



UNIVERSITY OF
KWAZULU-NATAL

INYUVESI
YAKWAZULU-NATALI

The production, distribution and reception of Zimbabwe National Family Planning Council (ZNFPC) reproductive health messages in Chikombedzi rural Zimbabwe

BY

Rosemary Chipso Masakadza (215079939)

Submitted to the School of Applied Human Science, College of Humanities, University of KwaZulu-Natal, in fulfilment of the requirements of a Master of Social Sciences degree at the Centre for Communication, Media and Society (CCMS)

December 2015

Supervisor:

Dr Lauren Dyll-Myklebust

DECLARATION

I, **Rosemary Chipo Masakadza (Student Number 215079939)**, declare that:

1. The research reported in this dissertation, except where otherwise indicated, is my original research.
2. This dissertation has not been submitted for any degree or examination at any other university.
3. This dissertation does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
 - a. Their words have been re-written but the general information attributed to them has been referenced
 - b. Where their exact words have been used, then their writing has been placed inside quotation marks, and referenced.
4. This dissertation does not contain text, graphics or tables copied and pasted from the Internet, unless specifically acknowledged, and the source being detailed in the dissertation and Bibliography.

Signature:  Date: 22 March 2016 Place: Zimbabwe

Supervisor: Dr Lauren Dyll-Myklebust Date: 22 March 2016 Place: Durban

Dedication

I dedicate this work to my family; for you I have endured so much to make this a reality.

Acknowledgements

I am indebted to all those who never left my side and with whom I constantly dialogued. And also the remarkably insightful discussions with my supervisor Doctor Lauren Dyll-Myklebust, I cherish every email, meeting and conversation and look forward to more beyond this study. For I have found my role model in you. I would also like to thank Prof. Ruth-Teer Tomaselli and Doc. Lauren Dyll-Myklebust, for ushering me into the life of academia.

I will never be able to repay all the love and support I got from my CCMS family; Kena, Ndu, Siya and Shumba ‘Baba Popo’. Thank you for being there through all the joyful, productive and painful days of this dissertation. Special thanks go to Tulani Ngwenya, Jacqueline Nyahuye, Collen Chambwera and Sharon Gombiro, for being my best buddies and the same time, my worst enemies.

Finally, I would like to thank my mother for her continuous love, care and support through the course of my work and always.

Abstract

This study explores the production and distribution of Zimbabwe National Family Planning Council's (ZNFPC) female reproductive health communication messages and their reception by females in Chikombedzi, rural Zimbabwe. The study arises from the realisation that female reproductive health remains low, particularly in marginalised communities, as the mass media seem not to prioritise reproductive health communication. Taking a Cultural Studies approach (CS), the study employs the Encoding/Decoding model (Hall, 2010/1980) and the Circuit of Culture (Du Gay *et al.*, 1997). This is combined with the Social Ecology Model of Communication and Health Behaviour (SEMCHB) (Kincaid *et al.*, 2007) thus also framing the study within health communication. In this qualitative research, data is collected through archival research at the ZNFPC offices complimented by semi-structured interviews of ZNFPC key personnel to determine the production and distribution processes. Focus groups are held with different women in Chikombedzi to establish the reception patterns. For data analysis semiotic analysis is employed coupled with an adaptation of the SEMCHB as a data analysis tool. The research establishes that while ZNFPC tries to cater for Chikombedzi females in its packaging and distribution of IEC materials for behaviour and social change, there is still room for improvement. On their part, the women of Chikombedzi acknowledge the importance of ZNFPC messages but have to grapple with cultural and social expectations that are sometimes not conducive to the adoption of the communicated messages. IEC materials are used as a system of representation of the reproductive health challenges faced by woman in Chikombedzi.

Key words: Reproductive health, IEC materials, ZNFPC, Chikombedzi, Production, Distribution, Reception.

Acronyms and Abbreviations

AIDS – Acquired Immune Deficiency Syndrome

ASRH – Adolescents Sexual and Reproductive Health

BCC – Behaviour Change Communication

CBD – Community Based Distributor

CCMS – Centre for Communication Media and Society

CIN – Cervical Intraepithelial Neoplasia

CS – Cultural Studies

ESAP – Economic Structural Adjustment Programme

FPA – Family Planning Association

FPAR – Family Planning Association of Rhodesia

GOZ – Government of Zimbabwe

HBM – Health Belief Model

HIV – Human Immunodeficiency Virus

HPV – Human Papilloma Virus

IAWG – Inter-Agency Working Group on Reproductive Health in Crises

ICPD – International Conference on Population and Development

IEC – Information Education and Communication

IPPF – International Planned Parenthood Federation

I-TECH – International Training and Education Centre for Health

LGBTIs – Lesbians, Gays, Bisexuals, Transgender and Intersex

MCH/FP – Maternal and Child Health/Family Planning

MCO – Marketing and Communication Officer

MDGs – Millennium Development Goals

MENA – Middle East and North Africa

MESC – Ministry of Education, Sports and Culture

MoHCW – Ministry of Health and Child Welfare

MOU – Memorandum of Understanding

NAC – National AIDS Council

NACA – National Agency for Control of AIDS

NGO – Non-Governmental Organisation

NRV – National Region V

PE – Peer Educator

PMTCT – Prevention of Mother to Child Transmission

SADC – Southern Africa Development Community

SAfAIDS – Southern Africa HIV and AIDS Information Dissemination

SBCC – Social Behaviour Change Communication

SCC – Social Change Communication

SDC – Service Delivery Coordinator

SEMCHB – Social Ecology Model for Communication and Health Behaviour

SICC – Sister-In-Charge Community

Soul City – Soul City Institute of Health and Development Communication

SRHR – Sexual and Reproductive Health Rights

STI – Sexually Transmitted Infection

TfD – Theatre for Development

UCLA – University of California, Los Angeles

UKZN – University of KwaZulu-Natal

UN – United Nations

UNAIDS – the Joint United Nations Programme on HIV and AIDS

UNFPA – United Nations Funds for Population Activities

UNHR – United Nations Human Rights

UNICEF – United Nations Children’s Emergency Fund

UNPOPIN – United Nations Population Information Network

USAID – United States Agency for International Development

WHO – World Health Organisation

ZBC – Zimbabwe Broadcasting Cooperation

Zimstats – Zimbabwe National Statistics Agency

ZNBFP – Zimbabwe National Board of Family Planning

ZNFPC – Zimbabwe National Family Planning Council

ZYC – Zimbabwe Youth Council

List of Tables, Maps and Pictures

Fig. 1.1	Map of Chikombedzi.....	12
Fig. 3.1	Circuit of Culture.....	47
Fig. 3.2	SEMCHB Model.....	52
Table 4.1	IEC Materials Collected.....	65
Fig. 5.1	ZNFPC Poster on Early Pregnancies.....	76
Fig. 5.2	Pamphlet on Female Condom Use.....	78
Fig. 5.3	Booklet: Young 4 Real; Young Women First.....	80
Fig. 5.4	Pamphlet: Benefits of Family Planning.....	81

TABLE OF CONTENTS

DECLARATION	i
Dedication	ii
Acknowledgements	iii
Abstract	iv
Acronyms and Abbreviations	v
List of Tables, Maps and Pictures	viii
TABLE OF CONTENTS	x
CHAPTER ONE	1
INTRODUCTION AND BACKGROUND	1
Introduction	1
Significance of study	2
Background of Reproductive Health	2
<i>Global Overview of Reproductive Health</i>	3
<i>Reproductive Health in Africa</i>	6
<i>ZNFPC and Reproductive Health in Zimbabwe</i>	8
<i>Research site: Chikombedzi</i>	12
Research Objectives and Questions	13
<i>Overview of Chapters</i>	14
Conclusion	15
CHAPTER TWO	16
REVIEW OF LITERATURE	16
Introduction	16
Female reproductive health, an empowerment and humanitarian agenda	16
Reproductive health communication in Africa	20
Production, distribution and reception case studies	24
Socio-cultural contexts and female reproductive health communication	28
Zimbabwe's socio-economic status and health care utilisation	34
Conclusion	37

CHAPTER THREE	38
THEORETICAL FRAMEWORK.....	38
Introduction	38
Cultural Studies (CS) Approach.....	38
<i>Encoding/Decoding Model</i>	41
<i>Circuit of Culture Model</i>	45
CS and public health communication.....	49
<i>Social Ecology Model of Communication and Health Behaviour (SEMCHB)</i>	50
Health Belief Model (HBM).....	53
Social Cognitive Theory	54
Conclusion.....	55
CHAPTER FOUR.....	57
RESEARCH METHODOLOGY.....	57
Introduction	57
Research Paradigm and Design.....	57
Sampling.....	58
Recruitment Strategy.....	60
Data Collection.....	62
<i>Archival Research</i>	63
<i>Interviews</i>	65
<i>Challenges encountered during data collection</i>	69
Data Analysis and Presentation.....	70
Ethical Considerations.....	71
Reliability and validity of the study	72
<i>Credibility</i>	72
<i>Dependability</i>	72
<i>Confirmability</i>	72
<i>Transferability</i>	72

Conclusion.....	73
CHAPTER FIVE	74
DATA PRESENTATION AND ANALYSIS: ENCODING AND DISTRIBUTION OF ZNFPC’S IEC MESSAGES	74
Introduction	74
Semiotic analysis of sample IEC materials	74
Production and distribution of ZNFPC’s female reproductive health IEC messages	81
<i>Place of production</i>	81
<i>Relationship between text and context</i>	82
<i>Research for IEC material message production</i>	84
<i>Time and relevance</i>	86
<i>Distribution of IEC materials</i>	86
<i>Funding</i>	88
Preferred reading.....	88
Conclusion.....	91
CHAPTER SIX.....	92
DATA PRESENTATION AND ANALYSIS: DECODING OF ZNFPC MESSAGES AND FACTORS INFLUENCING RECEPTION.....	92
Introduction	92
Individual level.....	92
<i>Knowledge about female reproductive health</i>	93
<i>Contraceptive and condom messages promote diseases and population control</i>	95
<i>Attitudes and perceptions and the negotiated reading</i>	97
Social Network.....	99
<i>Social influences of partner and family</i>	99
<i>Peer influences</i>	101
<i>Moral decency and social networks in Chikombedzi</i>	102
<i>Cultural and group norms</i>	104

Community Level.....	107
<i>Community and religious leadership</i>	107
<i>Access to resources</i>	108
Societal level.....	109
<i>Gender norms and patriarchy in Zimbabwe</i>	109
<i>Service delivery</i>	110
<i>Physical environment and infrastructure</i>	111
Conclusion.....	112
CHAPTER SEVEN.....	113
CONCLUSION.....	113
Introduction.....	113
ZNFPC’s female reproductive health IEC message production/encoding.....	113
ZNFPC’s female reproductive health IEC material distribution.....	114
Perceptions and attitudes of Chikombedzi females towards ZNFPC’s female reproductive health communication.....	115
Factors influencing reception patterns of ZNFPC’s reproductive health communication.....	116
Recommendations.....	117
Further research.....	118
References.....	119
Primary Sources.....	119
Secondary Sources.....	120
Appendix i: Gatekeeper Letter.....	136
Appendix ii: Ethical Clearance.....	137
Appendix iii: ZNFPC Poster.....	138
Appendix iv: ZNFPC Pamphlet.....	139
Appendix v: ZNFPC Booklet.....	140
Appendix vi: Discussion Guide.....	141
Appendix viii: Informed Consent- Permission to Interview (Semi-structured Interviews)...	143

CHAPTER ONE

INTRODUCTION AND BACKGROUND

Introduction

The reproductive health status of females in sub-Saharan Africa is generally low (Gribble *et al.*, 2008; Grown & Gupta, 2005; Southern Africa Development Community (SADC), 2008) thereby making information, education and communication important concerns on the agendas of health and policy issues (Nwadiwe, 2012). Communication researchers believe that the current media systems in Africa have been unable to properly and adequately address important issues in the continent (Nwadiwe, 2012) hence there is need for alternative communication to be able to bridge the gap between health product, service availability and utilisation. This need motivated this study that seeks to analyse the production, distribution and reception patterns of Zimbabwe National Family Planning Council's (ZNFPC) female reproductive health communication messages in Chikombedzi, rural Zimbabwe. ZNFPC is solely responsible for offering Zimbabweans with education and information on sexual and reproductive health and family planning to people of all ages in urban and rural areas.

Even though there is a growing concern about reproductive health issues in sub-Saharan Africa, reproductive health statuses remain low as it is given low priority in the mass media (Oronje *et al.*, 2011). Charles Emeka Nwadiwe, (2012) argues that reproductive health communication via the mass media is not viewed as a priority due to control and ownership patterns of the mass media and politics. Reproductive health communication messages carried through the mass media channels are often lost or ineffective due to factors such as basic needs, language barriers, as well as technological infrastructure (Nwadiwe, 2012). This paves the way for alternative media such as Information, Education and Communication (IEC) materials in the form of posters, pamphlets, booklets, theatre and films produced by local and international organisations to take over and create awareness, knowledge and promote and maintain behaviour change at grassroots individual and community level.

Organisations such as ZNFPC have set an agenda to bridge the gap between resource availability and utilisation and/or behaviour change in reproductive health through IEC materials. Taking a cultural studies approach, this study is interested in investigating how female reproductive health communication messages, in the form of posters, pamphlets and

booklets are produced and distributed by ZNFPC and how they are received by females of reproductive age in the rural area of Chikombedzi located in the South-Eastern part of Zimbabwe in Masvingo Province.

Significance of study

Most available literature on reproductive health focuses on the urban population, adolescents, youths and at times, key populations such as female sex workers and truck drivers and mainly focusing on reception (Iwokwagh *et al.*, 2014; Nwadigwe, 2012; Nxumalo, 2013; Soul City Institute of Health and Development Communication (Soul City), 2014 and 2009). This study acknowledges that reproductive health issues differ at every stage in life and if a reproductive health issue is not taken care of at particular stages, its effects can surface later (United Nations Population Information Network (UNPOPIN), 1994). The knowledge gap of reception, production and distribution patterns of ZNFPC's female reproductive health communication messages is worth studying and therefore essential to conduct from a Cultural Studies (CS) perspective. CS approach is a set of theories and methodologies that are applied across many disciplines. In this study, it is applied within the field of public health communication. CS is commonly articulated around debates that centre on: "1) the claim that culture (and hence Cultural Studies) has strong political force; 2) the determining power of economic structures on cultural formations; and 3) the debate over the role that individual experiences should play in analysis" (During, 2005: 38). The relevance of this CS approach will be elaborated upon in Chapter three; Theoretical Framework. Public health communication is a process that is intended to intensify the impact of public health initiatives (Bernhardt, 2004; Chasi, 2014). The field has developed to take cognisance of Social Change Communication strategies (SCC), rather than simply the individually-based behaviour change communication strategies (McKee *et al.*, 2014; Scalway, 2010; Storey & Figueroa, 2012) which will also be discussed in Chapter three.

Background of Reproductive Health

The former United Nations Secretary General, Kofi Annan stated that "the Millennium Development Goals, particularly the eradication of poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed" (SADC, 2008: 8). This highlights the importance of addressing reproductive health, not only in achieving general health, but also in attaining national and international developmental and economic goals. This makes people the centre of development (UNPOPIN, 1994). Not only is

reproductive health an important aspect for human development, it is also a crucial component of general health and wellbeing (UNPOPIN, 1994).

Before the concept of reproductive health was adopted, the terms population demographics and dynamics defined population with an interest in family planning for population control (Kaddour *et al.*, 2005; Mahmood *et al.*, 2001; Mairiga *et al.*, 2007). A difference exists between the reproductive health approach and the family planning approach, though family planning can be argued to be a component of reproductive health (Roseman & Reichenbach, 2010). Reproductive health focuses on all life's stages with particular importance and interest in the reproductive years (which are the focus of family planning) (Kaddour *et al.*, 2005; Roseman & Reichenbach, 2010).

Reproductive health is concerned with the fulfilment of desires and risks that come with selected choices; choices on whether or not to have a child and when and the risks involved (UNPOPIN, 1994). Though reproductive health neither starts nor ends with challenges and diseases, reproductive health challenges and diseases include maternal and prenatal mortality and morbidity, Sexually Transmitted Infection (STI) prevention and management, family planning, gender based violence, HIV and AIDS, early marriages and pregnancies, breast and cervical cancer, harmful practices and infertility (Roseman & Reichenbach, 2010; SADC, 2008).

The International Conference on Population and Development (ICPD) in 1994 defined reproductive health, why it should be addressed and why prioritise females (Petroni & Fritz, 2013). As compared to males, females carry the greater burden of reproductive health challenges and are at more risk (Petroni & Fritz, 2013). Though the focus shifted from population control to the reproductive health concept, sexual and reproductive health and rights remain socially, politically and policy debated (Roseman & Reichenbach, 2010). In contrast to 12 per cent for males, 36 per cent of the healthy years of life of females are lost due to reproductive health challenges (UNPOPIN, 1994). The difference in the percentages between males and females shows the magnitude of the problem and also indicates how much females suffer because of their poor reproductive health statuses.

Global Overview of Reproductive Health

At the ICPD, through the ICPD Program of Action, reproductive health was defined as:

...a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other methods of their choice for regulation of fertility which is not against the law and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (United Nations (UN) 1994: paragraph 7.2).

This definition moved the worlds' attention from population dynamics to the wider focus of reproductive health (Mahmood *et al.*, 2001; Mairiga *et al.*, 2007; Petroni & Fritz., 2013). The 1995 Fourth World Conference on Women that was held in Beijing, China, supported this definition (SADC, 2008). The definitions before the ICPD viewed reproductive health in the light of controlling the worlds' growing population through fertility regulation (AbouZahr, 1995). The government delegations that participated at the ICPD agreed that family planning should be included in reproductive rights and health care (Roudi-Fahimi, 2003). This study makes use of the 1994 definition of reproductive health.

Though the ICPD viewed people as the most important in development and active in controlling their own reproductive health (SADC, 2008), the role that communication would play was not clearly stated in the agenda. The ICPD brought to light the view that reproductive health is not an issue for countries or continents facing the challenges alone but is a universal concern (UN, 1994; UNPOPIN, 1994). Since reproductive health concerns and challenges affect women more, this makes women an important focus in addressing reproductive health issues and to be protected (Kulczycki, 2014). Women carry the major responsibility and burden due to issues such as insufficient empowerment to improve their health, lack of adequate involvement, knowledge, educational levels and cultural and patriarchal factors (Africa Health Strategy, 2007). Therefore, this study focuses on reproductive health communication channelled to females of reproductive ages in the rural area of Chikombedzi. Women in this area have no basic health cover not many basic necessities. This study is vital in understanding the lives of these women in this area.

In some societies, women have limited or no access at all to education and health care services and this puts them at a disadvantage as they are not the decision makers and have

limited access to resources (Africa Health Strategy, 2007; Manchak, 2009; SADC, 2008; Zimbabwe Youth Council (ZYC), 2014). How women and girls are treated or mistreated is an important aspect of reproductive health (Kulczycki, 2014). SADC (2008: 18) discusses “the feminization of poverty” in which poverty is considered as affecting females more than males. Globally, poor populations are the most affected by reproductive health challenges (Kevany *et al.*, 2012; Ringheim & Gribble, 2010) and India and Sub-Saharan Africa are the worst affected (AbouZahr 1995; Ringheim & Gribble, 2010). Poor reproductive health indices include unwanted pregnancies, abuse, diseases and death (SADC, 2008).

In developing countries, the rates of women dying due to pregnancy related complications and maternal mortality rate are nearly 50 times higher than those in developed countries (Grown & Gupta, 2005). Globally, developing countries are argued to be having the highest percentages or levels of reproductive tract infections and STIs (Kulczycki, 2014). This therefore supports the arguments that reproductive health issues are mostly characteristic of poor countries (AbouZahr, 1995). Termination of pregnancy or abortion is also cause of high death rates in the world more especially in countries in which abortion is illegal such as China, Russia, Botswana, Malawi, Zambia and Zimbabwe (SADC, 2008).

Reproductive health is also important and related to different stages of life (Mahmood *et al.*, 2001). These are infancy and childhood, adolescence, adulthood and old age (Mahmood *et al.*, 2001). In many countries, the reproductive health status of females is still low and their reproductive health rights remain to be fully acknowledged (Grown & Gupta, 2005) thereby explaining the mortality and morbidity rates and other reproductive health challenges females face. Meka Manchak (2009) posits that reproductive health knowledge among women is low. This study therefore notes that communication plays a pivotal role in bridging the gap and imparting knowledge and information.

Worldwide, approximately 400 000 women develop cervical cancer and the morbidity and mortality rates are higher in developing countries (Manchak, 2009). A 2002 study in Latin America and the Caribbean revealed that cervical cancer is the second deadliest cancer among women after breast cancer (Manchak, 2009). World Health Organisation (WHO), (2013) posits that the rate of Cervical Intraepithelial Neoplasia (CIN) is higher, by 10 per cent, in women who are HIV positive as compared to those whose serostatus is negative. In 2002, the survival rate for cancer was at 21 per cent in sub-Saharan Africa, 66 per cent in Western Europe and 70 per cent in the United States of America (Manchak, 2009).

After defining reproductive health, came the actual implementation in which a visible change was expected (Roudi-Fahimi, 2003). The “national governments and international community have increasingly adopted language supporting reproductive health but orienting policies and programs has been more challenging” (Roudi-Fahimi, 2003: 1). This shows that though agreed upon, the implementation of reproductive health policies and programs has been difficult and not effectively done. However, a common set of indicators was developed with the aim of monitoring the progress of reproductive health (Roudi-Fahimi, 2003). These include the percentage of women using contraceptives and the percentage of children delivered by medical professionals (Roudi-Fahimi, 2003). In this light, it is possible that communication efforts have not been effective so far, hence it is necessary to research on how reproductive health messages by ZNFPC are produced, distributed and received in the rural area of Chikombedzi. To understand how messages are received we assess the increase in knowledge, attitude and behavioural change. This is a useful way in which we are able to discern if the encoded and disseminated messages have been decoded and understood by the inhabitants of an area.

The new millennium saw a rise in political and religious concerns and shift in health focus; from reproductive health concerns to the feminisation of HIV and AIDS (Roseman & Reichenbach, 2010; SADC, 2008). This resulted in little attention being paid to other reproductive health issues and more on HIV and AIDS (Roseman & Reichenbach, 2010). Though HIV and AIDS is worldwide concern, “the epicentre of the pandemic within sub-Saharan Africa remains Southern Africa, a region whose epidemic constitutes the largest in the world” (Mathew, 2012: 7). There was now a need to bring reproductive health and HIV and AIDS service provision and advocacy together, particularly in Africa (Roseman & Reichenbach, 2010).

Reproductive Health in Africa

High unemployment rates, droughts and war are some of the challenges that have resulted in Africa witnessing high rates of migration from rural areas to cities and industrial and mining sites and from one country to another in search of employment and better living (Bambura, 1999). This has resulted in high rates reproductive health concerns which include prostitution, unsafe abortions, rise in STI cases and fast spread of HIV and AIDS (Bambura, 1999). Sexual behaviour has a direct bearing on reproductive health, therefore, changing the sexual

behaviour of individuals, is one way of trying to change and improve reproductive health in Africa (Bambura, 1999).

Women in Africa face a number of challenges in reproductive health including access to adequate reproductive health information, services and products (Grown & Gupta, 2005). In less developed countries reproductive health; especially modern use of contraceptive methods are used by only 43% of women of reproductive age overall, and a wide gap in use is seen between the highest and lowest wealth quintiles (52% versus 35%, respectively) (Bulletin of the World Health Organization, 2011). Andrzej Kulczycki (2014: 36) argues that “women suffer deep-seated discrimination across the MENA region, holding back economic and social development.” In the MENA region, the reproductive health challenges which women face are a result of gender roles and social and economic conditions (Roudi-Fahimi, 2003). Though James Gribble and Joan Haffer, (2008) assert that in Eastern and Southern Africa, efforts in reproductive health should focus on reaching the poor populations with high quality services and information, how the information should be imparted is however not stated.

Sub-Saharan Africa has the fastest growing population (Ringheim & Gribble, 2010) and is “deficient in areas of reproductive health which are crucial for meeting MDGs” (Gribble & Haffer, 2008: 1). The spread of HIV and AIDS in sub-Saharan Africa continues in spite of the fact that HIV and AIDS awareness is high (Bambura, 1999). Sub-Saharan African females between the age of 15 and 49 constitute almost 60 per cent of the HIV positive population in the world (Grown & Gupta, 2005).

By 2008, Nigeria, South Africa, Tanzania and Zimbabwe were the four sub-Saharan African countries hosting more than half of the HIV positive population in the world (Gribble & Haffer, 2008). In sub-Saharan Africa alone, women constitute 57 per cent of all the adults living with HIV and AIDS (Grown & Gupta, 2005). However, between 2005 and 2011, the number of people dying from AIDS related causes in sub-Saharan Africa declined by 32 per cent and between 2005 and 2013, new HIV infections declined by 33 per cent (UNAIDS, 2012; 2014). Of the 536 000 worldwide deaths of women mostly due to pregnancy and childbirth related complications in 2005, more than half of the deaths occurred in sub-Saharan Africa (Gribble & Haffer, 2008). The unfair burden of HIV and AIDS and other reproductive health issues on women shows the need for services, programs and interventions that address both reproductive health services for the individuals who are HIV positive and for HIV prevention (Gribble & Haffer, 2008).

In developing countries, some young women still depend on the use of traditional methods of family planning (Gribble & Haffer, 2008; Walliamson *et al.*, 2009). In 2012, 54 per cent of the married reproductive age women in the developing countries acknowledged using modern methods of contraception and in sub-Saharan Africa 22 per cent of the married women admitted to using contraceptives whilst a quarter had unmet contraceptive needs (Petroni & Fritz, 2013). Hazel Barrett (2011) asserts that women in sub-Saharan Africa have the highest fertility rates in the world. In 1994, the numbers of children per woman were 5.9 in sub-Saharan Africa, 3.6 in South Asia and 1.9 in Europe and the rates ranged from 7.5 in Ethiopia to 4.0 in Zimbabwe (Barrett, 2011). However, Gribble and Haffer, (2008) posit that in the early 1990s, the average number of children that a woman in sub-Saharan Africa would have was 6.1 and in the early 2000s, the average was at 5.4 thereby showing a slight decline. These statistics are of relevance to my study as they bring to light the gaps in reproductive health and in particular, the utilisation of reproductive health services and products despite their availability. This study then comes in to investigate women's perceptions and attitudes towards IEC messages encouraging the adoption of reproductive health behaviour change.

In Africa as a whole, cancer is now recognised as a public health problem as cancers diagnosed in Africa are resulting in higher death rates as compared to other parts of the world (American Cancer Society, 2011). This is due to poor access to treatment and resources (American Cancer Society, 2011; Manchak, 2009). Whilst 80 per cent of cervical cancer cases are found in developing countries, only five per cent of women receive cancer screening (Manchak, 2009). Women in sub-Saharan Africa have limited knowledge of cervical cancer and approximately 60 to 75 percent of the women who develop cervical cancer live in the rural areas (American Cancer Society, 2011; Manchak, 2009).

ZNFPC and Reproductive Health in Zimbabwe

In Zimbabwe, before the ICPD, reproductive health was also defined in terms of population concerns with regards to family planning and HIV and AIDS (Zimbabwe Ministry of Health and Child Welfare (MoHCW), 2009). Health programs, mostly family planning programs before and after Zimbabwe attained independence in 1980, faced a number of challenges which had a negative impact on their effectiveness (Zinanga, 1992). The new language of reproductive health was also adopted by Zimbabwe after the ICPD in which the Zimbabwean delegation participated and presented issues to do with the then recent demographic trends

and the results of the 1992 population census which showed the need “for the development of a national population policy” (Huber *et al.*, 1994: 4).

Health programmes in Zimbabwe, before the ICPD, were aimed at “meeting the needs of child bearing women and children under the age of five” (MoHCW, 2009: *vii*). This meant defining reproductive health only in the light of fertility, family planning, infant mortality, safe childbirth and bearing during only infancy and reproductive years, any time outside these periods did not matter much. Thus, reproductive health was only seen as necessary to address during the reproductive stage in females’ life cycle alone. In the process, less or no attention was paid to adolescence, youth, the elderly, commercial sex workers and men. In contrast, while reproductive health is of importance during the reproductive age, it is also crucial in all the other stages of life (UNPOPIN, 1994).

In Zimbabwe¹, in 1953, a group of women, the Pathfinder Association of Boston, voluntarily started providing community-based family planning information and services in Harare², led by Paddy Spilhaus³ (Huber *et al.*, 1994; Zinanga, 1992). The first family planning clinic was only for the white population and was opened in Waterfalls, a suburb for the whites, just outside Harare (Zinanga, 1992). The first black majority clinic that offered family planning services and information was opened in 1959 at Harare Central Hospital by the same group of women with the assistance of the government through the MoCHW (Huber *et al.*, 1994; Zinanga, 1992).

The 1961/62 national census findings showed an African population growth rate of 3.5 per cent (Zinanga, 1992). This pushed the MoCHW to allow contraceptives to be distributed in all government health facilities and the concept of Community Based Distributors⁴ (CBDs) was introduced (Huber *et al.*, 1994; Zinanga, 1992). In 1965, the Family Planning Association of Rhodesia (FPAR) was formed and registered as a welfare organisation and became officially attached or connected to the International Planned Parenthood Federation (IPPF) (Zinanga, 1992). The FPAR was given an annual grant by the government for its day-to-day running (Zinanga, 1992).

¹ The then Rhodesia.

² The then Salisbury.

³ Led the Pathfinder Association of Boston, introduced family planning products and services in black communities in and around Harare and with her own money, she built the first family planning clinic (Zinanga, 1992).

⁴ They would distribute contraceptives, family planning pills and information in and around Harare (Huber *et al.*, 1994; Zinanga, 1992).

1976 saw the Rhodesian government, through a policy, giving the FPAR permission to use lay personnel in the first and resupply of oral contraceptives (Zinanga, 1992). The accessibility and availability of contraceptives was furthered to the rural population which at that time constituted close to 76 per cent of the Rhodesian population (Zinanga, 1992). Alex Zinanga (1992: 2-3) asserts that during the colonial period, the white government and the FPAR “promoted family planning aggressively among the black population to arrest what they termed as an alarming growth rate among the African population.” As a result, the black majority viewed family planning with great suspicion and the effectiveness of the program was then concentrated to the urban few who accepted it (Zinanga, 1992).

A new era began after Zimbabwe attained independence in 1980. As the name of the country changed from Rhodesia to Zimbabwe, FPAR was changed to the Family Planning Association (FPA). Changes were also made in the health sector by the new government (Zinanga, 1992). The FPA was restructured through government and international funding (Huber *et al.*, 1994; Zinanga, 1992). The changes also came with the establishment of the Maternal and Child Health/Family Planning (MCH/FP) Unit in the MoCHW. The new government sought to address imbalances in the primary health care system through the Primary Health Care Approach⁵ (Huber *et al.*, 1994; Zinanga, 1992; ZNFPC, 1998). As a result, the MCH/FP unit was to oversee the delivery of primary health care services throughout the whole of Zimbabwe (Huber *et al.*, 1994; Zinanga, 1992). In September 1981, the government took over the FPA and placed it into the care and authority of the MoHCW (Huber *et al.*, 1994; Zinanga, 1992).

In 1984, the FPA became known as the Zimbabwe National Family Planning Council (ZNFPC) (Huber *et al.*, 1994; Zinanga, 1992). ZNFPC was established as a parastatal under the MoCHW through an amendment of the 1985 Act of Parliament and governed by the Zimbabwe National Board of Family Planning (ZNBFP) (Huber *et al.*, 1994; Zinanga, 1992; ZNFPC, 1998). Among some of its mandates, ZNFPC was to coordinate the provision of family planning information and services in Zimbabwe, conduct research on reproductive health and effects of contraceptives on the health of the users, diagnosis and treatment of breast and cervical cancer and STI researches (Huber *et al.*, 1994; Masakadza, 2011; Zinanga, 1992).

⁵ An approach in which the initial levels of healthcare services is made accessible to all individuals (Huber *et al.*, 1994).

The objective behind the formation of ZNFPC was to embrace the idea that both couples and individuals have the right to decide when and how many children to have (Masakadza, 2011). The vision of ZNFPC is “to be the centre of excellence in family planning and reproductive health in Zimbabwe and beyond” (Masakadza, 2011: 33). During its take-off days, there was limited knowledge of the importance of family planning among the people; therefore the services were accepted by only a small population (Zinanga, 1992). It was at this stage that an Information, Education and Communication (IEC)⁶ unit was established to oversee the provision of family planning and reproductive health information and education in the whole country (Zinanga, 1992). The focus of the IEC department, that is, providing information and conducting research, paves way for an analysis of how such research is incorporated into the production and distribution of ZNFPC’s IEC materials, and how that plays out in reception patterns of females, in Chikombedzi.

ZNFPC provides reproductive health education, information and communication and services in urban and rural Zimbabwe to both males and females of different age groups including adolescents and youth who had been generally ignored in the past (MoHCW, 2009). Just as in the colonial era, ZNFPC receives yearly grants from the government (Masakadza, 2011; Zinanga, 1992). ZNFPC has established itself as one of the market leaders in the provision of reproductive health services and information in Zimbabwe (Masakadza, 2011).

Zimbabwe is faced with a number of reproductive health issues that include HIV and AIDS, Prevention of Mother to Child Transmission (PMTCT), STIs and family planning (MoHCW, 2009; ZNFPC, 1998). The National AIDS Council (NAC) in December 2013 released a quarterly report that showed that there was an increase in STI cases in the country and Masvingo Province was the worst hit. Furthermore, the greatest number of new infections was in females at 60 per cent of the infected population (Muzulu, 2014).

During the colonial era, 76 per cent of the population lived in the rural areas (Zinanga, 1992) and that has slightly reduced to the current 70 per cent (Kevany *et al.*, 2012). Just as in other sub-Saharan countries, in Zimbabwe, the migration of men out of rural areas to cities and other neighbouring countries affects the state of the rural household and reproductive health (Bambura, 1999). Though health care service providers in Zimbabwe compare favourably to other African countries (Kevany *et al.*, 2012), healthcare utilisation in rural Zimbabwe is low (Chiremba, 2013).

⁶ Now the Marketing and Communications Unit

In order to improve the reproductive health status and healthcare utilisation of individuals and the society at large, ZNFPC uses strategies such as IEC materials, jingles, newspaper supplements and press releases. These strategies carry messages for awareness creation, imparting knowledge and changing people's attitudes (ZNFPC, 1998). The ZNFPC strategy of interest to this particular study is the IEC strategy focusing on pamphlets, booklets and posters distributed in the rural area of Chikombedzi.

Research site: Chikombedzi

Located in the South-Eastern part of Zimbabwe in Masvingo Province, Chikombedzi is under Chiredzi rural District and is 120 kilometres from Chiredzi town (Zimbabwe National Statistics Agency (Zimstats), 2012). Masvingo Province is mostly rural and its total population by 2012 was approximately 1 486 604 (Zimstats, 2012). During the time of the 2012 census, two per cent of the economically active population were children between 10-14 years of age. In terms of literacy levels, the 2012 census information revealed that 13 per cent of the population has never had any formal schooling and 61 per cent was in school (Zimstats, 2012). The report stated that as compared to males, more females had left school for different reasons (Zimstats, 2012). The provincial statistics also showed that fertility rate is at four children per woman but this varies depending on the mothers' level of education and factors of influence. The entire Chiredzi rural population is estimated at approximately 275 759 (Zimstats, 2012).

