paper*. University of South Wales.

National Women's Council of Ireland. 2014. *Training handbook. Gender mainstreaming in health.* Dublin: National Women's Council of Ireland.

Ndhlove, T. 2015. *Silent victims or agents of change? An exploration of the lived experience of African Widows confronted with the practice of customary law of succession and inheritance in South Africa*. A dissertation submitted in partial requirements of University of Witwatersrand for the degree of Master of Arts. Johannesburg: University of Witwatersrand.

Ndoma, S. and Kokera, R. 2016. Reaching for equality: Zimbabweans endorse gender equality in politics but say citizens are treated unequally before the law. *Afrobarometer 87 6 May 2016.*

Ndulo, M. 2011. African customary law, customs and women's rights. *Indiana Journal of Global Legal Studies 18 (1) 87-120.*

Ngubane, S. J. 2010. *Gender roles in the African culture: Implications for the spread of HIV/AIDS.* A dissertation submitted for the requirements of University of Stellenbosch for Master of Philosophy. Cape Town; University of Stellenbosch.

Ngulube, P., Mathipa, E.R. and Gumbo, T. (eds). 2015. *Theoretical and conceptual frameworks in the social and management sciences. Addressing research challenges: Making headway in developing researchers.* Johannesburg: Mosala-Masedi Publishers and Booksellers.

Ngwena, C. 2007. *Access to legal abortion: Developments in South Africa from a reproductive and sexual health perspective, in Health and Human Rights.* England: Ashgate.

Ngwenya, S. 2016. Communication of reproductive health information to the rural girl child in Filabusi, Zimbabwe. *Afri Health Sci 16 (2) 451-461*.

Nicolaides, A. 2015. Gender, equity, ethics and feminism: An assumption of an unfair Ubuntu oriented society. *Journal of Social Science 42 (3) 191-210*.

Niewenhuis, J. 2010. Social justice in education revisited. *Education Inquiry 1 (4) 269-287.*

Nikolay, D., Olesya, B., Elizabeth, B., Gennandy, B. and Inga, K. 2014. Self-murder and self-murderers in social representations of young Russians: An exploratory study. *Psichologija 32-48.*

Nkosi, G. 2007. Indigenous African marriage and same sex partnerships and conflicts and controversies. *International Journal of African Renaissance Studies 2 (2) 200-216.*

Nkosi, S. 2011. *Lobola: Black students' perception of its role on gender power dynamics*. A dissertation submitted in partial fulfilment for the requirements of University of Witwatersrand for Master of Arts. Johannesburg: University of Witwatersrand.

Ntlama, N.P. 2010. *Impediments in the promotion of the rights to gender equality in post-apartheid South Africa*. A thesis submitted in partial requirements of University of South Africa for the Doctor of Philosophy. Pretoria: University of South Africa.

Ntseane, G.P. 2011. Culturally sensitive transformational learning: Incorporating the Afrocentric paradigm and African feminism. *Adult Education Quarterly 61 (4) 307-323*.

Nussbaum, M.C. 2003. Capabilities as fundamental entitlements: Sen and social justice. *Feminist Economics 9 (2-3) 33-39.*

Nwokocha, E.E. n.d. Maternal crises and the role of African men: The case of a Nigerian community. *African Population Studies 22 (1) 36-58*.

Nyamadzawo, R.T. 2015. Addressing child marriages through law reform: A case study of Zimbabwe. A dissertation submitted in partial requirements for the degree of Master of Law. Pietermaritzburg: University of Kwa-Zulu Natal.

Nyamhanga, T.M. and Frumence, G. 2014. Gender context of sexual violence and HIV sexual risk behaviours among married women in Iringa Region, Tanzania. *Global Health Action 7 (1) doi: 10.3402/gha.v7.25346*.

Nyarango, I., Ambani, J.O., Wekesa, S.M., Scheepers, E., Lakhan, I., Deyi, B., Mandipa, E., Mahadew, R.A., Raumnauthh, D.S., Lopes, E., Olebile, L.C., Ayeni, V.O., Onura- Oguno, A.C., Togue, M., Namwase, S. and Jjuko, A. 2017. *Protecting the rights of sexual minorities in contemporary Africa.* Pretoria: Pulp.

Nyathikazi, T.J.L. 2013. *Investigating association between HIV and AIDS and polygamy amongst practising polygamists in KwaZulu Natal.* A dissertation submitted for the requirements of University of Stellenbosch for Master of Philosophy. Cape Town: University of Stellenbosch.

Nzwegu, N. 2006. *Family matters: Feminists concepts in African philosophy of culture.* Albany: State University of New York Press.

O'Brien, S.M. and Gwisai, M. 2017. Living with HIV and advocating for health in urban Zimbabwe. *Politikon 44 (2) 247-263.*

O'Cathain, A., Murphy, E. and Nicholl, J. 2010. Three techniques for integrating data in mixed methods studies. BMJ 341 doi: https//doi.org/10.1136/bmj.c4587

O'Connor, C. 2012. Using social representations theory to examine lay explanations of contemporary social crises. *Journal of Community and Applied Social Psychology 22 453-469.*

O'keffe, J., Buytaert, W., Mijic, A., Brozovic, N. and Sinha, R. 2013. The use of semi-structured interviews for characterisation of farmer irrigation practices. *Hydrology and Earth Systems Sciences 20 1911-1924.*

O'Sullivan-Lago, R. 2011. "I think they are just the same as us": Building solidarity across the self/other divide. *Papers on Social Representations 20 (1) 3.1- 27*.

Oakely, A. 2015. *Sex, gender and society*. Burlington: Ashgate Publishing Company.

Oakely, L.P. 2015. *Perceived relationship power, relationship characteristics and sexual risk taking among black women*. A dissertation submitted for the requirements of Emory University for Doctor of Philosophy in Behavioral Sciences. Atlanta: Emory University.

Ocholla, D.N. and Le Roux, J. 2011. Conceptions and misconceptions of theoretical framework in library information science research. *Paper presented at the 6th Biennial Proussa Conference 9-11 March. Pretoria.*

Odeny, M. 2013. Improve access to land and strengthening women's land rights in Africa. Paper presented at the 3rd annual World Bank Conference on Land and poverty. *The Washington D.C April 8- 11 2013.*

Odimegwu, C., Bamiwuye, O.S. and Adedini, S.A. 2015. Gender-based violence as a new proximate determinant of fertility in Sub-Saharan Africa. *Southern African Journal of Demography 16 (1) 87-121.*

Office of the United Nations High Commissioner for Human Rights. n.d. *Human rights. A basic handbook for United Nations staff.* Geneva: United Nations.

Okin, S.M. 2013. *Women in western political thought*. Oxford: Princeton University Press.

Olabisi, I.A., Aransola, J.M. and Osezu, C. 2006. Sexual health and sexual rights within marriage. African Regional Sexuality Centre. Understanding human sexuality seminar series 1-20.

OlaOlorun, F.M. and Hindin, M.J. 2010. Having a say matters: Influence of decision-making power on contraceptive use among Nigerian women ages 35-49 years. *PLoS One 9 (6) e98702*.

Olife, J.L. and Greaves, L. 2011. *Designing and conducting gender, sex and health research*. London: Sage.

Oliffe, J.L. 2011. *Designing and conducting gender and health research*. London: Sage.

Oluoch, A. and Nyongesa, W.J. 2013. Perceptions of the rural Luo community on widow inheritance and HIV/AIDS in Kenya: Towards developing risk communication messages. *International Journal of Business and Social Science 4 (91) 213-220.*

Oluwakemi, E.B. 2017. Cultural practices and the reproductive health rights of women in Nigeria. *International Journal of Economics, Commerce and Management 5 (5) 756-777.*

Oluwu, D. 2014. Poverty, migration and the incidences of HIV/AIDS among rural women in Lesotho: A rights-based approach to public health strategies. *Gender and Behavior 12 (2) 6317-6328.*

Omaswa, F. and Crisp, N. 2014. *African health leaders: Making change and claiming the future.* Oxford: Oxford University Press.

Opoku, J.O. 2017. *Effects of spousal decision-making on the type of contraceptive method used in Ghana*. A dissertation submitted for the requirements of University of Ghana for Master of Arts Population Studies. Accra: University of Ghana.

Oronje, R.N., Crichton, J., Theobald, S., Lithur, N.O. and Ibisomi, L. 2011. Operationalising sexual and reproductive health and rights in Sub-Saharan Africa: Constraints, dilemmas and strategies. *BMC International Health and Human Rights 11 (Suppl 3): S8.*

Ortenblad, A., Marling, R. and Vasiljevic, S. 2017. *Gender equality in a global perspective.* London: Routledge.

Orza, M., Crone, T., Mellin, J., Westerhof, N., Stackpool-Moore, Restoy, E., Gray, G. and Stevenson, J. 2017. Searching for the second R in sexual and reproductive rights. *Journal of Adolescent Health 60 (2) S10-S14.*

Ostlund, U., Kidd, L., Wengstrom, Y., Rowa-Dew, A. 2011. Combining qualitative and quantitative research within methods research: A methodological review. *International Journal of Nursing Studies 48 (3) 369-383.*

Otjeg. K. 2009. Socio-economic determinants of HIV in Zambia: A district-level analysis. A dissertation submitted for the requirements of Lund University Master of Arts. Sweden: Lund University.

Owuegbuzie, A.J. and Combs, J.P. 2010. Emergent data analysis techniques in mixed methods research. A synthesis. In: Tashakkori, A. and Teddlie, C. (Eds) Handbook of mixed methods in social and behavioural research. *A Primer International Journal of Education 3 (1) 1-25.*

Oyewuni, O. 2005. *African gender studies. A reader*. New York: Palgrave Macmillan.

Ozer, A., Orhan, F.O. and Ekerbicer, H.C. 2013. Socio demographic variables and depression in Turkish women from polygamous versus monogamous families. *Health Care for Women International 34 1024-1034.*

Pallant, J. 2011. *A step by step guide to data analysis using the SPSS program: Survival manual.* 4th edition. McGraw-Hill, Berkshire.

Parker, R. 2009. Sexuality, culture and society: Shifting paradigms in sexuality research. *Culture, health and sexuality 11 (3) 251-266.*

Patto, M,Q. 2014. *Qualitative research and evaluation methods: Integrating theory and practice*. 4th edition. Thousand Oaks: Sage.

Pearson, S. and Makadzange, P. 2008. Help-seeking behaviour for sexual, health concerns: A qualitative study of men in Zimbabwean culture. *Health and Sexuality 10(4) 361-376.*

Perry, B., Olouch, L., Agot, K.E., Taylor, J., Onyango, J., Ouma, L., Otieno, C., Wong, C. and Corneli, A. 2014. Widow cleansing and inheritance among the Luo in Kenya: The need for additional women-centred HIV prevention options. *Journal of International AIDS Society 17 19010-19016*.

Perry, B., Oluoch, L., Agot, K., Taylor, J., Onyango, J., Ouma, L., Otieno, C., Wong, C. and Corneli, A. 2014. Widow cleansing and inheritance among the Luo in Kenya: The need for

additional women-centred HIV prevention options. *Journal of the International AIDS Society DOI:10.7748/VAS.17.1.19010*

Petrosyan, Y. n.d. Assessing research protocols: Mixed methods research. Method for the Ministry of Health and Long-term Care. Available at www.hsprn.ca/uploads/files/[Handout]%20Methods%Research_YP.pdf retrieved 20 October 2018.

Phelps, J.M. and Nadim, M. 2010. Ideology and agency in the ethnic identity of negotiation of immigrant youth. *Papers on Social Representations 19, 13.1- 13.27*.

Piang, L.K., Khattar, P. and Nandan, D. 2010. Mainstreaming gender in the national health programmes the challenges ahead. Health and population. *Perspectives and Issues 33 (1) 34-41.*

Pickles, C. 2012. Termination of pregnancy rights and foetal interests in continued existence in South Africa: The Choice of Termination of Pregnancy Act 92 of 1996. *PER/PELJ 15 (5) 403-434.*

Pillai, V.K. and Gupta, R. 2011. Reproductive rights approach to reproductive health in developing countries. *Global Health Action 4: 82423 DOI:10.3402/GDA.14:084234: 82423 DOI:10.3402/GDA.14:08423.*

Pleasants, R.K. 2011. Men learning feminism: Protecting privileges through discourses of resistance. *Men and Masculinities 14 230-250*.

Plummer, K. 2010. *The social reality of sexual rights* In P. Aggleton and R. Parker (eds). Routledge handbook of sexuality, health and rights. New York: Routledge.

Polat, A; Dogan, S. and Demir, S.B. 2015. The constructivist approach? I have heard about it but I have never seen it "An example of exploratory sequential mixed methods design study." *International Journal of Higher Education 5 (1) 62-82*.

Ponelis, S.R. 2015. Using interpretative qualitative case studies for exploratory research in doctoral studies: A case information systems research in small and medium business enterprise. *International Journal of Doctoral Studies 10 535-550*.

Ponzanesi, S. 2012. *Paradoxes of post-colonial culture: Sanskrit terms defined in English*. New York: Sunny Press.

Posel, D., Rudwick, S. and Casale, D. 2011. Is marriage a dying institution in South Africa? Exploring changes in marriage in the context of ilobolo payments. *Agenda 25 (1) 102-111*.

Pratto, F. and Walker, A. 2004. *The bases of gendered power*. In A. H. Eagly, A. E. Beall, & R. J. Sternberg (eds.). *The psychology of gender* (pp. 242–268) (2nd ed.). New York: Guilford.

Preetha, U. 2016. Right to health- A human rights based approach. *Vidhigya the Journal of Legal Awareness 11 (2) 54-66.*

Price, K. 2010. What is reproductive justice? How women of colour activists are redefining pro-choice paradigm. *Meridians 10 (2) 42-65.*

Princewill, C.W., Jegede, A.S., Wangamo, T., Riecher-Roseler, A. and Elger, B.S. 2017. Autonomy and reproductive rights of married Ikkerre women in River State, Nigeria. *Journal of Bioethical Enquiry 14 (2) 205-215.*

Progressio. 2016. *Young women sexual reproductive rights in Zimbabwe.* London: Progressio Southern- Africa.

Pruss-Ustin, A. 2013. HIV due to female sex work: Regional and global estimates. *PLoS One 8 (5) e63467-10*.

Psaila, E., Leigh, V., Verbari, M., Fiorentini, S., Pozza, V.D. and Gomez, A. 2016. *Forced marriage from a gender perspective. Study for the FEMM Committee. Policy Department Citizen's Rights and Constitutional Affairs.* Brussels: European Parliament.