The rural area of Chikombedzi is male dominated (Mediel Hove, 2011). As in most African communities, the Chikombedzi community is patriarchal and is characterised by strong cultural practices, which in terms of reproductive health, include male circumcision and womanhood initiation ceremonies and practices (Kachere, 2011; ZYC, 2014). This rural area is home to the Shona and the majority of the Shangani ethnic groups in Zimbabwe. Whilst Shona is a majority language, Shangani is a minority language. Figure 1.1 below shows the location of Chikombedzi.

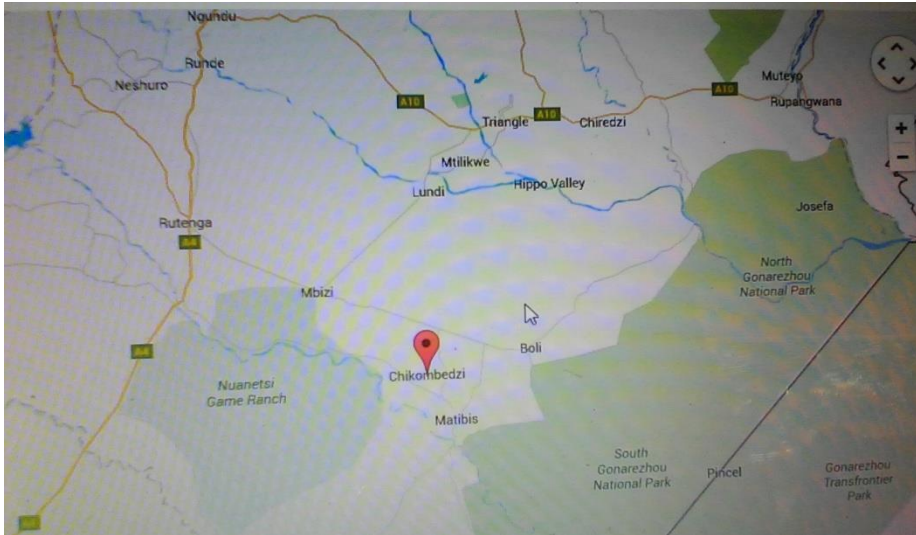


Fig. 1.1 shows the location of Chikombedzi, the research site⁷.

Chikombedzi is hot and dry and falls under Natural Region V (NRV) (Hove, 2011). In most of the villages in Chikombedzi, there is no Zimbabwean radio and television signal (*The Herald*, March 19 2015). Radio and television signals come from South Africa and Mozambique. Income is generated through local trade and trade in Mozambique and South Africa (SA) (Hove, 2011; Zimstats, 2012). In addition, there are high rates of school drop outs, early and polygamous marriages and illegal migrations to Mozambique and SA (Kachere, 2011; Katsande, 2014; ZYC, 2014). Due to the lack of signal, access to television, radio and internet, the researcher chose to explore alternative media, as the study is specifically about message design.

Having noted that the reproductive health status of women is low and acknowledging the efforts being made to improve it, this study seeks to find out how reproductive health communication messages produced and distributed by ZNFPC are received by females of reproductive age in Chikombedzi. From a Cultural Studies (CS) perspective, the study understands the Chikombedzi females as an active population in the meaning making process.

Research Objectives and Questions

The main objective of this study is to analyse how ZNFPC produces and distributes female reproductive health IEC messages and how the females in Chikombedzi receive them.

7

The specific objectives of the study are to:

1. Explore ZNFPC's IEC female reproductive health message production/encoding and distribution in Chikombedzi.
2. Analyse the perceptions and attitudes of Chikombedzi females towards ZNFPC's reproductive health communication.
3. Investigate the factors influencing reception patterns of ZNFPC's reproductive health communication.

As such, the following research question and its sub-questions drive this study:

How does ZNFPC produce and distribute female reproductive health IEC messages and how do the females in Chikombedzi receive them?

1. How are ZNFPC's IEC messages produced/encoded and distributed in Chikombedzi?
2. What are the attitudes and perceptions of females in Chikombedzi towards ZNFPC's reproductive health communication?
3. What are the factors influencing the reception patterns of ZNFPC's reproductive health communication in Chikombedzi?

Overview of Chapters

Chapter Two of my inquiry is focused on documenting the various available literature in my area of study. Having defined reproductive health and its current status in Africa and particularly in Zimbabwe in Chapter One, the literature review; Chapter Two, includes previous researches in reception studies, health communication and other fields, case studies, conference and working papers from various countries on the production, distribution and reception of health communication messages in Africa. Chapter Three is comprised of the theoretical approaches and models that underpin my study. From a CS perspective, this chapter focuses on the Circuit of Culture model that describes a process through which all cultural texts arguable undergo in the discipline (Du Gay *et al.*, 1997). Subsequent to this, both textual production and audience interpretation are cultural processes related to discourse as proposed by the Encoding/Decoding Model (Hall, 2010/1980) which is used to explain how both message production and interpretation are actively made. From a health perspective, the study employs the Social Ecology Model for Communication and Health Behaviour (SEMCHB) (Kincaid *et al.*, 2007) and its associated theories in explaining the

different levels of influences on behaviour and social change. The fourth chapter of the study delineates the research methods and methodology. This chapter includes an explanation of the research paradigm and the qualitative approach, design, sampling, methods of data collection, data analysis, validity, ethical considerations and limitations of the study. In Chapter Five and Six, the key research questions are addressed in presenting and analysing the collated data. Drawn from data analysis, the conclusion, Chapter Seven, forms the final chapter of the study.

Conclusion

The above chapter introduces and discusses the concept of reproductive health and in the process, highlights the concern of the need for communication. The chapter gives a picture of the nature of the reproductive health status of females in the world, Africa and Zimbabwe and how ZNFPC plays a role worth studying. The concept of reproductive health communication is further discussed in Chapter Two and will help in contextualising my study. Chapter Two gives greater room for the discussion of reproductive health communication through exploring relevant literature from Zimbabwe and beyond.

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

Chapter Two assesses literature on female reproductive communication. It explores the research methods, results and arguments of different scholars from Africa and beyond. As this study maintains the hypothesis that the reproductive health status of women in sub-Saharan Africa is low (Nwadigwe, 2012), this chapter reviews literature that explores the reproductive health statuses, challenges and issues that women face. Explored are journal articles, book chapters, research papers and also policy documents in order to contextualise this study. In light of the view that the Chikombedzi community is not only a geographical community, but also a community of interest in respect to culture, this chapter also discusses some of the cultures and practices prominent in the area. The reproductive health challenges reviewed in the various literature include HIV and AIDS, Sexually Transmitted Infections (STIs), cervical and breast cancer and harmful cultural practices that lead to school drop outs and early pregnancies and marriages.

Female reproductive health, an empowerment and humanitarian agenda

The reproductive health of women can be regarded as both an empowerment and humanitarian matter. The United Nations Population Information Network (UNPOPIN), (1994) asserts that;

reproductive health affects and is affected by the broader context of people's lives, including their economic circumstances, education, employment, living conditions and family environment, social and gender relationships, traditional and legal structures within which they live. Sexual and reproductive behaviours are governed by complex biological, cultural and psychosocial factors (UNPOPIN, 1994: 1).

Reproductive health among African women is regarded as a private and sensitive issue especially in rural settings (Kulczycki, 2014). In public health agendas, reproductive health has become an important aspect, with regards to the health and economic status of women and girls in African communities (Nxumalo, 2013; Piotrow *et al.*, 1997). This points to the

importance of reproductive health communication. This study qualifies these initiatives to place particular importance on how female reproductive health issues are communicated to females and how they receive the messages.

The 1994 International Conference on Population and Development (ICDP) addressed various worldwide population and development concerns with a focus on women because they bear the greatest burden of reproductive health problems (Kaddour *et al.*, 2005; Mairiga *et al.*, 2007; UNPOPIN, 1994). The 1994 UN document on women and health points out that “the empowerment autonomy of women and the improvement of their political, social, economic and health status, is a highly important end in itself” (UN, 1994: 22). Hence female reproductive health should be prioritised and not only for their benefit alone but for human and social development. This can be achieved by analysing the various elements in female reproductive health and in this instance, this study addresses this need by exploring how ZNFPC’s IEC messages are produced and delivered to rural females in Chikombedzi and how they are received. This in a way compliments what UN (1994) highlights as a means of empowering women and giving autonomy over issues which affect their health and wellbeing. This is as suggested by scholars (Dutta, 2008) that in health communication, the culture-centred approach gives voice to local communities; and in this particular instance, females, in relation to communicating, understanding and interpreting ZNFPC’s female reproductive health messages.

Globally, reproductive health interventions include attention to matters such as family planning, STIs and contraception, however, the aim of these interventions is to enhance and promote reproductive health and rights and not fertility control and population policies (UNPOPIN, 1994). This stands as a way of correcting the misunderstanding that some researchers brought to light as existed in Africa, especially during the colonial era (Turshen, 2000; Zinanga, 1992). Reproductive health interventions in Africa were not welcomed as the general misconception was that their aim was to erase the black population, as such the interventions failed (Turshen, 2000; Zinanga, 1994). Is it possible that such misconceptions have changed and to what extent? Through the study of the attitudes and perceptions of Chikombedzi females, this study seeks to unpack and establish how it may influence the decoding of ZNFPC’s IEC messages.

Limited information and new ideas, lack of control over their own lives, negative experiences and perceptions with regards to formal health care facilities, stand as barriers to good

reproductive health status of females (AbouZahr, 1995; Mahmood *et al.*, 2001). The 1994 conceptualisation of reproductive health “addressed sensitive areas long ignored, especially in highly patriarchal societies such as sexual behaviour and reproductive choices and focused on how unequal power relations between men and women profoundly influence sexual behaviour and reproductive choices” (Kaddour *et al.*, 2005: 34- 35).

This state of affairs encouraged Kaddour *et al.* (2005) to explore how underprivileged women in communities around Beirut, Lebanon understand the concept of reproductive health. This was “based on the assumption that women attach meaning to the concept within specific socio-economic and cultural contexts” (Kaddour *et al.*, 2005: 35). The study found out that due to socio-economic challenges, bearing a lot of children was seen as the role of women and a way of preventing future economic problems as the children would then look after their mother later in life (Kaddour *et al.*, 2005). This demonstrates Carla Makhoul-Obermeyer’s (1999: S50) argument that reproductive health is in actual fact a concept that is culturally constructed, meaning that it is “a product of specific historical, ethical and legal transformations.” This particular study follows the trajectory of both the culture-centred (Dutta, 2008) and the constructivist (Makhoul-Obermeyer, 1999) approaches using methods that will solicit information vital to the study from women who will speak for themselves.

In a study by Chimaraoke Izugbara (2000: 65), one participant highlighted the importance of female reproductive health saying that “a land without women has no tomorrow.” Therefore, in as much as the role of women is socially and culturally constructed, women are important and therefore their reproductive health is not only important for their wellbeing alone but is beneficial for the entire human race. “For success and sustainability, health policies and interventions must gain from the perspectives and interpretations of both insiders and outsiders” (Izugbara 2000: 63). In keeping with this assertion this study explores how the production and distribution of reproductive health IEC materials by ZNFPC (outsiders) relate to how Chikombedzi females (insiders) receive the communicated messages. The study accomplishes this through listening to the voices of the rural females and professionals involved in the production of the communicating messages.

Poor reproductive health statuses of females have consequences from the individual level to societal level and these

looming consequences would be horrendous, multi-dimensional and multi-sectoral. For instance, the continuous poor reproductive indices of adolescents will multiply health costs, put pressure on available health services, orchestrate untimely deaths, deplete the work force and ultimately limit the productivity of the nation (Iwokwagh *et al.*, 2014: 190).

This highlights the need to improve the reproductive health status of females for developmental purposes.

Whilst reproductive health addresses issues to do with STI prevention and management, harmful practices, unwanted pregnancies, family planning, HIV and AIDS, gender based violence, infertility and cancers, dealing with reproductive health itself needs involves a change in all issues that the reproductive lives of females (SADC, 2008; UNPOPIN, 1994). It is in the interest of this study to find out whether or not there is a relationship between the text/encoded messages and the social, economic and cultural contexts of Chikombedzi.

Zimbabwe is still faced with crucial health issues especially in rural areas and even after 2009⁸, the utilisation of healthcare services is low thereby showing that there are factors influencing its utilisation (Chiremba, 2013; Kevany *et al.*, 2012). The Ministry of Health and Child Welfare- Zimbabwe (MoHCW) (2009: *viii*) posits that young women in Southern Africa are vulnerable to sexual and reproductive health challenges because of “gender imbalances, social norms and values that require girls to remain ignorant of sex and sexuality until they marry.” In Zimbabwe, girls from poor households are the least educated and are likely to get married before they reach the age of 18 (Zimbabwe Youth Council (ZYC), 2014). Socio-cultural norms put a woman’s health at risk if she gives birth to a child “too early, too late or too frequently” (Mahmood *et al.*, 2001: 678).

Rural areas have a much higher incidence of teenage pregnancy as compared to urban areas (Mahmood *et al.*, 2001). Research found out that despite a notable increase in knowledge and positive attitudes, “a significant majority of young women still resort to seeking traditional means of health care, especially among poor rural and uneducated families” (Mahmood *et al.*, 2001: 683). In spite of the increase in knowledge, the question is, from adolescence, does the rural girl child carry that knowledge into womanhood and use it, and what then affects her reception patterns at this stage. This is a knowledge gap worth studying, including the patterns of production and distribution of reproductive health communication messages

⁸ 2009 marked the establishment of the Government of National Unity (GNU) which was meant to improve the economic situation in Zimbabwe.

targeting this crucial population. A Cultural Studies (CS) perspective can help, as will be elaborated in the outline of this study's theoretical (Chapter Three) and methodological (Chapter Four) approach.

Reproductive health communication in Africa

Africa, as a developing continent, is heavily burdened with various challenges and diseases making health communication vital (Haider, 2005; Nwadigwe, 2012). As a way of reaching out to the public and policy makers with health information, health communication has now become important and powerful (Haider, 2005). Public health communication is a process that aims at strengthening the impact of public health initiatives (Bernhardt, 2004; Chasi, 2014). Health challenges in Africa are interwoven with social, political, economic, religious and environmental issues which result in reproductive health problems (Haider, 2005).

Muhiuddin Haider (2005) posits that reproductive health communication has proved to be a challenge in the twenty-first century. The mass media has the power to reach a large number of audiences at the same time but is only effective in creating awareness and not behaviour change (Melkote & Steeves, 2001; Nwadigwe, 2012). In urban Africa, radio and television stations have increased and radio is regarded as the best medium for Africa (Melkote & Steeves, 2001; Myers, 2008). However, the mass media is regarded as having failed to effect change in the African populations' health status (Nwadigwe, 2012).

The important role of the mass media cannot be downplayed though. Soul City Institute of Health and Development Communication (Soul City) (2009: 6) asserts that "for communication to contribute to social change and development in Southern Africa; social change organisations, media specialists, health professionals, civil society and broadcasters must contribute to the development of the continent." Though lowly funded or having small budgets, in countries such as South Africa (SA), HIV communication programmes through the mass media have had positive results (Scalway, 2010). Thomas Scalway's (2010) study argues that if the funding of the communication programmes were increased, the impact and results would increase in turn, however, this is not so. As a result, communication researchers in the African continent argue that the current mass media systems have failed to do justice in addressing Africa's important and urgent developmental needs (Nwadigwe, 2012).

In the Nigerian context for example, Obielozie (2009) argues that;

in the Nigerian context...mass media with their straight news journalism cannot do the tricks. They can create awareness but it requires a different brand of communication to convince the mother to take her child to the clinic for a type of treatment she does not understand (Obiezolezie, 2009: 131).

In addition, the American Cancer Society (2011) postulates that though the burden of breast and cervical cancer is growing in Africa, the response to cancer is still low in Africa. This shows the need for different health organisations and agencies to find ways of bridging the gap between awareness, knowledge and utilisation and behaviour change about reproductive health issues that the mass media is failing to bridge.

Despite the fact that mass media has a wide reach and great influence, its coverage of reproductive health messages in sub-Saharan Africa is not made a priority by media practitioners and therefore remains low even though the continent is in a crisis (Oronje *et al.*, 2011; Soul City, 2009). Following a top-down approach, reproductive health information in the mass media is unidirectional (Nwadigwe, 2012). To compound this is the fact that reproductive health communication via the mass media is not prioritised due to politics and the control and ownership patterns of the mass media (Nwadigwe 2012).

In Zimbabwe for example, state controlled media has the widest reach and coverage but has largely become a tool for political communication and mouthpiece for the ruling political party (Chuma, 2005). Such a scenario can result in the mass media pushing to the periphery crucial agendas such as reproductive health communication. In Africa, reproductive health communication messages carried through different mass media channels are often lost or ineffective due to factors such as language barriers and lack of technology (Nwadigwe, 2012). It is in this perspective that Non-Governmental Organisations (NGOs), international agencies and other organisations employ interpersonal communication channels as useful alternatives to the mass media (Nwadigwe, 2012).

Scholars contend that in order to achieve desired results in health care and status, there is need for effective and efficient means of communication, other than the mass media (Haider, 2005; Nwadigwe, 2012). This then paves way for alternative media. Though Nwadigwe (2012) argues that Theatre for Development (TfD) is the best alternative to mass media in communicating reproductive health, this study acknowledges that TfD has not been widely used in Zimbabwean rural communities in addressing reproductive health issues. Alternative media also includes IEC materials which this particular study focuses on and is interested in

finding out the nature of their production and distribution by ZNFPC in Chikombedzi and how females in Chikombedzi receive them. To illustrate the importance of alternative forms of communication, the MoHCW (2009) argues that though ministries, agencies, NGOs and parastatals such as ZNFPC are taking it upon themselves to promote and improve reproductive health for females, particularly Adolescent Sexual and Reproductive Health (ASRH) services in Zimbabwe, the involvement of the mass media is still low.

Southern Africa HIV and AIDS Information Dissemination (SAfAIDS) (2013) posits that IEC materials are an important part of Behaviour Change Communication (BCC). “BCC has its origins in the dominant medical model of public health and often uses communication to persuade individuals to adopt healthier behaviours and lifestyles” (McKee *et al.* 2014: 278). In explaining its value, the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) (2013: 119) asserts that IEC is a combination of “strategies, approaches and methods that enable individuals, families, different groups and communities to play pivotal roles in achieving, protecting and sustaining their own health.” ZNFPC (1998) explores the role of IEC materials in behaviour change and argues that they target both the individual and the society levels. SAfAIDS (2013: 5) also argues that the primary role of IEC materials is to “promote individual behaviour change, to reinforce a set of behaviours and to help create social change or change within a specific community.” In a bid to analyse the importance of IEC materials this study explores how they are produced and distributed by ZNFPC as well as the attitudes and perceptions of Chikombedzi females towards them.

IAWG (2013: 119) agrees with ZNFPC (1998) in arguing that, “embodied in IEC is the process of learning that empowers people to make decisions, modify behaviours and change social conditions.” In this light IEC not only aims at changing individual perceptions, attitudes and behaviours alone but also to change social conditions and attitudes in line with the positive behaviour. If it can change social conditions then IEC is also involved in social change communication. McKee *et al.*, (2014: 278) argues that social change communication “is influenced by the social sciences’ focus on social determinants or enablers of change” and the principles of social change communication show that Social Behaviour Change Communication (SBCC) is supposed to be empowering so as to encourage communities to be responsible for their own change.

In IEC, the target is to attain a high level of good individual health by creating and increasing awareness and changing attitudes and perceptions (ZNFPC, 1998). Ken Swann, (2015) notes

that achieved through a bottom-up approach in message production, the ultimate success and impact of IEC materials is dependent on the producers of IEC messages and their understanding of their targeted readers. Hence in analysing the production and distribution of IEC by ZNFPC it is important to establish whether the targeted Chikombedzi readers are involved in the production processes. SAfAIDS, (2013) gives different types of IEC materials which include t-shirts, caps, condom wrappers, pamphlets, posters and booklets. However, of interest to this particular study are posters, pamphlets and booklets.

In the production of IEC materials it is crucial that key messages should be “inspiring, memorable, positive, attention-grabbing, clear...taken from practical experience” (SAfAIDS, 2013: 19). However, various scholars have argued that the media messages are not all powerful as the times have moved from the information age to communication, whereby messages are neither encoded nor decoded passively (Nwadiwe, 2012). This therefore dismisses linear communication theories and ushers in theories that view audiences as active participants such as the Encoding/Decoding model (Hall, 2010/1980) and social change communication that acknowledges the influences of community and societal conditions on individual behaviour change (McKee *et al.*, 2014). SAfAIDS, (2013) also argues that organisations should segment their target readers and develop IEC materials targeted at different readers with different needs and also depending on geographical location.

“IEC materials have to be developed through evidence based research and situation analysis of the population and the disease in order to determine target audiences, appropriate health prevention messages and strategies of distributing the materials” (UNICEF, 2006: 1). It is therefore necessary to study how ZNFPC develops and later distributes its IEC messages. The study investigates whether or not ZNFPC female reproductive health messages are reflective of the contextual issues of females in Chikombedzi. In a recent study, Nxumalo (2013) brought to light that in universities, posters and pamphlets act as cues to action.⁹ However, the study did not discuss who produces them, when and how. This omission leaves room for a study that unpacks the intricate details of how the posters and pamphlets are produced. It is important to take into consideration IAWG’s (2013) argument that IEC production and development should take into consideration economic, social, cultural and environmental influences and realities. This is because these aspects play a pivotal role in the encoding and decoding of the IEC materials and the messages they bring.

⁹ One of the six key factors in the adoption of prescribed health behaviours in the Health Belief Model (Rosenstock *et al.*, 1988) and will be explained in Chapter Three.

Unlike Nxumalo's (2013) study location, a learning institution, the uniqueness of this particular study also lies in the fact that its location is in a rural environment with females of varying reproductive ages and different educational levels. Poor and good reproductive health statuses have adverse consequences (World Bank, 2002) and are affected by other higher levels of influences other than the individual. Theoretically, this is in line with the Social Ecology Model of Communication and Health Behaviour (SEMCHB) (Kincaid *et al.*, 2007) (will be discussed in Chapter Three), however, this study seeks to find out and understand whether or not ZNFPC's posters, pamphlets and booklets are distributed and received in a way that helps to improve the reproductive health status of Chikombedzi females.

Production, distribution and reception case studies

Cultural Studies involves the investigation of the creation/encoding and interpretation/decoding of messages (Hall, 1997; Tomaselli, 2012). This also applies to health communication messages. Through a review of case studies of production, distribution and reception of reproductive health messages, this particular study is contextualised.

Soul City (2014) conducted a study whose main objective was to reach mobile and key populations (truck drivers, female sex workers, youth, women and people living around border areas) with HIV prevention and Sexual and Reproductive Health Rights (SRHR) and SBCC interventions in Malawi, Namibia, Zambia and Zimbabwe and analyse their reception patterns. In Zimbabwe, sampled were Beitbridge and Chirundu border areas, though not rural areas. The study sought to find out the attitudes and perceptions of these populations towards materials that had been produced specifically for the campaign. The study explored the general perceptions about the materials produced, how the materials were distributed and received and their impact on the target audience (Soul City, 2014).

The program activities involved the specific development/production and distribution of SRHR pamphlets for the female sex workers, posters for key populations in the areas and audio materials for truck drivers. The posters produced were displayed at border posts, health facilities, hotels, shebeens and other public places (Soul City, 2014). Having used questionnaires as a recruitment strategy, data was collected through in-depth interviews and focus group discussions. The material distribution was done through local organisations, agents, Peer Educators (PE), clinics and hospitals. Though the study found out that the target audience liked the programme materials and considered them as informative, educative and

realistic, the research participants made reference to previously produced materials (Soul City, 2014). The study also found that reception patterns are affected by aspects such as social learning (Bandura, 2000), the line of business/employment and day-to-day life. This present study focuses on a typical rural area, Chikombedzi and seeks to establish the reception patterns of only females in a community whose circumstances may be markedly different from the border areas targeted in the Soul City study.

Nicholas Iwokwagh, Busayo Agbana and Bunmi Agbana (2014) in their study assess the extent of the impact of new communication intervention strategies by the National Agency for Control of AIDS (NACA) in a fight against poor sexual and reproductive health indices in Nigeria. The study focused on how new media communication strategies impact on the transformation of negative attitudes in young people's risky reproductive health behaviour. NACA was established through the National Agency for the Control of HIV and AIDS Act in 2006 and mandated to co-ordinate and plan activities and facilitate the engagement of government and all sectors on issues to do with the prevention, care and support of HIV and AIDS (Iwokwagh *et al.*, 2014). In their study, Iwokwagh *et al.*, (2014) assert that it is important to understand the target audience, the culture surrounding their sexuality, their sources of information and the existing factors which affect their reception of mediated sexual and reproductive health messages.

Through focus group discussions with university students and content analysis of the agency's Facebook page, the findings showed evidence of ignorance of the intervention strategies employed by the agency. The findings also showed low awareness of the organisation and its call centre services and Facebook page. The Nigerian study, in the same way as this current study, focused on intervention strategies employed by a local organisation in a bid to promote and maintain good reproductive health statuses. This current study also employs focus groups as in the Nigerian study although with rural females unlike university students. Where content analysis was used on NACA's Facebook page this study employs semiotic analysis of IEC materials produced by ZNFPC. Furthermore, this study seeks to find out the reception patterns of females who have come across at least one ZNFPC poster, pamphlet or booklet.

Nzokuhle Nxumalo, (2013) investigated the health communication strategies employed by University of KwaZulu-Natal (UKZN) Howard College Campus Health Clinic (HCCHC) and their effectiveness in impacting knowledge, attitudes and practices about Human Papilloma

Virus (HPV), pap smear and cervical cancer in black female students at the college. Through a qualitative methodological approach with data collected through questionnaires and focus groups, the study found out that some respondents had a basic idea of what cervical cancer is, however, most of the participants had never had a pap smear.

The study also revealed that students viewed posters and pamphlets as informative and effective when one is sitting in the clinic's waiting room where they see the materials. However, research participants held the notion that for the posters and pamphlets to be more effective, there was need to strategically place them at different points around the university campus where students can see them other than the clinic. The findings of the research showed that in a university setting, these IEC materials acted as cues to action as respondents took in the mediated messages but only to those who would have visited the clinic. In addition, the clinic pamphlets and posters increased the respondents' level of perceived self-efficacy (this is in line with the Health Belief Model and the Social Cognitive Theory) in the initiation and maintenance of the mediated behaviour change practices (Nxumalo, 2013). Chikombedzi is not only a geographical community but a community bound by cultural, economic and social practices that may have an influence on how females receive reproductive health messages. While this study does not attend to issues of behaviour change, it investigates influencing factors and how the messages are received which may have a knock-on effect on behaviour change.

TfD can be an alternative and complementary medium for communicating reproductive health information in Africa (Nwadiwe, 2012). The purpose of Nwadiwe's, (2012) study was to investigate "the process and impact of reproductive health communication by studying the design and content of messages, the media channels of their delivery and the responses of the target audience" (Nwadiwe, 2012: 106). This points to issues of production, distribution and reception of reproductive health communication via TfD as an alternative to mass media.

Through a multi-methodological approach to data collection, which included the use of interviews, observations and content analysis of a sample of sexual and reproductive health messages, in an urban setting, Nwadiwe's (2012) study found that a gap exists between the content of the messages and the realities of people's living conditions and cultures. According to Nwadiwe's, (2012) findings, the gap between the content of media messages and people's socio-cultural and economic conditions are not addressed in the design and delivery of the messages. Similarly, this present study seeks to investigate whether the

content of ZNFPC produced IEC materials takes into account the socio-cultural and economic conditions of Chikombedzi females.

The study sought to unpack the disadvantages of other forms of alternative media as compared to Tfd. Furthermore, the study also revealed that the vulnerability of females is linked to practices in society and also that though in an urban environment, the cultural practice of female circumcision existed. The study, through content analysis, further discovered that some mass media messages are said on behalf of women, not women speaking for themselves and are failing to convince the target audience to change behaviour. In this view, Nwadiwe (2012) argued that Tfd was the best suitable alternative channel for communicating reproductive health information to urban Nigerian dwellers. While theatre may work for urban dwellers, the same cannot be said about rural populations in Zimbabwe where theatre may be non-existent. Hence this study focuses on how a different alternative communication strategy, IEC, is employed by ZNFPC. Nwadiwe's (2012) findings that female voices are missing in the production process dovetails into part of what this study is about, the production of reproductive health communication messages by ZNFPC.

Soul City, (2009) assesses audience reception of nine locally produced films in nine countries, that is, Botswana, Lesotho, South Africa, Mozambique, Malawi, Zambia, Namibia, Zimbabwe and Swaziland. The film series was titled *Untold: Stories in a time of HIV and AIDS*. As part of a health communication project and through trained professionals, the *Untold* series was developed, produced and distributed via local television in the nine countries. With each film having its own distinct voice, *Untold* tells of issues which were not spoken and unheard of in an African society. Through the use of popular drama, *Untold* brought to light social and reproductive health issues and challenges faced by different people of different ages in Africa. *Untold* aimed at entertaining as well as educating the target audience thereby creating dialogue and debate in matters to do with HIV & AIDS and related issues.

Through purposive sampling in urban, semi-urban, rural areas and mining towns, in-depth interviews and focus group discussions were conducted on the basis of participants having watched at least one film in the series. The study found that reception patterns were positive as the people accepted the messages but were, however, met with resentments due to some scenes in some of the films which were regarded as culturally insensitive (Soul City, 2009).

Not only did the research participants show cross-country identification of issues relating to their own lives, they also showed a need for locally made content as compared to international content (Soul City, 2009). The study also found that the local films helped encourage the respondents to change their attitudes, behaviours and social norms. Furthermore, the study brought to light that people plan to change their behaviour based on what they think other people think (Soul City, 2009). This becomes an important aspect of the mediated behaviour change (Fishbein & Ajzen, 1980, Theory of Reasoned Action). Unlike much past literature, this particular study seeks to establish whether the element of ‘the local’ is incorporated into the production of IEC materials, which in this case are produced by the ZNFPC, and if the materials are culturally sensitive.

With the above studies in mind, this particular study seeks to explore the production, distribution and reception patterns of ZNFPC’s IEC female reproductive health messages in Chikombedzi, a rural area in Masvingo Province. This is in order to understand the production and distribution of messages, perceptions and attitudes of females towards their own reproductive health and what influences them in their interpretation of the messages.

Socio-cultural contexts and female reproductive health communication

“The context or environment of an individual has not always been recognised in the health promotion and communication fields as a significant factor in facilitating change in behaviour” (Nxumalo, 2013: 31). However, following a social ecological perspective such as the SEMCHB (Kincaid *et al.*, 2007) studies have shown that there is an interaction and a level of influence between an individual and their physical and socio-cultural environment (Mathew, 2012; Nxumalo, 2013). In order to understand the key issues in the effective utilisation of services and assessing the gaps in knowledge, it is important to “understand the socio-cultural aspects that affect reproductive health motivations and behaviour” (Mahmood *et al.*, 2001: 677). “Women’s ability to control their fertility and decide whether and when to have children must be examined in the social and cultural context in which their rights are exercised” (Lidia Casas, 2009: 83). This particular study not only seeks to investigate the nature of production and distribution of ZNFPC’s IEC materials in rural Chikombedzi but it also seeks to establish how, if at all, the socio-cultural background and status of females in Chikombedzi have a bearing on how they receive the reproductive health messages.

Abigail Harrison and Elizabeth Montgomery (2001) found that rural South African women’s ability to respond effectively to their health needs is affected by indirect factors that include

poverty and gender inequality. Furthermore, the study found that rural women are often unaware of health risks and health status and are unable to control their reproductive health because of socio-cultural reasons. In relation to maternal concerns, Izugbara, (2000: 68) asserts that “the solution to some of the maternal reproductive health problems can best be found within a framework that recognises local cultures and knowledge systems.” In conducting a CS as this present one, it is possible to establish to what extent socio-cultural issues influence how females in Chikombedzi receive reproductive health messages produced and distributed by ZNFPC. It is possible that the socio-cultural background of these females plays a role in whether they adopt a preferred, negotiated or oppositional reading of the ZNFPC messages (Hall, 2010/1980).

In a study conducted among a Muslim population, Mairiga *et al.*, (2007) found that most research participants held the view that behaviour change organisations did not know how to communicate with individuals or groups from various cultural and religious backgrounds with relation to their norms, values and beliefs. This shows a lack of cultural sensitivity. From an Islamic point of view, the research participants believed that it is necessary for them to contribute in enhancing reproductive health in a community but there is need for cultural sensitivity in communication (Mairiga *et al.*, 2007). Hence this particular study seeks to establish if ZNFPC’s communication of female reproductive health messages respects the social, cultural and religious practices, beliefs, norms and values that exist in Chikombedzi and how such respect or lack thereof influences Chikombedzi females’ reception patterns of the communicated messages.

Cultural practices and factors have an effect on the reproductive health of females especially during reproductive years (Moyo & Muller, 2011). Nolipher Moyo and Julian Muller, (2011) contend that women believe that if they do not follow cultural beliefs and practices, misfortune will befall them. Agus *et al.*, (2012) echo the same observations arguing that traditional beliefs and values are key factors of influence for expecting mothers’ choices of utilising professionally trained midwives or traditional birth attendants. Further emphasising the crucial role of cultural practices, Meka Manchak, (2009) posits that in sub-Saharan Africa, cultural factors and practices play a pivotal role in increasing the rates of cervical cancer in females, especially those in the rural areas, due to practices that include early and polygamous marriages. All of these studies show that rural women’s ability to respond

effectively to their health needs is affected by indirect factors that include poverty and gender inequality and their political economies.

The Ministry of Education, Sports and Culture (MESC) of Zimbabwe, (2007) asserts that traditional beliefs, myths and religion build human culture. Pitout (2007: 285) points out that “religion is an all pervasive cultural influence in many societies.” Therefore, in this particular study, religion falls under culture. Cultural beliefs include the rites of passage that are associated with puberty and marriage (Moyo & Muller, 2011). Factors such as early marriages, taboos and practices result in women being unable to control their own fertility (United Nations Human Rights (UNHR), n.d). The effects of cultural stereotypes and attitudes are felt by females as they are left out in decision making issues even pertaining to their own health (MESC, 2007). This study seeks to understand the extent to which such cultural practices influence the perceptions and attitudes of females in Chikombedzi.

MESC, (2007) posits that the main characteristic of people’s identity is language within which people are able to describe and identify their cultural practices, norms, values and issues. The 2013 Zimbabwean Constitution, Chapter 1 Section 6 recognises 16 official languages in the country. These are Chewa, Chibarwe, English, Kalanga, Koisan, Nambya, Ndau, Ndebele, Shona, Shangani, Sotho, Tonga, Tswana, Venda, Xhosa and sign language (Government of Zimbabwe (GOZ), 2013). Though language can differ, some cultural practices and beliefs can be similar in one way or another, for instance, female and male initiation ceremonies practiced by the Remba and the Shangani ethnic groups in Zimbabwe (Maringira & Sutherland 2010; Shoko, 2009, Shumba, 2014). The issue of language becomes key in this study considering that with such diverse languages and/or cultural differences in the country, there are bound to be differences in how women of different languages and cultures receive ZNFPC female reproductive health communication messages. The question to be answered in this instance is whether or not the issue of language is put into consideration during the production and distribution of reproductive health messages. In particular, this study seeks to establish whether local Chikombedzi languages are considered when ZNFPC IEC materials are produced.

Culture is sustained through the passing of practices from one generation to another (MESC, 2007). However, some of the practices are beneficial to the people involved whilst some are harmful or disadvantageous to groups such as women and girls (ZYC, 2014). It is important to establish the extent to which the perceived harmful cultural practices influence

Chikombedzi females' interpretation of ZNFPC IEC materials. By seeking the voices of the concerned group, that is Chikombedzi females, the study investigates the link between what may be perceived by outsiders as harmful practices and the concerned people's reception of messages aimed at promoting ideal reproductive health practices.

The reason why some of the harmful traditional practices persist in any society is because they are not questioned and as a result become morality and rites (Katsande, 2014). These traditional practices in turn have a strong impact on the reproductive health of the people who practice them. For instance, early marriages result in early pregnancies which may have a negative effect on the health of the girl whose body is not yet ready (ZYC, 2014). Godfrey Maringira and Charlotte Sutherland, (2010) argue that culture directs the will of individuals and ultimately, their behaviour. This study therefore seeks to establish whether and how cultural practices, norms and beliefs influence women and girls in Chikombedzi to accept, oppose or negotiate the mediated messages.

Zimbabwe is a country where traditional socio-cultural practices still persist within various ethnic groups and this has resulted in women's submissiveness and powerlessness, particularly in rural and remote areas (Maringira & Sutherland, 2010; Shoko, 2009). Zimbabwe is a patriarchal society which is "largely characterised by male dominance thereby exposing females to reproductive health problems more than their male counterparts" (MoHCW, 2009: 2). Kambarami, (2006) contends that even in the Shona culture, (one of the majority cultures in Zimbabwe) patriarchy shapes inequalities and also robs the female figure of any form of control over their lives.

As a result, not only do women become powerless but they also become voiceless as everything is dictated to them by males and the society and in the process are objectified and reduced to working and child bearing machines (Maringira & Sutherland, 2010; UNPOPIN, 1994). "Women's perceived submissiveness and powerlessness in sexuality are neither individual characteristics of persona, nor acted out by choice, but rather created by the norms and values of cultural beliefs and values" (Maringira & Sutherland, 2010: 1). Thus, it is possible to find women who cannot make independent decisions or choices but have to consult their husbands, fathers, brothers or other male relatives. This then can influence how they read reproductive health communication messages and this study seeks to establish whether and to what extent this is the case with Chikombedzi females.

The VaRemba people of the Shona-Karanga ethnic group in Mberengwa in the Southern part of Zimbabwe practice what is called the '*Komba*' traditional rites (Shoko, 2009; Shumba, 2014), whilst in the Shangani ethnic group in Chikombedzi in the South Eastern part of Zimbabwe, this rite of passage is known as *Chinamwari* meaning "with the gods" (Maringira & Sutherland, 2010). This is a rite of passage that is intended to usher the girl child into womanhood and this is done at the onset of puberty (Maringira & Sutherland, 2010; Shoko, 2009). For the VaRemba, non-VaRemba women, known as *vashenji* who are married to VaRemba men are also initiated into the Remba traditions and customs (Shoko, 2009).

For the Shangani, age does not matter, the rite of passage is the only thing that matters, thus the right age for sexual activities is socially constructed and therefore the initiation ceremonies authorise all sexual acts for the young girls, regardless of age (Maringira & Sutherland, 2010). However, the Zimbabwean law stipulates that any sexual activity with anyone under the age of 16 is a crime according to the Sexual Offences Act of 2003 (MoHCW, 2009). Whilst the UNFPA report *Marrying too young* indicates that girls living in remote and rural areas are most likely to get married at the age of 18 or below, a ZYC (2014) study revealed that early marriages are a common practice in Chikombedzi (ZYC, 2014). This particular study seeks to investigate if such statistics are taken to mind during production and distribution and also how early marriages influence the reception of ZNFPC's IEC messages.

Traditionally, the initiation period is understood as the stage for reaching out to adolescents and as a result the traditional initiators play a pivotal role in communicating reproductive health messages to the young girls (Moyo & Muller, 2011). The stage of puberty is regarded as an important entry point for reproductive health messages (Moyo & Muller, 2011). For both the VaRemba and the Shangani, the rites are conducted in bush camps in June and July as it is believed that winter wounds such as circumcision or any cuts heal much more quickly and easily and with lesser bleeding compared to other seasons (Shoko, 2009).

Chinamwari and *Komba* initiations have created problems in the educational sector as these rites are held during the second term of the school calendar meaning that the girls do not finish the term and most of them do not return for the third term (Kachere, 2011). The Zimbabwean primary (zero grade to grade seven) and high (form one to six) school calendars are divided into three terms with each term running for three months. This school calendar may have a material effect on the distribution of IEC materials hence this study seeks to

establish if ZNFPC considers such practices in their production and distribution of materials and messages. Furthermore, the study seeks to investigate how; if at all ZNFPC takes into account these practices in producing and distributing IEC materials.

Socio-cultural practices have resulted in major reproductive health issues that include the spread of HIV and AIDS and STIs, early marriages, early pregnancy, school drop outs and polygamy (Kachere, 2011; Katsande, 2014; ZYC, 2014). In most sub-Saharan African countries, early marriages are the social pride of the family (Moyo & Muller, 2011) therefore, after the initiation ceremony, the competition lies in getting married early (Kachere, 2011; Katsande, 2014). However, Shabaya & Konadu-Agyemang, (2004: 396) argue that, “educate a man, and you educate an individual; educate a woman and you educate a whole nation.” Education of the girl child is a fundamental right and is needed for economic and human development but socio-cultural barriers prevent these developments (Shabaya & Konadu-Agyemang, 2004). UNHR, (n.d) argues that in African rural areas, girls get married shortly after puberty and the general expectation is that they start bearing children immediately after the traditional marriage.

The reasons for early marriages are twofold, namely the girls’ virginity and the bride price (UNHR, n.d). This means that the girls then drop out of school in order for them to focus on their new lives and husbands. However, due to issues of age, a young girl might get married when she is not physically and mentally mature and as a result this affects their reproductive health and general well-being (ZYC, 2014). Unlike mothers, fathers in Zimbabwe do not prioritise securing education for their children (Gregson *et al.*, 2005). This means that even if the mother is keen on securing a better education and life for her daughter, she cannot pursue this because of the patriarchal nature of the Zimbabwean society, her lack of decision making power and also her lack of socio-economic independence (Gregson *et al.*, 2005). Other studies have revealed that the most undereducated women in the world are African women (Shabaya & Konadu-Agyemang, 2004). If women in Chikombedzi are illiterate or semi-literate, this could have an influence on how they receive IEC reproductive health communication messages from ZNFPC hence in seeking to establish reception patterns issues of literacy may come in.

ZYC (2014), in their study in Chikombedzi, Neshuro, Ngundu, Hwange, Lukosi, Uzumba and Mudzi found that early marriages are a common harmful practice in these areas thereby emotionally, psychologically and physically abusing the victims. ZYC defines harmful social

and cultural practices as “all behaviour, attitudes and/or practices which negatively affect the fundamental rights of women and girls as their right to life, health, dignity, education and physical integrity.” (ZYC, 2014: 1). While the negative impact of early marriages can never be overstated, it is necessary to investigate how, if they do have an influence on the reception patterns of females in Chikombedzi to ZNFPC reproductive health messages. These case studies are examples of how woman in rural areas live and it is thus important for this research to understand how messages are formulated by organisations attempting to implement social change and how the locals receive the organisation’s messages.

Zimbabwe’s socio-economic status and health care utilisation

Socio-economic problems are also the reason behind female reproductive health challenges faced by Zimbabwean women (Chiremba, 2013; Kevany *et al.*, 2012). During the colonial period, the healthcare delivery system was mainly based in the urban areas, especially in the big cities as black African women were sceptical of modern healthcare facilities and were the last resort for health services (Turshen, 2000; Zinanga, 1992). In then Rhodesia (before 1980), both black men and women viewed reproductive health messages and information, particularly family planning and contraceptives with resentment and saw it as a way of trying to eradicate the black population (Zinanga, 1992). This resulted in the Family Planning Association of Rhodesia (FPAR) (later known as ZNFPC after independence in 1980) and the government’s unsuccessful reproductive health interventions, more especially in the rural areas (Zinanga, 1992). Therefore, the reception of the reproductive health messages was poor and the utilisation of these health services remained low (Zinanga, 1992).

Recent reports have revealed that even today, some Zimbabwean government officials and politicians still view family planning as a method used by powerful nations to push the black race into extinction and resulting in poor economies. The Zimbabwean Registrar-General, Tobaiwa Mudede, in 2014 urged government to ban contraceptives as they cause cancers and deaths of productive females (Mangudhla & Mushava, 2014). The state-controlled daily newspaper, *The Herald* of 14 October (2015) reported the then ZANU-PF¹⁰ National Political Commissar supporting Mudede against family planning and contraceptive use and encouraging population growth as a way of fostering the country’s economy. Such utterances from senior political and government figures could play a role in how ZNFPC’s family planning and contraceptive messages are interpreted by females in places like Chikombedzi.

¹⁰ ZANU-PF is Zimbabwe’s ruling political party.

“The interaction among health, behaviour and communication is heavily influenced by the socio-economic circumstances of targeted individuals, groups or communities” (Haider, 2005: xxviii). Women’s health and use of health services is “intertwined with a heavy burden of work, harsh environmental conditions and oppressive poverty” (Reproductive Health Matters, 1995: 170). Many rural areas in Africa are characterised by fewer healthcare facilities and trained professionals as compared to urban areas (UNHR, n.d). This is so in the Zimbabwean context due to rural areas not being prioritised and also because of the economic challenges that Zimbabwe is facing (Murisa, 2010). This affects the utilisation of healthcare services by the rural folks. To be considered also in the rural setting is the distance between healthcare facilities and the people’s residences.

Traditional midwives have become popular among women in Chikomedzi because of the long distance to the hospital (*The Standard*, 2011). In the event that the nearest hospital or clinic is situated kilometres away, issues of income and the availability of ready cash come into play in terms of accessing transport to and from the facility. The fact that women are not economically independent of males puts them at a disadvantage as “the balance of power will be on the side of that partner who contributes greater resources to the marriage” (Blood & Wolfe, 1960: 12). This lack of economic independence can be due to socio-cultural imperatives such as early marriages, school drop outs and the son preference practice which denies the girl child good health, recreation, the right to select her own partner, education and economic opportunities (UNHR, n.d).

Just after Zimbabwe attained its independence in 1980, the new government made sure that “primary health and education were offered for free and this led to the significant improvement in literacy levels and health standards” of the general populace (Murisa, 2010: 5). Tendai Murisa, (2010: 3) argues that by 1990, Zimbabwe had “achieved impressive results in the area of primary health care and education for all and had become the envy of many other post-colonial states.” However, because of economic constraints and low government revenue, this scenario did not last long, as Murisa, (2010: 5) asserts “the immediate social outcomes from the ESAP¹¹ were a decline in social service delivery due to the introduction of user fees at health centres and school fees in an environment of declining employment.” This means that the number of people who were able to access health services and education greatly decreased due to financial problems.

¹¹ Economic Structural Adjustment Programme.

In Zimbabwe, after 2000, because of economic challenges, not only were the healthcare services in the country deteriorating but there was also a limited access to these services (Murisa, 2010). As a result, “there is evidence that many Zimbabwean women were opting to give birth without professional attendants despite the obvious danger” (Murisa, 2010: 6). In all health centres, expecting mothers were required to bring their own items such as gloves and other necessities that would be used when delivering the baby and because of economic constraints, some women opted not to seek professional medical attention (Murisa, 2010).

Even after 2009, healthcare service utilisation in Zimbabwe remained low despite the availability of services in health centres (Chiremba, 2013). These studies (Chiremba, 2013; Murisa, 2010) have brought to light that individual socio-economic challenges of females and the national economic challenges both affect the other in turn despite service delivery being favourable (Kevany *et al.*, 2012). Casas, (2009: 83) posits that “if economic constraints are at the core of a decision not to have children, for example, no real choice exists as economic determinants impair and limit ‘choice’.” In view of these economic challenges both at household and national level it is important to establish how females of rural Chikombedzi negotiate them in their reception of ZNFPC reproductive health messages.

Whilst Mazvita Machinga, (2011) posits that Zimbabwe has a three tier health system; traditional healers, church prophets and modern health facilities, MESC, (2007) contends that Zimbabwe has a traditional and modern health care system only. Machinga, (2011) further asserts that in Zimbabwe, religious beliefs and values play a pivotal role in the health care delivery systems. The existence of other health care systems other than the modern health care facilities affects the utilisation of modern health care services and the reception of the messages pertaining to the services (Machinga, 2011; MESC, 2007). How this multi-sectoral approach to health care may influence females of Chikombezi’s reception of ZNFPC’s IEC materials can be discovered through a CS approach as employed by this study.

Zimbabwe’s economic situation affects females’ access to reproductive health services which in turn affects economic aspects at community and societal levels (Grown *et al.*, 2005). In this view, the UNPOPIN, (1994) asserts that the highest possible level of health is both a fundamental right and a need for socio-economic development and cannot be achieved by passive and unhealthy people. These socio-economic difficulties can lead to lack of education which affects the reproductive health status of females and the control over their own health and lives (UNPOPIN, 1994).

Izugbara, (2000: 67) contends that “other studies have shown that women who attain high levels of education are likely to be more favourably disposed to understanding health issues and using appropriate treatment alternative.” Shabaya and Konadu-Agyemang, (2004: 398) argue that “education can influence fertility by changing perceptions of the costs and benefits of having children, postponing the time of marriage and helping shaping attitudes to contraception.” In simple, the education of females tends to help reduce fertility which in turn results in the reduction of the population growth rate (Shabaya & Konadu-Agyemang, 2004). It can be argued that women and girls in Chikombedzi are not highly educated therefore it worth investigating how their levels of education possibly affect how they receive reproductive health messages.

Conclusion

The available body of knowledge makes important arguments and observations and gives evidence showing that the reproductive health of women and girls in sub-Saharan Africa is low. However, no other study has explored ZNFPC’s female reproductive health communication messages and also only a few have attempted to employ a cultural approach to finding the perceptions, attitudes and views of women on reproductive health issues and also paying attention to issues of production and distribution of the messages. Though reports have noted a rise in new STI infections in Masvingo Province and mostly in women, none have explored the reception of IEC messages by rural women in Chikombedzi in relation to such statistics.

This knowledge gap is worth studying, including the production and distribution of the reproductive IEC messages from a CS approach and health perspective as will be elaborated upon in the outline in the study’s theoretical underpinnings, in Chapter Three. The theoretical framework rationalises the data collected for the study.

CHAPTER THREE

THEORETICAL FRAMEWORK

Introduction

Chapter Two, discussed literature relevant to female reproductive health communication and utilisation of health services in Africa and particularly in Zimbabwe. Various arguments helped to locate this current study. The chapter highlighted that although the mass media in Africa has great potential to effect behaviour change, there are several factors that limit its effectiveness including ownership and control patterns. Therefore there is a need for alternative communication strategies such as Information, Education and Communication (IEC) materials in the form of posters, pamphlets and booklets in bridging the communication and behaviour change gap in female reproductive health. Whilst Chapter Two illustrates the socio-cultural, socio-economic and reproductive health practices and dynamics of women in the rural area of Chikombedzi, and highlights the importance of Zimbabwe National Family Planning Council's (ZNFPC) IEC materials as an alternative to mass media, Chapter Three presents the theoretical framework that informs the study.

This study employs theories from a Cultural Studies (CS) and a health communication perspective. Drawing from one theoretical perspective in exploring the relationship between the production and distribution of public health communication, in particular female reproductive health messages and interpretations of readers does not do justice to the research aims and objectives and adequately form a theoretical ground in exploring this complex relationship. This research is grounded in CS which in response to the Frankfurt School that viewed the media as all powerful, propounded that media audience are active participants in the meaning making process (Hall, 2010/1980; Tomaselli 2012; Tomaselli & Mboti, 2013; Turner, 1996). The specific theories/models that underpin this study are Stuart Hall's Encoding/Decoding model (2010/1980) and the Circuit of Culture model (Du Gay *et al.*, 1997). From a health perspective, the study employs the Social Ecology Model of Communication and Health Behaviour (SEMCHB) (Kincaid *et al.*, 2007) and its associated theories in explaining the different levels of influences on behaviour and social change.

Cultural Studies (CS) Approach

CS is focuses on the everyday way of life such as how people see themselves in relation with others and everyday activities (Turner, 1996) and therefore "aspires to join- to engage- in the

world” (Tomaselli & Mboti, 2013: 3). CS, as discussed in Chapter One, is a set of theories and methodologies that are used in a number of disciplines (Tomaselli, 2012; Tomaselli & Mboti, 2013; Turner, 1996). As a result, CS “has enabled us to understand phenomena and relationships that were not accessible through the existing disciplines” and is therefore an interdisciplinary field (Turner, 1996: 12). In this study, CS is applied in the field of public health communication focusing on female reproductive health communication in the rural area of Chikombedzi in Zimbabwe.

CS is mainly centred on the arguments/debates around, “1) the claim that culture (and hence Cultural Studies) has strong political force; 2) the determining power of economic structures on cultural formations; and 3) the debate over the role that individual experiences should play in analysis” (During, 2005: 38). A CS approach is thus relevant to this particular study as it investigates how ZNFPC’s female reproductive health IEC materials are produced, distributed and interpreted by Chikombedzi females. CS and its concomitant analyses such as semiotics and models such as the Encoding/Decoding (Hall, 2010/1980) and the Circuit of Culture (Du Gay *et al.*, 1997) are not “evidence of the who, where and what of reality” (Van Leeuwen & Jewitt, 2001: 5) but focus on how meaning is made and attached by the producers of texts and re-constructed by readers during the meaning making process (Tomaselli, 1996). In keeping with this assertion, this study focuses on how ZNFPC ideologically package their reproductive health messages and how they are re-constructed by females of Chikombedzi.

Graeme Turner (1996) explains that CS started with the publication of Richard Hoggart’s *The Uses of Literacy* (1958) and Raymond Williams’ *Culture and Society 1780- 1950* (1958) and *The Long Revolution* (1961). However, the original structuralist CS approach focused on language and not on culture (Tomaselli, 2012; Turner, 1996). Bringing matters closer to Southern Africa, Keyan Tomaselli (2012: 22) contends that CS in South Africa and in particular the Centre of Communication, Media and Society (CCMS) has “shifted its focus from ‘pure’ CS analysis of ‘texts’ towards a concern with the actual production and circulation of media and their messages.” The moments of production and distribution of messages, alongside reception, are the focus of this particular study.

In Africa, CS is “first and foremost a lived practice, before it is a discipline” (Tomaselli & Mboti, 2013: 1). Keyan Tomaselli and Nyasha Mboti (2013: 5- 6) posit that through his work, Ngugi wa Thiong’o contends that “the roots of post colonial CS in Africa actually begin with the European carving up Africa.” Tomaselli and Mboti (2013) talk of ‘doing’ CS, referring to

conducting researches in CS (Tomaselli & Mboti, 2013). This particular study conducts empirical research in the field (ZNFPC's organisational offices and in the rural area of Chikombedzi) thereby applying or 'doing' CS in the public health communication field. From a CS approach, this study employs the Circuit of Culture model (Du Gay *et al.*, 1997) and the Encoding/Decoding model (Hall, 2010/1980) in conjunction with the SEMCHB (Kincaid *et al.*, 2007) from a health perspective in order to theoretically place the study and rationalise its findings.

As "CS breathes the oxygen of texts" (Tomaselli & Mboti, 2013: 2), it considers two types of texts; the inactive and activated texts (Tomaselli, 1996). Inactive texts refer to the media text as a product and the activated texts are those "created both by their producers and by their audiences" (Tomaselli, 1996: 33). Simply expressed, the activated texts relate to meanings attached to the texts during the production process and the meanings or interpretations that readers make. This notion therefore argues that readers are active participants in the communication process. Therefore, CS argues that readers are not passive recipients of media texts but make their own meanings, and this might not be the preferred meaning attached by the producers. This study subscribes to the view of the activated text and aims at exploring the production, distribution and reception of meaning and the possible existing interpretation differences.

The text-centred perspective in analysing only the media texts neglects the questions of production, distribution and consumption of these media texts by active audiences (Ferguson & Golding, 1997). This particular study therefore seeks to study both the production and distribution of ZNFPC's female reproductive health IEC materials as well as the reception of the messages by rural females, in Chikombedzi. Therefore from the CS perspective, this study acknowledges that there is a relationship between media texts and the world in the meaning making process. As a result, the researcher embarks on describing the relationship between texts and the world (Ferguson & Golding, 1997) as this study's theoretical underpinnings from a culture-centred approach employed in CS and health perspective (Dutta, 2008). "The culture-centred approach seeks to introduce the voice of local communities into the ways in which issues of health are understood, interpreted and communicated" (Dutta, 2008: 60).

Encoding/Decoding Model

Stuart Hall's Encoding/Decoding model (2010/1980) is viewed as the most important contribution to audience research in CS (Hagen & Wasko, 2000; Mathew, 2012). The model was first published in 1973 as "*The Encoding and Decoding in Television Discourse*" and in 1980 Hall developed it as a model of explaining the possible interpretations that can be attached to a text (Hall, 2010/1980: 44). The model moved from linear communication theories (Hagen & Wasko, 2000) and insists that meaning making is both actively constructed and socially structured (Hall, 2010/1980).

Hall (2010/1980: 44) rejected "the linearity and textual determinism of previous models since they did not account for different interpretations of the same message by different audiences." In the model, reception is "framed by structures of understanding, as well as being produced by social and economic relations, which shape (their) 'realisation' at the reception end of the chain and which permit the meanings signified in the discourse to be transposed into practice or consciousness" (Nightingale & Ross, 2003: 54). As a result, through the model, Hall suggests that the media message is not all powerful but rather meanings are actively attached to a text during both encoding and decoding of the text. Scholars (Leve, 2012; Nightingale, 1996) have argued that the model is semiological and can be taken or understood as a guide to a 'meaning-centred semiotic study.' As will be discussed in Chapter Four, this study employs semiotic analysis in analysing the collected data.

Hall's (2010/1980) model proposes that both message production and audience interpretation relate to discourse because they are cultural processes. Hall (1997) argues that in the meaning making process, the reader is as important as the writer or producer of the text. Tomaselli (1996: 32) argues that in encoding and decoding, the text "or interpretant is the meaning generated in the mind of the person/viewer/listener/reader who decodes the sign or message." Borrowing from Tomaselli's work, this study views the text in a semiotic view or sense of "the mental reconstruction of the idea, the thought, the associations, the image mentally generated, by the act of reading, decoding or interpreting" (Tomaselli, 1996: 32).

Tomaselli (1996: 33) further argues that the concept of text can be understood as a product (ZNFPC's posters, pamphlets and booklets) as well as "the interaction between the reader/viewer/listener and signs encoded in the message" thus the interaction between the females of Chikombedzi who are the readers and the signs encoded during production.

According to Halls' model, the main focus should be on the entire communication process, and not one aspect, starting from the initial stages of production of the message up until when the audience is exposed to the message and they interpret it (Pitout, 2007). This approach is adopted in this study which analyses the production and distribution of reproductive health messages, as well as the reception patterns as females of Chikomedzi interact with the messages.

According to Hall's theoretical model, the communication process has three related levels or stages and these are production, distribution and consumption (Mathew, 2012). In light of the sender-message-receiver model (Shannon and Weaver, 1949), Hall saw it possible to "think of this process in terms of a structure produced and sustained through the articulation of linked but distinctive moments- production, circulation, distribution" (Nightingale, 1996: 27). These distinctive moments form the core of this study in relation to female reproductive health communication, as will be more fully discussed in the section below on the Circuit of Culture (Du Gay *et al.*, 1997).

"The production, distribution and consumption of discursively constructed semiotic and linguistic texts represent a two way circuit of communication where audiences are active participants in the negotiation of meaning" (Mathew, 2012: 52). This serves to show that in the communication process, the readers are not passive and this may result in them interpreting the mediated message differently "as every act of decoding is another encoding/decoding/encoding ad infinitum" (Tomaselli 1996: 32). The existence of various factors of influence to one's interpretation can be explained through the SEMCHB model (Kincaid *et al.*, 2007) that will be discussed later in this chapter.

Hall's Encoding/Decoding model is useful in identifying the encoding process with issues of textual production and distribution of ZNFPC's posters, pamphlets and booklets. The decoding part of the model explores the dominant and/or negotiated and/or oppositional readings of mediated female reproductive health messages (audience interpretation). From a behaviour and social change perspective, John Storey (1999) also seeks to explain how audiences attach meaning and interpret messages presented to them through Hall's (1980) model. For Magriet Pitout (2007) the model is unique in that the preferred meaning or dominant ideology cannot be forced or imposed on the readers. Therefore, the readers stand to make their own meanings due to various influences that can be explained through the SEMCHB (Kincaid *et al.*, 2007).

Texts are polysemic as different meanings can be attached to them suggesting that there is no prescribed/definite relation the encoded and decoded meanings since the encoders cannot impose meaning on readers (Hall, 2010; Pitout, 2007). The three possible readings; dominant, negotiated and oppositional, can only be reached when the reader understands the mediated message. The dominant or preferred reading is reached when the readers accept the message that the producers have encoded as it is. The negotiated reading is reached after the readers try and decide whether or not to accept the dominant reading and as a result may adjust the preferred meaning to suit what they want and need (Pitout, 2007). In this reading, readers tend to agree with the dominant ideology but “reserve the right to modify their views in accordance with the needs of their social situation” (Pitout, 2007: 282). With regards to the oppositional reading, though they understand the preferred reading, the readers reject the message. “They intentionally decode or deconstruct it in a contrary or subversive manner” (Pitout, 2007: 282).

The production process or the encoding stage characterised with underlying meanings and ideas throughout as the message is constructed (Nightingale & Ross, 2003). This is the moment in which meanings are attached to the ZNFPC poster, pamphlet or booklet because they have a certain female reproductive health message they want to convey. Justin Wren-Lewis (1985: 180) contends that encoding is viewed by Hall as a “specific form of cultural production in a world of culturally produced significations.”

The message production is also affected by matters such as “knowledge-in-use, the routines of production, historically defined technical skills, professional ideologies, institutional knowledge, definitions, assumptions about the audience” (Nightingale & Ross, 2003: 53). Drawing from these arguments, the production of ZNFPC’s IEC materials is the moment in which the dominant ideology or meaning of the female reproductive health message is attached. This is done through skilled and knowledgeable personnel. It is in the interest of this study to investigate how meaning is attached in ZNFPC’s IEC materials through looking at their culture of production (Du Gay *et al.*, 1997) and representations used in the IEC materials collected during archival research.

In light of the model, culture is regarded as a site of struggle between the dominant/powerful and those who are the minorities/powerless (Pitout, 2007). Different meanings of the same mediated messages can be reached due to different social and cultural situations (Hall, 2010/1980). Hall, (2010/1980: 45) further argues that “how media texts are decoded depends

not only, or even primarily on the content of the message itself. It is also shaped by the social positioning of the receiver and the various codes and experiences they have access to and draw from as a result.” Both the encoded and decoded meanings are affected by various signs and symbols (Nightingale, 1996). It is in this light, that a media text is met by individuals who are already socially and culturally informed and are therefore not passive recipients of the media messages. The Chikombedzi community has its own different cultural practices pertaining to female reproductive health (Machinga, 2011; Maringira & Sutherland, 2010; Shoko, 2009). This study aims to establish how the social and cultural formations of Chikombedzi ‘colour’ the females’ attitudes and perceptions towards ZNFPC produced reproductive health messages.

Borrowing from the work of Ferdinand De Saussure on semiotics, Wren-Lewis (1985: 179) argues that “encoding is a signifying practice selecting and interpreting a whole world of signifiers, while decoding negotiates with an exclusively televisual object.” Hall (1997: 16) argues that ‘language is a system of signs’ and the “sign is a central fact of language.” A sign is made up of the signifier and the signified (Berger, 2004). In any cultural context or setting, every signifier given or encoded by the producer has to be meaningful so that the recipients can meaningfully decode the message (Hall, 1997; Wren-Lewis, 1985). This means that the signs used in the message should be ones that both the producers and readers are familiar with so that the message is decoded meaningfully or the message would be lost (Hall, 1997). In producing and distributing IEC messages ZNFPC encodes signifiers which can only make sense if the target population, in this case females of Chikombedzi, understand them. If they understand them then the signified becomes clear and the sign is complete. Thus it is the sign that Chikombedzi females make sense of in different ways which the study seeks to unpack.

The model presents communication as a process that happens between an individual and the text and also as open to external influences from social networks and community (Nightingale, 1996). Culture is seen through socially ascribed roles within any given society (Dutta, 2008; Nightingale 1996). From a health perspective, this particular study employs the SEMCHB in its discussion of the different levels of influence on individual attitudes and perceptions of ZNFPC’s IEC communication interpretation, and in total, the women’s reception of the messages. Expressed simply, the SEMCHB, in this study, picks up from where the Encoding/Decoding model would have left off, as it presents certain indicators of influence at different levels that may affect an individual’s interpretation.

Circuit of Culture Model

Traditionally, culture has been viewed as rather ‘superficial’ and ‘ephemeral’ because “cultural processes dealt with seemingly less tangible things- signs, images, language, beliefs- they were often assumed, particularly by Marxist theories, to be ‘super structural’” (Du Gay *et al.*, 1997: 1- 2). However, as of late, culture is viewed differently. Paul Du Gay *et al.*, (1997) suggest that culture is regarded as “being as constitutive of the social world as economic or political processes” (Du Gay *et al.*, 1997: 2). Hall (1997) posits that language works through representation and that language makes use of signs and symbols which can include written words and images produced electronically. For Hall (1997) culture is concerned with meanings that are shared within a specific group or context and is a result of representation and therefore an important moment in the Circuit of Culture. Representations impact on how readers decode mediated messages.

The Circuit of Culture was refined as a cultural analysis instrument in the late 1990s by British cultural studies theorists (Leve, 2012). The Circuit of Culture has five major processes and these are; production, representation, regulation, identity and consumption. “The five interrelated processes implicated in the production and circulation of meaning through language thereby form a useful framework to consider cultural meanings of commodities holistically” (Leve, 2012: 4). In this study, the interrelated processes of the Circuit of Culture form the basis to explain how meanings are attached to ZNFPC’s female reproductive health IEC materials during production and circulation of messages. The circuit neither has a beginning nor an end (Curtin & Gaither, 2007; Du Gay *et al.*, 1997). For Du Gay *et al.*, (1997) in studying cultural texts, every text should pass through the circuit (Du Gay *et al.*, 1997). Fig. 3.1 below is an illustration of the model.

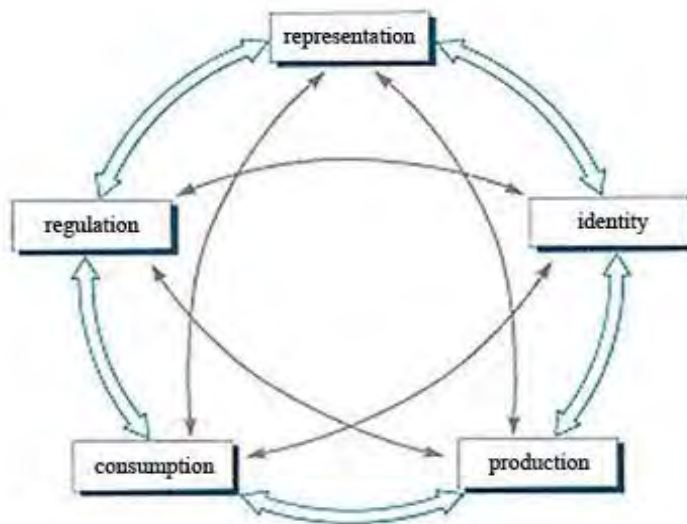


Fig. 3.1 The Circuit of Culture (Du Gay *et al.*, 1997: 3).

This present study concentrates on the stages of production, representation and consumption as it seeks to establish how ZNFPC produces and distributes its female reproductive health IEC materials in Chikombedzi and how the female readers interpret the messages during consumption. Based on the idea that people are always taking part in producing and reproducing culture (Lang & Zobl, n.d), this study uses the Circuit of Culture to investigate how meanings to ZNFPC’s IEC materials are attached by both ZNFPC (during production) and the female readers (during consumption). As such, these representations will be analysed in relation to the Chikombedzi cultural, social and economic contexts.

Du Gay *et al.*, (1997) contend that meaning is actively made during both production and consumption. This study acknowledges that in as much as ZNFPC professionals are active in attaching meaning to IEC messages, so are the female readers of Chikombedzi. It is these readings that this study investigates. In their study of the Walkman, Du Gay *et al.*, (1997) make use of the first poster of the Walkman that was produced for the Tokyo launch and was written in Japanese. Though some were unable to read Japanese, meaning could be attached if the reader knew about the walkman and meaning would therefore be deduced from the image used (Du Gay *et al.*, 1997). This highlights the importance of shared meanings in production and consumption.

As meanings bridge the gap between “the material world and the ‘world’ in which language, thinking and communication take place- the ‘symbolic world’,” belonging to a culture helps to provide a group of people with a shared framework used in communicating (Du Gay *et al.*,

1997: 10). As a result, when faced with media texts, the females of Chikombedzi read and interpret messages within their own cultural frameworks and stand to map their own meanings and interpretations which might be different from the inscribed or preferred meaning (Hall, 2010/1980).

At the production stage, the message is constructed and the preferred reading is attached (Nightingale & Ross, 2003). According to the Circuit of Culture, the stage of production involves two aspects, firstly, the culture of production in terms of the organisation that is producing the text and secondly and most importantly, the production of the message itself (Du Gay *et al.*, 1997). The culture of production focuses on production aspects in relation to the organisation (Curtin & Gaither, 2007; Du Gay *et al.*, 1997). These include issues such as the availability of technology, the department involved, and funds, (Leve, 2012; Curtin & Gaither, 2007; Du Gay *et al.*, 1997) and in the case of this particular study, research as well, since IEC material production has to be research based (Swan, 2015; ZNFPC, 1998). ZNFPC organisational practices in the production and distribution of IEC messages (culture of production) will be brought to the fore in this study.

In the Circuit of Culture, the moment of production “outlines the process by which creators of cultural products imbue them with meaning, a process often called encoding” (Curtin & Gaither, 2007: 39). This means that the production stage is when meaning is ascribed or encoded by the media producers and this meaning is what Hall, (2010/1980) calls the dominant ideology or preferred reading. At this moment, it is important for the producers of the message to put into consideration factors such as cultural meanings, values and norms (Leve, 2012). It is of crucial value to this study to establish the dominant ideology or preferred reading that ZNFPC professionals attach to the IEC materials. The preferred reading will be derived from the ZNFPC posters, pamphlets and booklets collected during archival research and supplemented by interviews of ZNFPC employees.