Puri, M. 2009. *Unintended pregnancies among couples in Nepal: Determinants and consequences of unintended pregnancy*. VDM Verlag Dr. Muller Aktiengesellschaft and Company K.G. Germany.

Rahman, M.A. 2017. *The role of the United Nations in the implementing of gender mainstreaming approach post 2011 in Egypt: The women's citizenship initiative as a case study.* A dissertation submitted for the requirements of the American University of Cairo for Master of Public Policy. Cairo: The American University of Cairo.

Rai, N. and Thapa, B. n.d. A study on purposive sampling method in research. Available at www.academia.edu/28087388/A_Study_On_Purposive_Sampling_Method_In_Research?auto=download retrieved 18 October 2018.

Raiford, J.L., Seth, P. and DiClemente R.J. 2013. What girls won't do for love: human immunodeficiency virus/sexually transmitted infections risk among young African-American women driven by a relationship imperative. *Journal of Adolescent Health 52(5) 566–571*.

Raliphada-Mulaudzi, M. 1982. *Reproductive health rights of women in rural communities*. A dissertation submitted for the requirements of University of Pretoria for Masters. Pretoria: University of Pretoria.

Ramazanoglu, C. 2012. *Feminism and the contradiction of oppression.* London: Routledge.

Ramírez-Ortiz, D., Rojas, P., Sánchez, M., Cano, M. A. and De La Rosa, M. 2018. Associations of self-silencing and egalitarian attitudes with HIV prevention behaviors among Latina immigrant farmworkers. *Journal of Immigrant and Minority Health* doi:10.1007/s10903-018-0773-y.

Ramjee, G. and Daniels, B. 2013. Women's and HIV in Sub Sahara Africa. *AIDS Research Therapy 10: 30*.

Ramuthaga, N.A. 2002. *Assessment of copying skills of single divorced Venda women*. A dissertation submitted for the requirements of University of Witwatersrand for Master of Social Science (Nursing). Johannesburg: University of Witwatersrand.

Rao, T.S.S., Gopalakrishnan, R., Kuruvilla, A. and Jacobs, K.S. 2012. Social determinants of sexual health. *Indian Journal of Psychiatry 54 (2) 105-107.*

Raphael, D. 2016. *Social determinants of health: Canadian perspectives*. Toronto: Canadian Scholars Press.

Raphalalani, T.D. and Musehane, N.M. 2013. Arranged marriage practices of the VhaVenda community of the Vhembe District Limpopo Province, South Africa. *Journal of Language and Culture 4 (2) 18-22.*

Raselekoane, N.R. 2010. *Literary conceptual methodological pluralism in African-language literature: Towards a multiple-reading approach*. A dissertation submitted for the requirements of University of South Africa for Doctor of Philosophy in Literature. Pretoria: University of South Africa.

Ravinran, T.K.S and Kelkar-Khambete, A. 2008. Gender mainstreaming in health: Looking back, looking forward. *Global Public Health 3 S1 121-142.*

Rawls, J. 1971. *A theory of justice.* Cambridge, Mass: The Belknap Press of Harvard University Press.

Rebouche, R. 2011. The limits of reproductive rights in improving women's health. *Alabama Law Review 63 (1) 1- 43.*

Reinchenbach, L. and Roseman, M.J. (eds). 2009. *Reproductive health and human rights: The way forward.* Philadelphia: University of Pennsylvania.

Reiners, G. and Watkins, S. 2010. Polygyny and the spread of HIV in Sub-Saharan Africa: A case of Benign. *Concurrency AIDS Journal 24 299-307.*

Reis, I. 1986. *Journey into sexuality: An exploratory voyage*. Englewood Cliffs: Prentice- Hall.

Report of Online Discussion. 2010. Women and human rights moderated by the office of the High Commissioner for Human Rights. 1-26 February 2010. Available at https://www.un.org/womenwatch/beijing15/FINAL_Report_OHCHR_Online_discussion_Beijing15.pdf retrieved 10 June 2017.

Richardson, J. and Sandland, R. 2013. *Feminist perspectives on law and theory*. London: Routledge.

Ridell, S. 2009. Social justice, equality and inclusion in Scottish education. *Discourse 30 (3) 283-297.*

Riessman, C.K. 1998. *Narrative analysis: Qualitative research methods*. London: Sage.

Riessman, C.K. 2008. *Narrative methods for the human sciences*. Los Angeles: Sage.

Risman, B.J. and Davis, G. 2012. From sex role to gender structure. *Sociopedia, isa 1-5*.

Rita, A.A. and Sultana, S. 2017. An overview of reproductive health and rights: In a component corporate social responsibility. *International Journal of Advanced Research and Review 2 (3) 40-47.*

Rosenthal, L. and Levy, S. R. 2010. Understanding women's risk for HIV infection using social dominance theory and the four bases of gendered power. *Psychology of Women Quarterly 34(1), 21–35.*

Ross, L. 2011. Understanding reproductive justice. Available on Trust Black Women. Available at http://trustblackwomen.org/our-work/what-is-reproductive-justice/9-what-is-reproductive-justice retrieved 20 May 2017.

Rossi, A.S. 1970. (ed). *Essays on sex equality: John Stuart Mill and Harriet Taylor Mill*. Chicago: University of Chicago Press.

Rovai. A.P., Baker, J.D. and Ponton, M.K. 2014. *Social science research design and statistics.* Chesapeake VA: Wateree LLC.

Russo, S. 2017. Respect, protect and fulfil sexual health and right. Available at http://womendeliver.org/wpcontent/uploads/2017/09/Deliver_For_Good_Brief_3_09.17.17.pdf retrieved 20 January 2018.

Rwafa, U. 2016. Culture and religion as sources of gender inequality: Rethinking challenges women face in contemporary Africa. *Journal of Literary Studies 32 (1) 43-52*.

Ryan, F., Coughlan, M. And Cronin, P. 2016. Interviewing in qualitative research: The one-on-one interview. *International Journal of Therapy and Rehabilitation 16 (6) 309-314.*

Ryle, R. 2015. *Questioning gender: A sociological exploration*. 2nd edition. Singapore: Sage.

S v Makwanyane and Another 1995 (3) SA 391 (CC)

Saasa, S.K. and Mowbray, O. 2019. Determinants of HIV- risk sexual behaviors among Zambian adolescents: The role of gendered power. *Children and Youth Services Review 106 (2019) 104486 1-8*.

Saddiq, A., Tolhurst, R., Lalloo, D. and Theobald, S. 2010. Promoting vulnerability or resilience to HIV? A qualitative study on polygamy in Maiduguri, Nigeria. *AIDS Care 22 (2) 146-151.*

Saloom, R. 2006. A feminist inquiry into international law and international relations. *12 Roger Williams U.L Rev 169.*

Sambe, N., Avanger, M.Y. and Agba, S.A. 2013. The effects of high bride-price on marital stability. *IOSR Journal of Humanities and Social Science 17 (5) 65-70*.

Samkange, W. 2015.The liberal feminist theory: Assessing its applicability to education in education and early childhood development in particular within the Zimbabwean context. *Global Journal of Advanced Research 2 (7) 1172-1178*.

Sanchez-Lopez, M.P and Liminana-Grass, R.M. 2016. *The psychology of gender and health: Conceptual and applied global concerns* .London: Academy Press.