The moment of representation is a key moment in the Circuit of Culture approach and is of importance to this study. Representation “is the form an object takes and the meanings encoded in that form” (Curtin & Gaither, 2007: 40). Representation produces culture (Hall, 1997). When a cultural product is produced, it is produced with specific audiences in mind and conveys certain messages and meanings through how it is presented (Curtin & Gaither, 2007; Du Gay *et al.*, 1997; Hall, 1997). In relation to this study, the cultural products are ZNFPC’s posters, pamphlets and booklets. Curtin and Gaither, (2007: 40) argue that, “the

method of distribution communicates an intended meaning.” Distribution patterns carry meanings in themselves and also further help to reinforce the intended meaning. In relation to this study, distribution strategies have an effect too on how the readers decode the messages carried by the cultural artefact, IEC materials. For instance, IEC materials distributed by people who are not respected in local communities can induce oppositional readings.

Language operates as a representational system (Hall, 1997). The moment of representation is of importance to this study as it explores how certain ‘representational systems’ such as language and images are used in communicating certain reproductive health messages distributed by ZNFPC. The study further establishes how the females of Chikombedzi view the messages as a representation of their situations and how they make meaning of these representations.

Du Gay *et al.*, (1997: 85) argue that consumption “lies at the heart of conducting a cultural studies.” Consumption refers to how the readers adopt the mediated message (Curtin & Gaither, 2007; Leve, 2012) and associated with “the satisfaction of needs and wants” (Du Gay *et al.*, 1997: 86). Consumption in this study can relate to Chikombedzi female participants reading and possibly adopting, negotiating or opposing (Hall, 2010/1980) the mediated message resulting in behaviour change. However, this study is concerned with interpretation or rather, meaning making of the messages by the readers and not necessarily, behaviour change in itself and what the messages are geared for. Leve (2012: 8) argues that consumption should not be regarded as the end of the circuit but as the beginning of another as “consumption plays a role in constructing identities” since “consumption in itself becomes a form of production as new meanings accrue” (Curtin & Gaither, 2007: 41).

In this study, identity formation would refer to how female reproductive health comes to ‘mean’ and ‘relate’ to the females of Chikombedzi (Leve, 2012). This is achieved through investigating how ZNFPC packages and represents female reproductive health in its posters, pamphlets and booklets. Regulation refers to how the text is controlled (Leve, 2012; Du Gay *et al.*, 1997). In this study regulation will mostly refer to ZNFPC’s institutional systems and Chikombedzi cultural norms, values and expectations which might stand as influences in the meaning making process. Market or target audiences control themselves (Leve, 2012) and in the regulation moment, “meanings arise governing what’s acceptable, what’s correct...what’s allowed in a culture is determined by groups with economic or political power in a given

situation” (Curtin & Gaither, 2007: 38). Though these two moments in the circuit are as important as the other three, this study, however, does not pay particular attention to them.

These views critically explain this study’s focus; the production, distribution and reception of ZNFPC’s IEC materials in rural Chikombedzi. Through investigating the moments of production, representation and consumption, the Circuit of Culture (Du Gay *et al.*, 1997) informs my study in that it has also guided the formulations of the study’s main research questions and as a methodological guide. The model also guides the analysis of the ZNFPC’s messages, paying particular attention to representations used in the IEC materials, in the form of language and images encoded and decoded.

CS and public health communication

The CS approach can also be applied in public health communication and in the case of this study, female reproductive health communication. Public health perspectives are premised on the idea that all human beings are faced with death; however, it is the role of public health communication to ensure that individuals take responsibility for their own health (Chasi, 2014). As highlighted in Chapter Two, the health communication field has developed to take cognisance of Social Change Communication strategies (SCC), rather than simply the individually-based behaviour change communication strategies (McKee *et al.*, 2014; Storey & Figueroa, 2012; Scalway, 2010).

Part of the SCC is the SEMCHB (Kincaid *et al.*, 2007), that also informs this study. In as much as CS theories (Encoding/Decoding model and the Circuit of Culture) posit that both the producers and readers are active participants in the meaning making process, they do not focus on influencing factors. The SEMCHB acknowledges higher levels of influence pertaining to behaviour change and therefore, individual interpretations and behaviour change do not take place in a vacuum. From a health perspective, the SEMCHB is a meta-theory (Storey & Figueroa, 2012) that acknowledges different ascending levels of influence on individual readings and behaviour and can therefore be employed together with CS theories.

In summary, the communication channels in which the messages are encoded refer to posters, pamphlets and booklets used by ZNFPC to communicate with the rural females of Chikombedzi. In the light of the Encoding/Decoding model, the ‘distinctive moments’ of production, distribution, consumption “involve transformation and translation” of a ZNFPC poster, pamphlet or booklet message “into ideas and opinions” as meaning is constructed and

attached at these stages (Nightingale, 1996: 29). This study therefore seeks to establish the preferred meaning of these IEC materials attached during production. After having deduced the preferred meaning of these mediated messages from the IEC materials collected during archival research, the study further investigates which readings are held by Chikombedzi females. Out of the three readings; preferred/dominant, negotiated and oppositional reading suggested by Hall's model, the study seeks to bring to light which of these three readings these females hold and the interconnected influences surrounding their readings (Kincaid *et al.*, 2007).

Social Ecology Model of Communication and Health Behaviour (SEMCHB)

From a health perspective, my study employs the SEMCHB (Kincaid *et al.*, 2007) which also worked as a theoretical approach to data collection. The SEMCHB “describes the complexity, interrelatedness and wholeness of the components of a complex adaptive system, rather than just particular components in isolation from the system” (Storey & Figueroa, 2012: 76). The model, acknowledges that change or meaning making does not happen in isolation or in a vacuum (McKee *et al.*, 2014), but “within a framework of various factors such as the individual, the community and society” (Durden & Govender 2012: xxi). Individual, social networks, community and society are the four ascending levels of the SEMCHB (Storey & Figueroa, 2012). The model also explains the approaches in communication that should be taken at each different level so as to foster the adaptation of behaviour (Mathew, 2012). This particular study, however, focuses on female reproductive health communication targeted at the individual level. Below, Fig. 3.2 is an illustration of the model.

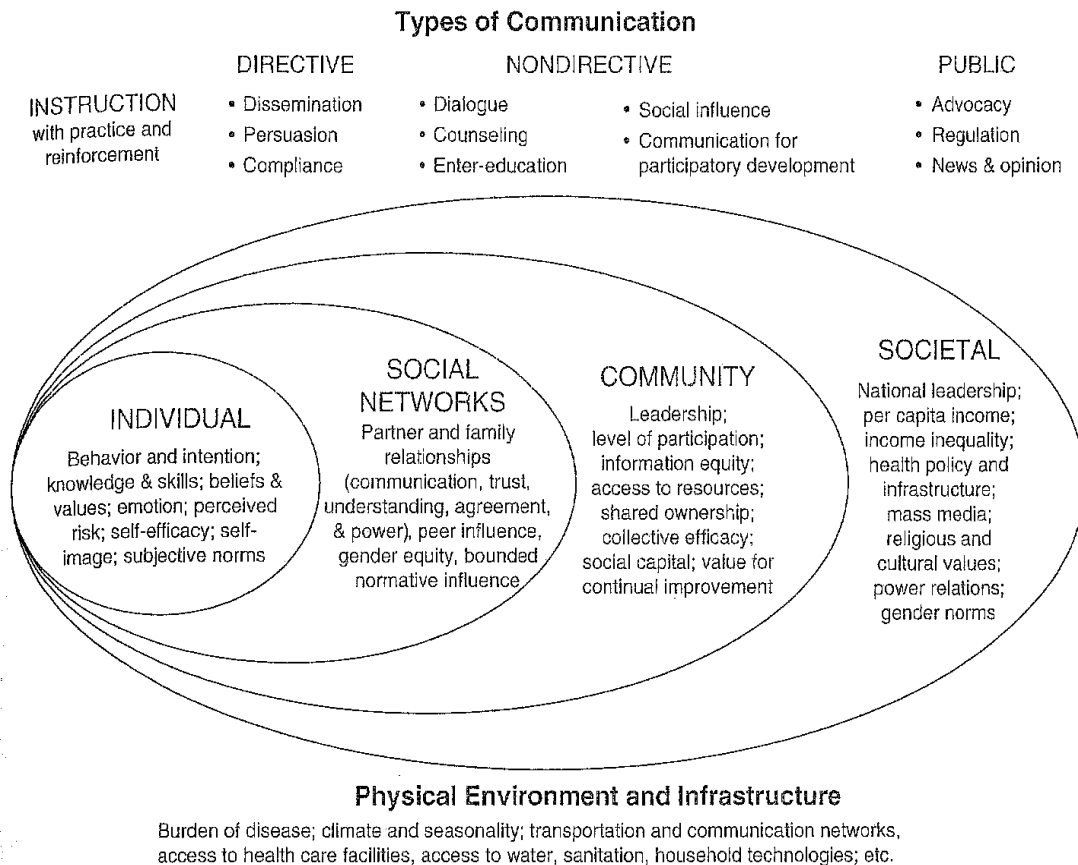


Fig. 3.2 The SEMCHB model adapted from Storey and Figueroa (2012: 75).

The SEMCHB is a model or rather a *meta-theory* in which each level takes into account other relevant health behaviour theories applicable to that level (McKee *et al.*, 2014; Storey & Figueroa, 2012). Douglas Storey and Maria Elena Figueroa (2012) note that the model has two distinctive attributes or aspects and these

are the assumptions of *embeddedness*, a state in which one system is nested in a hierarchy of other systems at different levels of analysis, and *emergence*, in which the system at each level is greater than the sum of its parts (Storey & Figueroa, 2012: 76).

The individual level describes matters that relate to the self or rather the individual. These can be taken as push factors that can result in an individual responding or interpreting mediated messages in a certain manner. These include factors such as “behaviour and intention; knowledge and skill; beliefs and values; emotions; perceived risk; self-efficacy; self-imaging; subjective norms” (Storey & Figueroa, 2012: 75). This level of the model ushers in health behaviour models that include the Health Belief Model (HBM) (Janz & Becker, 1984) and the Social Cognitive Theory (Bandura, 1971, 2005).

The inclusion of a variety of health behaviour models and theories is the reason why this study subscribes to the SEMCHB as suitable for this particular study. With its element of “embeddedness” (Storey & Figueroa, 2012: 76) at each level, the model gives room for other health behaviour theories and models to explain certain aspects pertinent to that level. Though the individual level is the main focus of this study, the other levels of the model are also discussed because of the interrelatedness of the four ascending levels and for the reason that the individual does not exist in a vacuum and is exposed to other factors of influence because of various interactions. The study also acknowledges that individual interpretations (Hall, 2010/1980) of ZNFPC poster, pamphlet and booklet messages are also influenced by other external and higher influences which can be described through the SEMCHB.

The second level of the model, social networks, is where relationships with peers, partner and family are situated. The issues of equity, gender and power dynamics enter at this level and become of influence to the woman who has come across a ZNFPC poster, pamphlet or booklet. At the community level, factors, for example, collective efficacy, access to resources and degree of participation come into play. The final level of the model, level of the society is characterised by factors such as leadership at national level, health policy and infrastructure (Storey & Figueroa, 2012). The model also acknowledges physical environment and infrastructure as important (Storey & Figueroa, 2012). Hall, (1997: 3) argues that “meaning is constantly being produced and exchanged in every personal and social interaction in which we take part.” As such, this particular study employs the SEMCHB because as pointed by Hall, interpretations or meaning making of ZNFPC’s female reproductive health messages is not achieved in the ‘individual’ level alone but can also be influenced by other factors due to the women’s social interactions and ascribed roles.

The model posits that the higher levels have an effect or impact on lower levels and this can either be negative or positive (Storey & Figueroa, 2012). Barriers and support for various interpretations of mediated messages exist in the ascending levels of the models. Furthermore, the model posits that if any change or interpretation is to occur, there needs to be support from the other higher levels. Barriers stifle positive interpretations and ultimately, behaviour change. The model is suitable for the study as it acknowledges multiple layers of influence on decoding of ZNFPC’s female reproductive health messages and is thus suitable to be used in conjunction with a CS approach through the use of the Circuit of Culture (Du Gay *et al.*, 1997) and Encoding/Decoding (Hall, 1980) models as they both consider the

influence of cultural and societal frameworks on interpretation. The aim is to bring to light the way in which the female individual perceptions, attitudes are facilitated and/or constrained by other higher levels of influence.

These interconnections were kept in mind during data collection, particularly in the framing of the focus group question guide and the actual questions during the discussions, as will be elaborated upon in Chapter Four. The responses of the focus group participants will be analysed in the light of the SEMCHB (Kincad *et al.*, 2007) and its associated theories. The model was also used as an instrument in data collection as the researcher was well aware of the cultural connotations of female reproductive health in the chosen research location. The use of the SEMCHB complements the constructivist perspective of the Encoding/Decoding and the Circuit of Culture models as they acknowledge the influence of society and cultural frameworks on production, distribution and people's attitudes and perceptions towards the produced and distributed messages.

As discussed earlier, the individual level ushers in health theories such as the HBM and Social Cognitive theory which focus on the responses of readers to health issues or threats. These two theories are used in health communication to explain, predict and influence behaviour (Rosenstock *et al.*, 1988). These theories take into account an individual's perceived risk to a disease and their self-efficacy in pro-social behaviour. These concepts are useful in the examination of the attitudes and perceptions of females in Chikombedzi towards ZNFPC's reproductive health messages and will therefore be discussed below.

Health Belief Model (HBM)

The HBM is argued to have been the first health education behavioural model and was propounded in the 1950s by US health public service workers and later advanced by Maiman and Becker in 1974 (Donovan & Henley, 2003). Wesley Mathew (2012: 47) argues that the model is based on the idea that "health behaviour is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence." The HBM "helps to find out why audience's perceptions are not in favour of change" and also posits that "beliefs about certain issues can be predictors of behaviours" (McKee *et al.*, 2014: 281). The model is individual based and posits that behaviour is voluntary and comes after risk assessment. Employed in this study, the HBM allows the researcher to closely analyse factors in the SEMCHB's individual level and thereby investigating the Chikombedzi females' perceptions and attitudes of ZNFPC's IEC material messages distributed in the area.

The HBM proposes that health related behaviour is associated with how an individual views aspects of susceptibility, severity, benefits and barriers associated with a mediated message or idea (Bandura 1986; Janz & Becker, 1984). Perceived susceptibility refers to the threat that the individual is facing whilst perceived severity focuses on how the individual relates or associates with the threat (Donovan & Henley, 2003). Perceived severity can include social and medical consequences (Mathew, 2012). Perceived benefits relate to the advantages, value or usefulness of the meaning conveyed by the message. Perceived barriers are those negative aspects or factors that can stifle uptake of the recommended behaviour or interpretation (Mathew, 2012; Janz & Becker, 1984). At the individual level of the SEMCHB, the individual brings to fore all these four perceptions during interpretation, thus, in the process of consumption.

The model was later advanced to include cues to action and self-efficacy (Rosenstock *et al.*, 1988). Cues to action are both internal and external and they create and facilitate change and action (Mathew, 2012). Internal cues to action include push factors such as pain and these occur at the intrapersonal level (Rosenstock *et al.*, 1988). External cues to actions are attained after interactions with others and thereby act as a push factor or advocate for a certain course of action (Mathew, 2012; Rosenstock *et al.*, 1988). Self-efficacy refers to whether or not an individual views herself as being able to practice the mediated behaviour or dominant ideology (Rosenstock *et al.*, 1988).

In relation to my study, taking cervical cancer, for example, a woman's response or interpretation of ZNFPC's IEC messages is determined by how she perceives the seriousness of cervical cancer to the extent that it can result in death and therefore weighs the benefits of getting a pap smear also looking at barriers that can stop her from going for a pap smear (Nxumalo, 2013). The barriers can include lack of transport to a health facility and financial resources. However, pain and continuous interaction with ZNFPC's IEC materials and advice from others can result in her considering going for the pap smear. Whether or not she can manage to continue going for check-ups is determined by her viewing herself as being able to maintain this behaviour.

Social Cognitive Theory

The Social Cognitive Theory was propounded by Albert Bandura in 1958 and has been advanced over the years (Bandura, 2004). This behaviour change theory is viewed as an individual psychological model (Airihienbuwa & Obregon, 2000). The model is based on

the realisation that individuals' behaviour, and in this study, interpretations, attitudes and perceptions of reproductive health communication messages is a result of other powerful forces of influence (Airihienbuwa & Obregon, 2000; Bandura, 1986). These external influences can lead to women of Chikombedzi adopting certain attitudes and perceptions towards ZNFPC's female reproductive health messages.

However, arguments have arisen that the model has been successful in Western countries, but its relevance in an African setting in which individuals are guided by collective or societal norms is questioned (Airihienbuwa & Obregon, 2000; Dutta, 2008). In the African context, going against social norms, values and practices has its own negative effects to the individual or individuals (Airihienbuwa & Obregon, 2000). Despite such arguments, the Social Cognitive Theory is 'embedded' in the individual level of the SEMCHB and therefore in my study seeks to explain how Chikombedzi females' interpretations of ZNFPC's posters, pamphlet and booklet messages is a result of "the interactions among cognition, behaviour, environment and physiology" (Airihienbuwa & Obregon, 2000: 7). This study thus overcomes the critiques of the use of the Social Cognitive Theory on its own as in this study it is used in conjunction with a social ecology perspective that takes cognisance of group norms and local culture.

In this study, the HBM and Social Cognitive Theory are employed to explain how social interactions (explained through the other levels of the SEMCHB) affect individual attitudes and perceptions of ZNFPC's female reproductive health messages in the rural environment of Chikombedzi. Since social learning is based on learning from others, this study, through investigating the attitudes and perceptions of females, seeks to establish whether or not the social context of Chikombedzi supports or acts as a barrier to certain individual interpretations of ZNFPC's female reproductive health messages.

Conclusion

The theoretical underpinnings discussed above highlight that in the communication process the reader's perceptions and attitudes of ZNFPC's IEC messages is influenced by forces other than the female herself. These theories advance understanding of message formulation in this area of study and how these messages are received by the people the messages are intended for. Both the producers of the media texts (ZNFPC posters, pamphlets and booklets) and the readers play a pivotal in female reproductive health communication, as the females are also active participants in the meaning making process. These theories and models play different

but equally important roles in the course of this research. These roles include locating the study within the theoretical body of CS from a health perspective, data collection and analysis, as discussed above. Furthermore, the theoretical framework helps in rationalising the data collected through archival research and interviews which will be analysed in Chapters five and six.

Chapter Four explains the research paradigm and design. The chapter also explores field experiences and data collection procedures before the research findings are presented and analysed in Chapters Five and Six.

CHAPTER FOUR

RESEARCH METHODOLOGY

Introduction

Chapter Three outlined and discussed the theoretical framework for the research approach, aims and assumptions. The theoretical framework was employed in describing and theoretically locating this study to better explain the production, distribution and reception patterns of Zimbabwe National Family Planning's (ZNFPC) female reproductive health communication messages in the rural environment of Chikombedzi.

This present chapter outlines the study's methodological approach and fieldwork in describing the methods employed in collecting and analysing the data. A research methodology clearly outlines and discusses how the researcher conducted the study in practice (Terre Blanche & Durrheim, 1999). This chapter delineates the way in which data was collected, starting from archival research to conducting semi-structured interviews and focus group discussions and employs the first person narrative. It also highlights the challenges encountered during data collection. Furthermore, the chapter discusses how the data collected will be presented and analysed in the following chapters. Ethical considerations are also explored.

Research Paradigm and Design

A qualitative approach to this study was adopted for the reason of its ability of allowing the researcher to gain a deeper understanding of the knowledge and lived experiences of both ZNFPC professionals and the females of Chikombedzi with the ultimate goal of understanding the production, distribution and reception patterns of ZNFPC's Information Education and Communication (IEC) messages by these rural females. Qualitative research uses "language to understand concepts based on people's experience...attempts to create a sense of the larger realm of human relationships" (Brennen, 2013: 4).

Unlike quantitative research, qualitative research focuses and emphasises on depth (Shumba, 2014; Ullin *et al.*, 2005). A qualitative research paradigm, "sees the world as constructed, interpreted and experienced by people in their interactions with each other and with wider social systems" (Ullin *et al.*, 2005: 18). This study is placed in the tradition of qualitative

Cultural Studies (CS) that “offers a lens to acknowledging a researcher’s place and position of power” (Marshall & Rossman, 2011: 24).

Catherine Marshall and Gretchen Rossman, (2011: 96) contend that a research design can be the first point of entry when taking down field notes and should include a reflection of “one’s identity and one’s sense of voice and perspectives, assumptions and sensitivities.” With a case study design focusing particularly on phenomenological, or rather lived experiences of both informal female social groups (focus groups) and ZNFPC professionals (through semi-structured interviews) the research focuses on how female reproductive health IEC material messages are encoded by ZNFPC professionals and later decoded in the meaning making process by rural females of reproductive age in Chikombedzi (Hall, 2010/1980).

The term “case study” has various meanings and “can be used to describe a unit of analysis (for example a study of a particular organisation), or to describe a research method” (Maree, 2007: 75). A case study can be referred to as a unit of analysis used when collecting research information (Dyll-Myklebust, 2011). The case study design opens a way of giving a voice to the voiceless, powerless or marginalised by letting them speak for themselves (Maree, 2007) and this study aims to give voice to women and girls to speak of their own interpretations of ZNFPC’s female reproductive health messages and also analysing the patterns in production and distribution as revealed by semi-structured interviews and archival research. As such, this case study aims to answer the why and the how questions of the research (Maree, 2007).

Sampling

The study employed two types of sampling and these are purposive and snowball sampling. Purposive sampling is done so as to select “information-rich cases whose study will illuminate the questions under study” (Patton, 1990: 169). Based on the judgement of the researcher (Bless & Higson-Smith, 2004) and for the research purposes, the rural area of Chikombedzi was selected as the research location, and the organisation ZNFPC and its employees for interviews and IEC materials for archival research. Snowball sampling complimented purposive sampling in the recruitment of Chikombedzi female participants for focus group discussions as will be later discussed in this chapter. Snowball or chain sampling is a method in which the research gains momentum as it goes and also locates participants who can richly inform the study (Bless & Higson-Smith, 2004; Patton, 1990).

ZNFPC is a parastatal that is directly involved in the production and distribution of IEC materials pertaining to reproductive health concerns of both males and females in urban and rural Zimbabwe, with a history dating back to the colonial era. It is also the biggest organisation in the country whose focus is reproductive health hence it was purposively sampled for this research. I attained approval for researching on the organisation, engaging ZNFPC professionals and voluntary and selected personal (Community Based Distributors (CBDs) and Peer Educators (PEs)) and storeroom (see appendix i for gatekeeper letter and appendix ii for ethical clearance). The rural area of Chikombedzi was purposively sampled because it has no Zimbabwean television and radio signal (*The Herald*, March 19 2015), and is home for Shangani (a minority culture) and the Shona (a majority culture) in the country. Furthermore, Chikombedzi is characterised by strong cultural practices particularly with regards to reproductive health and the female figure (Kachere, 2011; Katsande, 2014; Maringira & Sutherland, 2010; Zimbabwe Youth Council (ZYC), 2014). Chikombedzi is also characterised by high rates of school drop outs, early and polygamous marriages, harmful traditional practices and Sexually Transmitted Infection (STI) cases (Kachere, 2011; Katsande, 2014; ZYC, 2014). This made the Chikombedzi a relevant and crucial research location.

For data collection, professionals for the semi-structured interviews were purposively selected and recruited depending on their roles, experience, knowledge and influence in the production and distribution of IEC materials and in the field. As a result, two departments were sampled; the Marketing and Communication department, and the Service Delivery department. These two departments were purposively selected because they are instrumental in the service delivery, as well as the production and distribution of reproductive health-related materials within the selected sample community, Chikombedzi. The IEC materials (booklets, pamphlets and posters) were also purposively sampled with regards to their focus on female reproductive health and distribution during the chosen period as will be discussed further in this chapter. Female participants were also purposively sampled for focus group discussions based on whether they had encountered a ZNFPC IEC material, as well as based on the categories of age (between 18 and 45 years) and availability.

With the assistance of CBDs and purposive sampling having paved way for the initial focus group participants, I employed snowball sampling. Snowballing was used in gathering more participants and were further purposively selected on the basis of having come across at least one ZNFPC IEC material. Through the use of snowball sampling, the researcher relies on

social knowledge and recommendations from various individuals or participants as they provide contacts of other potential participants and the sample continues to grow (Bless & Higson-Smith, 2004). The initial females who had agreed to participate in the focus group discussions informed me of other potential participants for the discussions, as a result, the research sample continued to grow.

The research sample included hard copies of IEC materials and ZNFPC professionals for semi-structured interviews and Chikombedzi females for focus group discussions. The selected samples were viewed by the researcher as a representative sample. The main aim of sampling is to have a group or sample that is deemed as representative by the researcher (Terre Blanche *et al.*, 2006) and this I achieved through sampling focus group participants from various villages in Chikombedzi and different IEC materials. The focus group sample was aged between 18 years (the Zimbabwean legal age of majority) and 45 years. A total of 23 IEC materials (posters, pamphlets and booklet) were sampled. With regards to informant sampling, this study includes 3 semi-structured interview participants, and 22 focus group participants were sampled across the 3 focus groups.

Recruitment Strategy

The study employed two recruitment strategies; word-of-mouth or direct recruitment and referrals, as it has two different groups of participants; ZNFPC Masvingo Province employees and the rural females of Chikombedzi. In recruiting research participants, a study can use more than one method or strategy of recruitment (University of California, Los Angeles (UCLA), 2012).

Through word-of-mouth or direct recruitment and also through the use of the gatekeeper letter (see appendix i) (Jones *et al.*, 2009), I purposively recruited two ZNFPC MCOs and the SDC at the provincial offices for semi-structured interviews. The recruitment was based on their roles and responsibilities in the production and distribution of posters, pamphlets and booklets, in the field and also their different skills, knowledge of and influence in Chikombedzi. I had initially intended to recruit one MCO, the SDC and the Sister-In-Charge Community (SICC). However, I later learnt that the SICC did not have a direct and active role in the production and distribution of IEC materials and in the field as she worked closer with the clinic at the Provincial offices in Masvingo city itself. Therefore, I recruited another MCO in order to replace the SICC. The difference between the two MCOs is that one has

more knowledge of and experience in Chikombedzi, whilst the other is more hands on in the production of IEC materials thereby making them both of importance to this particular study.

As these three participants were from two different departments, their roles and influence, particularly in the production of the IEC materials and in the field differed. The interview participants, one male and two females were all interviewed on the same day. This was due to their busy schedules as they had to do field work in different areas of the province. From these interview participants, I was informed of the location of the Chikombedzi Youth Centre where I would find the CBDs and PEs in the area who could assist me in finding and recruiting my focus group research participants. These interviews, along with all data collection techniques, will be elaborated on below.

Through collaborating with the CBDs and PEs, I managed to recruit 22 female participants for three focus group discussions. I took the cue that in qualitative research, one of the most successful recruitment strategies involves working in partnership with healthcare providers and/or community gatekeepers who are trusted by the potential research participants (Felsen *et al.*, 2010; Namageyo-Funa *et al.*, 2014; Renert *et al.*, 2013). This strategy helped to build confidence and trust between the participants and I thus making the recruitment easier. Recruitment of the focus group participants was done just after a funeral in one of the villages. Lawrence Neuman (2014) contends that a researcher should always be prepared and flexible once he or she has entered the field. “You will not follow clearly laid-out, pre-set, fixed steps...shift directions and follow leads as needed, learn to recognise and seize opportunities, and adjust quickly to fluid social situations” (Neuman 2014: 439). In the light of this notion, I seized the opportunity of sampling and recruiting participants and later the discussions.

Though CBDs and PEs were not part of the focus group discussions, they helped in the direct recruitment of focus group participants. The CBDs and PEs were the key sources of knowledge regarding the contact details of females, occasions and happenings in the community as they were familiar with the community. When I entered the community, one of the CBDs took me to a homestead where a funeral had just happened and the deceased had been buried. Considering the fact that rural homesteads are far from each other, I saw this as an opportunity (Neuman 2014) to introduce myself and informing the already gathered females about my research. In addition, since there had been a funeral, women from different

villages across Chikombedzi were there and so a representative sample was highly likely to be attained.

My role as an observer and participant was rewarding as I took account of some of the cultural and traditional ways of life of the women. Entering the homestead, some people were already leaving, others were still eating whilst some women were cleaning the dishes, packing and fetching water before they left for their own homes. It is a standard cultural practice in most parts of Zimbabwe that women and girls do the cleaning up after a funeral. Neuman (2014) posits that a researcher in the field has two roles; a social role and the role of field researcher and at this stage, I took the social role in helping the women and girls with their work. Whilst helping the women and girls, the CBD introduced me and informed them that I needed their assistance and wanted to talk to them. This gave me the chance to introduce myself and explain why I was in their community and allowed them the time and comfort to ask me questions in a relaxed environment.

Working alongside the women was useful as “a field researcher’s success depends on how he or she negotiates symbolic interaction processes, such as presentation of self and performing roles” (Harrington, 2003: 609). Some of the women that were in the homestead agreed to be part of the discussions but noted that because of distance, responsibilities and time constraints, the discussions had to be conducted on that very day before they left for their own homesteads that evening and the next morning and so I organised for this to happen.

These research participants that I recruited first also referred me to other women who they thought would be able participate in the research. These are noted as important referrals as “referral may be from non-investigator healthcare providers, snowball sampling, participants referring other participants” (UCLA, 2012: 3). Some of the young women who could not be part of the discussions at that particular time offered to invite some of the young women they knew for a discussion on a different day. This I welcomed as I did not want mothers, daughters and relatives to mix in the same focus groups. As a result, two focus group discussions were held on that day, one in that homestead and another one at a nearby homestead and the third was held four days later near a school.

Data Collection

The data collection techniques that I employed are archival research, semi-structured face-to-face interviews and focus group discussions. Archival research was the first to be conducted,

followed by semi-structured interviews and then lastly focus group discussions. This procedure allowed the archival research to inform the questions asked in the semi-structured interviews and focus groups. Data collection aims at bringing to shore how information was collected thereby asking the how part of research (Flick, 1998). Semi-structured interviews were used in generating information from ZNFPC professionals whilst focus group discussions were only for gathering information from the Chikombedzi females.

Archival Research

Archival research data is information which has been gathered over time in relation to a particular society, community or an organisation (Marshall & Rossman, 2011). With the gatekeeper permission letter and ethical clearance (see appendix i and ii), I had access to the ZNFPC Masvingo province storeroom where all IEC field materials are kept. I collected data from ZNFPC's IEC field materials which comprise of posters, pamphlets and a booklet. The material sample was distributed in Chikombedzi between June 1 2014 and January 31 2015. The IEC materials collected during archival research were also used as reference material during the focus group discussions (see appendices iii, iv and v for samples). This systematic collection of samples was purposive because of the vast data in the material for the study during the chosen period.

The distribution time frame (June 1 2014 and January 31 2015) of the materials that were selected for analysis and used in focus groups was of importance to this study because of its cultural significance in Chikombedzi. The months of June and July are culturally important and significant for the Chikombedzi population, particularly the Shangani, as they conduct their womanhood initiation and male circumcision ceremonies during this period as they believe the wounds heal much quicker and easily during winter (Shoko, 2009). After the initiation ceremonies, the second term on the school calendar is characterised by a large number of school drop outs and more drop outs in the third term, as various scholars have argued (Kachere, 2011; Katsande, 2014; ZYC, 2014).

Furthermore, the months between October and January are the ploughing months therefore females of different age groups focus mainly on ploughing than their own health so as to be able to feed their families. In addition to this, towards the end of November and beginning of December, most individuals, particularly males, who have been working in neighbouring South Africa (SA) and Mozambique return home and are in search of women to marry (ZYC,

2014). In this regard, the chosen time period for the materials for archival research becomes purposive as it covers critical periods in the lives of my research participants.

Though I had aimed at collecting a total sample of 24 IEC materials, (three samples for every month from June 2014 to January 2015) I discovered that some IEC materials were repeated over the months and years in order to try and increase their impact and accessibility. I therefore sampled and collected 23 IEC materials. I collected a total of 12 posters, 10 pamphlets and only one booklet. All the IEC materials that I collected during archival research are presented in the table 4.1 below.

Type of IEC material	Quantity	Title and Language
Poster	12	Substance abuse affects your health (English) Do you think you are pregnant? (English) Happy Family (English) Hokoyo nenhamo (Shona) School dropout (English) Vabereki (Shona) Family Planning methods are safe even for HIV positive (English) No gift or money is worth your life (English) Kuva mubereki uri mudiki kwakaoma (Shona) The FC2 female condom (English) Be responsible (English) Plan your family now (English)
Pamphlet	10	Basic facts on STIs (English) Making informed decisions (English) Negotiating for safer sex (English) The big missiles of Adolescent Sexual and Reproductive Health (English) Dual Protection (English) Breast Cancer: Your responsibility (English) Methods of Family Planning (English and Shona) Talking Abstinence (English and Shona) Benefits of Family Planning (English)

		How to use the female condom (English, Shona and Ndebele)
Booklet	1	Young 4 Real: Young Women First (English)

Table 4.1: IEC materials collected

In conducting archival research, I discovered that ZNFPC, as a parastatal, also distributes IEC materials that it had not produced but were produced by other organisations, other arms of the government and materials produced for campaigns. The only materials that were part of the sample but not directly produced by ZNFPC was the booklet produced by the Reproductive Health unit under the Ministry of Health and Child Welfare (MoHCW), and the Happy Family produced by the Integrated Support Programme for Sexual and Reproductive Health and Prevention of HIV and Gender Based Violence for a male circumcision campaign. However both these materials were distributed by them and were thus included in the focus group discussions. IEC materials were the only materials included because they were the primary source of data for the responses from the woman in Chikombedzi area. All the pamphlets, posters and booklet that I gathered had either been produced or reprinted between 2012 and 2015 but had, however, been distributed in Chikombedzi between June 1 2014 and January 31 2015.

Interviews

The study employed two types of interviews; semi-structured interviews and focus group discussions in gathering the required data (see appendix vi for the discussion guide and vii for the interview guide). Interviewing in qualitative research is viewed as closer to a dialogue “than to a question-and-answer session” (Barker, 1999: 247). It is a “conversation with a purpose” (Burgess, 1984: 102). Through snowball and mostly purposive sampling, I sampled participants for these two types of interviews. Maree, (2007: 88) posits that “the key to successful interviewing is to find the person(s) who (are) best qualified in terms of your research question, to provide you with the information required.”

Both the semi-structured and focus group participants had to sign an informed consent form showing their willingness to participate and that they had understood what their participation meant and was for. The informed consent forms were in English and Shona. The one in English was for the ZNFPC professionals (see appendix viii) and in Shona for the focus group participants (see appendix ix). With permission from all the research participants, I

audio recorded all the semi-structured interviews and focus group discussions using my mobile phone and laptop and I later transcribed using these recordings.

I used semi-structured interviews for interviewing ZNFPC professionals because they are flexible and make room for unexpected responses which structured interviews might inhibit (Wood, 2011). “Semi-structured interviews allow for the probing and clarification of answers” and the “schedules basically define the outline of the inquiry” (Maree, 2007: 87). Steinar Kvale (1996: 124) posits that semi-structured interviews have “a sequence of themes to be covered, as well as suggested questions.” Through the use of the gatekeeper letter (appendix i) and their willingness, I sought permission to interview and purposively sampled and recruited three purposively selected ZNFPC professionals from the Masvingo provincial offices. The interview participants were two MCOs and the SDC as explained above.

Having recruited these interview participants through word-of-mouth and with the use of the gatekeeper letter (Jones *et al.*, 2009), the three participants willingly agreed to participate in the research under the condition that I email them the finished copy of my research to which I agreed. Furthermore, the research participants worked together in deciding the perfect day for the interviews and they decided that I interview them all on the same day due to issues of availability, time constraints and other responsibilities. I therefore seized this opportunity (Neuman, 2014). I also learnt that the SDC was leaving for a field visit later on the agreed day for a whole month and one MCO was to leave for a field visit in another part of the province that very week. Therefore the issues of availability and time were of importance.

The interviews were a few hours apart from each other and this helped the researcher to interact with the participants before and after the interviews. All the interviews were recorded with the permission of the interviewees. Since the interviews were semi-structured, for all the three interviews, I had an interview guide (see appendix vii). The ZNFPC employee interview questions were informed by the Circuit of Culture Model, (Du Gay *et al.*, 1997) in relation to the production, representation moments of the circuit and Stuart Hall’s (2010/1980) Encoding/Decoding model. The interview participants chose not to disclose their names and will be addressed as MCOs and SDC in this chapter and the ones to follow.

First to be interviewed in the morning was the SDC in her office. Prior to the interview, the SDC clearly noted that she was unable to address issues to do with the production of IEC materials as this was not in her area of expertise but was comfortable to answer other

questions. I kept the interview questions to a minimum. However, through clarification and probing, the number of questions increased (Maree, 2007).

The next interview was conducted mid-morning in the MCO's office. This was an interview of a male MCO who happens to have years of experience in Masvingo province and particularly in the rural area of Chikombedzi. The interviewee was comfortable in addressing all the questions that I posed and when I asked for elaborations and clarifications, he seemed to do it with ease. The last interview of the second MCO was conducted in the organisation's boardroom, in the afternoon. The interviewee was selected because I had been advised that she was more hands on and experienced in the production of the organisation's IEC materials at national level. The interviewee showed confidence in addressing all of my interview questions and through her answers, the number of my questions increased.

In addition to semi-structured interviews, I also made use of focus group discussions in collecting data. I employed focus group discussions as a way of getting an understanding of how the rural females decoded the ZNFPC's IEC messages (Encoding/Decoding model, Hall, 2010/1980), as well as their attitudes and perceptions of the materials and what influences them (Kincaid *et al.*, 2007). This technique was useful as focus group interviews are "based on the assumption that group interactions will be productive in widening a range of responses, activating forgotten details of experience and releasing inhibitions that may otherwise discourage participants from disclosing information" (Maree, 2007: 90). Due to increased interaction, focus group discussions concentrate on the in-depth aspect of a particular topic or issue (Walliman, 2006) which is exactly what I needed so as to adequately answer the research question. The focus groups consisted of between six to ten respondents who were interviewed together.

Through purposive and snowball sampling, I managed to recruit a sample of 22 Chikombedzi women between the ages of 18 and 45 for my three focus group discussions. The participants chose to remain anonymous (and will therefore be referred to using numbers in the chapters to follow). They were from various villages in Chikombedzi that include Batiti, Haisa, Ponyoka, Mahlalele and Hatsvukwe villages. I learnt this through interacting with them before and after the discussions and took down as part of my field notes.

Before each focus group discussion begun, all the participants had to each sign an informed consent that was written in Shona (see appendix ix). With permission from all participants, after I had explained to them why I needed recordings of the proceedings, I recorded all the

focus group discussions using my mobile phone and my laptop. For the laptop recording I had to cover the webcam with a piece of paper. This made the participants comfortable and free as they were now certain that I was not taking pictures or video recording them as one participant had questioned; “*ko mukazotitora mapicture isu tisingazivi?*” (What if you take us pictures without our knowledge and consent?).

With the assistance of the CBD and the referrals from the women, I managed to recruit more participants for the other focus group discussions and some agreed to have the discussions that day. Since my primary language is Shona, I had found a translator in case during the discussions a mixture of the Shona and Shangani was used (Krueger, 1998). However, the participants offered to use Shona since they did not have a problem using it. I conducted the first focus group discussion later in the afternoon that day after I had managed to recruit enough participants.

Before an interview, the research participants should be fully aware of what the research entails and what kind of information is required from them (Maree, 2007). I made this clear through word of mouth and also through the informed consent form. For all the focus group discussions, I had a discussion guide (see appendix vi). According to Neuman (2014: 472) “focus groups should be segmented by status” so I segmented my focus group participants by marital status. However, one of the groups consisted of women with husbands mixed with women with children but without husbands, meaning it was on the basis of motherhood.

The first focus group discussion was conducted outdoors in a secluded part of the compound. A total of thirteen participants arrived for the discussion. However, due to the limitation in number for a focus group; between six and ten participants (Bless & Higson-Smith, 2004; Walliman, 2006), some participants had to join a different group. Four participants kindly agreed to join the focus group discussion that was to follow later thereby leaving a total of nine participants. This group was segmented on the basis of motherhood as it consisted of women married with husbands and women with children but without husbands. These participants gave different interesting dynamic views pertaining to their reproductive health and how they interpreted and viewed ZNFPC’s IEC strategy.

I conducted the second focus group discussion in the evening, just after sunset. However, due to the issue that the family members of that homestead had now gathered indoors, the venue for the second discussion was changed to a nearby homestead that belonged to one of the participants. Of the four that had agreed to join the second discussion, one decided to leave

but the other three waited. Four more women had also arrived for the discussions making a total of seven participants. This group was homogenous in the sense that it was made of married women, living with their husbands. Of this group, though they all contributed, two participants were less active as compared to the others.

The third focus group consisted of six school going girls ranging from Upper six (the last level of Zimbabwean High School education) and those who were in tertiary institutions. None of these girls were married but were however, 18 years (Zimbabwean legal age of majority) and above. This particular focus group discussion was conducted four days after the other two as I faced difficulties in getting the participants together at the same time and place. The discussion was conducted outdoors at a clearing near a local high school. The discussion lasted for one hour and one minute.

Challenges encountered during data collection

During data collection, I was faced with a number of tricky and challenging situations. For the interest and success of my research, I however managed to overcome these challenges, by adopting flexibility that is recommended in field work (Neuman, 2014).

The issue of time was a major constraint during field work. The ethical clearance took a long time and my study was only given full approval at a time when ZNFPC was conducting field work in various parts of the province. The SDC, for instance, was going for field work in various parts of the province for a whole month and would only be in town during weekends but the offices would not be open. Also, one of the MCOs was also going for a field visit in Chiredzi later that week. This resulted in them squeezing me in their schedules and I had to conduct all the interviews in one day.

The language barrier was one of the challenges I faced during field work. The Chikombedzi community is a mixture of Shona and Shangani speakers (as outlined in Chapter One) and a few Ndebele speakers here and there. I am conversant in Shona and understand a little bit of Ndebele but cannot speak it. However, the CBD who introduced me to the initial participants assisted by introducing me in Shangani and Shona and I later introduced myself and explained why I was in their community in Shona. Though I had found myself a translator to help me with the communication part, the research participants refused and said they would speak in Shona. This worked to my advantage.

Gathering the participants for the last focus group proved to be a challenge as the girls had different time schedules and getting them together in one place at the same time was difficult. Agreeing on a convenient venue for all of them was also challenging. Whilst some would be busy with daily chores, some who are in high school were getting ready to start vacation school, known as extra lessons. However, with a little persistence and persuasion, I finally managed to gather six of them for the discussion. During sampling and recruitment of focus group participants, the participants admitted to having seen or come across at least one of ZNFPC's IEC materials. However, during the discussions, some participants said they had never come across any of ZNFPC's IEC materials. I overcame this problem as I had with me ZNFPC's posters, pamphlets and booklet which I had collected during archival research. As a result, all the participants knew what we were talking about and could therefore relate to the materials and their own experiences. Despite these challenges, I managed to collect all the required data sufficient for analysis.

Data Analysis and Presentation

This study makes use of semiotic analysis. Semiotic analysis is the study of 'science of signs' (Berger, 2004). Derived from linguistic studies of Ferdinand De Saussure (1857-1913) and Charles Saunders (1839-1914), it aims to get a deeper understanding of meanings through the interpretation of single elements of text (Berger, 2004; Walliman, 2006). Semiotics is concerned with meaning making and representation (Chandler, 2002). In doing reception studies, it is of importance to acknowledge that language shapes people's perceptions and attitudes (Chandler, 2002). Daniel Chandler, (2002: 8) posits that semiotics is rarely quantitative and "is now closely associated with cultural studies...semiotics seeks to analyse texts as structured wholes, investigates latent, connotative meanings." Therefore, this particular study seeks to 'unlock meanings' through the use of the two 'key notions of semiotic analysis'; signs and relations (Berger, 2004).

For Keyan Tomaselli, (1996: 29), the semiotic approach does not only include "how things come to mean, but how prevailing meanings are the outcomes of encounters between individuals, groups and classes and their respective cosmologies and conditions of existence." "In semiotic analysis, an arbitrary and temporary separation is made between content and form, and attention is focused on the system of signs that make up a text" (Berger, 2004: 6). "A social semiotician would also emphasise on the importance of the significance which readers attach to the signs within a text" (Chandler, 2002: 8). The material was selected from

a wider selection because of its rich data which informed the study. Before the data collected was analysed, I transcribed all of it using verbatim transcription and focus group discussions had to be translated from Shona to English as well.

This study makes use of a semiotic analysis in investigating the meanings attached to ZNFPC posters, pamphlets and booklets and also to explore how those meanings and meanings made by the readers arise from relationships (Berger, 2004). The analysis is employed on the IEC materials in order to establish the encoded preferred meaning (Encoding/Decoding model 1980) of the ZNFPC messages. This preferred meaning will be supplemented with interviews of ZNFPC employees, thus looking at issues of production and representation (Circuit of Culture) (Du Gay *et al.*, 1997). Furthermore, the responses of female research participants during the focus group discussions will be compared against the preferred meaning. This is so as to establish whether they hold a dominant, negotiated or oppositional reading of these materials (Hall, 1980). The responses of the female research participants will be analysed with reference to the SEMCHB (Kincaid *et al.*, 2007) and its associated theories. The SEMCHB will serve as an analytical guide on what levels of factors influence the females in their reading of the material and possible behaviour change.

Ethical Considerations

In qualitative research, the issue of ethics is addressed so as to bring to light that the researcher took considerable measures and efforts to protect the participants (Matthew, 2012). The aim of this study was explained to all the research participants during, sampling, recruitment and in my introduction during the actual interview. The issues of confidentiality and privacy especially in the case of focus groups were assured and numbers will be used in the discussion of findings.

Prior to data collection, I obtained an ethical clearance from the University of KwaZulu-Natal (UKZN) Ethics Committee (see appendix ii). Before an interview started, each participant signed an informed consent form (see appendix viii (semi-structured interviews) and ix (focus groups)) which also addressed issues of privacy, had a brief summary of my study and also included details of my supervisor. It was also explained that the participants could use languages of their choice and were free to choose either to continue or stop participating at any given moment. With permission from all participants and conditions (that I cover my laptop camera with a piece of paper), I recorded all the interview proceedings which were later transcribed using verbatim transcriptions.

Reliability and validity of the study

Reliability and validity of the study refers to the research methodology and its chances of yielding similar results under the same conditions, as well as the importance and use of each step in attaining the research objectives (Matthew, 2012). Through the use of credible sources of information and methods of data collection, this particular study is credible, dependable, confirmable and transferable. These aspects are explored below.

Credibility

Research that can be regarded as credible is one whose findings are believable (Durrheim & Wassenaar, 1999). The credibility of findings can be established through the “checking of findings alongside existing theory” (Smailes & Street, 2011: 258). This research is credible in the sense that research findings were recorded, presented and analysed using a well established form of analysis (semiotics) and the guide of the SEMCHB (Kincaid *et al.*, 2007). Furthermore, the findings of this research can be located within the discussed theoretical framework in Chapter Three.

Dependability

“Dependability refers to the degree to which the reader can be convinced that the findings did occur as the researcher said they did” (Durrheim & Wassenaar, 1999: 64). Research dependability is concerned with research transparency (Smailes & Street, 2011). In ensuring dependability and showing the transparency of my research and its findings, I clearly note and justify the steps, procedures and decisions I took and made during data collection, recording the findings and presenting them in data analysis.

Confirmability

Confirmability refers to the level or extent to which the research findings directly show what was found and collected in the field (Babbie & Mouton, 2004). In order to maintain confirmability, I reviewed my field notes and made reference to my research objectives and questions more often than not. In addition, all the archival materials and interview and focus group recordings are available to be compared against the final write-up.

Transferability

Transferability refers to “the extent to which the findings can be applied in (to) other contexts or with other respondents” (Babbie & Mouton, 2004: 277). This research does not generalise findings or present data applicable to other populations (Smailes & Street 2011) other than the female population of Chikombedzi. However, the methodology employed may be useful in other similar contexts.

Conclusion

The chapter discussed the steps that I took in collecting data for the study. Maintaining a clear focus on the study’s research objectives and acknowledging and noting the research environment, I collected data pertaining to the production, distribution and reception of ZNFPC posters, pamphlets and booklets by females of reproductive ages in Chikombedzi. The measures taken in ethical consideration were also delineated.

Data analysis is divided into two chapters (Chapters Five and Six) with each employing a different tool for analysis. Through a semiotic analysis, all the data collected through archival research supplemented by semi-structured interviews will be presented and analysed in the next chapter, Chapter Five.

CHAPTER FIVE

DATA PRESENTATION AND ANALYSIS: ENCODING AND DISTRIBUTION OF ZNFPC'S IEC MESSAGES

Introduction

Chapter Five and Six of this study focus on the presentation and analysis of data collected in Chapter four. Guided by the Circuit of Culture model (Du Gay *et al.*, 1997), both as a theoretical and methodological guide, this particular chapter employs semiotic analysis in analysing data collected through archival research and supplemented by semi-structured interviews. Though the model has five interrelated stages; production, regulation, representation, identity and consumption (Du Gay *et al.*, 1997), this study only focuses on production, representation and consumption as encoded and decoded in the Zimbabwe National Family Planning Council's (ZNFPC) female reproductive health Information Education and Communication (IEC) materials.

The chapter explores the moment of production of the Circuit of Culture model (Du Gay *et al.*, 1997) and all related issues; including distribution and other relevant issues. The analysis also establishes the preferred reading of the messages. As highlighted in Chapter Four, three ZNFPC employees from the Masvingo provincial offices participated in the research through semi-structured interviews; Marketing and Communications Officer 1 (MCO1), Marketing and Communications Officer 2 (MCO2) and the Service Delivery Coordinator (SDC). All the interviews were conducted by the researcher on 7 August (Aug) 2015. First to be discussed is a basic semiotic analysis of a sample of the materials collected during archival research.

Semiotic analysis of sample IEC materials

This particular study is limited to female reproductive health IEC materials produced and distributed by ZNFPC in Chikombedzi between 1 June 2014 and 31 January 2015. As highlighted in the methodology chapter, a total of 23 IEC materials; 12 posters, 10 pamphlets and one booklet were sampled and collected for the research, however, only a selected sample of four materials are presented and analysed in this chapter. While a single poster and two pamphlets were selected on the basis of being some of the major female reproductive health challenges in Chikombedzi, the booklet was the only one collected during archival research. Below, (Fig. 5.1) is a poster *Kuva mubereki uri mudiki kwakaoma* (It is difficult being a parent at a young age).



Fig. 5.1 ZNFPC poster on early pregnancies. Source: ZNFPC Masvingo provincial office¹².

The poster depicts in the foreground what appears to be a young woman carrying a baby on her back and what appears to be a nappy bag. She appears to be walking on a dusty road apparently heading towards a clinic which is five kilometres away as indicated by the direction sign board. She is thinking to herself and the thought bubble says in Shona *hopenyu hwangu hwakaoma* (my life is difficult). Her hair is unkempt and she is putting on a white t-shirt, a pair of jeans and sandals. Her face looks deep in thought and miserable. In the background is a contrasting green lawn of Shinga High School (written on the white sign board). The green lawn leads to classroom blocks. On the lawn, is a boy in school uniform holding a book. He seems to be staring at the young woman while further on two girls in school uniform appear to be strolling on the lawn, all apparently oblivious to the troubled young woman.

Just below the young woman is a message written in Shona saying *Zvibate ugone kudzivirira pamuviri, kana kutora zvinodhaka uye zvirwere zvepabonde* (STIs, HIV ne AIDS) (Be responsible to avoid unwanted pregnancy, alcohol and drug abuse and Sexually Transmitted

¹² See appendix iii for a larger image.

Infections (STIs) and diseases). Below this message is yet another one albeit in smaller font size which says in Shona; *Tsvaka rubatsiro kukiriniki, kuYouth Centre kana kuma Peer Educator ari pedyo newe* (Seek help from your nearest clinic, youth centre or peer educator). To complete the picture is the ZNFPC logo as well as the United Nations Fund for Population Activities (UNFPA) logo underneath it. The ZNFPC logo is clearly bigger than the UNFPA logo.

This poster is clearly targeted at young women of school going age. This is because it would not make sense to advise someone who is already in a situation such as the young woman, to be responsible. The poster uses fear appeal to warn young girls and women that they could end up in the same situation as the young woman. The contrasting of the seemingly care-free girls and focused boy with the seemingly troubled young woman is meant to emphasise that staying in school is 'cool' while early pregnancy leads to a life of hardship and nostalgia. The dusty path where the young woman is walking stands in contrast with the lush green lawn of the school. This connotes that there is life and brighter future in school (green colour represents life) whereas dropping out because of unplanned pregnancy, alcohol and drug abuse or STIs and diseases leads to the dusty path of poverty and despair. The two sign boards also are contrasted. The clinic sign board signifies a long walk of sweat and despair while the Shinga High School sign board signifies the wise choice of staying in school. Its closeness to the school signifies that the choice to stay in school is still within the grasp of those who are responsible but the wrong choice can easily lead one to the long dusty path poverty and despair.

The name of the school, Shinga, can mean any of be strong, persevere, stay focused or be courageous. This is a message to young girls that to avoid ending up like the young woman, they need to stay focused on their education and have the courage to withstand negative vices that can take them out of school. While the school represents empowerment there is an exhortation to young girls to be strong and resist peer pressure and the stated vices. That the young woman is dressed in a seemingly modern way, that is, t-shirt and jeans, suggests that 'the worst can happen to the best of us' if wrong choices are made. While the dressing may not be culturally acceptable to the older generation of Chikombedzi (as highlighted in the focus groups) this message was clearly meant for young women who identify with this kind of dressing and consider it modern.

The unkempt hair signifies that life is hard (as in her thought bubble) because any girl who wants to appear presentable has her hair kempt or even has modern hair extensions. Such representation is meant to induce a sense of distaste and disgust from the targeted audience so that they take seriously the message being communicated. The words STIs, HIV and AIDS are in red to emphasise the gravity of the danger that these pose to individuals and society at the present moment. Zimbabwe is one of the countries in sub-Saharan Africa worst hit by HIV and AIDS (Gribble *et al.*, 2008; Joint United Nations Programme on HIV and AIDS (UNAIDS), 2014). Messages are encoded with the ideology of the encoder (Hall 2010/1980) and ZNFPC seems to send the message that they are at the forefront of promoting female reproductive health by having the bigger logo while UNFPA are only supporting partners therefore their logo is smaller. It can be regarded as a ‘main player’ mentality that emphasises the importance of the organisation in relation to other ‘players’.



Fig. 5.2 Pamphlet on female condom use. Source: ZNFPC Masvingo provincial office.

Fig. 5.2 is a small ZNFPC pamphlet *How to use the female condom*. On the cover, there is an image of a packaging of the female condom and the pamphlet message is encoded in English, Shona and Ndebele. Whilst English is the official language, Shona and Ndebele are the majority languages and ethnic cultures in Zimbabwe. The pamphlet is in the colours red, purple and white. Whilst red is signifies danger, purple resembles independence and white signifies peace. The pamphlet is an informative pamphlet and seeks to empower females so that they can be able to control their own sexual and reproductive health by giving them adequate information on how to use the condom. The pamphlet acknowledges the dangers

associated with sexual and reproductive health activities and the risks that females face and therefore gives them the female condom as a way of liberating them and peace of mind when it comes to issues of controlling fertility and reproductive health challenges and diseases they might be at risk of.

The pamphlet gives off a message that knowledge is power. It is a message that seeks to empower women who previously relied on men to use a condom. By gaining information about the correct use of the female condom the woman is taking her power back. The rationale behind this pamphlet is to challenge female individuals and the community to be informed and know how to use the female condom for their own benefit. This also comes at a time in which Masvingo province was argued to be the province with the highest new STI cases and most are of females recorded in 2013 (Muzulu, 2014). The red colour of the pamphlet symbolises danger (danger warning signs are usually in red) and signifies the impending danger that can befall those women who fail to take their power back by correctly using the female condom.

The purple colour symbolises independence that comes with the female condom. It signifies a new found freedom for women in that they get to take charge of their reproductive health. Purple also symbolises royalty (Zimbabwean chiefs have their official regalia in purple) thus giving a connotative meaning that those who use the female condom are royalty and therefore get to make decisions without seeking the approval of anyone (males in terms of reproductive health). The white colour signifies the peace that comes to all those women who correctly use the female condom because they know they cannot contract sexually related infections and diseases or have unwanted or unplanned pregnancies. It is peace that arises from the sense and reality of being independent decision makers in terms of using condoms.

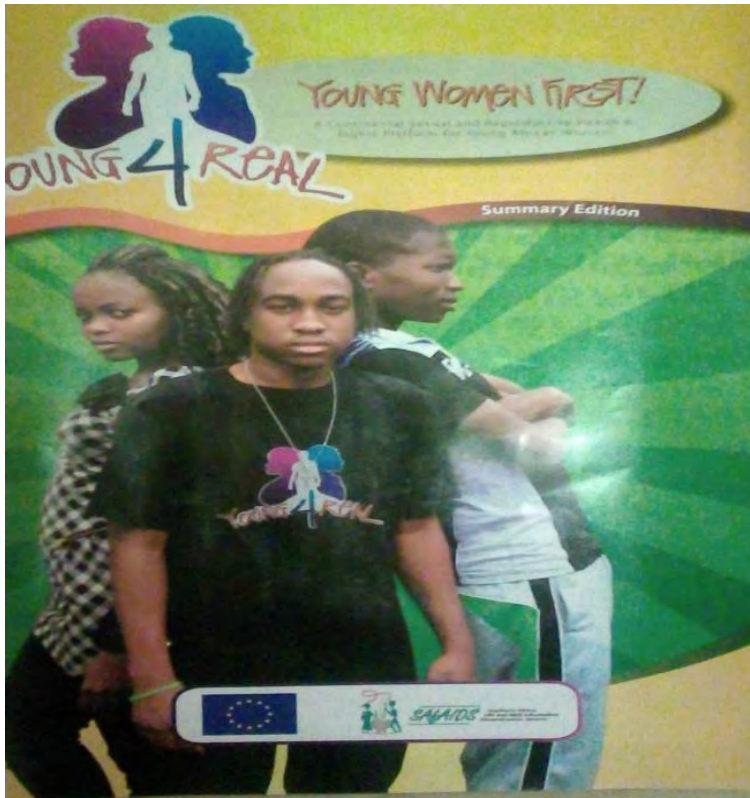


Fig. 5.3 Booklet; *Young 4 Real: Young Women First!* Source: ZNFPC Masvingo provincial office¹³.

This cover of the booklet speaks to young males as much as it speaks to young females. At the level of iconic signification the Young 4 Real logo on the top left denotes an outlined image of a female and a male with their backs against each other. There is an image of a female figure in a strong stance pose between them. At the level of indexical signification is that the back to back male and female figures can connote supporting each other to allow an empowered woman (the strong stance female image) to emerge. The use of pink for the female and blue for the male reinforces the different gender. The same image is replicated in the main picture though with clearly identifiable young people. There is one young woman and two young men all with their backs against one another. All the young people in the image are wearing trendy clothes and can be said to represent the young people of today.

At the level of symbolic signification the preferred meaning that is encoded (both with the main image and the logo) is that it takes more than just the young female to empower themselves with regards to reproductive health, but it also depends on the response and support of young men. By calling the booklet Young 4 Real, the preferred meaning is for

¹³ See appendix v for a larger image.

young people to only view themselves as real or original if they support each other to realise their reproductive health well-being. It is a call especially for young men to shun a view that sees young ladies as objects but to begin to view them as only being real if they support young ladies to fulfil their potential. This type of interdependent understanding of behaviour change is espoused in the SEMCHB (Kincaid *et al.*, 2007) and will be discussed further in Chapter Six.



Fig. 5.4 Pamphlet describing the benefits of family planning. Source: ZNFPC Masvingo provincial office¹⁴.

At the iconic order of signification the image denotes a rural home in Zimbabwe. There is a woman sitting on a grass mat with her legs folded whilst the male is sitting on a wooden stool holding a baby. At the level of indexical signification the set-up of the home connotes success by rural standards. The asbestos roof house is not affordable to many in the rural areas. Not only is there success but harmony with the woman seated below the husband, and the husband playing with the baby. This is the perfect home set-up according to Zimbabwean cultural codes where the woman is supposed to submit to her husband even in terms of sitting arrangements. Where babies traditionally used to be tended to by their mothers, this picture

¹⁴ See appendix iv for a larger image.

connotes modernity where the man helps although within the culturally acceptable set-up of the woman being below her husband. This picture falls within the culture-centred approach (Dutta, 2008). This is because in Western codes this picture connotes the continued subjugation of women where the woman is considered a lesser being hence she sits in a lower position to her husband. It connotes male power and superiority over the woman.

At the level of symbolic signification the encoded preferred meaning is that family planning leads to success and harmony in the home. The preferred meaning is that when a husband and wife plan their family they succeed not only in terms of material things (the neat and smart home) but in their relationship as well where the woman is happy to take her place while the husband is happy to help. This is a picture to be aspired by couples especially in rural areas. It is also a picture that symbolises the benefits of collective effort in reproductive health.

Production and distribution of ZNFPC's female reproductive health IEC messages

Through semi structured-interviews of ZNFPC personnel involved in the production and distribution of female reproductive health IEC messages, the researcher managed to gain an understanding of the processes involved. In terms of the organisational culture of production and distribution are related issues of funding, language, research, place of production, time and relevance, (Du Gay *et al.* 1997) and the preferred reading (Hall, 2010/1980). Also discussed is the relationship between the ZNFPC text and Chikombedzi context.

Place of production

The production process of female reproductive health IEC messages by ZNFPC has room for improvement. The data collected from the semi-structured interviews with ZNFPC officials in Masvingo revealed what appears to be some lack of consensus in terms of how IEC messages are produced. Whilst MCO1 stated that;

Our IEC materials are produced provincially...but there are others which call for national interventions but normally it's localised IEC materials because of the different contexts. For example, I can give a situation of why we resorted to localised IEC material development, Chikombedzi has got a unique culture, we had a picture of a youth with a spaghetti top, they said no, this is not a youth, this is a radio creation, our youth cover their arms, so we do localised, culturally sensitive IEC development as a whole (MCO1, Interview, 7 Aug 2015).

MCO2 seemed to contradict that by stating that;

these messages are not produced for a specific community but they are produced for the whole nation...so we don't focus on a particular community as such but just national...they are produced at our Head Quarters in Harare and distributed to every provincial office quarterly (MCO2, Interview, 7 Aug 2015).

The lack of consensus between the two professionals left the researcher wondering which of the two to believe and unable to specifically pin point the place of production. The assumption of the researcher in this case was that there appears to be some discord in the production process. While this may appear like a small anomaly, it can easily be interpreted as a sign of inefficiency in the organisational culture of production. The researcher noted that because there was no evidence of IEC materials (collected during archival research) in the Shangani language, MCO2 could be right. There could have been attempts by MCO1 to paint a picture of appropriate production processes, specifically market segmentation (Southern Africa Aids Dissemination Services (SAfAIDS), 2013), which may have been discussed at organisational level but had not yet been implemented. The researcher drew this conclusion from the fact that MCO1 (Interview, 7 Aug 2015) pointed out that they had made arrangements with Great Zimbabwe University (GZU) to help in coming up with culturally acceptable messages and translating messages to Shangani, when stating that “we have signed a MOU (Memorandum of Understanding) with the Department of African Languages.”

Relationship between text and context

Focusing on the moment of representation, one of the five moments of the Circuit of Culture model (Du Gay *et al.*, 1997), this study incorporates ZNFPC's female reproductive health IEC materials as a system of representation of the reproductive health challenges faced by Chikombedzi females. Explored here is the relationship between the ZNFPC messages and the social, cultural and economic contexts of Chikombedzi. Of particular concern are socio-cultural codes such as language and dress code.

IEC materials have to be culturally relevant and conform to the traditional and cultural codes, religious and belief systems and lived experiences of the target readers so that the languages, signs and symbols used in the text have meanings that are shared by both the producers and target readers (Du Gay *et al.*, 1997; Hall, 2010/1980). Whilst MCO1 argued that ZNFPC's IEC material for the province are in four languages,

English, Shona, Ndebele and Shangani, we are a provincial office here, in other provinces, their local languages there determine...the Shangani they speak is not standard Shangani and that is why even the translation of our IEC materials from English to Shangani or from Shona to Shangani we have signed an MOU with the Department of African languages (MCO1, Interview, 7 Aug 2015),

the analysis of the materials collected during archival research revealed only English, Shona and Ndebele as the languages used in the texts. MCO2 confirmed the existence of materials in these three languages but added, “recently we entered into an agreement with Great Zimbabwe University...they are going to translate all our IEC materials especially for the Shangani community...unless if they [Chikombedzi females] can read English, Shona or Ndebele, otherwise they have been left out” (MCO2, Interview, 7 Aug 2015).

Though there is evidence of willingness and drive to translate texts into Shangani, it can be argued that there was perhaps an attempt by ZNFPC officers to gloss over previous production oversights or shortfalls. However, the agreement between the MCOs concerning efforts to localise messages through language points to possible concrete steps being made to remedy the situation. While this is laudable, it can be argued that there was an inadvertent marginalisation of the minority groups of Chikombedzi who could not read the available languages or preferred to have messages communicated in their own local language of Shangani as a sign of being recognised and respected.

Zimbabwe has the highest literacy rate in Africa at 91 per cent, meaning that only nine per cent of this population is illiterate (*African Economist Magazine*; 2013); this population however small has to be catered for by one-on-one discussions or education, explaining the messages to the females and also by the production of IEC materials in vernacular local languages such as Shangani. MCO2 (Interview, 7 Aug 2015) stated that “we really need to sit down with those in the rural areas and explain to them what is written on those pamphlets and posters but sometimes we are limited by funding and some of the rural areas and villages are hard to reach so we just leave them at a centralised point.” As a result, this impacts on how the messages are decoded as it will depend on images alone since they carry meanings in themselves but only if one can relate without reading and understanding the textual message (Du Gay *et al.*, 1997).

ZNFPC appears to be in a quandary in terms of encoding appropriate dress codes in the Chikombedzi community. As highlighted under semiotic analysis above when messages are

targeting at the youth, the dress code is what may be considered as modern, such as young women in jeans as in Fig. 5.1 and Fig. 5.3. While this is acceptable for the targeted young people, when the older generation sees these messages they view ZNFPC is disrespecting their cultural and moral dress codes. In admitting this quandary MCO1 noted that “Chikombedzi, it has got a unique culture. We had a picture of a youth with a spaghetti top, they said this is not a youth, this is a radio creation, our youth cover their arms and don’t wear trousers.” (MCO1, Interview, 7 Aug 2015).

This quandary arises from the fact that posters and pamphlets are distributed in places like clinics where both the young and the old visit. Whereas the messages targeted at young people may be acceptable when distributed to schools and youth centres, they may become problematic in places where all ages converge such as healthcare facilities. It follows therefore that ZNFPC may have to come up with strategies in both production and distribution to deal with such possible barriers to the adoption of preferred meanings. It is possible that with the stated moves to engage GZU to help in translation of IEC messages, culturally acceptable codes will be encoded leading to shared meanings between ZNFPC and Chikombedzi female audiences.

Research for IEC material message production

MCO1 (Interview, 7 Aug 2015) highlighted the various issues involved in research, particularly in the rural area of Chikombedzi;

Masvingo is a mosaic province and Chikombedzi in particular. If we focus on Chikombedzi, the issue of language...so we have got CBDs who are on the ground and we also have Peer Educators who are on the ground and Youth Friendly Advisors who are also on the ground, so what we do in our material development issues, it’s bottom-up, people on the ground inform us about the problems, the rationale and the stats then we also do a bit of research so all our IEC material development is research based...Research is very important, it’s a component in our programming, all our interventions are evidence based...We have got many approaches, focus group discussions, we do interviews, we do community mobilisation sessions, we do community mapping, we also do, during our community mobilisation sessions we also do force field analysis. So our interventions are participatory that women participate and we then determine what is happening, like the force field analysis that we say what are the issues which are happening here, what are the enabling factors, what are the disabling factors. Then we, after every year, we do a research on the impact of what we have been doing so every year we do an impact assessment and quarterly we also do some Monitoring and

Evaluation so through those reports and stuff like that we then realise how our engagement is good, how our engagement is lacking or working and what we need to strengthen our CBDs. Health professionals and community leaders and the people themselves as well as Peer Educators are the key or the linkage between ZNFPC and the community (MCO1 Interview, 7 Aug 2015).

SDC (Interview, 7 Aug 2015) stated that research is also conducted, “through outreaches and we also visit schools and colleges through career guidance days, open days, induction of new students and also individually at health clinics.” This depicts ZNFPC as exploring various research methods for IEC message development. However, it appears there are still gaps that need to be addressed considering that there are still issues such as the failure to accommodate culturally acceptable dress codes in Chikombedzi, as pointed out above.

Furthermore, there is inadequate research information pertaining to the Shangani female reproductive health practices as admitted in the interviews;

We haven't been able to penetrate their programs because they are so secretive, they don't want outsiders to come in so if we could be able to attend such programs and maybe do a research...since male circumcision was successful we are hoping that with time we will be able to also attend the initiation ceremonies so that we actually see how they do it so that we can actually incorporate our own messages so that we work together (MCO2, Interview, 7 Aug 2015).

The beginning of puberty is the vital stage for female reproductive health communication (Moyo & Muller, 2011). Without adequate information, ZNFPC would generally end up assuming or painting its own picture of the initiation rites in a bid to put a certain message across, which might be biased or be interpreted in a totally different way. It can be argued that ZNFPC needs to be innovative in trying to penetrate these secretive initiation ceremonies. The use of opinion leaders may be one way of addressing the limitation (Valente & Davis, 1999). Opinion leaders are influential individuals in a community who “initiate the diffusion of a new idea or practice” (Valente & Davis, 1999: 57). At the same time it should be appreciated that sometimes despite the best of intentions by external organisations some communities just can be unwilling to open up to outsiders especially in what they consider sacred traditions (Shumba 2014).

Time and relevance

The issues of time and relevance are important factors in production (SAfAIDS, 2013) and ZNFPC puts this into consideration.

Materials are produced throughout the year...but if there are any new challenges on the ground which require our attention, we then respond. So it can be issue of time, the issue of relevance, the issue of the period and the issue of the reality on the ground. Like for instance, cancer in Zimbabwe, of late, cancer was not an issue but now there is the issue of cervical cancer coming on board so we could not produce cervical cancer pamphlets say 10 years back because it wasn't an issue but it's now an issue (MCO1, Interview, 7 Aug 2015).