Sanghera, J; Gentile,L;Guerras-Delgado, I; O'Hanlon,L; Barraques, A; Hinton, R.L; Khosla, R; Rasanathan, K and Stahlhofer, M. 2015. Human rights in the new global strategy. *BMJ 2015: 35.* Available at http://www.bmj.com.content/351/bmj.h4184 retrieved 10 November 2017.

Sarwatay, D. and Divatia, A. 2016. A study of interpersonal communication between married couples on planned parenthood. *International Journal of Social Science and Humanity 6 (1) 1-8*.

Savage-Oyekunle, O.A. 2014. *Female adolescents' reproductive health rights. Access to contraceptive information and services in Nigeria and South Africa.* A dissertation submitted for the requirements of University of Pretoria for Doctor Legum. Pretoria: University of Pretoria.

Sayadmansour, A. and Momenirad, A. 2014. Letters to the editors. An argument against considering women's rights as all belonging to the category of human rights. *Journal of International Law 459-464.*

Schimtz, H.P. and Mitchell, G.E. 2015. The other side coin: Non-governmental organisations, rights-based approach, and public administration. *Public Administration Review 76 (2) 252-262.*

Scholz, S.J. 2011. *Feminism: A beginner's guide*. New York: One World Publications.

Schuftan, C. 2016. How is the human rights based approach to change ethics and praxis of achieving universal health coverage? Is UHCA Progressive reform of a neo-liberal plot? *Social Medicine 10 (2) 36-41.*

Sedwick, P. 2014. Cross-sectional studies: Advantages and disadvantages. *BMJ doi 10.11.1136/bmj.g2276.*

Sempruch, J. 2008. *Fantasies of gender and the witch in feminist theory and literature*. West Lafayette: Purdue University Press.

Sen, G. 2014. Sexual and reproductive health and rights in the post 2015 development agenda. *Global Public Health 9 599-606.*

Sen, G. and Ostlin, P. 2009. *Gender equality in health: The shifting frontiers of evidence and action.* London: Routledge.

Serpa, S. 2016. An overview of the concept of organizational culture*. International Business Management 10 (1) 51-61.*

Serres, M. 1995. *The natural contract*. Michigan: University of Michigan.

Shaghaghi, A; Bhopal, R.S. and Sheikh, A. 2011. Approaches to recruiting "hard to reach" populations into research: A review of the literature. *Health Promotion Perspectives 1 (2) 86-94.*

Shamu, S., Abrahams, S., Temmernan, M., Shefer, T., Shefer, T. and Zarowsky, C. 2012. That pregnancy can bring noise into the family: Exploring intimate partner sexual violence during pregnancy in the context of HIV in Zimbabwe. *PLoS One 7 (8): e4318:DOI:10.1371/journal.pone.0043148.*

Shannon-Baker, P. 2016. Making paradigms meaningful in mixed methods research. *Journal of Mixed Methods Research 10 (4) 319-334.*

Sharma, B. and Nam, E.W. 2018. Condom use at last sexual intercourse and its correlates among males and females aged 15-49 years in Nepal. *International Journal of Environment Research and Public Health 15 535-552.*

Sharma, K. 2012. Missing: *Half the story: Journalism as if gender matters*. New Delhi: Zubaan.

Shastri, A. 2014. Gender inequality and women's discrimination. *Journal of Humanities and Social Science 19 27-30*.

Shefer, T., Glowes, L. and Vergnani, T. 2012. Narratives of transactional sex on a university campus. *Culture health and sexuality 14 (4) 435-447.*

Shimanoff, S.B. 2008. Encyclopaedia of Communication. *Theory 1 433-434.*

Shonayin, L. 2012. *The African Report number 44:8*. GrouPEJeuneAfrique, Paris.

Shoola, T. 2014. The effect of the Sub Sahara Africa Gender divide on the rights and the status of women in a globalised world. *International Research Scape Journal 1 Article 7 1-48*.

Siann, G. 2013. *Gender, sex and sexuality: Contemporary psychological perspectives*. London: Taylor and Francis.

Sibanda, P. 2014. The dimensions of hunhu/ubuntu (Humanism in the African sense): The Zimbabwean conception. *IOSR Journal of Engineering 4 (1).*

Sidanius, J., Pratto, F., van Laar, C. and Levin, S. 2004. Social dominance theory: Its agenda and method. *Political Psy-chology 25 845–880.*

Siedner, M.J., Tsai, A.C., and Dworkin, S. 2012. Sexual relationship power and malnutrition among HIV-positive women in rural Uganda. *AIDS Behaviour 16,1542e1548*.

Simmons, S. 2014. Curriculum making in South Africa: Promoting gender equality and empowering women (?). *Gender and Education 26 (6) 636-652.*

Simon, M. n.d. The role of the researcher. Available at www.dissertationsrecipes.com/wp-content/uploads/2011/04/Role-of-the-Researcher.pdf retrieved 14 July 2018.

Singh, A.S. 2014. Conducting case study research in non-profit organisations. *Qualitative market research: An International Journal 17 77-84.*

Siringi, S. 2010. Polygamous marriages exposing Kenyans to risk of HIV and AIDS. *Kenyan Demographic Health Survey 2008/2009.*

Smith, B., Sparkles, A.C., Phoenix, C. and Kirkby, J. 2012. Qualitative research in physical therapy: A critical discussion on mixed-methods research. *Physical Therapy Review 17 (6) 374-381.*

Smith, C. and Ce, C. (eds). 2015. *Female subjectivities in African literature*. Nigeria: Handel Books.

Smith, D. 2007. Modern marriage, men's extra-marital sex and HIV risk in Southern Nigeria. *American Journal of Public Health 97 997-1005.*

Smith, S. 2013. Reproductive Health and the question of abortion in Botswana: A review. *African Journal of Reproductive Health 17 (4) 26-34*.

Smith-Greenaway, E. and Trinitapoli, J. 2014. Polygamous contexts, family structure and infant mortality in Sub-Sahara Africa. *Demography 51 341-366*.

Sonfield, A., Hasstedt, K., Kavanaugh, M.L. and Anderson, R. 2013. The social economic benefits of women's ability to determine whether and when to have children. Available at https://www.guttmacher.org/report/social-and-economic-benefits-womens-ability-determine-whether-and-when-have-children retrieved 13 April 2019.

South Africa. 1996. Constitution of South Africa Act 108 of 1996. Chapter 2. South Africa: Statutes of the Republic of South Africa, Constitutional Law.

South Africa. 1998. Recognition of Customary Marriages Act 120 of 1998.

South Africa. 2005. Children's Act 55 of 2005. South Africa: Government Gazette.

South Africa. 2008. Child Justice Act 75 of 2008. Chapter 6, 8. South Africa: Government Gazette.

South Africa. 2009. National Youth Policy 2009-2014.

Squire, C. 2013. *From experience-centred to socioculturally-oriented approaches to narrative*. In Andrews, M., Squire, C. and Tamboukou, M. (Eds). Doing narrative research. 2nd edition. London: Sage.

Sridharan, S., Maplazi, J., Shiookar, A., Richardson, E. and Nakam, A. 2016. Incorporating gender equity and human rights into the action plan process: Moving from rhetoric to action. *Global Health Action 9 (1) 1-13.*

Staab, S. and Studer, R. 2010. *Handbook of ontologies*. New York: Springer Science and Business Media.