However, with regards to relevance of IEC materials, during archival research, the researcher did not come across any IEC materials carrying cervical cancer messages but only breast cancer messages. In essence, this reflects on the organisation as having sound knowledge of the reproductive health issues and challenges that females are facing, but their research is not adequately supported by the IEC materials. The reasons could include funding or bottlenecks in distribution of materials from HQ to provincial offices. However, it can also point to trivialisation of cervical cancer as a reproductive health problem.

The production process of ZNFPC's female reproductive health IEC materials involves not only the production of new female reproductive health messages but also reviewing them after a certain period of time.

In our IEC material development, if any new invention, if any new challenge comes or if anything that requires attention there and then, we seize the opportunity but in terms of our material already there, after two years we review and then after five years we then change (MCO2, Interview, 7 Aug 2015).

Considering that societal discourses are in a state of flux, for example what may be a catchy phrase for young people today may not be so in the next six months, the approach of reviewing after two years or when need arises paints a picture of efficiency, pro-activeness and robustness on ZNFPC's part. This prevents redundancy and the messages being trivialised by the readers (Swann, 2015).

Distribution of IEC materials

As highlighted in Chapter Three, distribution patterns of materials serve to reinforce the preferred meaning (Curtin & Gaither, 2007). The SDC (Interview, 7 Aug 2015) revealed that

the distribution methods “differ depending on the messages that are required by the client and the posters are there on the walls for them to read.” MCO2 (Interview, 7 Aug 2015) highlighted that,

We have got a number of centres in the rural community. First we got a youth centre in Chikombedzi...we also stock these places with our IEC materials and when we hold community mobilisation we also go out with pamphlets and we also distribute them to every health care centre so that everyone and particularly women have access to them when they visit the centres for health services. We also give them to schools so that the pupils can access them easily...our youth centres and youth corners are marked by Peer Educators, so Peer Educators are the ones who will be giving them out and also CBDs (MCO2 Interview, 7 Aug 2015).

MCO1 (Interview, 7 Aug 2015) also added that;

for Chikombedzi we have got so many ways, the CBD route one, the Peer Educator route two, we have a community based youth friendly centre where young people come for entertainment, television, computer training, library, treatment and all other things. We also utilise the faith based organisation and the schools, so it's a multi-faceted approach, we also do community mobilisation and every Thursday they have got a market so our team goes there and distributes in the market until a level of saturation (MCO1 Interview, 7 Aug 2015).

Highlighted in the responses by both MCOs is that ZNFPC employs various strategies of distribution particularly in Chikombedzi as was employed in the Soul City Institute of Health and Development Communication (Soul City) (2014) study. This therefore results in the wide distribution of the female reproductive health messages in the rural area. However, these distribution trends are influenced by funding as revealed by MCO2 (Interview, 7 Aug 2015); “sometimes we are limited by funding and some of the rural areas and villages are hard to reach so we just leave them at a centralised point.” Funding constraints and the Zimbabwean economic status as a whole has resulted in ZNFPC focusing on the villages nearby so that their financial budgets are not strained. Therefore, not all the targeted readers get exposed to the female reproductive health messages thereby resulting in the messages getting lost and the communication becoming ineffective (Nwadiuwe, 2012).

The uneven distribution due to limited funds results in some females having limited or no access to the messages. It is clear that funding places a limitation on the distribution and reach of messages and ultimately behaviour change as Thomas Scalway (2010: 4-5)

contends, “social and behavioural communication is largely left to civil society groups and external donors...if funding was cut...and hard choices had to be made, many core elements of health communication programming would be the first to be axed.” Distribution is also important in health communication (Curtin & Gaither, 2007).

Funding

In both the production and distribution of ZNFPC’s female reproductive health IEC messages, funding plays a pivotal role. As argued in Chapter Two, Zimbabwe is a country going through economic challenges which in turn have impacted on the reproductive health status of females, directly and indirectly (Murisa, 2010). ZNFPC gets annual grants from the Zimbabwean government (Masakadza, 2011; Zinanga, 1992). However, looking at the economic crisis in the country, this annual grant is bound not to be enough since ZNFPC is non-profit making. This therefore leaves them in need of extra funding. “We have got an allocation from the government as well as from other partners and NGOs. We also use funds from Global Fund and IPPF [International Planned Parenthood Federation] to help us to make and distribute the IEC materials” (MCO2, Interview, 7 Aug 2015). MCO1 (Interview, 7 Aug 2015) viewed them as technical partners and added UNFPA to the list.

The two MCOs highlighted that even though they have funding from the above organisations, their funding does not in any way affect the message, “our technical partners, they do not have much influence on our role...the only thing that the partner does in material development is their logo besides our logo. They are not involved in any way what-so-ever in the content” (MCO1, Interview, 7 Aug 2015). While this may be true, it is inevitable that after receiving funding there is pressure to align with the values and beliefs of the funder as “funding of health communication is focused on certain and not all aspects of a health challenge” (Scalway, 2010: 5).

Preferred reading

This part of the chapter presents a semiotic analysis of selected IEC materials in order to establish the encoded preferred meaning (Hall, 2010/1980). This preferred reading will be supplemented with analysing the data provided in the ZNFPC employee interviews, with a specific interest in the moments of production, representation and consumption (Du Gay *et al.*, 1997). The preferred reading will be established before the readings of the target readers is established in the chapter to follow.

McKee *et al.*, (2014) make clear the distinction between Behaviour Change Communication (BCC) and Social and Behaviour Change Communication (SBCC). BCC has its roots in the medical field, particularly public health communication where the aim is to persuade individuals to change behaviours to healthier ones (McKee *et al.*, 2014). SBCC on the other hand is rooted in social sciences and focuses on factors that can influence change (McKee *et al.*, 2014). In view of these definitions it is necessary to determine whether the preferred meaning of ZNFPC IEC messages is to encourage behaviour change or social and behaviour change.

Through a semiotic analysis of the IEC materials collected it is evident that ZNFPC's female reproductive health IEC messages can be put into three different categories; Adolescents Sexual and Reproductive Health (ASRH), condom programming and family planning. From the sample IEC materials discussed earlier on, IEC materials in Fig. 5.1 and Fig. 5.3 fall under ASRH programming, Fig. 5.2 falls under condom programming and Fig. 5.4 under family planning programming. The IEC materials indicate that messages are targeted at the individual as well as the interpersonal levels of the SBCC by McKee *et al.*, (2014). Fig. 1 for example is targeted at school going girls and appeals to their cognitive to consider the risk of unplanned pregnancies. Fig. 5.2 addresses the interpersonal where both young girls and boys are encouraged to be each other's strength in order to build strong individuals particularly girls. According to McKee *et al.*, (2014) the interpersonal level involves an individual's relationship with partners, family and peers. This also appears to be the case with Fig. 5.4 where the benefits of family planning are portrayed as benefiting not just the woman but the husband as well leading to a happy and successful family.

In the interviews with ZNFPC personnel, MCO1 (Interview, 7 Aug 2015) indicated that;

we deduce our material from our programming areas...these three pillars; condom programming, ASRH and family planning shape our what, our focus on material development and now we are focusing much on cervical cancer which is a new thing coming on board...In particular areas, especially in rural areas, our thrust is the health, wellbeing of young women and girls in terms of information about their reproductive system, how to take good care of them, how to avoid infection among other issues. So generally we are saying we are trying to feed into a positive health status of young women's reproductive health issues (MCO1 Interview, 7 Aug 2015).

Under the different programming areas, particular areas of focus include;

the issues of delaying sexual debut, issue of STI prevention, even basic hygiene, like the anatomy and stuff like that, even the issue of knowledge, do they have the knowledge because we believe knowledge, information and communication are the basis of what, of reproductive health, then we look also at the issue of pregnancies, maybe when they are 23 they want to get married, we are talking about *Too early, too soon* and all that stuff, that's when family planning programmes now come in. We want to see change in all those areas. (MCO1, Interview, 7 Aug 2015).

There appears to be less of community engagement not only in the sampled IEC materials but in interviews with key informants as well. As highlighted earlier, MCO1 stated that ZNFPC conducts research first before producing IEC materials in what they call a bottom-up approach. Such an approach suggests a lean towards SBCC but the evidence from IEC materials as well as statements quoted above, do not seem to reveal an appeal to the role that the community can take, instead it is more about what the individual can do. SBCC

should be empowering and horizontal; encourage communities to be agents of their own change; promote dialogue, debate and negotiation (as compared to information and persuasion techniques); emphasise the process of interactions, shared knowledge and collective action (rather than sender-receiver model); and focus beyond but to include individual behaviours – on social norm change, policies and culture to unfold sustainable change in communities and among individuals (McKee *et al.*, 2014: 278).

While the will to lean towards the SBCC model may be there, evidence from both IEC materials and semi-structured interviews appears to suggest that there is little in terms of encouraging collective action and focus on social norm change, policies and culture. There therefore is room for improvement in terms of the preferred meaning of ZNFPC reproductive health messages to go beyond the individual and focus on social change as well.

As shown by the semiotic pointers in the IEC materials and supplemented by interview responses, “teenage pregnancies are on the rise, STI cases are on the rise, child marriage, rape, here and there we also find cases of rape, the issue of cervical cancer is also on the rise and the other issue of family planning is still to be accepted by them” (MCO1, Interview, 7 Aug 2015) as the females in rural areas “are in need of education for their female reproductive systems to function well” (SDC, Interview, 7 Aug 2015). MCO2 further emphasised that “they still have little information on how to take care of themselves mainly due to poverty and lack of information so as an organisation we are still viewing them as

lacking a lot of knowledge; they still need more information on their sexuality” (MCO2, Interview, 7 Aug 2015). All this points to a drive towards providing information and persuasion which is characteristic of BCC. A candid conclusion may be that the current focus of ZNFPC IEC messages is BCC and not SBCC.

Conclusion

Borrowing from the production stage of the Circuit of Culture model (Du Gay *et al.*, 1997), the chapter identified the semiotic pointers in sample ZNFPC female reproductive health IEC materials and presented and discussed findings relating to the production and distribution of the materials. Also established is the preferred reading attached to the texts (Hall, 2010/1980). Chapter Six presents and discusses findings from focus groups in the light of the SEMCHB (Kincaid *et al.*, 2007).

CHAPTER SIX

DATA PRESENTATION AND ANALYSIS: DECODING OF ZNFPC MESSAGES AND FACTORS INFLUENCING RECEPTION

Introduction

Chapter Five presented and analysed data collected in archival research alongside responses from semi-structured interviews. It analysed the moment of production (Du Gay *et al.*, 1997) and the encoding process of the Zimbabwe National Family Planning Council's (ZNFPC) messages (Hall, 2010/1980). In order to gain a fuller understanding of the circuit of the ZNFPC messages, this present chapter focuses on the moment of consumption (Du Gay *et al.*, 1997). It analyses data from the three focus groups with a sample of 22 Chikombedzi females in order to understand how these ZNFPC messages were decoded using the Encoding/Decoding model (Hall 2010/1980), as a guide. It also aims to identify factors that may influence these perceptions, based on the theoretical guidance of the Social Ecology Model of Communication and Health Behaviour (SEMCHB) (Kincaid *et al.*, 2007).

As noted in Chapter Four, focus group participants chose to remain anonymous and are therefore referred to in numbers, for instance; Participant one in focus group one conducted on 10 August 2015 will be referred to as (P1, FG1, 10 Aug 2015). Findings from the focus group discussions are analysed and presented using the ascending levels of the SEMCHB (Kincaid *et al.*, 2007). In the process, there will be some overlaps in the sections due to the interrelated nature of the model.

Individual level

Located at the individual level of the SEMCHB (Kincaid *et al.*, 2007) are "behaviour and intention; knowledge and skills; beliefs and values; emotions; perceived risk; self-efficacy; self-image; subjective norms" (Storey & Figueroa, 2012: 75). It is at this level that individual attitudes and perceptions are located (Kincaid *et al.*, 2007). Attitudes are concerned with the beliefs that an individual has towards a cultural artefact and is concerned with behaviour and emotions (Culbertson, 1968; Pickens, 2005). "Perception is closely related to attitudes...a person is confronted with a situation or stimuli. The person interprets the stimuli into something meaningful to him or her based on prior experience" (Pickens, 2005: 52). In relation to this particular study, attitudes are understood as emotions, opinions and responses to ZNFPC's female reproductive health messages communicated in the form of IEC

materials. Furthermore, as can be seen in the definition by Pickens (2005) perception involves cognition and therefore is located at the individual level of the SEMCHB (Kincaid *et al.*, 2007). This study takes cognisance that the external environment affects these individual attitudes and perceptions, as will be elaborated.

Knowledge about female reproductive health

Though the focus group participants acknowledged that females are more affected by reproductive health issues as compared to males, most of them found it difficult to explain or define reproductive health. Below are some of the definitions of reproductive health that were given during the discussions:

It is when you have no pains in your body (P1, FG1, 10 Aug 2015).

It is when you do not fall sick frequently and you are able to do your tasks without any health disturbances, you will be in perfect health (P2, FG1, 10 Aug 2015).

I think reproductive health has to do with the physical health of a person at a certain period of time, either that person is sick or not (P1, FG3, 14 Aug 2015).

I think it has to do with a person's health but it goes on further to focus on the reproductive organs, particularly whether or not a person is able to have children even if when that person has a certain illness and whether or not he or she can engage in any sexual activities so that they can be able to reproduce (P2, FG3, 14 Aug 2015).

I think reproductive health, to us females mainly focuses on our reproductive health system and our sex organs (P3, FG3, 14 Aug 2015).

Participants from the second focus group failed to at least try and define reproductive health. From this and the definitions given by participants from the other two focus groups it is clear that Chikombedzi females have limited knowledge about their reproductive health. In most of the definitions given, the participants largely believe that reproductive health is being in total health with no illness. This, however, is not the case as reproductive health is the “state of complete physical, mental and social well-being of an individual in all matters relating to the reproductive system and its processes and functions but not merely the absence of disease or infirmity” (United Nations (UN) 1994: paragraph 7.2). This shows that the focus group participants lack adequate reproductive health knowledge. Therefore, ZNFPC employs posters, pamphlets and booklets as a way of bridging this knowledge gap and encouraging behaviour change.

The perceptions and attitudes towards ZNFPC's female reproductive health messages in Chikombedzi are related to the knowledge held by the females. It is evident that the third focus group which consisted of six young women in high school and tertiary institutions had a richer knowledge of what reproductive health is, compared to participants from the other two focus groups. These two groups included housewives, single mothers and widowed women who have minimal educational levels as some stated that they had stopped school at early ages. This confirms that the level of knowledge and education determines a person's understanding of what female reproductive health is, as well as their interpretation and assumed behaviour change (Shabaya & Konadu-Agymang, 2004).

However, as argued by Airhihenbuwa & Obregon (2000), it is not definite or obvious that the linear model of knowledge results in behaviour change and is therefore not guaranteed as higher levels of influence on behaviour change exist as argued by the meta-theory; SEMCHB (Kincaid *et al.*, 2007). An advantage of the SEMCHB model is that many of the sources of resistance to change at one level can be found in obstacles that exist not only at the same level but also at a higher level of analysis. And the contribution of the ecology model is to emphasise how higher levels constrain and act as barriers to change at lower levels of analysis. In this case it is evident that the lack of understanding at the individual level by women not in educational facilities is influenced by them having stopped their education prematurely. This can then be explained by practices at community level where early marriages for example are prevalent (Kachere, 2011; Katsande, 2014; ZYC, 2014).

The third focus group participants see the IEC materials in their schools and colleges where they spend the larger part of their time, whilst the women who do not attend formal educational institutions showed limited or no knowledge of what reproductive health is. One of the focus group participants highlighted "when I once went to the clinic to register my pregnancy that is when I came across the information" (P1, FG2, 10 Aug 2015). Knowledge acquisition is thus constrained by their access to education, as it is usually only acquired via infrequent clinic visits. The fact that the females in schools and tertiary institutions are in a better or closer position to define or relate to what reproductive health is paints a picture of distribution flaws in Chikombedzi which seem to be mainly concentrated in educational and health facilities. One participant suggested that; "not everyone has money to go to the clinic or send children to school so it is best they put the materials at the Chief's place and the court yard where we meet frequently for different occasions" (P1, FG2, 10 Aug 2015). The

suggested distribution places also show the importance of community and/or opinion leaders (as will be discussed later on in this chapter).

The Chikomedzi women, therefore, have a limited understanding of what reproductive health really is about though they can identify the reproductive health challenges and concerns that they have. The difference in levels of knowledge of female reproductive health influences the perceptions and attitudes that they have of ZNFPC's posters, pamphlets and booklet messages. The focus group participants' responses revealed that for most Chikomedzi females, female reproductive health is defined by family planning and condoms, and perceive anything other than that as a result of family planning and condom messages, especially with regards to cancers, abuse of women, Sexually Transmitted Infections (STIs) and HIV and AIDS, as will be discussed below.

Contraceptive and condom messages promote diseases and population control

In an oppositional reading (a reading in which a woman understands the message but chooses to totally disregard and reject it) of the preferred message (the intended behaviour change message by the producers of the IEC materials; ZNFPC) (Hall 2010/1980), the sample of females perceived ZNFPC messages as promoting the spread of diseases through the use of contraceptives and condoms. The participants stated that:

It is these pills that they encourage us to take that bring in all these illnesses (P3, FG2, 10 Aug 2015).

Cancers are also a result of family planning pills and condoms (P1, FG3, 14 Aug 2015).

What I see as the problem are these people from the hospitals bringing these reproductive health messages to us. They want us to change from what we have been doing for years and years; before they came we were happy and healthy (P4, FG2, 10 Aug 2015).

The above perceptions suggest a disregard of ZNFPC's IEC messages because the females hold misconstrued and suspicious perceptions of both the contraceptives and the messages. In light of the SEMCHB where there is interconnectedness in all the levels from the individual to the societal level (Storey & Figueroa 2012), a disjuncture exists between the societal level, in which ZNFPC is mandated to provide family planning and reproductive health services and information in the whole country (Zinanga, 1992), and the perceptions which the targeted individuals hold. Such a disturbance in the ecology calls for interventions that bridge the gap between individual and societal influences. As highlighted in Chapter Five, ZNFPC

reproductive health communication currently is geared more towards Behaviour Change Communication (BCC) than Social and Behaviour Change Communication (SBCC). The responses of women as above highlight the need for ZNFPC to realign their communication perhaps towards SBCC. Communication that targets change at societal level could help bridge the noted disjuncture. This communication would evoke dialogue and debate in the Chikombedzi community on issues pertaining to reproductive health as advocated by McKee *et al.*, (2014). Peer educators can be trained to engage the community in a bid to build horizontal acceptance of issues to do with reproductive health.

It is also of importance to note that these women perceive and interpret ZNFPC messages, products and services in the light of influential societal icons such as the Zimbabwean Registrar-General, Tobaiwa Mudede and the ZANU-PF¹⁵ National Political Commissar, Saviour Kasukuwere who urged the Zimbabwean government to ban contraceptives as they believe them to be the cause of reproductive cancers and deaths in reproductive women and are against family planning which they view as a population control mechanism (Mangudhla & Mushava, 2014; The Herald Reporter, 2015). This is evidenced in the following statements:

These messages will end up telling us not to have children (P4, FG2, 10 Aug 2015).

They say we are reproducing like mice...why talk of family planning, it happens naturally, menopause will come eventually (P1, FG2, 10 Aug 2015).

This form of local discourse relates to Keyan Tomaselli's (2011) ideas on micro level myth making and mediatisation. Of importance to note is the value of role modelling following Bandura's social cognitive theory – a theory that is situated at the individual level of the SEMCHB (Kincaid *et al.*, 2007). Tomaselli (2011: 41) argues that these local oppositional readings and discourses;

have enormous implications for campaigns based on social learning theories (Bandura, 1962) that assume popular industrial-type rationality. Mediatisation occurs when media and meaning interact to generate socially and culturally based interpretations of a phenomenon. For example LoveLifes' assumptions about the links among media imaging, sex, body shape and consumption as indicated in its advertising constitute a deliberate mediatised construction. In contrast a different type of organic mediatisation is revealed in that the stigma and discrimination are still commonplace in some rural parts of KwaZulu-Natal. The way that

¹⁵ ZANU-PF is Zimbabwe's ruling political party.

the media are hailed by a valley community to image/imagine the cycle of HIV/AIDS hinders the uptake of HIV/AIDS counselling and testing.

Similarly, the myth making and misconceptions in Chikombedzi obstructs the interpretations of the preferred messages of the IEC materials, as does cultural norms, morality and beliefs which come from factors of influence higher than the individual level (as will be discussed later).

However, one participant had a contrasting view; “I have heard, read and understood these female reproductive health issues, the messages are of value to me” (P2, FG2, 10 Aug 2015). Such a perception, however, might be regarded as “going against the grain” (Airihienbuwa & Obregon, 2000: 7) in this rural environment. The views of participant (P2, FG2, 10 Aug 2015) leaves no room for the myths and misconceptions about condoms and contraceptives as forming the basis of perceptions and attitudes as highlighted by the other views.

Attitudes and perceptions and the negotiated reading

In as much as some research participants showed an oppositional reading of the preferred reading; behaviour change, some participants held a negotiated reading. In the light of Hall’s Encoding/Decoding model (2010/1980), the negotiated reading is reached when the reader weighs the preferred reading against her needs and wants, adjusts the preferred reading to suit her social situation, uses and gratifications (Pitout, 2007).

Perceived risk is one of the indicators at the individual level of the SEMCHB (Kincaid *et al.*, 2007). The females of Chikombedzi also expressed the perceived risk involved in adopting the preferred reading of ZNFPC reproductive health messages. The perceived risk results in a negotiated reading (Hall 2010/1980). The focus group participants stated that;

Yes, the messages are right, they are good, but it’s pointless when the health service providers tell everyone information that is supposed to be confidential (P1, FG1, 10 Aug 2015)

The messages are good but those nurses do not immediately attend to us (P4, FG1, 10 Aug 2015).

The perceived risk associated with visiting a healthcare centre leads the women to adopt a negotiated reading where they agree that the messages are good but are hesitant because of the fear of having their confidential information exposed and perceived inevitable ill-treatment by nurses.

Beliefs and values as well as subjective norms at the individual level of the SEMCHB (Kincaid *et al.*, 2007) were also found to lead to negotiated reading of ZNFPC IEC materials. Some of the participants noted that;

These messages have a positive influence to our children with regards to education, but we do not always have the money to pay (P1, FG2, 10 Aug 2015).

Though education is good, some of these things can be acquired even without high levels of education (P4, FG2, 10 Aug 2015).

Chikombedzi is an area close to both the Mozambican and South African borders as highlighted in Chapter One. Uneducated young people often cross the borders especially into South Africa often illegally and some of them support families back home with whatever they get across the border. This has led to subjective norms such as education does not determine success since success can be achieved even by the uneducated.

Knowledge and skill as an indicator at the individual level of the SEMCHB (Kincaid *et al.*, 2007) was found to induce a negotiated reading. Participants acknowledged that;

The messages are good, but do you expect me to immediately adopt a message which I do not know where it came from, what if it's end result is death? (P3, FG2, 10 Aug 2015).

Yes, the issues on the materials are true and that is exactly what is happening here, but we never see these ZNFPC people here asking us (P1, FG2, 10 Aug 2015).

There is evidence of lack of adequate knowledge about ZNFPC reproductive health messages in the responses above. Adoption of the preferred reading is hindered by the lack of adequate knowledge even though there is an acknowledgement that the messages are good. This reveals gaps that ZNFPC can make efforts to cover by widening their reach and involving the community in the production of messages. As highlighted in Chapter Five, ZNFPC's IEC materials can be left at centralised points as some areas in Chikombedzi are hard to reach, therefore, it can be argued that the above responses are from research participants who have limited participation in ZNFPC programs and exposure to messages because of inadequate infrastructure such as roads and bridges. Participants further revealed that;

Some only understand the messages depending on the images because they cannot read and understand the languages used...the pictures are attractive so it only depends on whether or not that person likes the images used (P3, FG3, 14 Aug 2015).

We want to follow the messages but we have to understand it looking at our situation, culture and environment (P2, FG3, 10 Aug 2015).

This shows the negotiation of the preferred reading because of literacy rate and the marginalisation of the Shangani through language. Also highlighted is a negotiation of behaviour and intention after reading the messages against socio-cultural situations and environment.

The reception patterns or interpretations of ZNFPC's IEC messages by Chikombedzi females are a result of other higher ascending levels of influences as these females do not exist in a vacuum. These higher levels of influence stand either as barriers or as support pillars of the preferred reading attached during the production process. At the moment of consumption (Du Gay *et al.*, 1997), various factors come into play which impact on how they decode the message (Hall, 2010/1980). These factors of influence are discussed below in the light of the SEMCHB (Kincaid *et al.*, 2007) whilst at the same time discussing and emphasising issues of attitudes and perceptions and the readings held by the sample.

Social Network

Social networks stand as a level of influence higher than the individual level in the SEMCHB (Kincaid *et al.*, 2007). Influences to behaviour change come from forces that include “partner and family relationships (communication, trust, understanding, agreement and power), peer influence, gender equity, bounded normative influence” (Storey & Figueroa, 2012: 75). These influences can either be supporters or barriers to behaviour change. In this particular study, discussed under social networks are issues pertaining to influences from partners, family, peers and group norms.

Social influences of partner and family

Some of the females in the sample held the notion that if ZNFPC messages are entirely followed (dominant reading), they could cause social problems that include divorce, inappropriate dressing, prostitution and young women not getting married as spouse or partner and family might stand as barriers to the mediated behaviour (Storey & Figueroa, 2012). Participants highlighted that;

These messages, your husband will say you are being promiscuous (P6, FG1, 10 Aug 2015).

Men do not accept, you will end up divorced (P1, FG1, 10 Aug 2015).

Wesley Mathew (2012: 74) posits that partners or spouses are “strong inter-personal influence” to behaviour change. Though Mathew’s (2012) study was dedicated to Medical Male Circumcision (MMC), the influence of partners in adopting reproductive health behaviours was also discussed in this current study. Participants revealed that;

When I once went to the clinic wanting to register my pregnancy that is when I came across the information but I delivered my baby at home after my husband turned down some of the information I brought (P1, FG2, 10 Aug 2015).

As women we are faced with challenges to do with birth control because it’s difficult for our husbands to accept family planning (P3, FG2, 10 Aug 2015).

If you do not bear many children, the possibility is that your husband will marry another woman and this can end up affecting all parties involved because you do not know the health status of the other woman (P2, FG2, 10 Aug 2015).

These responses show that their own interpretations are influenced by what their husbands think and perceive about these messages. As argued in Chapter Two, Chikombedzi is characterised by unequal power relations and male domination therefore, the women are not independent enough to make the decisions as they are supposed to be submissive to their husbands (Kambarami, 2006; Mairingira & Sutherland, 2010). Furthermore, for the sake of their marriages and to please their husbands, the women interpret messages the way they think would be best for other parties involved; their spouses. The views highlighted above portray husbands as barriers to the preferred reading and ultimately, behaviour change. This again calls for a well-researched inclusive approach by ZNFPC where SBCC is emphasised above BCC.

However, one participant stated that; “My husband and I plan our family and our children will continue going to school” (P2, FG2, 10 Aug 2015). Though this participant was “going against the grain” (Airhihenbuwa & Obregon, 2000: 7) and was even accused of bewitching her husband during the discussion, her response shows that social networks can be enablers of behaviour change not just barriers. A preferred reading is adopted because of the support of the husband. This also reflects on individual values, perceived risk of behaviour change and subjective norms that exist at the individual level of the SEMCHB (Kincaid *et al.*, 2007) as this sample revealed that they are not empowered enough to stand alone without their male counterparts. Participants further highlighted that;

We do not want these ones about condoms because a man will tell you that he will not eat a sweet in its wrapping, worse still for us, a woman who he paid bride price for (P1, FG2, 10 Aug 2015).

Family can either be a constraint or a pillar of support to certain interpretations and behaviour change. This was evident in the third focus group in which participants stated that:

At home, I will be humiliated and be degraded to the last bit. Some of us, especially for me, I am a pastor's daughter...As for me, I imitate my sister, my sister has a proceeded education, is taking his masters, eeh PDF whatever whatever at university level. I just seem to like it. Also I am very proud of my church...my sister is my role model (P2, FG3, 14 Aug 2015).

She can follow in her sisters' footsteps because her parents allow them to go to school and can afford but for some, what your parents say goes. How can I proceed with school when my parents say I should get married, where will I get school fees from, shelter and food...if you refuse to listen, your parents can disown you and that in itself is a curse (P3, FG3, 14 Aug 2015).

Highlighted in the responses above, is the importance of family support and role modelling in the interpretation of female reproductive health messages. Highlighted in P2's responses is the issue of her family's social and religious standing and support and her sister as her role model. These pillars of support impact on how she reads ZNFPC's education messages as an indirect influence on positive reproductive health status and also the issue of role modelling in within the family.

The broken English of P2 shows an attempt to demonstrate difference as a result of better education leading to a better reading and understanding of messages and family support. Also brought to light is that higher levels of family support and education result in better reception, that is, the adoption of the preferred reading. In as much as P3 in FG3 would want to adopt the preferred reading, her family and their finances determine her reception patterns and ultimately behaviour.

Peer influences

Focus group responses showed evidence of peer influences in the meaning making process. In the third focus group, participants revealed that peer influence is mostly evident when it comes to issues of sexual relationships.

The problem starts when I see some of my friends with things that I do not have because my parents cannot afford. That is when I start having multiple relationships so that I have what my friends have and can afford to buy myself goodies. Even when one boyfriend is broke, the other one will always give me money (P1, FG3, 14 Aug 2015).

The above response shows that even if the consequences of risky behaviour are understood through the IEC materials, the quest to identify with peers overrides the message. Suzanne Leclerc-Madlala (2001: 43) contends that in the St Wendolin community, “for many young women, having relationships with a number of men was seen as the pre-marital ideal situation, a situation which many were prepared to initiate and maintain.” As shown above, this is also the case with young women in Chikombedzi. Though this shows the poverty that pervades the fabric of many families in the rural community of Chikombedzi, peers as a part of social networks play a pivotal role in influencing reception patterns as love for perceived luxuries and rewards that others have leads to the negotiation of otherwise understood reproductive health messages (Leclerc-Madlala, 2001).

The second focus group discussion showed evidence of peer influences in reception as some participants exhorted others saying;

women, some of these messages, just read and ignore...we know of some women who are now divorced because of wanting to follow the messages in these pamphlets, posters and booklets, let's ignore these messages and continue with our usual ways (P4, FG2, 10 Aug 2015).

Even during the focus group discussions, as shown above, traces of peer influences were evident as some took the liberty to encourage the others to respond in the way they saw fit. This demonstrates that peers are either a positive or negative influence in decoding of messages and in the end, behaviour change as one learns from others.

Moral decency and social networks in Chikombedzi

The issues of moral decency in Chikombedzi are influential in how the females decode ZNFPC's female reproductive health IEC messages. One participant highlighted that; “a poster I once came across, the girl on the picture had her shoulders showing, here women do not walk around like that, such images give our children the wrong ideas and even I as a mother, I cannot show or discuss such with my family” (P4, FG2, 10 Aug 2015). For the women, a poster that seems to promote, in her view, moral indecency cannot be good for

anyone in the community. This is an example of how the normative influence, as accounted for in the social network level of the SEMCHB (Kincaid *et al.*, 2007) acts as a barrier to spreading the ZNFPC messages, as women feel they do not want to engage with images that do not conform to the morality they wish to teach their children.

The use of condoms is regarded as more or less immoral and used by unfaithful women as implied by one of the focus group participants who pointed out that “condoms are used by prostitutes” (P1, FG2, 10 Aug 2015). This shows a negative attitude towards messages advocating for the use of condoms for protection against HIV and AIDS, pregnancies and STIs. The perception of condoms as a method used by prostitutes shows a contrast in the portrayal of two different types of women and therefore serves as a distinction between the immoral (prostitutes) and the moral (faithful) women.

“It seems like these messages are encouraging our daughters to engage in sexual activities through using protection but here in Chikombedzi, we do not permit our daughters to indulge before getting married” (P4, FG1, 10 Aug 2015). This sentiment shows that some women perceive the messages as encouraging their daughters to engage in sexual activities before marriage which is against their beliefs and values. This highlights that females in Chikombedzi read the messages differently to that intended by ZNFPC as they weigh the messages in the light of their own socio-cultural norms, values, beliefs and practices. As highlighted during the first focus group discussion, many females do not give themselves time to read and understand the messages and stand to be corrected and influenced by peers and family, as is documented in the SEMCHB (Kincaid *et al.*, 2007).

However, one participant attempted to correct the misunderstanding of messages related with condom use stating that; “No, you do not understand the message. They are saying you should not indulge in any sexual activities but if you fail, use condoms so that you protect yourself from early and unwanted pregnancies, STIs and HIV and AIDS, not that they are saying have sex” (P7, FG1, 10 Aug 2015). This participant demonstrates that there is room for ZNFPC to use individuals as positive influence to the rest of the community as urged by McKee *et al.*, (2014).

The desire of parents upon their daughters in light of upholding moral decency has an influence in the meaning making process. One of the participants argued that;

it's better that my daughter gets married early as compared to her going to school because I want her to look after me in future, that is when she ends up falling pregnant and then leaves the baby with me. It is better she gets married early and goes and stays with her husband (P7, FG1, 10 Aug 2015).

The adoption of the preferred reading is further affected by mothers' desire for their children to avoid known social phenomena such as sugar daddies/intergenerational relationships. One participant stated that; "there is a woman close to where I live who decided to follow these messages and send her daughter to school, now we see her being dropped off by different older men, this is what these messages are teaching our children" (P4, FG2, 10 Aug 2015). This view shows the preferred reading being weighed against social experiences. Though this behaviour is regarded as immoral, as highlighted above, young women in this rural community view the relationships with older and multiple men "from a financial point of view, rewarding" (Leclerc-Madlala, 2001: 43).

Cultural and group norms

Cultural aspects such as language and group norms are influences to how individual females decode ZNFPC's female reproductive health messages and therefore stand as normative influences. In this rural setting, females do not exist in a vacuum or as individuals and therefore are bound by group norms, so as to belong (Airhihenbuwa & Obregon, 2000), which influences their attitudes and perceptions. As argued by the Ministry of Education, Sports and Culture (MESC) (2007) language binds a culture together, therefore, the languages used in the encoding of female reproductive health messages by ZNFPC influences how Chikombedzi females, as a community decode the messages. Some of the focus group participants revealed that;

I came across one in Shona and I also saw a woman holding one written in English, but she used it to make a fire (P3, FG2, 10 Aug 2015).

How can you say, for example, me, I am not educated and you give me a pamphlet written in a language that I do not understand, where will I get the time to read it? If they cannot write in languages we understand, then it is best they do not give us the pamphlets and posters, we will go and seek help and advice at the churches (P4, FG2, 10 Aug 2015).

As highlighted in these responses language can act as bounded normative influence. The normative for these women is that it is a sign of respect if ZNFPC produced their materials in

local languages that they understand. The production of messages in English for example acts as a barrier to the adoption of the preferred reading. ZNFPC produces female reproductive health IEC material messages in English, Shona and Ndebele as revealed through a semiotic analysis of a sample of IEC materials collected through archival research and supplemented by semi-structured interviews of selected ZNFPC personnel.

The fact that there are no Shangani IEC materials, as revealed in Chapter Five, shows neglect and marginalisation of minority cultures and languages which therefore impacts on how they interpret the encoded messages. The above views show an oppositional reading and messages that are disregarded and lost due to the language barrier (Nwadigwe, 2012). The language barrier also makes the Chikombedzi females perceive the messages as targeted to other females and not them. The relationship between the images used in the text in terms of dress code and the Chikombedzi context contributes to females' perceptions and attitudes of these messages. Participants highlighted that:

Here, girls do not walk around wearing sleeveless tops like in those pictures (P4, FG2, 10 Aug 2015).

Our daughters do not wear trousers; it is against our culture (P1, FG2, 10 Aug 2015).

Whilst the message may be targeted at the young women or youth the representation of the female body; a modern young woman in fashionable clothes, is not in line with the Chikombedzi cultural norms and values results in oppositional readings that could even lead to social problems as older females do not accept this kind of dressing as it is regarded as indecent. As a result of the bounded normative influences, the messages are perceived as not for the Chikombedzi females but for other populations or ethnic groups which accept that kind of dressing. This may result in an opposition of the preferred reading.

From lived experiences, these women draw their attitudes and perceptions of these reproductive health messages weighing them against other influences such as social networks and the cultural practices of the community. Participants exclaimed;

Have you seen this educated girl who comes from this area, now she wears trousers. This is the schooling that they are talking about (pointing at the posters), have you ever seen anyone dressed like that here...they claim to be educated but now their behaviour is diluting our culture (P4, FG2, 10 Aug 2015).

looking at this poster women, a girl sitting in class with such a short skirt is bound to get raped (P2, FG2, 10 Aug 2015).

In the light of their arguments, this sample posits that through the promotion of the girl child education, ZNFPC indirectly promotes behaviours that are socially unacceptable in this rural community, particularly in relation to dress codes. Some participants also highlighted that because high levels of education, if the messages are followed, some girls, “will never get married” (P1, FG2, 10 Aug 2015). This shows the importance of marriage in this rural community unlike education as argued by another participant “whatever problems she might face, the fact that she is in her home, that’s the most important part” (P1, FG1, 10 Aug 2015).

The cultural norms followed by the females in Chikombedzi direct their will in terms of girl child education and healthcare as revealed by participants that;

as girls we are not empowered to voice or go against attending initiation ceremonies...and after that it is dependent on our parents whether or not I should continue attending school because I am now a woman, tradition says I should get married (P3, FG3, 14 Aug 2015).

modern health services are not accepted by most people here, there are plenty of witch doctors who give traditional herbs as medication, so we get medical help from them (P1, FG3, 14 Aug 2015).

Therefore, girl child education is least important as compared to marriage and the traditional schools of womanhood and so are modern health services as compared to traditional medication. Considering the cultural norms and values in Zimbabwe, the process of a man paying bride price for his wife, known as *roora*, is valued by both the family (social networks) and at societal level as it is a cultural practice (ZYC, 2014). However, some respondents revealed that;

the low status of women is a result of the fact that men argue that they paid the bride price, so I therefore do not have a say in anything and even in these issues to do with reproductive health that we are talking about, aah, it’s very difficult (P2, FG2, 10 Aug 2015).

As argued in Chapter Two, in Chikombedzi, an attractive bride price is the family’s aim and pride of early marriages of their daughters (Maringira & Sutherland, 2010; ZYC, 2014). The above response shows a cultural practice that is culturally valued by the Zimbabwean society at large, but that seems to be used as a tool by men in marriages against the freedom of

women with regards to reproductive health choices as they will be young. This, therefore, directs the interpretation of reproductive health messages by women.

Community Level

As revealed by focus group responses, the level of community stands as a factor of influence in females' interpretation of ZNFPC's IEC reproductive health messages. At this level, influences come from factors that include "community leadership, level of participation, information equity, access to resources" (Storey & Figueroa 2012: 75). During focus groups, issues pertaining to community and religious leadership or role modelling and access to resources were revealed and are therefore discussed as factors of influence to reception.

Community and religious leadership

One of the indicators at community level is leadership (Storey & Figueroa, 2012). Focus group participants suggested that the distribution and research of ZNFPC's IEC materials should be done through the community leaders such as the village heads and churches as this can help influence their reception of the messages. Participants pointed out that;

even at the village court, where we find the village head, they should put a few posters so that we go there and we will then be able to see the materials and participate in ZNFPC activities (P4, FG2, 10 Aug 2015).

at the churches, it's easier for the messages to be accepted because of the respect they have for the leaders (P5, FG3, 14 Aug 2015).

The suggestions of the village court and the churches as places for distributing ZNFPC's IEC materials show the influence of religious leaders and community leaders over the community. Religious and community leaders therefore play a pivotal role of opinion leaders in this rural environment and can therefore influence certain interpretations, behaviour and collective norms if engaged (Cornwall, 2008). The fact that ZNFPC does not employ the village heads and religious leaders in their distribution and research strategies lowers the level of participation of these rural females and therefore the effectiveness of the messages. For a community that is steeped in cultural practices, the respect for traditional and religious leaders could increase levels of acceptance of ZNFPC's messages.

Access to resources

Access to resources focuses on aspects of access to education and other resources and the marginalisation of minority ethnic groups (Storey & Figueroa, 2012). Discussed under access to resources in this study are influences of resource allocation and marginalisation of minority ethnic groups to reception. The limited access to resources at community level in turn affects how these resource limitations are dealt with by the various social networks in which the individual females exist in. This then impacts on how reproductive health messages are read and made meaning of at individual level as the levels of the SEMCHB (Kincaid *et al.*, 2007) are interrelated.

As revealed by the focus groups, it can be argued that the fewer the educational facilities, the lesser the females access to education. The participants revealed that; “the school is far from where I stay, sending a child to school is pointless as she will get there tired and will later have to walk back home where she also has chores to do, were will she get the time to study” (P7, FG1, 10 Aug 2015). This shows that limited access to resources such as educational facilities further marginalises the young women by denying them the right to education as they also have socially ascribed duties within the home. The end result of minimum or no access to resources to increase educational facilities is young women dropping out of school and getting married early as this is a practice characteristic of rural and marginalised areas (ZYC, 2014).

Though service delivery is the responsibility of the societal level as it pertains to government work and responsibilities, it is implemented at community level through various municipalities (Storey & Figueroa, 2012). In Chikombedzi, the healthcare facilities are few and short stuffed (*The Standard*, 17 December 2011) and as indicated by focus group participants; “at the clinic, there can be only one nurse attending to both males and females” (P2, FG3, 14 Aug 2015). This gives a reflection of a work overload for the medical staff and as they become more acquainted with the villages, the villagers start losing faith in the delivery system particularly with interest to issues pertaining to confidentiality. One participant highlighted that; “the nurse knows me, so going there for medical assistance, I will not lie to you, I will not go...I’m afraid she will tell my mother” (P1, FG3, 14 Aug 2015). Therefore, limited access to resources at community level stands as a barrier to female reproductive health behaviour change at individual level as educational and health facilities

marginalise the already marginalised minorities; females, though these resources are allocated at societal level.

Societal level

Located at the societal level are influences related to “national leadership; per capita income; income inequity; health policy and infrastructure; mass media; religious and cultural values; power relations; gender norms” (Storey & Figueroa, 2012: 75). This level stands as the highest level of influence in the SEMCHB (Kincaid et al., 2007) and can either be a barrier or enabler of behaviour change at the national level (Mathew, 2012).

Gender norms and patriarchy in Zimbabwe

Located on the level of the society of the SEMCHB (Kincaid *et al.*, 2007), patriarchy and gender norms stand as influences in how Chikombedzi females interpret ZNFPC’s IEC messages. The focus groups revealed that patriarchy and gender relations influence the way in which Chikombedzi females make meaning of the messages. Some IEC material advocate for girl child education, however, this message is met with various attitudes and perceptions in relation to social security;

I lack nothing in my home. Yes, my daughter got married early, just after initiation, but now, even if you were to come at my home, I have everything, my son-in-law provides everything for me, so what is the difference? (P5, FG2, 10 Aug 2015).

After us the parents have spent a lot of money sending her to school, she will get married and we will get nothing out of it, and her in-laws benefit at our expense” (P1, FG1, 10 Aug 2015).

It is better to educate a boy, he and his wife will look after us (P1, FG2, 10 Aug 2015).

The sentiments shared above highlight the existence of gender norms which deny the girl child the right to education as compared to the boy child and force her into early marriage (ZYC, 2014). With a limited access to resources at the community level, the boy child is more preferred, by the family at the level of social network, in terms of education. The reason why these gender norms exist is because they are neither contested nor questioned at societal level (Kachere, 2011; Katsande, 2014).

However, one participant held a contrasting view arguing that “the problem with you women is that you are focusing immediate benefits mostly in relation to food and you ignore the consequences of your actions on yours futures of which that should be your concern” (P2,

FG2, 10 Aug 2015). This again points to opportunity for ZNFPC to involve women in the community in addressing barriers to them taking the preferred reading.

The girl child is therefore at a disadvantage as most respondents showed that she is viewed as a cash cow or an investment because of the bride price that her family can get if she gets married early. As P2, FG3, 10 Aug 2015 argued “they say your wealth is the number of beasts we get for your bride price.” His paints a picture of the girl child as just a commodity that provides immediate social comfort, financial security and pride to her parents because of an attractive bride price but the boy child provides social security for a longer period to his parents as he carries the family name (Moyo & Muller, 2011; Shoko, 2009). These views by females contradict Gregson *et al.* (2005) finding that mothers are keener on educating their daughters than the fathers as this study revealed that mothers themselves want their daughters to get married early for social security reasons. Drawing from their responses, it can be argued that poverty and cultural practices lead to the girl child being viewed as a social security object in no need of education. Her reproductive health is not prioritised as a result leading to ZNFPC reproductive health messages being pushed to the periphery by mothers as well as the daughters.

Service delivery

Service delivery though implemented at community level through various municipalities is the responsibility of the societal level (Storey & Figueroa, 2012). Service delivery stands as an influence to the way the females interpret ZNFPC’s reproductive health messages. Included under service delivery is the influencing factor of availability of medication itself. This results in females opting for traditional midwives, healers and churches as alternatives to modern health services though they know the health risks involved (Machinga, 2011; Murisa, 2010).

Service delivery is an influencing factor in reception as these females take previous experiences and fears at the health facilities to assess how they will be served if they seek modern health services as communicated by ZNFPC’s IEC messages. Participants stated that;

When you get to the hospital, the nurses do not even attend to you, they ignore. At the end of the day it is better to just spare yourself the embarrassment (P4, FG2, 10 Aug 2015).

She¹⁶ will tell the whole village that I went for HIV testing and that I am sick...I can get better help from the witch doctor or the apostolic churches and it works (P1, FG2, 10 Aug 2015).

There was a time when the granddaughter of a woman I know was sexually abused, we all heard about it. So if I get sexually abused, and follow the message and go and report to the hospital, she will tell everyone, and I will be embarrassed, what will people say (P4, FG2, 10 Aug 2015).

The nurse knows me, so going there for medical assistance, I will not lie to you, I will not go...am afraid she will tell my mother (P1, FG3, 14 Aug 2015).

I will go and get help from my grandmother...she knows all kinds of herbs and can heal any illness from STIs and terminating pregnancies and she will not tell anyone...the nurses might use me as an example when they come for health education at school (P3, FG3, 14 Aug 2015).

Seeking modern health services is good but it is expensive for some of us and the nurses might tell others, so I will go to Prophet Magaya¹⁷... or the apostolic church, they help (P1, FG1, 10 Aug 2015).

Thus experiences and fears of service delivery influence reception. Associated with the issues of females' socio-economic status, the above perceptions result in the Chikombedzi females interpreting ZNFPC's IEC messages with contempt as they do not believe that the modern health practitioners can keep information and health status private and confidential. The professionalism of local health workers is put into doubt though it is hard to ascertain whether the women's fears are just a myth or reality. This shows the battle between modern, religious and traditional health practices. Therefore, service delivery, implemented at the community level influences females' reception of ZNFPC's female reproductive health communication messages in Chikombedzi. The issues pertaining to services show a disjuncture between the societal intentions and the individual perceptions and the need to bridge this disjuncture through communication.

Physical environment and infrastructure

The physical environment and infrastructure in Chikombedzi play a significant role as influences on how Chikombedzi females make meaning of ZNFPC's female reproductive health messages in posters, pamphlets and booklets. Focus group discussions revealed that

¹⁶ A nurse who was referred to as the one who wears a green uniform at their local health centre

¹⁷ Prophet Magaya is one of the prominent healing prophets in Zimbabwe at the moment

access to health facilities, burden of disease and illness and transportation influence how they interpret the messages and ultimately, behaviour change.

Participants highlighted that “Our roads are bad to the extent that no vehicle comes” (P7, FG1, 10 Aug 2015), “If only they could fix our bridge, because where we stay, no vehicle can come since there is no bridge and the clinics are few” (P6, FG2, 10 Aug 2015). The lack of adequate infrastructure results in IEC materials being left at a centralised point and this impacts on how these females receive the messages as they rarely see them.

The fact that the roads and bridges are not in a good state has resulted ZNFPC neglecting some rural female populations in the communication and distribution processes because they reside in areas and villages that are hard to reach. Infrastructure issues are an indication of a neglected population by the government, something ZNFPC has no control over though it affects the reproductive health status of females. It is this exclusion of the subaltern groups like the Chikombedzi community that results in uneven access to reproductive health messages thus perpetuating an unequal society. This therefore influences their message reception and ultimately behaviour change. The research participants pointed out that their access to health services is limited due to the issue of service delivery topped up with the issues of transportation, roads and bridges and the rural health facilities are limited in Chikombedzi.

Conclusion

Addressing the study’s research questions pertaining to consumption (Du Gay *et al.*, 1997), the chapter presents and discusses attitudes and perceptions, the decoded reading (Hall, 2010/1980) and factors of influence to such reception patterns of ZNFPC’s IEC messages in the light of the SEMCHB (Kincaid *et al.*, 2007). In as much as the ZNFPC is active in the production of the IEC messages (Chapter Five), Chikombedzi females are as much active in the production of meaning during consumption. Having presented and analysed the research findings, Chapter Seven, concludes this study.

CHAPTER SEVEN

CONCLUSION

Introduction

This study explored the production, distribution and reception patterns of Zimbabwe National Family Planning Council's (ZNFPC) female reproductive health communication messages in Chikombedzi, rural Zimbabwe. The first chapter sought to introduce the state of female reproductive health across the globe and then it narrowed its exploratory discussion to Zimbabwe and communication strategies employed by ZNFPC. The second chapter reviewed literature in order to contextualise the study and identify the gap of how, from a Cultural Studies (CS) perspective, ZNFPC's Information Education and Communication (IEC) messages are encoded, distributed and decoded by Chikombedzi females. Chapter Three places the study within the theoretical body of CS by explaining the use of the Encoding/Decoding model (Hall, 2010/1980) and the Circuit of Culture (Du Gay, *et al.* 1997) in analysing the IEC materials. From a social ecological health communications perspective, the Social Ecology Model of Communication and Health Behaviour (SEMCHB) (Kincaid *et al.*, 2007) was employed. The qualitative research methods and data collection procedures are delineated in Chapter Four, leading to the presentation and analysis of archival, interview and focus group data in Chapters Five and Six.

This final chapter, Chapter Seven provides an overall conclusion for the study. This chapter will systematically summarise a response to each of the study's objectives as shown from the collected data and explained through the literature and theory in the previous chapters. It will end with making a few recommendations and suggestions for further research.

ZNFPC's female reproductive health IEC message production/encoding

Involved in the production/encoding of ZNFPC's are issues pertaining to the preferred reading (Hall, 2010/1980) and the culture of production as suggested in the Circuit of Culture model (Du Gay *et al.*, 1997). Culture of production refers to organisational processes involved in the production of a media artefact and these include issues of infrastructure, funds, personnel/professionals involved in the production processes (Du Gay *et al.*, 1997).

Through a semiotic analysis of a selected sample of IEC materials, supplemented by semi-structured interviews of sampled ZNFPC employees, it was established that the preferred

meaning attached to IEC materials during production is behaviour change. Though IEC materials are derived from Adolescents Sexual and Reproductive Health (ASRH), family planning and condom programming, the aim of the IEC materials and messages is behaviour change in these three areas.

There is room for improvement in ZNFPC's production practices as shown by the lack of evidence on the ground to support stated considerations in production. Whereas research and localised production were stated to mark production, there was no adequate evidence of this in the IEC materials sampled where there was no representation of the local Shangani language. In addition one of the MCOs stated that there was no localised production since all IEC materials were produced at national level at ZNFPC Head Quarters (HQ) in Harare. The lack of consensus between the two personnel directly involved in production is telling on production efficiency which needs to be addressed.

During encoding, representations used should be shared between ZNFPC and Chikombedzi females so that meanings are understood and decoded. It is the shared cultural codes that are important in the communication of female reproductive health messages. Cultural codes are codes that hold certain meanings and are shared or common within a group of people (Berger, 2004). Though consumption does not determine behaviour change, culturally-sensitive encoded messages (with specific target readers in mind), and representations result in messages having both cultural and health relevance both to an individual and to the community. The messages are thus likely to be decoded via a dominant reading and are more acceptable. Although reproductive health communication is not prioritised by mass media systems (Nwadiuwe, 2012), ZNFPC's IEC materials, as alternative media, do not appear to adopt a culture-centred approach (Dutta, 2008) in communicating health. This is evident in ZNFPC's production process which has over the years not given much attention to the minority ethnic groups and languages of Chikombedzi in communicating health.

ZNFPC's female reproductive health IEC material distribution

ZNFPC employs various distribution strategies that include Peer Educators (PEs), health and educational facilities. These distribution strategies send the preferred reading of behaviour change in female reproductive health, both directly and indirectly. It is indirect in the sense that ZNFPC distributes female reproductive health IEC materials in schools as a way of trying to influence young women's perceptions and attitudes towards education as a way of financial and reproductive health empowerment and independence. It is also direct in the

view that materials in a health facility communicate a health behaviour message. Though these distribution strategies might reach some of the target readers, responses from focus group participants as well as admission by ZNFPC officials suggest that there is still lack of total reach, therefore presenting the need for innovation and refinement in the methods of distribution.

As revealed by the responses from focus group discussions, involvement of community and religious opinion leaders can help influence the Chikombedzi community towards preferred reading of ZNFPC reproductive health messages, which may lead to behaviour change. This is so because opinion leaders such as village heads and church leaders are viewed as role models in the community and can therefore help in the reinforcement and support of the intended reading. Role models are important as the females learn, adopt and maintain behaviours through others (McKee *et al.*, 2014). As argued by Andrea Cornwall (2008: 281) “participation in rural areas should include the powerful who dominate the lives of the people” and this therefore improves levels of participation and reading.

Access to resources by ZNFPC affects the distribution of IEC materials. ZNFPC receives an annual grant from the Zimbabwean government and funds from organisations that include Global Fund to assist in both the production and distribution of IEC materials. However, as revealed through semi-structured interviews, in some instances insufficient funds result in IEC materials being left at centralised places. This scenario is also exacerbated by inadequate infrastructure such as bridges and roads. Exposure to the messages therefore might be limited and less frequent thereby limiting the effectiveness of the messages. These limitations in distribution in-turn affect individual perceptions and attitudes towards ZNFPC’s reproductive health messages.

Perceptions and attitudes of Chikombedzi females towards ZNFPC’s female reproductive health communication

The focus group sample did not hold the same reading of IEC material messages. Whilst a majority of them held an oppositional reading, some held a negotiated reading and yet a few others had dominant readings.

One participant highlighted that; “I came across one in Shona and I also saw a woman holding one in English, but she used it to make a fire” (P3, FG2, 10 Aug 2015). This shows an oppositional reading in which the message is ineffective and ends up lost (Nwadiuwe,

2012). Findings revealed that the oppositional reading is a result of representations in the form of images and languages used during production, influences from higher levels of influences that can be explained through the SEMCHB (Kincaid *et al.*, 2007). These include influences from family, partner and peers; located at the level of social networks (Storey & Figueroa, 2012). The other levels of influence are explained in the discussion of influencing factors.

The negotiated reading stood differently from the oppositional reading as the focus group participants admitted that the messages were relevant but however showed and stated their resentments. One participant stated that; “yes, the messages are right, they are good, but it’s pointless when the health service providers tell everyone information that is supposed to be confidential” (P1, FG1, 10 Aug 2015). This shows a message that has been understood but is weighed against prior experiences and therefore, these female readers adjust the preferred reading to suit their social situations. This meaning making or reception is also influenced by higher powers or levels of influence as espoused in the SEMCHB (Kincaid *et al.*, 2007).

The dominant reading was also evident as one participant declared that “I have heard, read and understood these female reproductive health issues, the messages are of value to me” (P2, FG2, 10 Aug 2015).

Factors influencing reception patterns of ZNFPC’s reproductive health communication

Following the SEMCHB (Kincaid *et al.*, 2007) as both a theoretical and methodological tool, this study found that factors of influence to the reception (at individual level) of ZNFPC’s female reproductive health messages distributed in Chikomedzi are social networks, community and societal influences.

Located at the individual level of the SEMCHB (Kincaid *et al.*, 2007) are issues pertaining to “behaviour and intention; knowledge and skills; beliefs; perceived risk; self-efficacy; self-imagining; subjective norms” (Storey & Figueroa, 2012: 75). The indicators that were found to mostly influence reading were behaviour and intention, knowledge and skills, beliefs and perceived risk. These were largely barriers to the adoption of dominant reading of the communicated messages.

The individual level of the SEMCHB (Kincaid *et al.*, 2007) is influenced by higher levels as asserted by Storey and Figueroa (2012). Social networks as a higher level are one of the influencing factors. These include family, marriage, groups of friends and peers. This study

found that bounded normative influences that include cultural and group norms, moral decency in Chikombedzi and issues of transactional sex are prevalent and therefore influence how an individual reads and makes meaning of ZNFPC's IEC messages.

At the community level, the lack of involvement of opinion leaders in the female reproductive health communication process was evident. As highlighted by the responses from focus groups, opinion leaders such as village heads and religious or church leaders are important in conducting researches and distribution of IEC materials as they stand as community role models. Therefore, the lack of these opinion leaders in the communication process stands as a barrier to the adoption of dominant readings of ZNFPC reproductive health messages in Chikombedzi.

The final level of the SEMCHB (Kincaid *et al.*, 2007), the societal level stands as a barrier to behaviour change. This is evident through the gender norms and patriarchy that exist and are not contested at societal level. These underlying and unquestioned gender norms that portray the young woman as a cash cow and as one who should be submissive to her male counterpart leaves the female with little or no control over her sexuality and reproductive health decisions. Experiences in service delivery and inadequate infrastructure also stand as barriers to female reproductive health behaviour change.

Recommendations

It appears that despite the stated desire by ZNFPC to engage in Social Behaviour Change Communication (SBCC), based on available evidence there is more of Behaviour Change Communication (BCC) (McKee *et al.*, 2014). There is therefore room for ZNFPC to come up with initiatives to encourage more dialogue and collective participation in a drive geared towards SBCC (McKee *et al.*, 2014). Such an approach would accommodate the unique cultures of communities like Chikombedzi.

It would be in ZNFPC's best interest to improve their distribution strategies to include opinion leaders in the form of religious and community leaders as they are influential in the behaviour change process as highlighted by responses from focus groups. Placing the IEC materials in places other than educational and health facilities would help increase females' exposure to the messages. Such additional places can be those frequented by females such as shops, churches and community meeting areas.

Considering that Chikombedzi is home to the Shangani and Shona, it would be ideal for ZNFPC to produce IEC material messages in their vernacular languages, something highlighted by the MCOs that it is already being implemented in conjunction with Great Zimbabwe University (GZU). The consideration of culturally acceptable dress codes can also help in the encoding of culturally sensitive images that may aid in reduction of barriers to adoption of preferred readings of ZNFPC female reproductive health messages.

Further research

This study employed the theoretical underpinnings of the Circuit of Culture model (Du Gay *et al.*, 1997) from a CS perspective. The moments focused on were production, distribution and consumption (Du Gay *et al.*, 1997), it would add to the current body of literature if future studies would focus on the other moments of the model; identity and regulation or study the entire circuit.

Limited in the scope of this particular study is the generalisation of various female reproductive health issues. It would offer interesting insights if further studies would focus on specific or particular female reproductive health issues and challenges such as cervical and breast cancer in rural Zimbabwe. IEC is just but one alternative to mass media. This particular study was limited to IEC materials and it would therefore be necessary to have future studies exploring other alternatives that include Entertainment Education (EE) in areas and organisations where applicable. Just like IEC, EE can be used for purposive communication (Singhal, 2013).

In this light, it is hoped that this study has laid a foundation for more and further researches in female reproductive health communication in Zimbabwe and beyond.

References

Primary Sources

Marketing and Communications Officer (MCO) 1, (2015), Interviewed by Rosemary Masakadza, at Zimbabwe National Family Planning Council (ZNFPC)- Masvingo Offices, Zimbabwe on 7 August 2015.

MCO2, (2015), Interviewed by Rosemary Masakadza, at ZNFPC-Masvingo Offices, Zimbabwe on 7 August 2015.

Service Delivery Coordinator (SDC), (2015), Interviewed by Rosemary Masakadza, at ZNFPC-Masvingo Offices, Zimbabwe on 7 August 2015.

Focus Group Discussion 1, (2015), Moderated by Rosemary Masakadza, in Chikombedzi, Zimbabwe on 10 August 2015.

Focus Group Discussion 2, (2015), Moderated by Rosemary Masakadza, in Chikombedzi, Zimbabwe on 10 August 2015.

Focus Group Discussion 3, (2015), Moderated by Rosemary Masakadza, in Chikombedzi, Zimbabwe on 14 August 2015.

Secondary Sources

AboutZahr, C. (1995) *Background Paper on Reproductive Health*, WBI Course on Population, Reproductive Health and Health Reform: pp 1-22. Available at: <http://www.info.worldbank.org/pdf> (Accessed on 10 April 2015).

Africa Health Strategy (2007) *Africa Health Strategy 2007-2015: Strengthening the Health Systems for Equity and Development in Africa*, Draft Rev. 2, CAMH/MIN/5(III) Available at: [http://www.nepad.org/system/files/AFRICA_HEALTH_STRATEGY\(health\).pdf](http://www.nepad.org/system/files/AFRICA_HEALTH_STRATEGY(health).pdf) (Accessed on 15 June 2015).

African Economist Magazine (2013) Available at: <http://theafricaneconomist.com/ranking-of-african-countries-by-literacy-rate-zimbabwe-no-1> (Accessed on 19 October 2015).

Agus, Y., Horinchi, S. and Porter, S. E. (2012) *Rural Indonesia Women's Traditional Beliefs about Antenatal Care* Available at: <http://www.biomedcentral.com/1756-0500/5/589> (Accessed on 20 July 2015).

Airhihenbuwa, C. O. and Obregon, R. (2000) A Critical Assessment of Theories/Models used in Health Communication for HIV/AIDS, *Journal of Health Communication*, Vol. 5, pp 5-15 (Accessed on 20 October 2015).

American Cancer Society (2011) *Cancer in Africa*, World Health Organisation (WHO) Available at: <http://www.cancer.org/acs/groups/content/@epidemiologysurveillance/documents/document/acspc-031574.pdf> (Accessed on 5 June 2015).

Babbie, E. and Mouton, J. (2005) *The Practice of Social Research*, Cape Town: Oxford University Press.

Bambura, C. S. (1999) Current Status of Reproductive Health in Africa, *European Society of Human Reproduction and Embryology, Human Reproduction*, Vol. 5, No. 1, pp 1-20.

Bandura, A. (1971) *Social Learning Theory*, United States of America: General Learning Press.

- Bandura, A. (1986) *Social Foundations of Thought and Action: A Social Cognitive Theory*, New Jersey: Prentice-Hall.
- Bandura, A. in Bryant, J. and Zillman, D. (Ed.) (2000) *Media Effects: Advances in Theory and Research* (2nd Edition) Social Cognitive Theory of Mass Communication, Mahwah, New Jersey: Lawrence Erlbaum.
- Bandura, A. (2005) The Primacy of Self-Regulation in Health Promotion, *Applied Psychology: An International Review*, Vol. 54, No. 2, pp 245-254.
- Barker, T. L. (1999) *Doing Social Research*, 3rd Edition, Boston: McGraw Hill.
- Barrett, H. R. (2011) Women, Occupation and Health in Rural Africa: Adaptation to the Changing Socio-economic Climate, *Journal of Occupational Science*, Vol. 4, No. 3, pp 93-105.
- Berger, A. (2004) *Semiotic Analysis*, Sage Publications Available at: http://uk.sagepub.com/sites/default/files/upm-binaries/5171_Berger_Final_Pages_Chapter_1.pdf (Accessed on 9 September 2015).
- Bernhardt, J. M. (2004) Communication at the Core of Effective Public Health, *American Journal of Public Health*, Vol. 94, No. 12, pp 2051-2053, doi: 10.2105/AJPH.94.12.2051.
- Bless, C. and Higson-Smith, C. (2004), *Fundamentals of Social Research Methods: An African Perspective*, 3rd Edition, Lusaka: Juta Education Limited.
- Blood Jr, R. O. And Wolfe, D. M. (1960) *Husbands and Wives: The Dynamics of Family Living*, New York: The Free Press.
- Brennen, B. S. (2013), *Qualitative Research Methods for Media Studies*, New York: Routledge.
- Bulletin of the World Health Organization 2011;89:258-266. doi: 10.2471/BLT.10.083329
- Casas, L. (2009) Invoking Conscientious Objection in Reproductive Health Care: Evolving Issues in Peru, Mexico and Chile, *Reproductive Health Matters*, Vol. 17, No. 34, pp 78-87.

- Chandler, D. (2002) *Semiotics: The Basics*, London: Routledge.
- Chasi, C. T. (2014) Public Health, in: Wilkins, K. G., Tufte, T., Obregon, R. (Eds.) *The Handbook of Development Communication and Social Change*, Wiley & Sons Inc. pp. 92-107.
- Chiremba, T. (2013) *Determinants of Demand for Health Care Services in Rural Zimbabwe: A case of Bikita District, Masvingo Province*, Harare: University of Zimbabwe. Available at <http://www.ir.uz.ac.zw/.../pdf> (Accessed on 23 March 2015).
- Chuma, W. (2005) Zimbabwe: The Media, Market Failure and Political Turbulence, *Equid Novi: African Journalism Studies*, Vol. 26, No. 1, pp 46-62.
- Cornwall, A. (2008) Unpacking ‘Participation’: Models, Meanings and Practices. *Community Development Journal*, Vol. 43, No. 3, pp 269-283.
- Culbertson, H. M. (1968) What is an Attitude. *Journal of Cooperative Extension*, Vol. 6, No. 2, pp 79-84.
- Curtin, P. and Gaither, K. T. (2007) *International Public Relations: Negotiating Culture, Identity and Power*, London: Sage Publications.
- Dhakwa, D. (2011) *A Sexual and Reproductive Health Success Story: Youth Leading Youth*. Available at: <http://www.safaids.net/files/A-Sexual-and-Reproductive-Health-Success-Story-Youth-Leading-SAFAIDS-SAYWHAT.pdf> (Accessed on 29 March 2015).
- Donovan, R. and Henley, D. (2003) *Social Marketing: Principles and Practises*, Australia: IP Comm Print Group.
- Du Gay, P., Hall S., Janes L., Mackay H., and Negus, K., (1997) *Doing Cultural Studies: The Story of the Sony Walkman*, New Delhi: Sage Publications.
- Durden, E. and Govender, E. (Eds) (2012) *Investigating Communication, Health and Development: 10 Years of Research in the Centre for Communication, Media and Society (CCMS)*, Durban: CCMS.
- During, S. (2005) *Cultural Studies: A Critical Introduction*, London: Routledge.

- Durrheim, K., and Wassenaar, D. (1999) Putting Design into Practice: Writing and Evaluating Research Proposal, in: Terre Blanche, M. & Durrheim, K. (Eds.) *Research in Practice: Applied Methods for the Social Sciences*, Cape Town: UCT Press.
- Dutta, M. J. (2008) *Communicating Health: A Culture-centred Approach* Cambridge: Polity Press.
- Dyll-Myklebust, L. (2011) 'Lodge-ical' Thinking and Development Communication: !Xaus Lodge as a Public-Private-Community Partnership in Tourism, Durban: University of KwaZulu-Natal (UKZN).
- Felsen, C. B., Shaw, E. K., Ferrante, J. M., Lacroix, L. J. and Crabtree, B. F. (2010) Strategies for in-person recruitment: Lessons learned from a New Jersey Primary Care Research Network Study, *Journal of the American Board of Family Medicine*, Vol. 23, pp. 523-533 Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2940109/pdf/nihms233976.pdf> (Accessed on 15 July 2015).
- Ferguson, M. and Golding, P. (Ed.) (1997) *Cultural Studies in Question*, New Delhi: Sage Publications.
- Flick, U. (1998) *An Introduction to Qualitative Research*, London: Sage.
- Government of Zimbabwe, (2013) *Zimbabwe's Constitution of 2013*, Available at: https://www.constituteproject.org/constitution/Zimbabwe_2013.pdf (Accessed on 20 July 2015).
- Gregson, P. S., Nyamukapa, C. A., Garnett, G. P., Wambe, M., Lewis, J. J. J., Mason, P. R., Chandiwana, S. K., and Anderson, R. M. (2005) HIV Infection and Reproductive Health in Teenage Women Orphaned and made Vulnerable by AIDS in Zimbabwe, *AIDS Care*, Vol. 17, No. 7, pp 785-794.
- Gribble, J., and Haffer, J. (2008) *Reproductive Health in Sub-Saharan Africa*, Population Reference Bureau Available at: <http://www.prb.org/Publications/Reports/2008/reproductivehealthafrica.aspx> (Accessed on 28 May 2015).

- Grown, C. and Gupta, R. G. (2005) United Nations Millennium Project, *Taking Action: Achieving Gender Equality and Empowering Women*, United Nations Development Programme, Available at: www.unmillenniumproject.org/document/Gender-chapters4-6 (Accessed on 28 May 2015).
- Hagen, I. and Wasko, J. (Eds.) (2000) *Consuming Audiences? Production and Reception in Media Research* Cresskill, New Jersey: Hampton Press.
- Haider, M. (Ed.) (2005) *Global Public Health Communication: Challenges, Perspectives and Strategies*, Canada: Jones and Bartlett Learning.
- Hall, S. (1980) 'Encoding/Decoding', in: Hall, S., Hobson, D., Lowe, A. & Willis, P. (Eds.), *Culture, Media, Language*, London: Hutchinson.
- Hall, S. (1997) *Representation: Cultural Representations and Signifying Practices*, London: Sage Publications.
- Hall, S. (2010) Encoding-Decoding Model (1980) in *Crime and Media: A Reader*, Greer, C., (Ed.) Routledge, pp 44-55, Available at: <http://carleton.ca/.../CRCJ-4001E-FALL-2013-Crime-Media-Pop-Culture.pdf> (Accessed on 28 May 2015).
- Harrington, B. (2003) The Social Psychology of Access in Ethnographic Research, *Journal of Contemporary Ethnography*, Vol. 32, No. 5, pp 592-625.
- Harrison, A. and Montgomery, E. (2001) Life Histories, Reproductive Histories: Rural South African Women's Narratives of Fertility, Reproductive Health and Illness, *Journal of Southern African Studies*, Vol. 27, No. 2, pp 311-328.
- Health and Fitness (2011) "Rural Women turn to Traditional Midwives", (The Standard 17 December 2011) Available at: <http://www.thestandard.co.zw/2011/12/17/rural-women-turn-to-traditional-midwives/> (Accessed on 10 September 2015).
- Hove, M. (2011) Lack of Development in the Midst of Plenty: An Investigation into the Socio-economic Development of Chikombedzi (Gaza Khomanani), District Service Centre 1999-2010, *Journal of Sustainable Development in Africa*, Vol. 13, No. 5, ISSN: 1520-5509.