Stark, B. 2013. Marriage equality, gender equality and the women's convention. Mich St. L. Rev 941 (2013). Available at http://www.scholarlyfommons.law.hofstra.edu/faculty-scholarship/324 retrieved 10 December 2016.

Starman, A.B. 2013. The case study as a type of qualitative research. *Journal of Contemporary Educational Studies 1/2013 28-43.*

Starrs, A.M. and Anderson, A. 2016. Definitions and debates: Sexual health and sexual rights. *The Brown Journal of World Affairs II (XXII) 7-23.*

Stephenson, R., Bartel, D. and Rubardt, M. 2012. Constructs of power and equity and their association with contraceptive use among men and women in rural Ethiopia and Kenya. *An International Journal for Research Policy and Practice 7 (6).*

Stern, E., Cooper, D. and Gibbs, A. 2015. Gender difference in South African informal sources of sexual and reproductive health (SRH) information. *Sex Education 15 (1) 48-63.*

Stover, J., Hardee, K., Ganatra, B., Moreno, C.G. and Horton, S. *2016. Reproductive, maternal, new born and child health: Disease control Priorities*. 3rd edition Washington D.C: World Bank.

Strasburger, V.C. and Brown, S.S. 2014. Sex education in the 21st century. *JAMA 312 (2) 125-126*.

Strauss, G. 2012. Is polygamy inherently unequal. *Ethics 516-544*.

Stromquist, N. 2014. *Women in the Third World. An encyclopaedia of contemporary issues*. New York: Garland Publishers.

Sultana, A. 2010. Patriarchy and women's subordination: A theoretical analysis. *The Arts and Faculty Journal, June 2010-July 2011 4 1-18.*

Sustainable Development Solutions Network. 2015. A global initiative for the United Nations: Indicators and a monitoring framework for Sustainable Development Goals. Launching a data revolution for the SDGS. A report by the leadership council of the Sustainable Development Solutions Network. *Revised Working Draft 7 March 20, 2015.*

Swedish International Development Cooperation Agency. 2010. Sexual rights for all. Global Issues Stockholm. Sweden. Available at http://www.Sexual-rights-for-all_webb.pdf retrieved 22 August 2017.

Szabo, M. and Kotch, S. 2017. *Food, masculinities and home: Interdisciplinary perspectives*. London: Bloomsbury Publishing.

Tabi, M.M., Doster, C. and Cheney, T. 2010. A qualitative study of women in polygamous marriages. *International Nursing Review 57 121-127*.

Tadele, G. and Kloos, H. 2013. *Vulnerabilities, impacts and responses to HIV/AIDS in sub-Saharan Africa*. London: Springer.

Tadesse, S. 2015. Culture, human rights and social change: In the context of polygamy: The universalism-relativism debate. *Addis Ababa University Centre for Human Rights 1-23.*

Tahmindjis, P. 2014. *Sexuality and human rights: A global overview*. London: Routledge.

Taket, A.R. 2012. *Health equity, social justice and human right.* New York: Routledge.

Tallis, V. 2012. *Feminist, HIV and AIDS. Subverting power, reducing vulnerability*. London: Pallgrave McMilan.

Tamale, S. 2011. *African sexualities: A reader.* Oxford: Fahamu Publishers.

Tandon, N. 2008. *Feminism: A paradigm shift*. New Delhi: Atlantic Publishers and Distributors.

Tashakkori, A. and Teddlie, C. 2010. *Sage handbook of mixed methods in social and behavioural research*. London: Sage.

Tatira, J. 2016. The Shona concept of marriage with special reference to procreation and fertility. *South Africa Journal African Language 36 (1) 123-127.*

Teays, W; Gordon, J and Rentein, A.D. 2014. *Global bioethics and human rights*. Lantham: Rowman and Littlefield.

Teddlie, C. and Yu, F. 2007. Mixed method sampling. A typology with examples. *Journal of Mixed Methods Research 1 (1) 77-100.*

Temmerman, M., Khosla, R. and Say, L. 2014. Sexual and reproductive health and rights: A global development health and human rights priority. *The Lancet 384 e30-31*.

Terre Blanche, M., Durrheim, K. and Painter, D. 2016. *Research in practice. Applied methods for the social sciences*. Cape Town: Juta and Company.

Tfwala, N. 2008. *Women's control over sexual matters in traditional marriages: A development perspective*. A dissertation submitted in partial requirements for the Master of Arts. Pretoria: University of South Africa.

The Danish Institute for Human Rights. 2014. *Reproductive rights are human rights. A handbook for national human rights institutions.* Geneva: United Nations.

The Holy Bible English Standard Version, 2013. *Holy Bible*. Wheaton: Crossway.

The Women's Health Council. 2007. Gender and Health: Strategies for implementation. *Seminar proceedings. The Women's Health Council.*

Thobejane, T.D. 2016. Polygamous marriages in Zimbabwe: The case of Gutu District in Masvingo Province. *Gender and Behavior 7263-7274.*

Thobejane, T.D. 2017. Probing language and patriarchy in South Africa. *Journal of Social Science 53 (1) 57-60*.

Thobejane, T.D. and Takayindisa, F.M. 2014. An exploration of polygamous marriages: A world view. *Mediterranean Journal of Social Science 1 (5) 27.*

Thobejane, T.D., Mogorosi, L.D. and Okere, B.C. 2017. A study on gender mainstreaming: The case of rural university of Limpopo Province, South African. *Gender and Behavior 8926-8945.*

Thomas, F. 2016. *Handbook of migration and health*. Cheltenham: Edward Elgar Publishing.

Tilly, C. 1999. *Durable inequality*. Berkeley: University of California Press.

Tjabane, M. 2010. *Education policy and social justice in higher education: A South African case study.* A dissertation submitted for the requirements of University of Pretoria for Doctor of Education. Pretoria: University of Pretoria.

Todres, J. 2011. Beyond the bedside: A rights based approach to adolescent health: *Journal of Law and Policy 192-228.*

Tolhurt, P., Leach, B., Robinson, J., Ettore, E., Scott-Samuel, A. Kilonzo, N., Sabuni, L.P., Robertson, S., Kapilashrami, A., Bristow, K., Lang, R., Romao, F. and Theobald, S. 2012. Intersectionality and gender mainstreaming in the international health: Using feminist participatory action research process to analyse voices and debates from global South and North. *Social Science and Medicine 74 (11) 1825-1832.*

Tong, P.R. 1998. *Feminist thought: A more comprehensive introduction*. 2nd edition. Colorado: Westview Press.

Tong, R. 2009. *Feminist thought. A more comprehensive introduction*. Colorado: Westview Press.

Tong, R. 2013. *Feminist thought: A comprehensive introduction*. London: Routledge.

Townsend, P.O. 2008. *A gender critical approach to the Pauline material and the Zimbabwean context with specific reference to the position and the role of women in selected denominations.* A dissertation submitted for the requirements of University of South Africa for Master of Arts. Pretoria: University of South Africa.

Tumlinson, K., Speizer, I.S., Davis, J.T., Fotso, J.C., Kuria, P. and Archer, L.H. 2013. Partner communication, discordant fertility goals and contraceptive use in urban Kenya. *African Journal of Reproductive Health 17 (3) 79-90*.

Uddin, M.N., Al-Hossiene, C.A. and Hamiduzzaman, M. 2012. Application of cross-national social research: Methodological dimensions and challenges in comparative analysis. *Universal Journal of Education and General Studies 1 (7) 210-215.*

Ukagba, G.U. 2010. *The KPIM of feminism: Issues and women in changing the world*. Victoria: Trafford Publishers.

Undie, C. and Izugbara, C.O. 2011. Unpacking rights in African societies indigenous culture and the question of sexual and reproductive health rights in Africa. *International Health and Human Rights 1 (3) Series 2 1-11.*

United Nations Children's Fund. 2007. *The state of the world's children: Women and children, the double dividend of gender equality.* New York: United Nations.

United Nations Children's Fund. 2011. *Promoting gender equality: An equity-focused approach to programming operational guidance overview*. New York: United Nations Children's Education Fund.

United Nations Development Programme. 2018. Human Development Indices and Indicators: 2018 Statistical Update Briefing note for countries on the 2018 Statistical Update South Africa. Available at http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/ZAF.pdf retrieved 31 November 2018.

United Nations Educational, Scientific and Cultural Organization. 2009. International guidelines on sexuality education: An evidence informed approach to effective sex, relationships and HIV/STIs education. Available at http://www.relief.int/sites/reliesfweb.int/files/resources/8556521DD9D4A9E64925762000240120-UNESCO-Aug2009.pdf retrieved 20 October 2018.

United Nations Educational, Scientific and Cultural Organization. 1997. *Gender mainstreaming. Extract from the report of the Economic and Social United Nations Council for 1997 (A/S2/3, 18 September 1997) (Vienna: Division for advancement of women. United Nations Department of Economic and Social Affairs)*. Available at http://www/un.org/documents/gd/docs/S2/plenary/a52-3.htm retrieved 12 November 2017.

United Nations Human Rights. 2014. *Women's rights are human rights*. New York: United Nations Publishers.

United Nations Population Fund. 1994. *International Conference on Population and Development Programme for Action*. United Nations Population Fund.

United Nations Population Fund. 2010. Sexual reproductive health for all. Available at https://www.unfpa.org/sites/default/files/pub-pdf/uarh_report_2010.pdf retrieved 20 March 2018.

United Nations Population Fund. 2011. Improving reproductive health. Available at http://www.unfpa.org/rh/ retrieved 4 December 2017.

United Nations Women. 2015. *Progressing the world's women 2015-2016. Transforming economics, realizing rights.* New York: United Nations Entity for Gender Equality and the Empowerment of Women.

United Nations. 1994. A/CONF.171/13/Rev.1- Report of the International Conference on Population and Development. Egypt September 5-13. Available at http://www.unfpa.org.sites/default/files/event-pdf/icpd-eng_2.pdf retrieved 20 February 2018.

United Nations. 1999. *Programme of Action of the International Conference on Population and Development*. Geneva: New York.

United Nations. 2009. Commission on Population and Development Resolution 2009/1 (par7) E/CN.9/2012/8 available at http://www.un.development/desa/population/commission/pdf/42_Res2009-1.pdf retrieved 20 September 2019.

United Nations. 2012. Commission on Population and Development Resolution 2012/1 Adolescents and Youth E/CN.9/2012/8 available at http://www.un.org/en/development/desa/population/pdf/commission/2012/country/Agenda520item5208/Decisions%20and20resolution/Resolution%2012_1_adolescents%20and%20Youth.pdf retrieved 20 September 2019.

United Nations. 2014. *Reproductive rights are human rights. A handbook for human rights institutions.* Geneva: United Nations.

United States Agency for International Development. 2009. Health policy initiative. Fact Sheet on Youth Reproductive Health Policy. Early marriage and youth reproductive health. *Task order 1 November 2009*.

United States Agency for International Development. 2012. *Gender equality and female empowerment policy*. Washington D.C: U.S Agency for International Development.

Universal Access Project. 2014. Briefing Cards: Sexual reproductive health and rights and post-2015 development agenda. Family Care International. Available at www.familycare.org retrieved 12 August 2017.

University of New Hampshire, 2015. Anonymity, confidentiality and privacy in human subjects research. (Online) Institutional Review Board for the Protection of Human Subjects in Research. Available at http://www.unh.edu/research/blog/201/08/irb-release-updated-guidance-anonymity-confidentiality-privacy-human-subjects-research/ retrieved 4 January 2017.

Upadhyayay, U.D. and Karaek, D. 2012. Women's empowerment and ideal family size: An examination of Demographic and Health Survey empowerment measure in Sub Sahara Africa. *International Perspectives on Sexual and Reproductive Health 38 (2) 78-89*.

Vambe, B. and Mupfariseni, B. 2011. Negotiating property rights in Southern Africa through the novel Panyama: A legal perspective. *Journal of Literary Studies 27 (3) 93-110*.

Van der Ploeg, L. and Vanclay, F. 2017. A rights based approach to project induced replacement and resettlement. *Impact and Project Appraisal 35 (1) 34-52.*

Van Gundy, A. 2014. *Feminist theory, crime and social justice*. London: Routledge.

Van Nierkerk, T.J. 2014. *Respectability, morality and reputation: Social representations of intimate partner violence against women in Cape Town*. A dissertation submitted for the requirements of University of Cape Town for Doctor of Philosophy. Cape Town: University of Cape Town.

Van Teijlingen, E. 2014. *Semi-structured interviews*. BU Graduate School.

Van Zyl, M. n.d. Beyond the constitution: From sexual rights and belonging. *The Prize and Price 364-387.*

Vardanyan, E. 2014. Gender mainstreaming at higher educational institutions. *Conference paper held on 16-18 September at the National University of Science and Technology tips://www.acu.ac.uk.*

Veale, H.J., Sacks-Davis, R., Weaver, E.N.R., Pedrana, A.E., Stoove, M.A. and Hellard, M.E. 2015. The use of social networking platforms for sexual health promotion: Identifying key strategies for successful user engagement. *BMC Public Health 15 (85)1-11*.

Venkatesh, V., Brown, S.A. and Bala, H. 2013. Bridging the qualitative-quantitative divide: Guidelines for conducting mixed methods research in information systems. *MIS Quarterly, 37 (1) 21-54.*

Vico, G. 1710/1988. *De nostril temporis studiorm ratione. On the study methods, our time (trans: Gianturco. E)*. Ithaca: Cornell University Press.

Voelklein, C. and Howarth, C. 2005. A review of controversies about social representation theory: A British debate. *Culture and Psychology 11 (4) 432-454*.

Vonderlack-Navarro, R. 2010. Targeting women versus addressing gender microcredit: Lessons from Honduras. *Affilia: Journal of Women and Social Work 25 (2) 123-134*.

Vuttanont, U. 2010. *"Smart boys" and "sweet girls"- Sex education needs in that teenagers: A mixed-methods study*. A dissertation submitted for the degree of Doctor of Philosophy at the University College London. London. University College London.

Wacheke, J. 2012. Social representations: A review of the theory and research from structural approach. *Universitas Psychologica 11 (3) 729-741.*

Wadesango, N., Rembe, S. and Chabaya, O. 2011. Violation of women's rights by harmful traditional practices. *Anthropologist 13 (2) 121-129.*

Walby, S., Armstrong, J. and Strid, S. 2012. "Intersectionality: Multiple inequalities in social theory" Sociology 2012 46. Available at http://www.soc.sagepub.com/content/46/2/224. retrieved 10 December 2016.