- Huber, S.C., Adamchak, S. E., Fielder, J. L., Naude, C., Sturgis, R. and Zanamwe, L. (1994) *Zimbabwe Population Sectoral Assessment*, POPTECH Report NO. 94-008-017 Available at: http://www.researchgate.net/profile/John_Fielder2/publication/267955944_ZIMBABWE_POPULATION_SECTORAL_ASSESSMENT/links/54ce6cfd0cf24601c09165f3.pdf (Accessed on 22 April 2015).
- Inter-Agency Working Group on Reproductive Health in Crises (IAWG) (2013) *Information, Education and Communication (IEC) Programmes* Available at: <http://www.iawg.net/resources/iafma1.pdf> (Accessed on 3 August 2015).
- Iwokwagh, N. S., Agbana, B. and Agbana B., (2014) *New Media Interventions for Adolescents Reproductive and Sexual Health: Evidence from Nigeria* Available at: <http://www.cmdconf.net/2014/pdf/31> (Accessed on 4 April 2015).
- Izugbara, C. O. (2000) Women's Understanding of Factors Affecting their Reproductive Health in a Rural Ngwa Community, *African Journal of Reproductive Health*, Vol. 4, No. 2, pp 62-68.
- Janz, N. K. and Becker, M. H. (1984) The Health Belief Model a Decade Later, *Health Education*, Vol. 11, pp 1-47.
- Jones, R. A., Steeves, R. and Williams, I. (2009) Strategies for Recruiting African American Men into Prostrate Cancer Screening Studies, *Nursing Research*, Vol. 58, No. 6, pp 452-456 Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2886148/> (Accessed on 15 July 2015).
- Kachere, P. (2011) *Chikombedzi's Child Brides* Available at: <http://www.chibhebhi.blogspot.com/2011/05/chikombedzis-child-brides.html> (Accessed on 14 May 2015).
- Kaddour, A., Hafez, R. and Zurayk, H. (2005) Women's Perceptions of Reproductive Health Communities around Beirut, Lebanon, *Reproductive Health Matters*, Vol. 13, No. 25, pp 34-42 (Accessed on 20 April 2015).
- Kambarami, M. (2006) *Femininity, sexuality and culture: Patriarchy and female subordination in Zimbabwe*, South Africa: ARSRC.

- Katsande, I. (2014) *Stop Harmful Practices against Youths* Available at: <http://www.herald.co.zw/stop-harmful-practices-against-youths> (Accessed on 14 May 2015).
- Kevany, S., Murima, O., Singh, B., Hlubinka, D., Kulich, M., Morin, S. F. and Sweat, M. (2012) Socio-economic Status and Health Care Utilization in Rural Zimbabwe: Findings from Project Accept (HP TN 043), *Journal of Public Health in Africa*, Vol. 3, No. 1, pp 46, Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3436598> (Accessed on 23 March 2015).
- Kincaid, D. L., Figueroa, M. E., Storey, D. and Underwood, C. (2007) Working Paper *A Social Ecology Model of Communication, Behaviour Change and Behaviour Maintenance*, Centre for Communication Programs, John Hopkins Bloomberg School of Public Health Available at: http://www.thehealthcompass.org/sites/default/files/strengthening_tools/Social%20Ecological%20Model-Ch04%20Storey-Figueroa.pdf (Accessed on 26 April 2015).
- Krueger, R. A. (1998) *Developing Questions for Focus Group*, New Delhi: Sage Publications.
- Kulczycki, A. (Ed.) (2014) *Critical Issues in Reproductive Health*, New York: Springer.
- Kvale, S. (1996) *Interviews: An Introduction to Qualitative Research Interviewing*, California: Sage Publications.
- Lang, S., and Zobl, E. (n.d) *"I am a Cultural Producer": An Educational Project to Create Culture actively and Collaboratively*, University of Salzburg.
- Leclerc-Madlala, S. (2001) Demonising Women in the Era of AIDS: On the Relationship between Cultural Constructions of both HIV/AIDS and Femininity. *Society in Transition*, Vol. 32, No.1, pp 38-46.
- Leve, A. M. (2012) *The Circuit of Culture as a Contemporary Tool for Contemporary Analysis: Examining the Construction of an Education Commodity*, Conference Paper, Sydney, (Accessed on 16 October 2015).
- Machinga, M. (2011) Religion, Health and Healing in the Traditional Shona Culture of Zimbabwe, *Practical Matters*, Vol. 4, pp 1-8.

- Mahmood, N., Durr-e-Nayab and Abdul, H., (2001) *An analysis of reproductive health issues in Pakistan* (Accessed on 10 April 2015).
- Mairiga, A. G., Kyari O., Kullima A. and Abdullahi H. (2007) *Knowledge, Perceptions and Attitudes of Islamic Scholars Towards Reproductive Health programs in Borno State, Nigeria* (Accessed on 10 April 2015).
- Makhlouf-Obermeyer, C. (1999) The Cultural Context of Reproductive Health: Implications for Monitoring the Cairo Agenda, *International Family Planning Perspectives*, Vol. 25, pp S50-S54.
- Manchak, M. (2009) *Cervical Cancer: Global Burden, Treatment and Challenges to Developing Countries*, Available on: <http://www.wwhi.org/media/3415/cervicalcancerreport.pdf> (Accessed on 5 June 2015).
- Mangudhla, T. and Mushava, E. (2015) “Kasukuwere Rallies behind Mudede on Contraception”, *use Newsday* (14 October 2015) Available at: <http://www.newsday.co.zw/2015/10/14/kasukuwere-rallies-behind-mudede-on-contraception-use/> (Accessed on 19 November 2015).
- Maree, K. (Ed) (2007) *First Steps in Research*, Pretoria: Van Schaik Publishers.
- Maringa, G. and Sutherland, C. (2010) Shangani Initiation Ceremonies in Zimbabwe: Traditional Practice and the spread of HIV & AIDS, *CAI Ad-Hoc-Gender Issues in Africa* (Accessed on 20 July 2015).
- Masakadza, C. (2011) *Audience reception of Zimbabwe National Family Planning Council (ZNFPC) health communication messages: A case of Midlands State University students*, Zimbabwe: Midlands State University.
- Mathew, W. (2012) *Cutting into Perceptions: Investigating Men’s Understanding of Protection- through Medical Male Circumcision for HIV Prevention in Durban, KwaZulu-Natal*, Durban: UKZN.
- Marshall, C. and Rossman, G. B. (2011) *Designing Qualitative Research*, 5th Edition, USA: Sage Publications.

- McKee, N., Bekcer, Benton, A. and Bockh, E (2014) Social and Behaviour Change Communication, in Wilkins, K. G., Tufte, T., Obregon, R. (Eds.) *The Handbook of Development Communication and Social Change*. UK: Wiley Blackwell, pp 278-297.
- Melkote, S. R. and Steeves, L. H. (Ed.) (2001) *Communication for Development in the Third World: Theory and Practice for Empowerment*, New Delhi: Sage Publications.
- Ministry of Education, Sports and Culture (MESC) (2007) *Cultural Policy of Zimbabwe*, Harare: Government of Zimbabwe.
- Ministry of Health and Child Welfare (MoHCW) (2009), *Equity and Quality in Health*, Harare: Government of Zimbabwe.
- Moyo, N. and Muller, J. C. (2011) The Influence of Cultural Practices on the HIV and AIDS Pandemic in Zambia, *HTS Theological Studies*, Vol. 67, No. 3, pp 412-417.
- Murisa, T. (2010) *Social development in Zimbabwe*, Development Foundation for Zimbabwe, Discussion paper Available at: http://www.dfzim.com/wp-content/downloads/Social_Development_in_Zimbabwe_by_Dr_T_Murisa.pdf (Accessed on 28 July 2015).
- Muzulu, P. (2014) “Zimbabwe needs Comprehensive Sexuality Education”, *Newsday* (6 February 2014) Available at: <http://www.newsday.co.zw/2014/02/06/zimbabwe-needs-comprehensive-sexuality-education/> (Accessed on 19 September 2015).
- Myers, M. (2008) *Radio and Development in Africa*, A Concept Paper, Canada, International Development Research Centre (IDRC) Available at: http://www.amarc.org/documents/manuals/12481943581Radio_and_Development_in_Africa_a_concept_paper.pdf (Accessed on 15 October 2015).
- Namageyo-Funa, A., Rimando, M., Brace, A. M., Christina, R. W., Fowles, T. L., Davis, T. L., Martinez, L. M. & Sealy, D. A. (2014), *Recruitment in Qualitative Public Health Research: Lessons Learned During Dissertation Sample Recruitment*, The Qualitative Report 2014, Volume 19, How To Article I, pp 1-17 Available at: http://www.nova.edu/sss/QR/QR_19/namageyo-funa_I.pdf (Accessed on 15 July 2015).

- Neuman, L. W. (2014) *Social Research Methods: Qualitative and Quantitative Approaches*, 7th Edition, Essex: Pearson.
- Nightingale, V. (1996) *Studying Audiences: The Shock of the Real*, New York: Routledge.
- Nightingale, V. and Ross, K. (Ed.) (2003) *Critical Readings: Media and Audiences*, Maidenhead: Open University Press.
- Nwadike, C. E. (2012) Theatre for Development: An Alternative Programme for Reproductive Health Communication in Urban Nigeria, *African Sociological Review/Revue Africaine de Sociologie*, Vol. 16, No. 2, pp 102-118 (Accessed on 21 April 2015).
- Nxumalo, N. (2013) *University Cervical Cancer Health Communication Campaigns: Knowledge, Attitudes and Practices of Black Female Students to Services offered at UKZN*, Durban: UKZN.
- Obielozie, E. (2009) Renewing the Face of the Nation of Reveille to the Folk Theatre, *Ama: Journal of Theatre and Cultural Studies*, Vol. 4, No. 1, pp 129-134.
- Oronje, R. N., Undie, C., Zulu, E. M., and Crichton, J. (2011) *Engaging the Media in Communicating Research on Sexual and Reproductive Health and Rights in Sub-Saharan Africa: Experiences and Lessons Learned* <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3121138/> (Accessed on 18 April 2015).
- Patton, M. (1990) *Qualitative Evaluation and Research Methods*, Beverly Hills, CA: Sage.
- Petroni, S., and Fritz, K., (2013) *Improving the Health of Women and Adolescents: An Unfinished Agenda*, Expert Paper No. 2013/12, United Nations (UN), New York, Available at: <http://www.ponline.org/node/579723> (Accessed on 18 April 2015).
- Pickens, J. (2005) Attitudes and Perceptions. *Organisational Behaviour and Health Care*, Sudbury, MA: Jones and Bartlett Publishers, pp 43-75.
- Pitout, M. (2007) Media Culture, in Fourie, P. J. (Ed.) *Media Studies: Media History, Media and Society*, Volume 1, pp 269- 305.

- Piotrow, P. T., Kincaid D. L., Rimon, J. G., Rinehart, W. and Samson, K. (1997) *Health Communication Lessons from Family Planning and Reproductive Health*, Connecticut: Prager.
- Renert, H., Russell-Mayhew, S. and Arthur, N. (2013) *Recruiting Ethnically Diverse Participants into Qualitative Health Research: Lessons Learned*, The Qualitative Report, Vol. 18, No. 23, pp 1-13 Available at: <http://www.nova.edu/ssss/OR/QR18/renert23.pdf> (Accessed on 15 July 2015).
- Ringheim, K. and Gribble, J. (2010) Improving the Reproductive Health of Sub-Saharan Africa's Youth, *Population Reference Bureau*, Available at: <http://www.ljemail.org/reference/ReferencesPapers.aspx?ReferenceID=1340314> (Accessed on 20 May 2015).
- Roseman, J. M. and Reichenbach, L. (2010) Commentary: International Conference on Population and Development at 15 years: Achieving Sexual and Reproductive Health and Rights for all? *American Journal of Public Health*, Vol. 100, No. 3, pp 403-406 (Accessed on 18 June 2015).
- Rosenstock, I. M., Strecher, V. J. and Becker, M. H. (1988) Social Learning Theory and the Health Belief Model, *Health Education Quarterly*, Vol. 15, No. 2, pp 175-183.
- Roudi-Fahimi, F. (2003) *Women's Reproductive Health in the Middle East and North Africa*, Washington DC: Population Reference Bureau.
- Southern Africa AIDS Dissemination Service (SAfAIDS) (2013) *Bridging the Gap: IEC for LGBTI: A Handbook to Support Strengthening of Organisational Capacity in Developing Information, Education and Communication (IEC) Materials for Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) People in Southern Africa* Available at: [http://catalogue.safaids.net/sites/default/files/publications/BridgingTheGap_IEC4LGBTI_Handbook_300813%20\(3\).pdf](http://catalogue.safaids.net/sites/default/files/publications/BridgingTheGap_IEC4LGBTI_Handbook_300813%20(3).pdf) (Accessed on 3 August 2015).
- Scalway, T. (2010) *Presenting the Evidence for Social and Behavioural Communication* South Africa: JHHESA.

- Shabaya, J., and Konadu-Agyemang, K. (2004) Unequal Access, Unequal Participation: Some Spatial and Socio-economic Dimensions of the Gender Gap in Education in Africa with Special Reference to Ghana, Zimbabwe and Kenya, *Compare*, Vol. 34, No. 4, pp 395-424 (Accessed on 11 July 2015).
- Shoko, T. (2009) *Komba: Girls' Initiation Rite and Inculturation among the VaRemba of Zimbabwe*, Harare: University of Zimbabwe (UZ).
- Shumba, K. (2014) 'Just a Snip' Lemba Circumcisers' Perspectives on Medical Male Circumcision for HIV Prevention in Mberengwa District of Rural Zimbabwe, (Unpublished Master's Thesis), Durban: University of KwaZulu-Natal (UKZN).
- Singhal, A. (2013) Introductions: Fairy Tales to Digital Games: The Rising Tide of Entertainment Education. *Critical Arts*, Vol. 27, No. 1, pp 1-8.
- Smailes, S. and Street, C. (2011) *Palgrave Student Companions: The Health Studies Companion*, London: Palgrave MacMillan.
- Southern Africa Development Community (SADC) (2008) *A Sexual and Reproductive Health Strategy for the SADC Region 2006-2015*, Available at: <http://www.sadc.int/.../Sexual And Reproductive Health for SADC 2006-2015> (Accessed on 5 June 2015).
- Soul City Institute of Health and Development Communication (2014) *Audience Reception and Evaluation of Sexual and Reproductive Health Rights (SRHR) Communication Program in Malawi, Namibia, Zambia and Zimbabwe* Available at: <http://www.comminit.com/.../pdf> (Accessed on 23 March 2015).
- Soul City Institute of Health and Development Communication (2009) *Untold Stories in a Time of HIV and AIDS: Audience Reception and Capacity Building Report* <http://www.soulcity.org.za/research/evaluations/regional.../untold%20reportpdf> (Accessed at 20 April 2015).
- Storey, D. and Figueroa, M. E. (2012) Toward a Global Theory of Health and Social Change, in Obregon, R. and Waisbord, S. (Ed.) *The Handbook of Global Health Communication*, pp 70- 94, Boston, MA: Wiley Blackwell.
- Storey, J. (1999) *Cultural Consumption and Everyday Life*, London: Arnold Publishers.

- Swann, K., (2015) *IEC Production Guidelines*, Available at: <http://www.kswann.com/IEC%20Production%20Guidelines.pdf> (Accessed on 31 August 2015).
- Terre Blanche, M. and Kelly, K. (1999) Interpretive Methods, In Terre Blanche, M. and Durrheim, K. (Ed.) *Research in Practice: Applied Methods for the Social Sciences*, Cape Town: University of Cape Town Press, pp 123-146.
- Terre Blanche, M., Durrheim, K. and Painter, D. (Ed.) (2006) *Research in Practice*, 2nd Edition, Cape Town: University of Cape Town Press.
- The Herald Reporter (2014) “Ban Contraceptives: Mudede”, The Herald (15 July 2014) Available at: www.herald.co.zw/ban-contraceptives-mudede/ (Accessed on 11 November 2015).
- The Herald Reporter (2015) “Broadcasting Revolution Underway”, The Herald (19 March 2015) Available at: <http://www.herald.co.zw/broadcasting-revolution-underway> (Accessed on 20 September 2015).
- Tomaselli, K. G. (1996) *Appropriating Images: The Semiotics of Visual Representation*, Denmark: Intervention Press.
- Tomaselli, K. G. (2011) Sham reasoning and Pseudo-Science: Myths and Mediatisation of HIV/AIDS in South Africa. In Tomaselli, K. G. and Chasi, C. (Eds), *Development and Public Health Communication*, pp. 25-50, Cape Town: Pearson.
- Tomaselli, K. G. (2012) Alter-egos: Cultural and Media Studies, *Critical Arts: South-North Cultural and Media Studies*, Vol. 26, No. 1, pp. 14-38 (Accessed on 27 September 2015).
- Tomaselli, K. G. and Mboti, N. (2013) ‘Doing’ Cultural Studies: What is Literacy in the Age of the Post? *International Journal of Cultural Studies*, DOI: 10.1177/1367877912474564 (Accessed on 27 September 2015).
- Turner, G. (1996) *British Cultural Studies: An Introduction*, London: Routledge.
- Turshen, M. (Ed.) (2000) *African Women’s Health*, New Jersey: Africa World Press.

University of California, Los Angeles (UCLA)-Office of the Human Research Protection Program (OHRPP) (2012) *Guidance and Procedure: Recruitment and Screening Methods and Materials*, AAHRPP Elements II.3.C, II.3.D. II.4.A, III.1.E Available at: <http://ora.research.ucla.edu/OHRPP/Documents/Policy/5/Recruitment.pdf> (Accessed on 15 July 2015).

Ullin, P.R., Robinson, T. R. and Tolley, E. T. (2005) *Qualitative Methods: A Field Guide for Applied Research in Sexual and Reproductive Health*, *Family Health International*, San Francisco: Jossey Bass.

United Nations, (1994) *Programme of Action of the International Conference on Population and Development*, paragraph 7.2 Available at: www.iisd.ca/linkages/Cairo/program/p07002.html (Accessed on 20 April 2015).

Joint United Nations Program on HIV/AIDS (UNAIDS), (2012) *Regional Fact Sheet*, Available at: http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/2012_FS_regional_ssa_en.pdf (Accessed on 16 June 2015).

Joint United Nations Program on HIV/AIDS (UNAIDS), (2014) *Fact Sheet*, Available at: <http://www.unaids.org/en/resources/campaigns/2014/2014gapreport/factsheet> (Accessed on 17 June 2015).

United Nations International Children's Emergency Fund (UNICEF), (2006) *Guidelines and Tips on how to organise IEC materials for maximum impact*, Available on: http://www.thehealthcompass.org/sites/default/files/strengthening_tools/Tajikistan%20IEC%20%20Distribution%20Guidelines.pdf (Accessed on 3 August 2015).

United Nations Human Rights (UNHR) (n.d) *Fact Sheet 23: Harmful Traditional Practices Affecting the Health of Women and Children*, Available at: <http://www.ohchr.org/Documents/Publications/FactSheet23en.pdf> (Accessed on 3 August 2015).

United Nations Population Information Network (UNPOPIN) (1994) *Implementations of the International Conference on Population and Development (ICPD) Programme of Action: Guidelines on Reproductive Health* Available at:

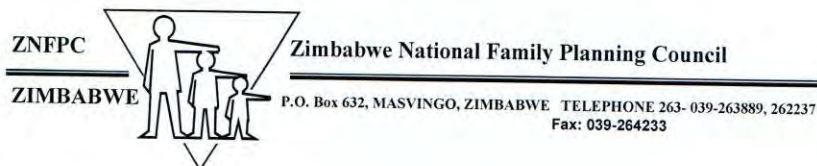
- www.un.org/popin/unfpa/taskforce/guide/iatfreph.gdl.html (Accessed on 15 April 2015).
- Van Leeuwen, T. and Jewitt, C. (2001) (Eds.) *Handbook of Visual Analysis*, London: Sage Publications.
- Valente, T. W. and Davis, R. L. (1999) Accelerating the Diffusion of Innovations using Opinion Leaders, *The Annals of the American Academy*, Vol. 566, pp 55-67 (Accessed on 28 November 2015).
- Walliman, N. (2006) *Social Research Methods*, London: Sage Publications.
- Williamson, L. M., Parkes, A., Wigh, D., Petticrew, M. and Hart, G. J. (2009) Reproductive Health Review: *Limits to Modern Contraceptive use among Young Women in Developing Countries: A Systematic Review of Qualitative Research*, Available at: <http://www.reproductive-health-journal.com/content/6/1/3> (Accessed on 16 June 2015).
- Wood, M. (2011) *Interviewing for Research and Analysing Qualitative Data: An Overview*, Massey University, Available at: <http://owll.massey.ac.nz/pdf/interviewing-for-research-and-analysing-qualitative-data.pdf> (Accessed on 15 June 2015).
- World Bank (2002) *Reproductive Health at a Glance* 23180 Available at: <http://www.worldbank.org/hnp> (Accessed on 30 March 2015).
- World Health Organisation (WHO) (2013) *WHO Guidelines: WHO Guidelines for Screening and Treatment of Precancerous Lesions for Cervical Cancer Prevention*, Available at: http://apps.who.int/iris/bitstream/10665/94830/1/9789241548694_eng.pdf (Accessed on 18 June 2015).
- Wren-Lewis, J. (1985) The Encoding/Decoding Model: Criticisms and Redevelopments for Research on Decoding, in *Media, Culture and Society*, 5th Edition, pp 179- 197.
- Zinanga A. F. (1992) Development of the Zimbabwe Family Planning Program, Working Paper, WPS1053, *Population Health and Nutrition* Available at: <http://core.ac.uk/download/pdf/6242935.pdf> (Accessed 5 May 2015).

Zimbabwe National Family Planning Council (ZNFPC) (1998), *Information Education and Communication (IEC): Reference Manual for Health Programme Managers*, Harare: ZNFPC.

Zimbabwe National Statistics Agency (ZimStats) (2012) Census 2012: Preliminary Report Available at: <http://www.zimstat.co.zw/dmdocuments/CensusPreliminary2012.pdf> (Accessed on 9 September 2015).

Zimbabwe Youth Council (ZYC) (2014) *Eliminating Harmful Cultural and Social Practices Affecting Children: Our Collective Responsibility*, ZYC Available at: http://www.unicef.org/Zimbabwe/Report_on_Harmful_Social_and_Cultural_Practices.pdf (Accessed on 14 May 2015).

Appendix i: Gatekeeper Letter



23/04/2015

Dear: Rosemary Chipo Masakadza (Student number 215079939) (Masters of Social Science Degree in Culture, Communication and Media Studies.)

RE: APPLICATION TO CONDUCT RESEARCH ON FEMALE REPRODUCTIVE HEALTH COMMUNICATION IN CHIKOMBEDZI DISTRICT, MASVINGO PROVINCE.

The Provincial Marketing and Communications Officer wishes to inform you that you have been granted permission conduct your research and have access to information and necessary materials from our staff members, storeroom and target population.

Thank you for showing interest in ZNFPC Masvingo.

For any enquiries, please do not hesitate to get in touch with us.

Kind Regards

Mazvazva. C.



Provincial Marketing and Communications Officer

(For ZNFPC Masvingo)

Appendix ii: Ethical Clearance



13 July 2015

Miss Rosemary Chipo Masakadza 215079939
School of Applied Human Sciences
Howard College Campus

Dear Miss Masakadza

Protocol reference number: HSS/0890/015m

Project title: The production, distribution and reception patterns of Zimbabwe National Family Planning Council's (ZNFFC) female reproductive health communication messages in Chikomedzi District, rural Zimbabwe

Full Approval – Expedited Application

In response to your application received on 10 July 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Dr Lauren Dyllo-Myklebust
Cc Academic Leader Research: Dr Jean Steyn
Cc School Administrator: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3887/038014657 Facsimile: +27 (0) 31 260 4609 Email: zimbap@ukzn.ac.za / arvmanm@ukzn.ac.za / mis@ukzn.ac.za

Website: www.ukzn.ac.za



100 YEARS OF ACADEMIC EXCELLENCE

Principals' Offices: Erigwood Howard College Medical School Pietermaritzburg Westville

Appendix iii: ZNFPC Poster

KUVA MUBEREKI URI MUDIKI KWAKAOMA

Hupenyu hwangu hwaoma

SHINGA HIGH SCHOOL

CLINIC 5 KM

Rega Zvapabonde Ugoita Zvaunoshivira Muhupenyu

Zvibate ugone kudzivirira pamuviri, kana kutora zvinodhaka, uye zvirwere zvepabonde (STIs, HIV ne AIDS)

Tsvaga ruzivo kukiriniki, kuYouth Centre, kana kuna Peer Educator ari pedyo newe.

© 2008 ZNFPC. All rights reserved. Printed in Zimbabwe. ZNFPC Logo

BENEFITS OF FAMILY PLANNING

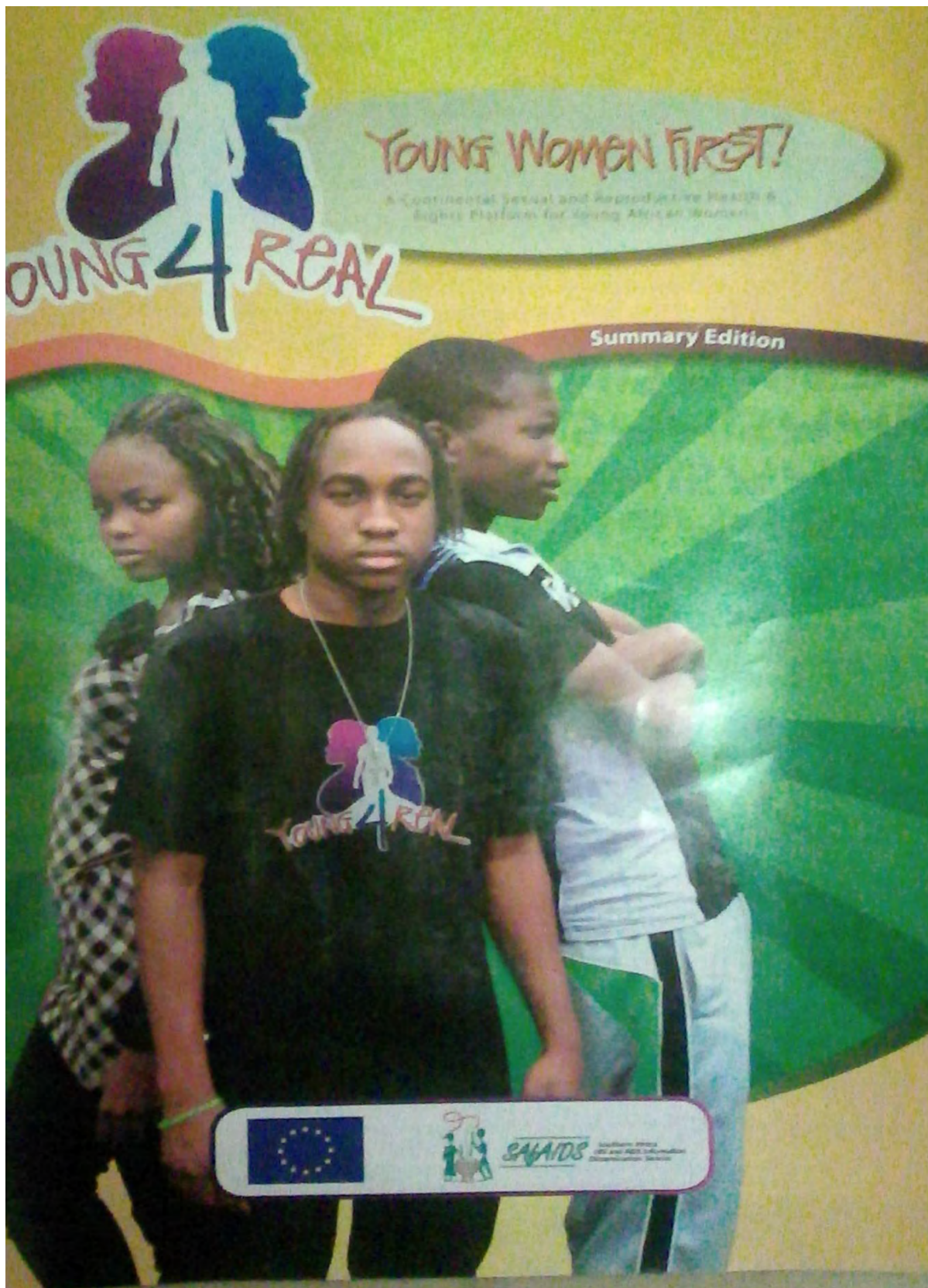


ZIMBABWE NATIONAL
FAMILY PLANNING COUNCIL



FAMILY PLANNING: IT'S YOUR CHOICE

Appendix v: ZNFPC Booklet



Appendix vi: Discussion Guide

With the selected IEC materials present, the following questions were the focus group guiding questions;

1. What does the term reproductive health mean to you?
2. Between males and females, who are the most affected by reproductive health issues?
3. From the ZNFPC posters, pamphlets or booklet we have here, which ones have you seen before?
 - Where?
 - Did you read and understand the message?
4. From the materials here, what are the messages?
5. What do you think about the messages?
 - Would you want to follow any of the messages?
6. In which areas and how would you want ZNFPC to improve in their communication processes with you?

Appendix vii: Interview Guide

The following questions were used as the guiding questions for semi-structured interviews of selected ZNFPC personnel;

1. Can you please introduce yourself?
2. Can you please define reproductive health?
 - Between males and females, who do you think are the most affected?
3. Focusing mainly on Chikombedzi, how are ZNFPC's IEC materials produced?
 - Research
 - Time, place and frequency
 - Languages
 - Funding
4. How and when are the IEC materials distributed?
 - Frequency
 - Funding
5. Can you say your messages are appropriately packaged for Chikombedzi females?
6. How do you see the females of Chikombedzi receiving the reproductive health messages you produce and distribute?

Appendix viii: Informed Consent- Permission to Interview (Semi-structured Interviews)

Researcher	Rosemary Masakadza	0742752245	crmasakadza@yahoo.com
Department	Centre for Communication, Media and Society (CCMS)	+27-31- 2602505	http://ccms.ukzn.ac.za
Institution	University of KwaZulu-Natal (UKZN) Howard College Campus Masizi Kunene Avenue Durban, 4000		www.ukzn.ac.za
Supervisor	Dr Lauren Dyll-Myklebust		ladyll@hotmail.com
Chair, UKZN Human Sciences Research Committee			
If have any further information or questions regarding to this research, please do not hesitate to contact any of the above persons.			

Dear Participant

Thank for taking part in this research. Your input will add significant value to the research project titled *The production, distribution and reception patterns of Zimbabwe National Family Planning Council's (ZNFPC) female reproductive health communication messages in Chikomedzi District, rural Zimbabwe*

The study aims to explore how reproductive health communication messages are produced, distributed and received by females in Chikomedzi. The research is conducted by Rosemary Chipso Masakadza (Student No. 215079939) towards her Master of Social Science degree.

Please be advised that you may choose not to participate in this research study and if you wish to withdraw at any stage, you have the full right to do so and your action will not be of any disadvantage to you in any way.

Your participation in this research will be through an interview or taking part in a focus group discussion. These will be arranged to ensure minimal disruption to your schedule.

Appendix ix: Shona Informed Consent Form

Informed Consent- Bvumo yekuve munhaurirano (Focus Group Discussion)

Zita remudzidzi	Rosemary Chipo Masakadza	0742752245	crmasakadza@yahoo.com
Zvidzidzo zveku	Centre for Communication, Media and Society (CCMS)	+27-31-2602505	http://ccms.ukzn.ac.za
Zita reUniversity	University of KwaZulu-Natal (UKZN) Howard College Campus Masizi Kunene Avenue Durban, 4000		www.ukzn.ac.za
Anotungamira (Supervisor)	Dr Lauren Dyll-Myklebust		ladyll@hotmail.com
Chair, UKZN Human Sciences Research Committee			
Kana muine mubvudzo kana zvamungada kutaura pamusoro petsvakurudzo iyi, zivisai vataurwa pamusoro.			

Wadiwa muverengi

Ndinotenda nekubvuma kwamaita kuve mutsvakurudzo ino. Rubatsiro rwenyu rwakakosha kutsvakurudzo ino iri maererano nekugadzirwa, matumirwo uye magamuchiriro enyu mashoko ehutano hwevanhukadzi hwatinoti female reproductive health, anobvawo kuZimbabwe National Family Planning Council (ZNFPC) muno muChikombedzi, mumaruwa eZimbabwe.

Dingindira retsvakurudzo ino kudakuziva kuti mashoko aya anobva kuZNFPC vaanomawana kupi, kuno anoiswa kunzvimbo dzipi uye imi sevanhukadzi vemuChikombedzi munoagamuchirawo sei. Tsvakurudzo iyi iri kuitwa naRosemary Chipo Masakadza (Student No. 215079939) muzvidzidzo zvake Master of Social Science degree.

Rubatsiro rwenyu rwuri kukumbirwawo kuti muve mumwe weboka revanhukadzi patinoita nhaurirano. Munokwanisa kushara kuenderera mberi kana kusiya tsvakurudzo ino pamungada, hapana chakaipa chingazoitika kwamuri, sunungukai zvenyu.

Ndinokuvimbisai kuti zvichataurwa munhaurirano ino, hazvina wazvichataurirwa, mazita enyu handimabudisi. Zvichabuda pano zvichachengetedzwa kuUniversity of KwaZulu-Natal Howard College Campus, uko kwandinoita zvidzidzo zvangu.

Sainayi kutaridza kuda kubatsira kwenyu

	HONGU	KWETE
Ndanzwisisa kuti nhaurirano ino ndeye dzidzo chete. Zvichabuda zvichaburitswa sechinyorwa chedzidzo nemumagwaro ezvedzidzo netsvakurudzo.		
Zita rangu harifanirwi kuzivikanwa kana kunyorwa.		
Ndanzwisisa kuti zvandichataura zvinogona kuburitswa muchinyorwa chedzidzo.		
Ndanzwisisa kuti handisi kuzobhadharwa kuva muboka rino.		
Ndakasununguka kusiya nhaurirano chero nguva yandingada.		
Ndichataura chokwadi.		
Ndakasununguka kurega kupindura mimwe mibvunzo uye hapana pandichamanikidzwa nenzira ipi zvayo.		
Nguva nenzvimbo yenhaurirano ino inosarudzwawo neni.		
Ndinobvuma kuti nhaurirano inotapiwe.		

Nekusayina bepa rino ndinobvuma kuti ndaverenga ndikanzwisisa zviri mariri.

_____	_____	_____
Zita remuverengi	Signature	Zuva
_____	_____	_____
Zita reari kuita tsvakurudzo	Signature	Zuva