Walton, T. 2016. Using mixed methods approach to investigate university student's success after support service integration: A case study and analysis. *Journal of the Australian and New Zealand Student Services Association 48 38-50.*

Wang, G. 2016. *Reproductive health and gender equality: Methods, measurement and implications.* London: Routledge.

Washington, L. and Tallis, V. 2012. Sexual reproductive health and rights. A useful discourse for feminist analysis and activism? *A Journal of African Women's Experiences 2 (1) 6-10.*

Watson, E. 2014. Gender equality is your issue too. *Speech presented at the Herforshire Campaign Event. United Nations Headquarters*. New York.

Waxman, A.M., Humphries, H., Frohlich, J., Dlamini, S. and Ntombela, F. 2016. Young women's life experiences and perceptions of sexual and reproductive health in rural Kwa Zulu Natal, South Africa. *Culture, Health and Sexuality 18 (10) 1122-1136*.

Weigl, C. 2007. *Reproductive health behaviour and decision-making of Muslim women.* London: Transaction Publishers.

Wellings, K., Collumbien, M., Slaymaker, E., Singh, S., Hodges, Z., Patel, D. and Bajos, N. 2006. Sexual in context: A global perspective. *Lancet 368 1706-1728*.

Wellings, K., Mitchell, K. and Collumbien, M. (eds). 2012. *Sexual health: A public health perspective: A public health perspective.* Berkshire: McGraw-Hill Education.

Wesonga, R., Owino, A., Ssekiboobe, A. and Atuhaike, L. 2015. Health and human rights statistical measurement framework using household survey data in Uganda. *BMC International Health Journal 15 (11) 1-10.*

Wiles, R., Crow, G., Heath, S. and Vikki, C. 2006. Anonymity and confidentiality. ESRC National Centre for research methods. NCRM Working paper series 02/06. *Paper presented at the ESCRC Research Methods Festival, University of Oxford July 2006.*

Wiliarty, S.E. 2010. *The CDU and the politics of gender in Germany: Bringing women to the party.* Cambridge: Cambridge University Press.

Wille, G. and DuBois, F. 2007. *Wille's principles of South African Law.* Cape Town: Juta and Company.

Williams, C. 2007. Research methods. *Journal of Business and Economic Research 5 (3) 65-72.*

Wojcicki, J, M., Van der Straten, A. and Padian, N. 2010. Bride wealth and sexual and reproductive practices among women in Harare, Zimbabwe. *AIDS Care 22 (6) 705-710*.

Wollstonecraft. M. 1975. *A vindication of the rights of women* In C.H Poston (ed). New York: Norton.

Woodley, X.M. and Lockard, M. 2016. Womanism and snowball sampling: Engaging marginalised population in holistic research. The Qualitative Report 21 (2) 321-329.

Woolf, S.E. and Maisto, A. 2008. Gender differences in condom use behaviour? The role of power and partner-type. *Sex Role 58 689-701*.

Woolf, S.E., Maisto, S.A., 2008. Gender differences in condom use behaviour? the role of power and partner-type. *Sexual Roles 58 (9e10), 689e701.* Available at http://dx.doi.org/10.1007/s11199-007-9381-3 retrieved on 12 January 2020.

World Association of Sexual Health. 2014. Declaration of sexual rights. Available at http://www.worldsexology.org/resources/declaration-of-declaration-sexual-rights/ retrieved 2 December 2017.

World Bank. 2007. Legal aspects of HIV/AIDS: A guide for policy and law reform. Available at https://openknowledge.worldbank.org/handle/10986/6754 retrieved 20 March 2018.

World Health Organisation Regional Office for Europe and BZgA. 2010. Standards for sexuality education in Europe: A framework for policy makers, educational health authorities and specialists. Available at http://www.cwhn.ca/en/node/43913 retrieved 22 August 2019.

World Health Organisation, 2014. Sexual and reproductive health. Available at http://www.who.int/reproductive_health/topics/sexual_health/sh_definitions/en/ retrieved 10 May 2016.

World Health Organisation, 2016. *World Health Organization Guidelines on the management of health complications from female genital mutilation*. Geneva: World Health Organization.

World Health Organisation. 2007. Country co-operation strategy. Zimbabwe. Available at http://.www.who.int/iris/bitstream/10665/136992/1/ccsbrief-zwe_en.pdf retrieved 1 January 2018.

World Health Organisation. 2009. *Women and health: Todays evidence tomorrow's agenda*. Geneva: World Health Organisation.

World Health Organisation. 2010. *Developing sexual health programmes: A framework for Action (WHO/RHR/HRP/10.22).* Geneva: Author.

World Health Organisation. 2011. *Human rights and gender equality in health sector strategies. How to assess policy coherence.* Geneva: World Health Organisation.

World Health Organisation. 2012. *Understanding and addressing violence against women. Health consequences*. Pan American Health Organisation. Geneva: World Health Organisation.

World Health Organisation. 2015. *Sexual health, human rights and the law.* Geneva: World Health Organisation.

World Health Organisation. 2016. 6 Sustainable health-related targets. Available at http://www.who.int/gho/publications/world_health_statistics/2016/EN_who2016_Chapter6.pdf retrieved 5 December 2017.

World Health Organisation. 2017. *Consolidated guideline on sexual and reproductive health rights of women living with HIV.* Geneva: World Health Organisation.

World Health Organisation. 2019. Sexual and reproductive health. Available at https://www.who.int.reprodcutivehealth/topics/sexual_health/sh_definitons/en retrieved 20 August 2019.

World Health Organization. 1975. Education and treatment in human sexuality: The training of health professionals. *Technical Report Series Number 572.*

Yamin, A.E. and Maleche, A. 2017. Realizing universal health coverage in the East Africa: The relevance of human rights. *BMC International Health and Human Rights 17 (2) 1-10.*

Yazan, B. 2015. Three approaches to case study methods in education. In: Yin, Merriam and Stake. *The Qualitative Report 20 (2) Teaching and Learning Article 1*.

Yee, J., Apale, N.A. and Deleary, M. 2011. Sexual reproductive health, rights, and realities and access to services for First Nations, Inuit and Metis in Canada. *SOGC Joint Policy Statement Number 259 June 2011.*

Yerges, A.L., Stevens, P.E., Mkwandawire-Valhmu, L., Baker, W., Mwenyekonde, T.N., Weinhardt, L.S. and Galvao, L.W. 2017. Women's narratives of living in polygamous marriages: Rural Malawian experience distilled preserved in poetic constructions. *Health Care for Women International 38 (8) 873-891*.

Yilmaz, E. 2016. A methodological dialogue on justice. *Nordic Journal of Political Economy 14 (1) 1-19.*

Yousefzadeh, S., Golmakani, N. and Nameni, F. 2017. The comparison of sex education with and without religious thoughts in sexual function of married women. *Journal of Midwifery and Reproductive Health 5 (2) 904-910*.

Zhang, K. 2011. *Sexual reproductive health in China: Reorienting concepts and methodology.* Leiden: Brill.

Ziedler, L. 2007. *What is a theoretical framework*? University of South Florida. Available at http://www/coedu.usf.edu/jwhite/seceseminar/theory.pdf retrieved 20 May 2018.

Zimbabwe National Statistics Agency and ICF International. 2016. *Zimbabwe Demographic and Health Survey 2015: Final Report*. Rockville, Maryland, United States of America: Zimbabwe National Statistics Agency and ICF International.

Zimbabwe. 1951. Customary Marriages Act of 1951.

Zuhmboshi, I.E.N. 2016. Narratives of post-apartheid gender deconstruction. A liberal-feminism reading of Nadine Gordimer's None to accompany me, Gillian Slovo's Red dust and Zoe Wilcomb's playing in the light. *Matatu 48 109-129*.

APPENDICES

Appendix A: Letter of informed consent

I am **Leah Gwatimba**, currently doing Ph.D. in Gender Studies at the University of Venda. The research topic is **"Customary Marriages and Young Women's Sexual and Reproductive Health Rights in Makwarela (South Africa) and Concession (Zimbabwe)."**

I would like you to participate in my research. Any information obtained from you will be confidential and your names will remain anonymous. Several steps will be taken to protect your anonymity and identity. Interviews will not mention of your name, and any identifying information will be removed. Your participation in this study is voluntary and you are free to pull out of this project at any time. Your decision to participate in this study will have no negative impact on your life or health. A tape recorder will be used to record this interview.

This interview will require about 45minutes to 2 hours of your time. During this time, you will be interviewed about your experiences within your marriage. It will be conducted wherever and whenever you are comfortable.

There are no anticipated risks, harm or discomfort related to this research. By participating in this research, you may assist others to better understand the effects of customary marriages on young women's sexual and reproductive health rights.

The results from this study will be used to write up my PhD thesis and also to publish journal articles. The policy recommendations will be disseminated to relevant institutions through a policy brief. However at all these stages, names of the study participants will not be mentioned.

Researcher signature…….. Date……..

I have read through the content of this form and hereby voluntarily consent to participate in this study.

……...(Printed Name)

……...(Signature)

……(Date and time)

Appendix B: Interview guide for young married women

1. Please tell us your knowledge and understanding about customary marriage.
2. In your culture, what are your thoughts about men and women's position with regards to how they interact within customary marriages.
3. In your own opinion, which roles are generally performed by men and women in Zimbabwe and South Africa. Do you think these roles played by men and women promote or undermine gender equality within customary marriages? Explain.
4. In your own opinion, how are the relations between men and women towards each other in South Africa / Zimbabwe.
5. *Roora/mamalo* is an important component of a customary marriage, what are the expectations that come with the practice of *roora/mamalo?*
6. What are your thoughts regarding the way families and society value customary marriage?
7. Are you able to negotiate safe sex in your marriage? Why? Please explain.
8. Are you allowed to determine the number and spacing of your children? Elaborate.
9. Do cultural practices conducted (wife inheritance, polygamy) in customary marriages benefit or disadvantage women? Elaborate.
10. Are there challenges which impede the enjoyment of your sexual and reproductive health rights in your customary marriage?
11. In what ways does polygamy threaten women's sexual and reproductive health rights? Please explain.
12. In what ways does wife inheritance threaten women's sexual and reproductive health rights?
13. Are there any other practices or expectations of women in customary marriages that we have not already discussed that can affect women's sexual and reproductive health rights?
14. In your own opinion what do you think can be done to support and promote gender equality and young women's sexual and reproductive health rights?

Appendix C: Interview guide for young married men

1. Can you please provide me with your personal feeling about gender equality.
2. How do you express your understanding of gender equality in your marriage?
3. How does this concept of gender equality affect the way society functions especially the change it brings to women who for the longest time been limited to household functions?
4. Are there any customary laws that you know of discriminate against women in family life?
5. In your own opinion is there equality in marriages regarding choosing
    a) number of children
    b) use of contraceptives
    c) spacing of children

Appendix D: Questionnaire

My name is **Leah Gwatimba** I am PhD candidate at the University of Venda studying towards a doctoral degree in Gender Studies. I am interested in your knowledge and perception on sexual and reproductive health rights of young women in customary marriages. My thesis is entitled **"*Customary Marriages and Young Women's Sexual and Reproductive Health Rights in Makwarela (South Africa) and Concession (Zimbabwe).*"** I would like you to answer a few questions and would be very grateful if you could spend a little time going through the questionnaire and try to answer as honestly as you can. Your name will not be written down and your answers will be kept strictly confidential. Your participation is voluntary, you can withdraw if you are not comfortable, and you are also not obliged to answer any questions you do not want to.

Instructions

Please tick the box with the appropriate answer.

Questionnaire number

☐

1. Nationality

1	2
South African	Zimbabwean

2. How old are you

1	2	3	4
14-20	21-27	28-35	35-40

3. Age of partner

1	2	3
25-35	36-45	46-55

4. State of marriage

1	2
Polygamous	Monogamous

5. Duration of marriage

1	2	3
0-5	6-10	10-15

6. Employment status

1	2
Employed	Unemployed

7. Number of children

1	2
0-3	4-6

8. I chose my partner

1	2
Yes	No

	Strongly Agree	Agree	Neutral	Strongly Disagree	Disagree
9. In a marriage men and women are regarded as equal partners therefore there is equality					
10. Quality and satisfaction in a marriage is also determined by factors like gender and marital roles.					
11. There must not be different treatment between a husband and her wife in a customary marriage.					
12. Inequality between the wife and husband in customary marriage affect/shape relations between husband and wife.					
13. Women are powerful at work and amongst their friends but they are powerless in their marriages.					
14. Payment of *roora/mamalo* renders women incapable and inferior in marriage and society.					
15. The roles that society assigns to women affect their sexual and reproductive health.					

	Husband	Woman	Jointly
16. Who decides when to have sex			
17. Who decides on the family size			

	Strongly Agree	Agree	Neutral	Strongly Disagree	Disagree
18. In a marriage the wife has a right to refuse sex.					
19. A woman does not have the right to determine the family size according to her wishes and desires without agreeing with her husband.					
20. Women have autonomous reproductive decision-making.					
21. All women should freely enjoy their sexual and reproductive rights.					
22. Husbands must have sex whenever they desire despite the wishes of their wives.					
23. Use of condoms in the house within a marriage leads to quarrels and in some cases spousal violence.					

	Strongly Agree	Agree	Neutral	Strongly Disagree	Disagree

24. Culture plays a vital role on the sexual and reproductive health of young women.					
25. The practice of wife inheritance places young widows at the risk of contracting HIV/AIDS and other sexually transmitted diseases.					
26. The practice of wife inheritance is indeed a harmful practice for women.					
27. Polygamous marriages are an agent that transmits HIV/AIDS.					
28. Women in a polygamous marriage find it impossible to assert their sexual and reproductive rights.					

Appendix E: Ethical clearance letter

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms L Gwatimba

Student No:
11605759

PROJECT TITLE: **Analysis of the effects of customary marriages on young women's sexual and reproductive health rights in Makwarela (South Africa) and concession (Zimbabwe).**

PROJECT NO: **SHSS/19/GYS/01/2305**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr NR Raselekoane	University of Venda	Promoter
Prof AO Nwafor	University of Venda	Co - Promoter
Ms L Gwatimba	University of Venda	Investigator – Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: May 2019
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Senior Prof. G.E. Ekosse

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION
2019 -06- 04
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060
"A quality driven financially sustainable, rural-based Comprehensive University"